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Approval Sheet

(Re)settled in Health? : An Evaluation of Community Health Promotion Program among Refugees in Clarkston, GA

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(Re)settled in Health? : An Evaluation of Community Health Promotion Program among Refugees in Clarkston, GA

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Bachelor of Arts, Biology
Earlham College
2009

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An abstract of
A thesis submitted to the Faculty of the
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In partial fulfilment of the requirements for the degree of
Master of Public Health
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Abstract

Background: Post-resettlement refugees in the Atlanta area face a gap in accessible health services such as health education and primary health screenings. This gap results from barriers in language, culture, knowledge, and the inability of many to pay for health services. The Health Promoters (HP) Program was designed to address many of these barriers and improve refugee health by training refugee women to promote health within their cultural communities. **Objectives:** To provide insight into the efficaciousness and effectiveness of the HP Program in achieving its primary goal of promoting refugee health and its secondary goal of heightening refugee women's empowerment. Additionally, this study sought to identify those systems or processes that have contributed to the programs successes and limitations. **Methods:** Qualitative research methods were used to address objectives of this evaluation. In-depth interviews and focus groups were conducted with Health Promoters, the communities in which they worked, and program staff and management. **Findings:** While the HP Program has had success in aiding refugees to navigate the linguistic and cultural barriers and has provided valuable health education to communities, its larger objective of improving refugee health has been challenged by inadequate resources. Internal to the implementing organization, the program has suffered from limited human resources and inconsistent funding. Additionally, a lack of external health services accessible to low-income refugees has severely limited the effectiveness of the program. While messages of health promotion are being heard by the target communities, many are unable to act upon those messages due to financial limitation. **Conclusion:** The HP Program has been successful in empowering refugee women to promote health within their cultural communities. However, in order for the program to be succeed in its goal of improving refugee health, additional resources will need to be provided to both the implementing organization and in support of health service provision for low income Atlanta refugees.

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Chapter One: Introduction and Background

Acting as a hub for several active resettlement organizations, including the International Rescue Committee (IRC) and World Relief, refugee resettlement in Atlanta grew rapidly in the late 1980s.[40] Specific geographic communities within the city's perimeter became home to new immigrant populations. Cities lining the perimeter of the metro-Atlanta area such as Clarkston, Stone Mountain, and Doraville were, and continue to be, popular resettlement destinations as they offered access to metro transportation and an abundance of inexpensive housing. As various waves of refugees were resettled into an area (following patterns of international affairs), these insular bedroom communities grew rapidly in diversity to include native central and east African, eastern European, and Asian peoples.

In response to the expanded refugee population, service organizations moved to the area to better provide for this group. However, due to the refugee community's dynamic nature and unique needs, many refugees continue to struggle as a result of gaps in post-resettlement services. Health is one area where these gaps are pronounced.[31] Lifelong US citizens often find health systems in the United States difficult to navigate, and recently arrived refugees find them more so. Challenges in accessing even the most basic services can be insurmountable for those unfamiliar with the system's language and culture. The Health Promoters program, implemented through Refugee Women's Network Inc. (RWN) in Clarkston, GA, was established with the goal of helping refugees to gain access to, understand, and navigate American health systems.[41]

RWN is a small non-governmental non-profit organization, established in 1995. While the Health Promoters program has a specific public health objective, the aim of the organization as a whole is to promote leadership and women's empowerment within the refugee and immigrant community. Most of the programs they facilitate are with the metro Atlanta community, however, they also partner with other organizations to establish and fund programs across the United States. RWN has limited fiscal and human resources. Other programs they fund and/or facilitate include a microcredit lending program for

entrepreneurial refugee women and a leadership training program aimed at empowering refugee women to become leaders within their communities. To sustain these ongoing programs, RWN relies on public and private grants for funding and the assistance of university students and volunteer professionals for human capital.

Across the United States, Community Health Worker (CHW) programs have proven to be effective strategies for improving participant knowledge, effecting behaviour change, and increasing health care utilization among communities suffering from persistent and substantial health disparities.[15, 25, 43,44, 55, 56, 64] CHW programs take many different names and forms. In Atlanta, the Health Promoters program implemented through the Refugee Women's Network is an example of a CHW program created to bring these benefits to the refugee population.

The program was designed to address the ongoing gap in services provided to refugees resettled in the metro-Atlanta area as well as to increase access to the existing health resources.[41] During the process of resettlement, much attention is paid to immediate needs including shelter and employment. Services addressing the long-term health of these communities, such as chronic disease prevention and management, mental health, and nutrition education are often either insufficient or non-existent. The need for accessible services is great and the cost of failing to address the need is significant.[31, 35]

The Health Promoters program has been in existence since 2003. The program was initially conceived as a collaborative effort between Georgia's DeKalb County Board of Health and RWN. Soon after its inception, however, RWN became the sole implementing organization, as the county found themselves without the resources to continue their involvement.[*] The program funds and facilitates the training of cultural/ethnic groups of 10-20 women in leadership development and health education. It works to identify the health topics of greatest need within the communities the women represent and provides participatory education on how to share this information with their communities. Health

[*] Personal Communication with DeKalb Board of Health Staff, July 2010.

Promoters receive an intensive training at the initiation of the cohort as well as continuing monthly education sessions throughout their term in the program. Each cohort is typically funded for twelve months. Since its inception, 65 refugee women have been trained in leadership and health education and have been sponsored to serve as health resources in their communities. The last group of women trained completed the twelve month program in September of 2010. Health Promoters from various ethnic and cultural backgrounds have participated in the program, including Bhutanese, Burmese, Ethiopian, Somali, Burundian, Iranian, Iraqi, Kenyan, and Kurdish.

The Health Promoter program at RWN has undergone several changes in funding, composition of target communities, and leadership over the past 8 years. As a result, it has been difficult to implement a consistent monitoring and evaluation protocol. Aside from monthly activity reports from Health Promoters, little monitoring or evaluation has taken place. The successes and failures of the Health Promoters program cannot be identified without a comprehensive evaluation. A program evaluation is now more important than ever since the program's funding ended in September of 2010 and no additional women will be trained until new funding is obtained. In order to secure more funding for the Health Promoters program, RWN will need to demonstrate to potential donors that the program has indeed had success, and, perhaps more importantly, that its failures and their causes have been identified.[29] Furthermore, RWN has expressed that (once additional funding has been secured) they will be ready and willing to incorporate lessons learned to strengthen the intervention to better serve this diverse and vulnerable community.

In response to this need, I conducted an end-of the program evaluation. The evaluation research sought to answer the following questions:

- Has the Health Promoters Program, been efficacious and/or effective in promoting refugee health?
- In heightening refugee women's empowerment?

- And what systems or processes have contributed to its successes and limitations?

While the results of this evaluation are specific to the subject intervention, much of what was learned will be valuable (if not directly transferable) to similar programs working to promote health among similar populations or given similar challenges. In addition to conducting this evaluation, a colleague and I developed monitoring and evaluation protocols that may be used to further inform the HP program's improvement. These protocols have been provided to RWN and may be used as guides for various small-scale programs with objectives similar to those of the HP programs'. Thus, the work presented here contributes both to the advancement of the specific program studied as well as similar programs that may be facing some of the same challenges.

Chapter Two: Literature Review

A summary of the current literature on refugees, refugee health, and community health workers (CHWs), which aided in forming a foundation for the following evaluation, is provided here. Additionally, a review of several theories in health promotion that support the design of CHW models and, thus, the Health Promoters Program is provided. These include the following: empowerment, community capacity, social capital, and ecological and natural helper theories.

Refugees and Refugee Health

A refugee, as defined by the United Nations High Commissioner for Refugees (UNHCR), is a person who "owning to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself to the protection of that country."[53] In 2009, there were an estimated 10.4 million refugees worldwide. Major countries of refugee origin in 2009 included Afghanistan (2.9 million), Iraq (1.8 million), Somalia (678,000), the Democratic Republic of Congo (456,000), and Myanmar (407,000).[11] As is apparent from the countries of origin, refugee flow closely follows patterns of international and civil conflict.

Once civilian victims of conflict have crossed international borders, becoming refugees, various fates await them. Possible outcomes for refugees include voluntary or forced repatriation, local integration into their host country, or resettlement into a third country.[20] With repatriation at its lowest rate in two decades and integration most often the result of long-term temporary residence, resettlement is often a desirable outcome. Resettlement provides long-term protection for those facing continued persecution from ongoing conflict. Within the international community, it is seen as a responsibility-sharing mechanism and a key component of a comprehensive response to refugee-producing conflict. In 2009, 112,400 refugees were resettled. While this marks a doubling of the resettlement rate since 2000, a large gap remains between the number of applications received by UNHRC and available slots in

accepting nations. Western recipient countries hosting resettled refugees in 2009 included; the United States (79,900), Canada (12,500), Australia (11,100), Germany (2,100), Sweden (1,900), and Norway (1,400).[11] Entry into a host country for resettlement marks the beginning of a new journey for the refugee; often equally as trying as those that came before.

Of those refugees resettled in the United States, 4% are resettled in the state of Georgia.[4] These individuals and families are most often supported by non-governmental resettlement agencies such as the International Rescue Committee (IRC), Catholic Charities, Lutheran Services, and the Refugee Resettlement and Immigration Services. The role of the resettlement agency is to provide for the immediate needs of newly arriving refugees, including food, shelter, clothing, medical attention, education, English language instruction, and cultural training.[9, 20] The period of resettlement refers to the time in which a refugee is receiving support and services from his/her resettlement agency. The funds for these services are provided by the US government for the refugee's first ninety days of residence. After ninety days, a refugee enters the 'post-resettlement' period. While they no longer receive those services provided to them during resettlement, they are offered the same social services as those provided to all US citizens made accessible to them based on earned income.

Maintaining health through the process of migration, resettlement, and post-resettlement is challenging. One's ability to navigate new systems, poor living conditions, limited resources, and those factors impacting the ability of service providers to target this transient population all act as barriers to health.[31] The migration made by resettled refugees, fleeing from persecution, war, or violent conflict in their homeland to a temporary camp and then a resettlement destination, is mentally, emotionally, and physically demanding. These demands add to their pre-existing health profile to create this group's unique and vulnerable health profile.[49,59] Largely out of necessity and a lack of resources, the medical services provided to refugees in the temporary settlement camps are often limited to emergency and curative care.[51] Necessity follows from overcrowding and a lack of infrastructure within the camps, together with the congregation of previously separated peoples, often in poor health which leads to the

spread of disease. Infectious conditions such as diarrheal disease, measles, malaria, respiratory illness and STIs are all common in refugee camps.[50, 52] Prior to entry into the United States, refugees undergo a mandatory health screening to identify and treat communicable disease and chronic health conditions and to assess vaccine history.[52] Upon entry into the US, health services are provided through resettlement agencies, but in the post-resettlement period little support exists for refugee health. After ninety days, it is expected that the resettled refugee will have found work and can largely support himself. Although many are eligible for ongoing services through Medicare or Medicaid, few are ready to access this resource, as language and resource barriers continue to challenge their ability to navigate the foreign systems.[31, 35] The physical conditions and health support infrastructure at the place of origin, in temporary settlements, and in resettlement destinations vary significantly and few refugees will have learned to navigate healthcare in the United States in ninety days.

Refugees have little choice in where they are resettled within the US. While there is some attempt to create intentional communities of refugees, much is left to chance. The housing provided by the resettlement agency is most often in apartments with access to public transportation and in proximity to local refugee services. While occupancy standards must be met by any facility provided through government funded resettlement agencies, living conditions are often not ideal.[10,45,54] Due to these and other issues, refugee communities are often extremely transient. As ethnic communities begin to establish themselves in various parts of the country or within a destination city, refugees re-locate to be a part of these groups. Additionally, as the ethnic identity of newly arriving refugees shifts with international political circumstances, new communities are constantly forming with unique characteristics and needs. In this way, the refugee community is not a single entity but is composed of many distinct ethnic populations. The ever-changing characteristics of a refugee community make the task of providing these individuals with the services they require in an accessible way even more complex. Often these circumstances result in refugees becoming isolated from the help they need.

Community Health Workers in the United States

Community health worker (CHW) interventions are one mechanism that has been used to bridge the gap between service provision and refugee communities. While the use of community members with specific social and intellectual skills in the promotion and delivery of health care has been a critical component of many societies for centuries, CHWs did not commonly appear in published academic discourse until the mid-1960's.[25] The emergence of CHW initiatives during this period was largely in recognition of and in response to the persistent needs of impoverished communities. During the 1960's through the mid 1970's CHW programs were seen largely as a component of anti-poverty strategy rather than part of a public health framework.[55]

This perception changed with the World Health Organization's 1978 Deceleration of Alma Ata. The Declaration emphasized the importance of community-driven primary health care. Significantly, Alma Ata identified CHWs as a critical component of primary health care's successful delivery.[24,61] This declaration as well as the growing emphasis on community participation in health planning and delivery contributed greatly to the rapid expansion of CHW programs in the 1980's, as they inherently included community representation and participation.[62]

A human-resource crisis within health systems grew throughout the late twentieth century, marked by a lack of trained health providers and felt most acutely in areas already under-resourced. In this context, the use of CHWs became increasingly popular as a way to 'fill the gap' in access to care. Internationally, this mechanism is referred to as 'task-shifting'.[63] In task-shifting, the duty called for is performed by the individual with the least training necessary to competently perform that task. Thus, those tasks previously delegated to nurses or social workers may be performed by CHWs with minimal training, freeing the more skilled workers to accomplish tasks of greater complexity.[25,63]

In the 1990's, federal and state governments introduced short-term funding for CHW programs and legislation was introduced in an effort to secure sustainable resources and to standardize CHW

training. While little legislation successfully passed into law in this decade, the national discourse around CHWs had advanced.[55] Despite increased recognition, CHW interventions still lack standardization with regard to definition, role, title, training, pay, etc. and CHW as a profession has yet to emerge.[25,26,34,55]

Today, CHWs go by many names including health promoters, outreach workers, lay health workers, and peer health advisors. This variety is not limited to titles, but reflects the many different roles played by CHWs in the United States. These roles, as they contribute to varying models of care, include; navigators, organizers, members of care delivery teams, education and screening providers, and outreach/enrolling/informing agents.[55] Often, a CHW will not function exclusively within any given model of care, but will perform a myriad of tasks belonging to many or all models.

In the role of navigators, CHWs aid community members in finding their way through the complex maze of the health care system. As target communities served by CHWs are often underserved and/or under-resourced, navigators work with their communities to ensure they know how, where, and when to seek critical health and social services. Organizers work in a self-directed manner to promote, educate, and advocate for action for change with regard to a specific health issue. Many CHWs function as organizers within their communities as they seek to empower individuals or families to come together in support of community health. As members of a care delivery team, CHWs act as subordinate providers of medical services whereby each patient's care is monitored by a team of health professionals, ranging from physician to social worker to CHW. As members of these teams, CHWs function as community liaisons between patient and formal care provider in order to provide continued support in the community setting. In the role of education and screening providers, CHWs perform health screening and deliver culturally appropriate and accessible information to their communities. In this role, CHWs are often recruited to work on a specific health issue with a specific community and are provided topic-based education to perform these tasks. CHWs in the role of outreach/enrolling/informing agents are commonly referred to as outreach workers or coordinators. They function in a similar, however perhaps more

logistic, way as ‘navigators’ as they aid community members in receiving social benefits to which they may be entitled.

Nearly universal to the role of CHWs is that they serve as cultural brokers between the communities they serve (commonly their own) and formal health care markets.[25] CHWs are able to play this role as they often represent those they serve geographically, racially, ethnically, socioeconomically, and linguistically and/or share critical life experiences (for instance, cancer survivors, immigrants, or parents).[2,14,32,47] It is common that CHWs are selected to work in this capacity due to these shared characteristics as well as having attributes such as a history as participation and leadership within their communities.[38,48] According to the National Workforce Study of 2007, “The common traits among these diverse roles have been found to be the commitment of these health workers to both the communities they assisted and the organizations for which they worked, the skill of interacting effectively with both, and the ability to motivate clients.”[55]

Because there is no established definition or occupational code for CHWs within the US health system, reports regarding their numbers and characteristics are often incomplete. A major effort to fill this gap in knowledge was conducted in 2007 with The Community Health Worker National Workforce Study. This study used a National Employer Inventory to access the personal and professional characteristics of CHWs. The study identified 6,300 CHWs working nationwide in 2007 with 3,250 in the state of Georgia. The proportion of those working within the refugee population is unknown.

It was found that a majority of CHWs were female (82%) and between the ages of 30 and 50 (55%). Thirty five percent of CHWs have completed a high school degree and approximately 20% have completed some college work with 31% of those having completed a four-year college degree. The most common ethnic and racial groups focused on by CHW interventions are Hispanics, African-Americans, and non-Hispanic White, respectively. Within these groups, women and adults age 18-49 were the most commonly served populations. Some programs target specific vulnerable populations such as

immigrants, migrant workers, the homeless, or the uninsured. The specific number of CHW interventions among refugee populations in the US has not been detailed.

While no standardized curriculum for post-hire education of CHWs exists, most employers require participation in some program of appropriate training. The two main areas of focus for post-hire education are; the strengthening of those generic skills on which the CHWs were selected (interpersonal skills, communication, cultural competency, etc) and developing "special competencies" to enhance their work in the community. The duration of this training ranged from 9-100 hours. Two states, Texas and Ohio, have adopted legislation requiring the credentialing of CHWs, however, their requirements for credentialing vary considerably.[55]

Most organizations engaging CHWs were small, with 5-50 employees (62.3%). CHWs are most often recruited by these organizations through networking. Churches, local businesses, and clinic-based programs have been identified as popular networking mediums. The funding for CHW programs is most often gathered from two or more sources. Over fifty percent of funding, for most programs, comes from either federal or state grants.[55]

Few studies have comprehensively and systematically reviewed the effectiveness of CHW programs in the United States. Frequently cited research in this area was conducted through the University of North Carolina's Evidence-based Practice Center under government contract with the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality. Published in 2009, this study identifies the strength of evidence for various outcomes of CHW programs. Of the 53 studies examined, 5 suggested that CHW interventions could improve participant knowledge in comparison to alternative interventions (such as pamphlets): 22 suggested effectiveness on participant behaviour change, 27 on health outcomes, and 30 on increasing health care utilization. With regard to improved health outcomes, the outcomes that showed the greatest effectiveness (relative to alternative

interventions) were those aimed at specific disease prevention efforts such as asthma management, cervical cancer screening, and mammography screening.

Many of the limitations of CHW programs arise from the informal nature of the position and programs. The lack of role development within the CHW community has both hindered the mainstream acceptance of CHW initiatives and limited the ability of CHWs and their supporters to establish their identities and work to foster their development in a formal way.[34] In addition to limited formality/standardization and a lack of role development within the CHW community, the often nebulous action plans and difficult to measure goals established by CHW programs can function to limit the success of the interventions.[30,57,60,64,65]

Theories in Asset-based Community Health Promotion

The concept of community health is built on the assumption that communities, whether defined by geography, ethnicity, or some other commonality, share a set of social conditions that contribute to health.[22] If a factor contributing to ill health is shared among/within a community, the community is a logical unit at which intervention should be aimed. Additionally, communities inherently contain assets including cohesion among/between individuals and a variety of skills drawn from both singular persons and collective groups. Community health interventions often incorporate and strengthen these assets as they may contribute to positive outcomes for health. A number of theories that form the foundation of asset-based community health practice are addressed here.

Empowerment Theory:

While definitions of empowerment abound, commonality exists among definitions so that a basic understanding of the concept can be established.[7] This common understanding has been expressed in various phrases. One particular conceptual definition that expresses much of this commonality was developed by the Cornell Empowerment Group in 1989 and reads as "an intentional ongoing process centred in the local community, involving mutual respect, critical reflection, caring, and group

participation, through which people lacking an equal share of valued resources gain greater access to and control over those resources."[37] Some key components of this concept include; engagement with ones' environment, asset-based analysis, individual and community participation, and moving toward action.[13]

Empowerment theory suggests that there are certain processes and outcomes, established through action and social structure, which can lead an individual or community to acquire a greater degree of empowerment. Defining these processes has proven to be difficult, as they vary across populations and environmental contexts. Examples of processes that may be empowering include collective decision making and shared leadership. Outcomes that might lead to or indicate empowerment include the existence of community coalitions, policy leverage, or organizational growth.[37] Being empowered contributes to an individuals' or communities' health status as it allows for personal or collective informed-choice and action toward behavioural or environmental change. This change may be the improved diet of an individual or the establishment of a Neighbourhood Watch to reduce crime and encourage safe outdoor activity.

Community capacity:

The expansion of community health worker interventions has gone hand-in-hand with increased discourse and action toward greater community participation in public health interventions. Community involvement in conceptualizing and defining an issue, identifying a solution, designing an action plan, implementing that plan, and monitoring and evaluating its efforts have been recognized by health professionals as contributing to the overall success of public health projects.[8] Specific methodologies, such as Community-Based Participatory Action Research (CBPAR), have proven to be effective not only in program planning but also for the generation and gathering of objective data.[58] Methodologies such as this emerge from an asset-based paradigm, where it is assumed that the resources (or capacity) exist within the community to solve problems and improve well-being. Community capacity can also be viewed as an important outcome of public health interventions. Programs aiming to build or strengthen

community capacity often employ participatory processes in domains such as leadership, civic engagement, conflict management, and community organizing.[33] These processes encourage communities to become active participants in public health projects as they make personal investments of time and resources that can contribute to their success.

Natural helper models:

Natural helper models build on both community capacity and social capital theory as they rely on the exchange of social support from one community member to another. Natural helpers are defined as "particular individuals to whom others naturally turn for advice, emotional support, and tangible aid."[12] Community health interventions working within the natural helper model seek to identify and employ (although do not necessarily pay) these individuals within a given community to disperse information or services. While these individuals exist naturally in most communities, in public health interventions they are provided with additional resources to be of even greater service in improving the health of their neighbours. The unobtrusive nature of these interventions, however, makes it difficult to demonstrate, operationalize, and empirically capture their impact.[12]

Social capital theory:

Much like other 'you'll know it when you see it' concepts, there are many definitions of social capital. Consistency in scholarship has, however, revealed that social capital is; defined by its function; a property of relationships; facilitates action toward the pursuit of shared objectives within social structures; enabled by networks, norms, and trust, and is able to access resources through membership in social structures.[22] Social capital theory, therefore, stems from the idea that there is inherent value in the formation of alliances and coalitions, regardless of their formality. Alliances contributing to social capital are built on mutual trust and reciprocity, implying that the exchanges that occur within the structure will be beneficial to the whole. Within these groups, collective action toward change builds on those resources that exist within, or are accessible to, its members. The operationalization of social capital

theory consists of two levels; bonding and bridging social capital. Bonding social capital refers to the social solidarity within social groups, while bridging social capital refers to connections between these groups.

Ecological models in health promotion:

Essentially, ecological models in health promotion theoretically illustrate the widely accepted concept that health is determined primarily by social and environmental conditions that lay outside the realm of the individual.[27] Thus, they suggest that a person's behaviour is not a phenomenon based solely on the choice of that person but on a multitude of interacting influences. These influences can be broken down into; interpersonal factors, interpersonal processes and primary groups, institutional factors, community factors, and public policy. Each of these factors carries weight in determining behaviour that impacts health.[28] For instance, a teen faces various influences in making the decision 'to smoke or not to smoke?' *Interpersonally*, s/he may have been taught that smoking is dirty or wrong. Within his peer group, however, it may be common practice (a *primary group* influence) despite the fact that the school he attends doesn't allow it on campus (*institutional* factor). The *community* may allow smoking in restaurants and social spaces, but a *policy* has imposed a steep tax on the cost of tobacco. All of these factors and more are weighed in this individual's decision of whether to participate in a health impacting behaviour.

In conclusion**,** refugees resettled in the state of Georgia come from diverse ethnic and cultural backgrounds. Their struggles with persecution, migration, and resettlement, however, bring them together as a vulnerable population with unique health needs. Georgia refugees struggle to access health services post-resettlement (90 days after arrival). This struggle results from barriers such as limited English proficiency and financial limitation. Community health workers are one mechanism that might be used to close the gap between Georgia's refugees and access to health services. While the CHW model suffers from a lack of role development, it has shown to be an effective model for reaching under-

resourced and minority populations. Several theories in health promotion that support the design of CHW models and, thus, the Health Promoters Program. These theories include: empowerment, community capacity, social capital, ecological and natural helper theories.

Chapter 3: Methodologies

The following study design and methodologies detail the process of data collection with the goal of providing insight to the research questions;

- Has the Health Promoters Program, been efficacious and/or effective in promoting refugee health?
- In heightening refugee women's empowerment?
- And what systems or processes have contributed to its successes and limitations?

Study Design

An evaluation of the Health Promoters Program was conducted during the summer and fall of 2010. It utilized participatory qualitative methods to assess the impact of the program and the processes contributing to its successes and limitations. The use of a qualitative approach allowed for a nuanced examination of the research questions. The nuance arose as multiple perspectives contributed to the formation of the research questions, the tools used to gather data, and the data itself. Cross-sectional semi-structured focus groups and in-depth interviews were conducted with the health promoters, representatives from the communities they served, and RWN staff (past and present). Over thirty individuals participated in a focus group or interview. The data collection took place over a three month period from late August through early November of 2010.

Proposed focus group and interview guides were developed by myself and circulated among a group of volunteer student researchers, Emory University faculty, and RWN staff and board members until consensus was reached regarding their content. This collaborative tool-development served to insure that as many perspectives were incorporated into the study design as possible.[2] Two separate guides were developed: one for the HP and community focus groups, and a second for the key informant interviews. These guides provided a level of continuity between data-collection sessions. The focus groups and interviews were facilitated by a team of graduate students from Emory University's Rollins School of

Public Health. These students had been working with the Refugee Women's Network on a variety of projects associated with the Health Promoters Program since beginning their studies at Rollins (approximately 12 months earlier). At each session, the facilitator prompted discussion with the pre-designed questions and probed the subject/s for more information when needed. The subject/s were allowed to stray from the guide, as was deemed appropriate by the facilitator.

Because levels of English language comprehension varied among HPs and community members, the HPs with stronger skills aided in the translation of the questions and helped to relay the answers in English to the researchers. In both the focus groups and in-depth interviews verbal consent was obtained from all participants prior to the initiation of the activity. Separate verbal consent was taken for both participation in and recording of the session.

Sampling/Recruitment

Purposive sampling was used to identify and recruit active HPs to participate in focus groups. All HPs currently being trained and provided a stipend from RWN were encouraged to participate. No further criteria were used to narrow the characteristics of participants. The participating HPs were stratified based on the ethnic communities they served; Burmese/Vietnamese and Somali/Ethiopian. This stratification was pre-existing, as the HPs were recruited by RWN for participation in the program in this manner. While all active HPs were encouraged to participate, participation was voluntary.

Convenience and Snowball sampling were used to identify and recruit community representatives for participation in focus groups. All active HPs were asked to provide names and contact information for two members of their community with whom they had worked for the purposes of the program and who might be willing to speak with a research team regarding their experience. These individuals were contacted by phone and asked if they would be willing to participate in an interview or focus group. If so, a time and place (most often the home of the community member or their respective HP) was decided upon between the student researcher and community representative. Community representatives were

encouraged to solicit additional community members who had come into contact with the Health Promoters program for participation, and who might be interested in voluntarily participating in the evaluation study. If interested community members were not able to attend a focus group, an in-depth interview was arranged where the same questions were asked of the individual in a one-on-one setting.

In-depth interviews were conducted with key informants, recruited through purposive and snowball sampling. Key informants were identified as individuals who had played a significant role in the design, implementation, or management of the current program or in the past. The first of these were the collaborating staff at the implementing organization. From communication with these individuals (inside and outside of formal interviews), additional persons within the community were identified and contacted for interviews.

Methods

In order to gain an understanding of the effect of the program on the HPs and their communities, semi-structured focus groups (and, in some cases, in-depth interviews) were conducted with these groups. These methods were selected as they allowed for deeper exploration of the research questions regarding the lived experiences of the participants (in comparison to alternative methods, such as a survey). The discussion format both encouraged participants to express their thoughts openly and honestly. Also, the open-ended format allowed for the researchers to probe further into aspects of interest during the data collection. The initial focus groups conducted with active HPs served to lay a foundation for the community focus-groups and key informant in-depth interviews that followed. In this way, the community focus-groups and key informant in-depth interviews were refined to look more deeply at those themes initially identified in the HP focus groups.

The focus groups with HPs took place in August, 2010. They were conducted at the RWN office in Clarkston, GA. The HPs were informed of the meeting's agenda and given a brief explanation of the process prior to their arrival. Two focus groups were conducted, one with each of the ethnically stratified

groups. The number of focus groups conducted with HPs was limited to two, as it was only possible to recruit currently active HPs. One student researcher acted as the primary facilitator for each discussion. The following community focus groups were conducted by an individual or pair of volunteer student researchers in the homes of community members or their respective HPs. Community focus groups ranged in size from five to ten individuals.

Each focus group began their discussion with a Free Listing or Brainstorming exercise. Free listing was used to list and prioritize health issues impacting the refugee community. This exercise both functioned to acclimate the focus group participants to the discussion format and to generate information regarding refugee health priorities, as perceived by the HPs. The lists were taken down on a piece of flip chart paper as they were generated. If one person seconded an issue already listed, a star was put next to that issue on the list to indicate emphasis. Once each participant had introduced them self and contributed to the list, consensus was reached regarding the significance of the listed issues. This supplementary information was later compared with those issues focused on by the HPs in their health promotion activities.

Key informant interviews with past and present RWN staff were conducted to gain insight into the motivation for and implementation of the program. The interview guides were tailored to gain specific information from specific informants. Key informant interviews targeted information regarding the current implementation, successes, and limitations of the program from the staffs' perspective, as well as the overall management structure of the organization.

Each interview and focus group was recorded using a handheld digital recorder and stored both on my personal computer as well as an external hard drive. The data were transcribed by the lead researcher, volunteers with the implementing organization, or a professional transcription service.

Limitations

Because this evaluation was designed and implemented after the implementation phase, the kind of information that could be collected was limited. The incomplete records kept throughout implementation made it difficult to do any quantitative analysis to support or contradict the findings of the qualitative analysis. This lack of baseline data also limits the internal validity of the findings, as no data exists to compare with the outcome measures. While these issues were limiting, it was decided that valuable information could still be generated from a qualitative evaluation despite having no baseline data.

Due to a lack of translation resources, it was necessary for the health promoters themselves to serve as translators during interviews and focus groups with their communities. This may have led to reporting bias by either or both the HP (in inaccurately or incompletely translating the information expressed by the community) and the community members (who may have felt they were unable to express their views regarding the HP or program freely in the presence of the HP). Additionally, the research team relied upon the HPs to recruit community members to participate in these interviews and focus groups. This non-random selection may have resulted in an inflated expression of positivity toward the program and the HPs. Also, in most cases 5-15 community members would be present at each gathering while the interview guide had been designed for only one or two participants. This lead to a shift from what had been intended to be in-depth interviews to a focus group format, as time would not allow for individual interviews with each community member present. While the importance of honesty and trust was emphasized with the participants, the presence of the staff at the HP focus groups and the HPs at the community focus groups may have caused a barrier to the type and depth of information the HPs provided.

Analysis

Textual analysis was conducted using MAXQDA 10 software. The process of textual analysis allowed for the identification of commonly expressed themes within the data such as feelings of

empowerment or frustrations with the program implementation. Aspects of the grounded theory of qualitative research were incorporated into data analysis. Grounded theory was selected as a guiding theory for data analysis as it allowed for ongoing enrichment of inquiry to take place in response to emerging themes identified throughout the research process.[17] Issues identified throughout the process of data collection were noted and resulted in additional questions to be asked. Thematic analysis continued and deepened throughout the process of working with and writing on the data.[5]

Chapter Four: Findings

In presenting the findings of the evaluation, I seek to provide insight into the research questions;

- Has the Health Promoters Program, been efficacious and/or effective in promoting refugee health?
- In heightening refugee women's empowerment?
- And what systems or processes have contributed to its successes and limitations?

I will detail the logistics of the programs implementation and then describe those findings related to refugee health, the HP Programs role in providing health promotion to this group, and the perception of the program from the eyes of the refugees it aims to serve. The following section will respond to the HP program's secondary goal of heightening refugee women's empowerment. Lastly, I will report those findings relating to the challenges faced by HPs and RWN staff.

How the Program Works: logistics

HPs are selected from within ethnically defined refugee communities in the Atlanta area. They are identified by the program director in collaboration with partner organizations including government and non-government refugee service organizations and religious institutions. The program director contacts these organizations directly and requests recommendations for individuals who may be interested in participating. An ideal candidate, as described by a recent director, is a natural community leader or helper in their respective ethnic community who has lived in the US long enough to be familiar with US culture and systems. The ability to communicate with English-speaking health professionals is ideal; however, not all HPs are English speakers. The emphasis put on English fluency is one characteristic of many that has varied greatly from one program director to the next. Generally at least one health promoter per ethnic community is an English speaker. However, some HPs spoke so little English that they could not understand either the researcher or the other participants when they spoke English.

About 10-20 HPs are recruited in each annual cycle. Depending on the ethnic community being approached, challenges in recruiting vary. Some groups, show great interest in the program while with

others, the director struggles to fill the spots. At times, waiting lists have been generated, as more eligible candidates have expressed interest in the program than can be supported at one time.

HPs participate in introductory training in health and community leadership. This training is highly participatory and is based on Freirian methodology.[19] The first class is reserved for orientation and to determine the assets that each HP brings to the training in order to tailor future sessions for the group. In subsequent classes, health topics are generated and selected by the HPs, with regard to their significance in their communities. Grassroots leadership training is incorporated in each session. The introductory training usually lasts 40-50 hours and takes place over a 2-3 month period. Attempts are made to include elements of experiential learning. For example, light physical exercise and reflective journaling have been included in the curriculum. These exercises were aimed primarily at increasing levels of confidence and empowerment among the women as well as building a sense of community within the group. HPs report having enjoyed these elements of the training and feel as though the learning environment created is conducive to personal exploration and growth.

Continuing education sessions occur monthly throughout the HPs' term of service. Health topics are again selected by HPs and incorporate grassroots leadership training. These sessions are designed to build HPs' knowledge of health issues in their community and enhance their communication and technological skills. HPs are asked to facilitate these sessions using PowerPoint presentations, internet resources, or using other skills commonly used to access and relay health information in the US. A monthly stipend of approximately $100 is distributed to HPs at the monthly meetings in return for a tracking form on which HPs record their working hours and activities.

The HPs' primary role during their year of service is to disseminate information to their communities about health resources and preventative strategies. Many also provide assistance to community members for accessing health services. Each HP disseminates health information in his or her own way. For example, one HP hosts a weekly radio program in the national language of her home country. Uniquely, this HP had earned her Master's in Public Health prior to participating in the HP program and was able to use these skills to develop appropriate curriculum to broadcast to her

community. Another HP gives regular presentations at her church after Sunday services. She would ask the church leader to make an announcement before or after the service, after which she would meet with whomever arrived to discuss issues of importance to them. She reported that those who came to speak with her most often had requests for assistance in obtaining a specific health service. Other activities conducted by HPs in fulfilment of their service commitment included; taking clients to the grocery and holding informal cooking classes for nutrition education, investigating local resources and requirements for access to such things as local service provider programs for the uninsured, food stamps, Medicaid, Medicare, and electrical bill assistance, assisting in social service and job applications, driving clients to medical appointments, acting as translators, providing instruction on technology that may be new to clients (ranging from electrical appliances such as stoves to computers), and providing reminders to clients requiring follow up for specific health conditions. Often times the activities performed by HPs are not planned in a formal way but rather arise from requests made by community members at the time of need. For instance, a client may call worried about the condition of her child and may request a ride and translation services at a doctor's appointment that afternoon. In this way, it is difficult for the HPs to plan and prepare for the needs of their clients.

Refugee Health: characteristics, concerns, and issues of access

While the refugee population is often referred to in the literature as a singular community, the data collected reveal several independent ethnic communities, each with a unique health profile. For instance, tuberculosis and hepatitis are issues that have been identified within newly arriving Vietnamese refugees, but these diseases are not significant in the Iraqi refugee community. Likewise, the data showed that ethnic communities differ in how they best take in information regarding health. For example, the highly patriarchal Somali community traditionally does not consider young unmarried women to have valuable knowledge, as she has yet to experience life as a wife and mother. This traditional mindset created challenges for some young unmarried Somali HPs as they tried to communicate health information to their community. "My people... are married and they have kids. So me, if I go to them,

they listen what I say, but they don't really." Despite these differences, many concerns regarding health and access to services were significant to all communities with whom I spoke.

Chronic conditions such as diabetes and heart disease (indicated by high cholesterol and blood pressure), overweight and obesity, and mental health are key concerns across ethnicities. The cause of these conditions is uniformly seen as their relocation to the United States. The abundance of inexpensive food, traditions of large portion size, and a sedentary lifestyle were documented as concerns among the HPs. This sentiment was expressed at multiple points in discussion with the Somali and Ethiopian HP's. A middle-aged Ethiopian HP who had resettled in the US in the late 1980's suggested;

> "The problem is here we eat excess because America has a lot of food and, you know, we have early death. Second, in Ethiopia we walk and work physical (group agreement) so we burn it. Hear we sit and eat… this is lack of education."

Across ethnic groups, I found the primary barrier to accessing health services within the refugee community was their cost. Many I spoke with were not eligible for Medicaid or Medicare, but found that the price of private insurance exceeded their means. When they did access services, they paid the fees out-of-pocket. An Ethiopian woman participating in a focus group said;

> "When I go to clinic... very expensive. I have no money. Sometimes I went to (indiscernible) clinic for my eyes... paid $260. So I have no money. So I stay home. They offer me to go another clinic. So, how much to pay for a visit to Dr. X? $598. So very expensive, much money, so I stay home."

Some said that they had tried to re-apply for Medicaid, but had been told they were not eligible for coverage. This Ethiopian woman expressed frustration, saying; "When you see the Medicaid is disconnect, you go to Defax and reapply, but if you not eligible, who am I going to talk with?" Many of the women with whom I spoke emphasized the significance of their children's health over their own. One mother expressed;

> "... If you don't have money, you cannot think about your own sickness. You're just thinking about the shelters and the children... But if you are focusing on bills and children and education, how can you think about yourself? We are sick, but we don't see our sickness."

Perceived Value of the HP Program

My data indicated that the work of the HPs is highly valued among refugee communities involved with the program. Community members found the information provided by the HPs to be impactful in promoting their and their families' health. One Somali woman, whose words were translated by a friend, said; "We have children, who, if she could not be here, who's going to help us the way we are getting help now?" Many spoke of the importance of having a community member who was familiar with their home culture and the challenges they meet as refugees act as a bridge between their families and healthcare services. In some cases, this was an essential service, as the interpretation offered through the medical provider was inadequate. A Burmese community member explained; "When we live in Burma, many language… so when they call interpreter, they not always understand."

Additionally, the data showed that HPs often serve as the first line of screening for some health conditions. As understandings of health and what conditions are treatable differ across cultures, HPs provide important information allowing community members to recognize infirmity and seek treatment when appropriate. For instance, a Bhutanese woman reported to an HP that she had been hearing voices in her head, feeling sad, and crying. The HP suggested that she accompany the woman to the county refugee health clinic. There, the woman was diagnosed with and prescribed medication for a mental illness. When asked if the woman had known she was suffering from a treatable illness, she said she had not.

The role of the HP Program in Facilitating Personal Growth among Women

Many women who had been trained as health promoters felt empowered on the micro and interface levels as defined in Albertyn's scale of empowerment. Indicators of macro-level empowerment were less apparent. The following quotes attest to senses of empowerment aligned with a number of Albertyn's indicators.[1,23]

TEXTBOX 1: LEVELS OF EMPOWERMENT: SUMMARY OF INDICATORS (Albertyn, 2000:41-43)

Micro-Level		
Ability to accomplish tasks Attitude change Behaviour change Belief in success Certainty of achievement of goals Command over events Competence Confidence Dignity Direct own choices Faith and growth in skills	Feeling of having power over one's life and destiny Improved coping skills Increased control over resource allocation Individual assertiveness Individual determination Individual growth Leadership Motivation New visions and possibilities	Paid work Personal control Pro-active Self-efficacy Self-esteem Self-respect Self-sufficiency Self-worth Sense of agency Upward mobility Use efforts and resources to achieve success
Interface Level		
Ability to effect the behaviour of others Ability to make a difference in the world around us Collective group efficacy Community organisation	Community participation Decision making Exercising influence Feelings of shared fate Group identity Individual assertiveness in group	Mutual support Problem solving Release of hidden resources Support systems Understanding power and status of groups
Macro-Level		
Ability to make a difference and have command over events Awareness of rights and increased collective political power Critical reflection of social problems and understanding their place in society Increased control and access to resources Ready to take action and participate in social change and reconstruction		

Micro level indicators: *Pro-active*, *Sense of Agency*, *Motivation*, *Individual growth*, and *Leadership*

> "I was hungry to talk to my people to learn some health issue... So this is the one that opened my mind and it was the one which opens the door on me to teach people. To talk to people."

> "I definitely like they look at me as a leader, because I'm giving them information that they didn't have. And personally I feel that I've been empowered with the information that I have been given and I have learned so much."

> "When I start this program, I wasn't a leader. I was just a person. But now people are taking me as a leader."

Interface level indicators: *Ability to make a difference in the world around us, release of hidden resources,* and *exercising influence*

> "For me, that makes me feel happy, because I do something for my community which I didn't do it before."

> "And being able to share that information with other people, especially women, it empowers them to make the right decisions in nutrition or whatever it is."

The HPs and staff are in agreement in that both groups largely credited their sense of empowerment with their gain in knowledge. It seemed that it was the act of sharing this new-found information (rather than the act of contributing to the family income or the belonging to a close-knit group) that they found to be empowering.

Challenges faced by the Health Promoters

My data revealed a number of challenges faced by HPs that impact the efficacy of their work. These challenges arise from various sources, one of which is the difficulty of finding an ideally qualified and situated HP candidate. Ideally, all HPs would be reside in and be active participants in their ethnic or cultural community, but it is also beneficial for HPs to be fluent in English and familiar with the US culture and social assistance and health care systems. These two sets of desirable characteristics are often in competition during recruitment. As refugees establish permanent residences apart from the insular lower-cost apartment-style housing where newly arrived refugees (often those with the greatest need) are situated, they are physically separated from the program's target group. One Ethiopian HP expressed in a focus group: "Like her, I don't live in the community. I live outside. My challenge has been how to get [to] this community." In addition to distance, cultural and religious practices also differ between newly

arrived and well established refugees. Those women with whom I spoke who had been in the US the longest tended to have assimilated to US culture to a greater degree than those who had been resettled more recently. For example, two women, one Afghani and the other Somali, had been in the US for over 12 years. Both of these women had stopped practicing the religion of their home country and had adopted a US style of dress, while those HPs newer to the US attended religious gatherings often and wore the traditional clothing from their home country. Factors such as these separate assimilated HPs from their targeted ethnic and cultural community and limit their ability to communicate their learned information to them.

> "My challenge is, because we are immigrants, we have different etiquette, we have different language, we have different religion. It's not centralized. Everybody have own different group, religious group and ethnic group."

On the other hand, HPs who are very much 'in' the community (who live in the apartment complexes with the newly arrived and less assimilated refugees) can be less effective in helping her community than assimilated HPs. For instance, this community focus group expressed that because they and their HP struggle with the same resource limitations, they could not come to her with issues that arose from a lack of resources.

> "We don't ask when we need to go to the doctor. But we cannot go to the doctor because of money. She is like us. We came the same thing. She have the children like us. She don't have Medicaid like us. If we ask her about we cannot go to the doctor, we don't have money... we cannot ask her about that."

Resource limitation impacts the work if HPs in a number of ways. As HPs seek methods to access hard to reach groups and disperse information, they often come across obstacles. Many feel as though community members will not come to events they have organized unless they have a tangible

incentive. When they cannot offer these incentives and people do not come, HPs often become frustrated and stop organizing groups all together.

Additionally, when seeking creative ways to access communities they may not be in direct contact with, HPs often find that the mechanisms of information dispersal available to them are limited. For instance;

> "I tried to get access to radio program you see. The problem is money. Some of the radio, they have don't have money nobody is going to subsidize. There is a program a subsidize radio program but that is very limited in one area and it is not for the Ethiopian community. So this is the hardest thing."

The stipend received by the HPs often goes directly toward mediating these resources limitations. "The money that you get in exchange is that really important to let you do your work." Rather than compensating HPs for their time, many spend their stipend on transportation and to purchase healthy food and drink for nutrition information sessions.

A third way in which limited resources impact the work of the HPs is by limiting access to care for them and their communities. Service providers that offer viable options for low-income and uninsured immigrants and refugees are few. Additionally, those who do offer mechanisms such as sliding scale fees or free screenings often have complex policies that can deter non-natives from accessing them. Another complication is that often times, even though the service or screening is provided free of charge, there are costs associated with laboratory analysis, medications, and follow up procedures. The complexity of all of this often results in the transmission of mixed messages and incorrect information regarding providers.

Challenges faced by Refugee Women's Network

Resource limitations severely constrained the RWN staff in terms of maintaining and sustaining a successful program. While no formal record of the duties required of the HP Program director exists, it is

her responsibility to deliver a program that is consistent with the expectations of the funding entity for that grant cycle. Past funders have included the DeKalb Board of Health and the Center for Disease Control and Prevention. Because of persistent resource limitation, the program director is the only staff member actively involved with the program and is thus in charge of every aspect of its implementation. Additionally, the director would be the individual to collect and analyse any monitoring or evaluation data.

Another difficulty stems from the lack of program norms and continuity in leadership. Apart from an HP Manual, distributed to the HPs and used to guide their training, no established guidelines exist to instruct the director on how to implement the program. This means that how each task is preformed is left to the director. RWN has had approximately five individuals in the director position since the programs onset in 2003. The skill sets of these individuals have varied. While one had earned an MPH in health education, another was interning at RWN when she was informally given the duty of implementing the HP program. Each of these individuals has had to begin her efforts with little to no guidance from the previous director. This, accompanied by the lack of monitoring and evaluation, has meant that the program has had little opportunity to identify and address short comings.

Monitoring and evaluation efforts to inform change benefiting the program objectives have been incomplete and inconsistent. A past director described her efforts as being "...very much the seat of the pants on this thing." While some directors have attempted to collect and analyse information regarding the HPs activities on a regular basis, others have felt that they were too overwhelmed with implementing the program to conduct these tasks.

> "I had two programs to run and to do the recruitment of the leadership training, the facilitations, recruit from all over America and everything, and at the same time do documentation."

In 2007, a formal evaluation of the program was conducted by an outside volunteer. Although current staff was aware of that report, they had not studied or attempted to implement change on the basis of its recommendations. "Yeah, I knew. I knew there were evaluations, but then there was no change."

One staff member felt that it was a less than ideal report, as the person conducting it did not have a close relationship with the program.

With regard to the funding of the program, various groups of HPs received funding from different sources. As is often the case with granters, there were specific stipulations as to what the group would focus on. These stipulations were often based on epidemiologic data indicating the prevalence of an issue in that given community. For instance; "X gave us funding for Somali for TB. And that was the funding... the program I was running after I got it was only focused on TB." While TB prevention and treatment may have been necessary, staff found it difficult to limit the curriculum and activity of the program to TB, since it wasn't an inherent interest of the HPs themselves and thus, may not have been a community priority.

Additional challenges identified stemmed from issues with inter-organization communication and leadership. I found there to be extreme tension between the organizations director and those staff in charge of program implementation. It seems that this was not a result of one specific personality, but rather the lack of any policy or structure to allow for transparency in communication. This lack of transparency is exemplified by the fact that the organizations director was in charge of all fundraising and grant applications but would not inform the program directors of the status of their budgets or the progress being made to secure funding for the programs future. According to several key informants, nearly all past directors of the HP program had left the organization "unhappy" with feelings of frustration toward the management. Program staff felt as though they have little support and that their efforts to garner support (both internal and external to the organization) are stifled by the upper management. A past director expressed her view that this lack of support from the upper management stifled the efforts of the intervention.

> "And just kind of plain and simple, it's just the things that make any program well run. Comes from the top of the leadership and it comes from the middle of good management and it comes from good line- levels of communication."

Chapter Four: Discussion, Recommendations for Change, and Conclusion

The literature indicates that, overall, the HP Program is following an appropriate model for health promotion within the context of the refugee community in Atlanta. The findings corroborated that theory, showing that aspects of the intervention have been effective to some extent. An additional resource informing and assisting in the navigation of the complex US health system has been provided to parts of an under-served and low-resource community. In addition to this added resource, women trained as HPs stated that they felt increased levels of empowerment and attribute that gain to their involvement with the program. Despite frustrations and limitations that have arisen from frequent changes in the individuals occupying the program directors position, the program has maintained these successes throughout.

The effectiveness of the intervention is consistent with predictions derived from the social theories upon which its design is based. Specifically, social capital, community capacity, and empowerment theories that have historically informed successful interventions in community-health promotion, indicate that the HP program has many of the characteristics important to an efficacious design. The program selects natural helpers from the ethnic groups to whom the intervention is aimed. It works with these individuals to combine their innate skills of communication and trust building with the training in health education and leadership provided through the programs curriculum. The curriculum has been intentionally designed to be highly participatory, allowing for the information provided to be developed specifically to the communities' needs as identified and communicated by the HPs. Not only does the participatory pedagogy allow for contextual specificity in development of information and services for the target communities, it also contributes to the empowerment of participants.[35] In turn, the increased empowerment experienced by HPs allows them to actively engage with their community around issues of health, delivering messages of health promotion with confidence. Existing social capital and community capacities, in the form social networks and natural helpers, are leveraged by the program to create an additional resource. These social networks, from which existing resources are leveraged,

derive themselves from commonalities among self-identified cultural communities. For instance, groups of matriarchal Somali women or a group of Burmese who share a linguistic dialect.

These successes, however, have coexisted with a number of challenges. Perhaps the most prevalent and overarching finding was the impact of resource limitation on the program's effectiveness and sustainability. While the implementation of the curriculum seemed to be largely appreciated by the communities, HPs, and staff, major challenges arose for all when these participants come into contact with resource limitation. Resource-driven roadblocks have not only limited the effectiveness of the intervention but have lead to feelings of apathy and disempowerment within these groups as they were consistently asked to do things that seemed impossible given their circumstances in attempt to fulfil the program's goal.

Resource limitation was felt by each group of participants (community members, HPs, and RWN staff) differently. For the community, resource limitation created barriers that meant the health supporting activities being promoted through the HP Program were inaccessible due to their cost. HPs would continually came up against financial limitations when attempting to identify affordable services on behalf of themselves or their communities. They felt as though they were not giving their community what they required for improved health[*]. While RWN staff tried to provide as much support to the HPs as possible, the organization did not have the power to impact those ecological conditions most limiting the program's success (the cost of health services). One past director expressed her frustration in this way. "I try my best to give all the resources possible to them. But the resource is not... so many other barriers... It's something more bigger than the society, systematic." This statement is indicative of the range of impact resource limitation has had on the HP program, as well as the (real or perceived) lack of control the program participants and staff have to mitigate this issue. In being "bigger than the society,

[*] This may also contribute to an explanation as to why the HPs did not express clear indications of Albertyn's macro-level empowerment. Indicated through one's ability to impact systemic and social change and increase control of resources, the resource limitations faced by the HPs is likely correlated with their inability to achieve macro-level empowerment.[1]

systematic", the ability of these individuals to change their condition is restricted. Thus, in order for the HP program to function to its full capacity, these resource limitations must be *systematically* elevated, requiring significant political will throughout local and state governments. However, with the current political and fiscal climate aimed toward decreasing spending on social services, progress toward the elevation of this issue does not seem likely.

Also identified in the data as a major impediment to the HP Programs effectiveness was the lack of inter-organization leadership and management. The duties delineated to each individual within the organization and the lines of communication between individuals were unclear. No policies had been put in place to provide structure to the organizations overarching mission or individual programs: for instance, policies detailing how resources were attained and managed or how staff might appropriately express ideas and concerns to one another and to the management. This lack of structure greatly contributed to an 'every man for himself' mentality within the organization, where staff felt they had or knew no alternative to working independently. This resulted in inefficiency, as efforts were duplicated and opportunities for positive collaboration were missed. The program staff identified the organizations director as the individual who should take the lead in facilitating collaboration among staff. However, the lack of trust between the director and program staff meant that the communication needed for collaboration did not take place. Additionally, staff felt that when they did offer their ideas for programmatic or organizational improvement, competition for credit for the new ideas would further this distrust and foster hostility between the director and staff. This lack of effective leadership and inter-organizational communication has continually limited the success and sustainability of the intervention.[16]

Recommendations for Change

I have made several recommendations to RWN regarding how the HP Program might be made more effective and its successes more sustainable. First, the conditions limiting access to health services should be carefully considered as the program moves forward. Additional resources for health access, such as low or no-cost clinics or expanded Medicaid coverage for refugees, must be established in order to insure that the health promoting messages presented by the HPs are attainable to the community. If this

is not possible, RWN should consider changing the nature of the health promotion messages so that only those for which access can be supported by available resources are presented. Second, clear and attainable objectives linked with appropriate indicators of progress should be established to provide more effective focus to program implementation and the ability to monitor the programs advancement. While staff and HPs have an inherent understanding of the programs over-arching mission, the program currently lacks precisely articulated and attainable objectives. For instance, staff and HPs stated that the program aims to "improve the health of the refugee community", however, the data established that the refugee community is not singular but is composed of many unique populations, each with distinct health needs. This objective might be rewritten to state more precisely; 'The HP Program aims to improve knowledge of healthy weight management among X population by promoting messages of low calorie nutritionally dense food consumption, decreased salt and sugar intake, and daily vigorous physical activity'. Progress toward this objective may be monitored by collecting information regarding an indicator such as 'knowledge of weight management techniques' among the target population. By establishing clear and attainable objectives and precise indicators to monitor their progress, the organization and program participants will be better able to meet the needs of target groups and account for its successes and short-comings. Mechanisms for improving role development among RWN staff and management should be considered as to provide structure to each participant. The precise job description of each individual needs to be clearly defined in a way that takes into consideration the requirements of each position and who might be able to best manage those needs. This may require the restructuring and re-defining of current roles within the organization. Care should be taken to establish clear lines of communication between each employee and put into place mechanisms for delegating work that is beyond the means of any one individual. These lines of communication should include the board of directors, the organizations director, the program director, and the HPs themselves. In establishing this communication system, a safe space (objective and free from judgement) should be created in order to allow these parties to make constructive suggestions for internal changes to programs and management. Additionally, RWN might consider seeking sustainable funding for and recruiting an additional staff

member so that the roles of management and leadership can be separated from those of fund raising. This would both create greater transparency in resource acquisition and allocation and allow the organization's director to focus her efforts of facilitating collaborative work among the staff and advancing the organization's mission within the larger community.

Conclusion

Post-resettlement refugees in the Atlanta area face a gap in accessible health services such as health education and primary health screenings. This gap results from barriers in language, culture, knowledge, and the inability of many to pay for health services. The Health Promoters Program, implemented through Refugee Women's Network, was designed as a strategy to address many of these barriers and improve refugee health. While the HP Program has had success in helping refugees to navigate the linguistic and cultural barriers and has provided valuable health education to communities, its larger objective of improving refugee health has been challenged by inadequate resources. Internal to the implementing organization, the program has suffered from limited human resources and inconsistent funding. Additionally, a lack of external health services accessible to low-income refugees has severely limited the effectiveness of the program. While messages of health promotion are being heard by the target communities, many within these communities are unable to act upon those messages due to financial limitation. In order for the program to be succeed in its goal of improving refugee health, additional resources will need to be provided to both the implementing organization and in support of health service provision for low income Atlanta refugees. While the need is significant among this population, their resulting gains in health and empowerment would not only strengthen the refugee community, but would contribute to the growth of a vibrant city. As expressed by a RWN staff member, "They're so resilient, and they just need a firm, solid ground to plot themselves in and they'll just flourish... they don't need much because they are fighters and they are survivors." Providing this solid foundation in health is a critical step in insuring that these invaluable persons are able to succeed in their new home and contribute fully to the benefit of all.

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Appendix 1

Refugee Women's Network

Health Promoters Program Evaluation

In-depth Interview Guide

September 13, 2010

Qualitative data collection through in-depth interviews will be conducted to explore the questions of;

"In what way/s has you or your families' wellbeing been influenced or impacted by the RWN Health Promoters Program?"

In-depth Interviews: Seven to twelve in-depth interviews will be conducted with members of the Atlanta refugee community to gain an understanding of how the Health Promoters Program conducted by Refugee Women's Network has impacted the health of community members. These interviews will be semi-structured, in order to allow for appropriate probing into any generative themes identified during the course of the interview.

> Recruitment: Community members will be referred to RWN by the Health Promoters that they work with. A meeting will be arranged between a student interviewer and the community member to suit the community members' needs. It is expected that most interviews will take place either in the referring Health Promoter's home or in the home of the community members themselves. If necessary, translation will be done by the Health Promoter. If this causes dis-ease or feelings of insecurity for the participant, an alternative location and/or translator will be agreed upon. Options for alternative locations include: the Clarkston Community Center, the Refugee Women's Network offices, and local churches. Alternative options for translators include other family and community members.

Introduction: Interviewer will briefly introduce herself. Provide name, occupation or topic of study, what questions they are hoping to gain insight into during the interview. Interviewer will note that the information shared will be confidential, the information will be used to improve the Health Promoters Program, and that they may stop the interview at any time.

1. Before we begin, is it alright if I record our interview?
2. Do you have any questions about this process?
3. Is there anything you would like me to clarify for you?
4. Is there anything else you would like to know about this project?

Warm up Questions:

5. Tell me a little bit about yourself.
    a. How long have you been in the US? Clarkston?
    b. Tell me about your family.
6. What are some of the major health issues impacting your community?
    a. How do you know that these are issues?
7. Tell me about the relationship you have with X Health Promoter.
    a. How did you first meet?
    b. How often do you see each other? What do you usually talk about?
    c. Do you ever speak about health? Your health? Your family's health?

Key Questions:

8. Tell me about a time when you came to X health promoter for help?

    a. What was the issue?

    b. Can you tell me more about that experience?

    c. What information did she share with you?

9. Did you feel as though she knows a lot about most health issues of concern to you?

10. What, if any, resources did she provide you with?

11. Did you follow up on any of the information/suggestions that X gave you?

12. What might have happened if X weren't available?

    a. Why would you have gone to them second?

    b. How might your experience have been different if you had gone to them?

13. Have you ever come to X seeking help for a non-health related issue?

    a. What was the issue?

    b. Why did you come to X?

14. Tell me about a time when you needed to see a doctor but you didn't?

    a. Tell me more about that.

    b. Did you ask X for her advice about your health in that situation?

15. How do you usually pay for health care services?

16. What do people in your community think about the Health Promoters?

    a. What have they said about their experiences?

Closing Questions: At this point, the interviewer will thank the participant for their participation and for sharing their stories and time.

17. Is there anything else you would like to share with me?

18. Do you know of anyone who might want to speak with me about the Health Promoters Program?

Appendix 2

Interview Guide for Key Informant Interviews

1. How were you first introduced to the health promoters program?
2. What where your thoughts feelings impressions regarding its purpose when you were first introduced to it?
3. What do you feel is its main purpose?
    a. Secondary purpose?
4. Are these gaps that need filling in the refugee community?
5. Do you think that the program is helping to fill these gaps?
    a. Why or why not?
6. What about the program is working?
    a. What makes a successful hp?
7. What about the program is not working?
8. What do you fear would come from this programs failure?
9. Tell me about the transitions the program has gone through over the past few years?
    a. Has this been difficult?
        i. How?
    b. Have you been involved in these transitions?
        i. How?
    c. Have you done things to try to mitigate these accompanying difficulties?
        i. What? How did that work? What was successful?
10. Do you have a vision for this program?
    a. What is it? How is it different from what exists now?

Added inqueries:

1. What was your working understanding of empowerment during this your time at RWN? How did it impact the direction of the program?
2. How do you feel the power structure within the implementing organization works?
    a. Does this have an impact on the program?
    b. On the way the communities are engaged?
3. Similar programs within refugee resettlement community?