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Since 1975, the United States has resettled over 3 million refugees fleeing persecution from conflict areas. Regardless of heterogeneity in cultural practices, religion and socioeconomic status, refugees collectively experience adverse health outcomes related to stress of displacement, trauma and/or torture compared to the general population. Practical stressors like financial constraints, legal status change, fragmented families and households, transportation, lack of culturally appropriate care and language barriers limit access to healthcare for refugees. Fortunately, community health workers (CHWs) are able to help connect refugees to healthcare through culturally appropriate strategies. Utilization of (CHWs) has been upheld as an effective model to increase community involvement in health promotion and health education. This study used a constructivist grounded theory lens to explore experiences specific to connecting refugee communities to the healthcare system. Data was collected through individual in-depth interviews and a demographic profile questionnaire with a purposeful sample of 10 CHW participants. Knowledge gained was used to develop an informal theory to allow for an improved understanding of CHW roles, strategies and burdens.

HOW COMMUNITY HEALTH WORKERS AFFILIATED WITH A PROGRAM
IN GREENSBORO, NORTH CAROLINA PROMOTE ACCESS TO
HEALTHCARE IN REFUGEE COMMUNITIES

by

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Committee Chair

I dedicate my dissertation to my parents, Dr. J.C. Eluka and Dr. M.A. Eluka. Thank you for your unconditional love, provision and encouragement. Thank you believing in me when I did not believe in myself. I now see what you saw in me and it is my mission to live your legacy and fulfill my God-given destiny. Cheers to good health, happiness and many returns on your investment!

APPROVAL PAGE

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TABLE OF CONTENTS

	Page
LIST OF TABLES	ix
LIST OF FIGURES	x
CHAPTER	
I. BACKGROUND AND STUDY INTRODUCTION	1
Introduction to Focus of Study	1
Statement of the Problem.....	2
Research Questions.....	4
Overview of Methodology.....	5
Definition of Terms.....	5
Refugee	5
Immigrant.....	6
Constructivist Grounded Theory.....	6
Access to Health	6
Resettlement.....	6
Assumptions/Limitations/Delimitations	6
Purpose of the Study	7
Significance of the Study	7
Organization of the Dissertation	9
II. LITERATURE REVIEW	10
The United Nations Refugee Agency	10
Brief History of Immigration Policy in the United States	13
Sociopolitical Climate and Access to Care.....	17
Access to Care for Refugees	18
Community Health Workers: A Primary Health Access Intervention	20
Challenges for CHWs	21
CHWs Serving Refugees	22
Natural Helper Model	24
Gaps in the Literature: The Missing Perspectives of CHWs	25
Importance of This Study.....	26

III. METHODOLOGY	28
Research Questions	28
Research Design.....	28
Setting	31
Participants and Data Collection.....	34
Theoretical Sampling and Theoretical Saturation.....	36
Demographic Questionnaire	37
Interviews.....	40
Data Analysis and Interpretation	42
Coding and Memoing	43
Constant Comparative Content Analysis	44
Ethical Considerations	45
Limitations	46
Expected Outcomes from Study Methods	47
IV. THE WHEEL OF MY WORK: MAPPING COMMUNITY HEALTH WORKER ACCESS TO CARE PROCESSES FOR SERVING REFUGEES	48
Abstract	48
Introduction.....	48
Methods.....	50
Approach.....	50
Sample.....	50
Data Collection Procedures.....	51
Data Analysis	52
Results.....	53
Overview	54
Why Do I Do What I Do?.....	54
Refugee Background.....	54
Love for Community.....	55
What is My Job?	56
Type of CHW and Interpretation of Role	56
Full time CHWs: Emma and Baba.....	56
Contractor CHWs: Heaven and Burmerican.....	58
Student CHWs: Prakriti, Rachel, and Barbara	58
Access to the Healthcare System	59
How Do I Do My Job?.....	60
Communication with Clients	60
Gaining Trust	61

What Are the Challenges to My Job?	61
Boundaries	62
Health Insurance	63
Discussion	64
Limitations	65
Conclusion	66
V. “IF THERE'S A WAY I COULD HELP, I WILL DO MY BEST”: COMMUNITY HEALTH WORKER PERSPECTIVES ON ROLE ENACTMENT	67
Abstract	67
Introduction.....	67
Methods.....	69
Setting	69
Sample.....	69
Data Collection Procedures.....	70
Data Analysis	71
Profile of CHWs	71
Reflexivity.....	74
Results.....	75
Communicating.....	77
Building Trust.....	77
Advocating.....	78
Interpreter.....	80
Discussion	80
Limitations	82
Conclusion	83
VI. DISCUSSION AND IMPLICATIONS	84
Restatement of Purpose.....	84
Key Findings.....	84
Significance of the Study	86
Recommendations and Future Research.....	86
Epilogue	87
REFERENCES	90
APPENDIX A. EMAIL RECRUITMENT SCRIPT	106
APPENDIX B. IN-PERSON RECRUITMENT SCRIPT	107
APPENDIX C. TELEPHONE RECRUITMENT SCRIPT	108

APPENDIX D. INDIVIDUAL INTERVIEW GUIDE	109
APPENDIX E. DEMOGRAPHIC PROFILE QUESTIONNAIRE.....	110
APPENDIX F. IRB INFORMATION SHEET	111
APPENDIX G. PERMISSION LETTER	113

LIST OF TABLES

	Page
Table 1. Rationale for Data Collection Methods	36
Table 2. Individual Interview Guide	42
Table 3. Community Health Worker Demographic Characteristics N=10.....	52

LIST OF FIGURES

	Page
Figure 1. United States Refugee Resettlement Ceiling and Refugee Arrivals from 1975 to 2018.....	16
Figure 2. Demographic Questionnaire	39
Figure 3. The Constructivist Grounded Theory Coding Process	44
Figure 4. Map of Community Health Worker Access to Care Work.....	53
Figure 5. Interpretation of CHW Role	76

CHAPTER I

BACKGROUND AND STUDY INTRODUCTION

Introduction to Focus of Study

Refugees in the United States have been marginalized throughout the nation's history. Refugees, who by definition are legal immigrants, have less healthcare access and experience worse health outcomes compared to the general population (Crosby, 2013; Wagner, Burke, Kuoch, Scully, Armeli & Rajan, 2013; Wong, Schell, Marshall, Elliott, Babey & Hambarsoomians, 2011; Mishori, Aleinikoff & Davis, 2017). Access to healthcare is one of the most frequently expressed needs among refugees (World Health Organization, 2010). However, barriers such as culture, language and socioeconomic factors limit healthcare access (Mishori, Aleinikoff, Davis, 2017; Crosby, 2013; Wagner, Burke, Kuoch, Scully, Armeli & Rajan, 2013; Wong, Schell, Marshall, Elliott, Babey & Hambarsoomians, 2011; Langlois, Haines, Tomson & Ghaffar, 2016).

Community health workers (CHWs), who are typically members of the communities with training on outreach and education, have connected refugees to care through culturally appropriate health communications (Arvey & Fernandez, 2012; World Health Organization, 2008; Mirambeau, 2012; Nunnery & Dharod, 2015). CHWs have ameliorated sociocultural and structural barriers to healthcare access such as language, culture, and perceptions of distrust, and have been efficient in reaching refugee populations (Arvey & Fernandez, 2012; World Health Organization, 2008; Mirambeau,

2012; Nunnery & Dharod, 2015). CHWs combine insider knowledge of refugee communities with the ability to navigate complex American social and healthcare systems (Langlois, Haines, Tomson, & Ghaffar, 2016; Arvey & Fernandez, 2012; World Health Organization, 2008; Mirambeau, 2012; Nunnery & Dharod, 2015). In order to leverage these talents and skills to increase healthcare access, CHWs must understand where and how to best align and insert multifaced strategies to help improve refugee health (Arvey & Fernandez, 2012).

Little is known about what strategies CHWs choose to implement in order to positively impact refugee health and well-being. Specifically, an examination of how CHWs perceive their job and how they do their job is important because it could potentially impact CHW efforts to increase healthcare access and utilization among refugees. Moreover, obtaining CHW perspectives on their experiences is a critical need as it will help inform selection, training and support for agencies implementing community focused CHW programs. Lastly, shedding light on CHW voices is needed because for decades, their efforts have consistently provided refugees with access to healthcare services that have led to improved health outcomes (Woolhandler & Himmelstein, 2017). There is, however, a noticeable gap in the literature on the specific details of these CHW efforts, and how they lead to increased healthcare access for refugees.

Statement of the Problem

Since 1975, the United States has resettled over 3 million refugees who fled persecution from conflict areas (Mishori, Aleinikoff & Davis, 2017). Regardless of

heterogeneity in cultural practices, religion and socioeconomic status, refugees collectively experience adverse health outcomes related to the stress of displacement, trauma and/or torture compared to the general population (Mishori, Aleinikoff, Davis, 2017; Crosby, 2013; Wagner, Burke, Kuoch, Scully, Armeli & Rajan, 2013; Wong, Schell, Marshall, Elliott, Babey & Hambarsoomians, 2011). These issues have consistently presented challenges to efforts aimed at improving overall health in refugee populations (Mishori, Aleinikoff & Davis, 2017). Lack of skills for navigating the complex United States healthcare system especially makes it difficult for refugees to access care and often results in worsening of already poor health (Woolhandler & Himmelstein, 2017). Practical stressors like financial constraints, immigration status, fragmented families and households, limited transportation options, lack of culturally appropriate care and language barriers further limit access to healthcare for refugees (Dow, 2011; Langlois, Haines, Tomson & Ghaffar, 2016).

On the other hand, CHWs help to connect refugees to healthcare through culturally appropriate health communications. CHWs are trusted public health workers who share the same language and culture and have an unusually close understanding of the community served (American Public Health Association, 2009). Previous literature lends support for refugees being more trusting of members of their own community and more likely to participate in a program when such persons help them better understand program components (Johnson, Ali & Shipp 2009; Nunnery & Dharod, 2015). By talking to members of the target population, CHWs help to increase community involvement in health promotion and health education and subsequently help to reduce barriers to

healthcare access (Arvey & Fernandez, 2012). CHWs in this study were individuals who worked with the University of North Carolina at Greensboro's Center for New North Carolinians (CNNC) and, specifically, its Immigrant Health Access Project (IHAP) to bridge existing access to healthcare gaps in refugee communities. IHAP has been utilizing community health workers as an intervention strategy since 2001 to help connect immigrant and refugee clients in the greater Greensboro area with access to healthcare. Typically, IHAP reaches about 600 clients per year and is funded through the Cone Health Foundation, a local health foundation affiliated with the local hospital system (CNNC IHAP, 2019). In recent years, IHAP has reported dwindling numbers of refugee clients accessing local healthcare resources which they are qualified (CNNC IHAP, 2019). If this trend continues, it is projected that refugee health outcomes will progressively worsen and negatively affect future family generations (Lu & Halfon, 2003). It is therefore imperative to obtain CHW feedback on recent challenges in health access and identify how these challenges can be tackled through enhanced training of CHWs and informed CHW program planning (Boyd, Mogul, Newman & Coyne, 2011).

Research Questions

The overarching aim of this study was to examine how CHWs promote access to care within the refugee communities that they serve. This aim was achieved by a qualitative exploration of one research question and one sub-research question:

- How do CHWs who work with refugee communities in Greensboro, NC connect refugee clients with access to the healthcare system?
 - How do CHWs perceive their role?

Overview of Methodology

The specific qualitative research inquiry method that I used in this study was constructivist grounded theory (CGT) by Charmaz (2014). Constructivist grounded theory is a systematic social sciences methodology and a version of grounded theory. It takes into account the subjectivity of the researcher and posits that data and theory are constructed by the researcher through interactions with social processes (Charmaz, 2014). Using this approach helps researchers build an informal theory to describe the research topic studied (Charmaz, 2014). I used CGT as a lens to explore perspectives and experiences of CHWs working with refugee communities to examine how they did their job of connecting communities to the healthcare system, with a specific focus on how they perceived their role. I conducted individual semi-structured interviews and a brief close-ended demographic questionnaire with a purposeful sample of 10 CHW participants.

Definition of Terms

Refugee

According to the United Nations, a refugee is someone who “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country” (UNHCR, 1951).

Immigrant

A person who comes to a country to take up permanent residence (Merriam-Webster.com, 2019).

Constructivist Grounded Theory

Constructivist grounded theory is a version of grounded theory that accounts for the subjectivity of the researchers and posits that data and theory are constructed by the researcher through interactions with social processes (Charmaz, 2014).

Access to Health

Access to health services is defined as the use of personal health services to achieve the best health outcomes within a timely manner (Institute of Medicine, 1993).

Resettlement

Resettlement is defined by UNHCR as “the transfer of refugees from an asylum country to a country that has agreed to admit them and ultimately grant them permanent settlement” (UNHCR, 2018).

Assumptions/Limitations/Delimitations

In this study, I selected a purposeful sample of 10 CHWs affiliated with The University of North Carolina at Greensboro’s Center for New North Carolinians (CNNC). These CHWs did not represent all the refugee groups residing in Greensboro, North Carolina; however, they represented the most populous groups in Greensboro and those served through CNNC. The CHWs who worked with the CNNC represented a mix of student interns, contractor CHWs, and full-time CNNC staff members who had CHW responsibilities included in their roles.

Purpose of the Study

This study aimed to identify how CHWs did their job and how they perceived their role. It examined CHW experiences and perspectives on connecting refugee communities with the healthcare system. The unique contribution of this study was that the sample included CHWs who have served different refugee groups from a heterogeneous group of countries, compared to prior studies focused on CHWs working with Latino immigrants. Thus, I anticipated that interviewing this mixed group of CHWs would uncover the similarities and differences in their approaches.

Significance of the Study

Through my four-year employment as a graduate assistant with the CNNC (2016-2019) and experience as an administrative support personnel with IHAP, I noticed that: although utilization of CHWs appeared to be an effective strategy in connecting refugees with the healthcare system, there was limited focus on the actual access to care strategies used by CHWs, and; little documentation about the shifting roles and associated struggles CHWs experience when connecting members to healthcare, particularly during a time of shifting immigration policy. Further, much of the literature on CHW-based interventions with refugees lacked inclusion of or emphasis on the CHWs' perspectives on doing this work.

I decided to focus my dissertation on these areas to help to bridge the gap in the literature and create better understanding about CHWs roles and practices when connecting refugee adult clients to the local healthcare system in Greensboro. Therefore, this study brings attention to 1) refugees, an overlooked minority population whose first

line of access to healthcare is often through CHWs, and 2) CHW perspectives and experiences within efforts to advance refugee access to healthcare. CHWs ability to leverage trusting relationships with refugee communities is essential to promoting access to care and improving overall population health (World Health Organization, 2008; Nunnery & Dharod, 2015). It was necessary to incorporate CHWs' voices because they are trusted key informants and natural helpers within their communities and are experienced in connecting community members with the larger healthcare system (Arvey & Fernandez, 2012; Nunnery & Dharod, 2015; Israel, 1985). This study departed from prior studies which have looked at client or skilled healthcare provider perspectives, to focus more on CHWs as liaisons between their communities and the larger healthcare system.

This study was new and meaningful because it focused on a more expansive investigation of perspectives and experiences of CHWs involved with promoting refugee healthcare access. The findings contributed to development of an informal theory (i.e. a guiding framework) to explain how CHWs in this study connected refugee clients to the U.S. healthcare system. The results will also inform practitioners and researchers about important focus areas that can enhance training of and support for CHWs as they tackle health challenges facing refugee communities in the United States. The results contribute to the literature on promising practices and their potential contributions to reducing the existing burden of poorer health outcomes among refugee communities (Mishori, Aleinikoff & Davis, 2017). By highlighting the voices of CHWs within an examination of refugee access to care, my dissertation adds to researcher and practitioner

understanding about additional factors that affect refugee health in Greensboro, North Carolina. Second, this dissertation provides culturally rich and practical accounts that can be used to shape or tailor future training protocols for CHWs to better equip them for work with refugee health needs. Lastly, this dissertation research has implications for CHW program administrators and public health practitioners who are making informed decisions about resource allocation within programs designed to improve refugee health.

Organization of the Dissertation

This dissertation is divided into six chapters. Chapter 1 provides the background and introduction to the dissertation study. Chapter 2 is a targeted literature review on refugee resettlement and access to healthcare for refugees in the United States. Chapter 3 describes the methodology and details how the study was conducted using a constructivist grounded theory qualitative research approach. Chapter 4 describes the grounded theory that emerged to help explain how CHWs promoted access to healthcare for refugees. Chapter 5 provides results on how CHWs interpreted their roles. Chapter 6 is an epilogue, which revisits the purpose of the study, summarizes key findings, details research significance, and provides recommendations for future practice. Lastly, the appendices are a compilation of figures and instruments pertinent to this study.

CHAPTER II

LITERATURE REVIEW

The United Nations Refugee Agency

The United Nations High Commissioner for Refugees (UNHCR) is the program of the United Nations (UN) dedicated to protecting and assisting people who have been forced to flee their homelands. The UNHCR reports that there are approximately 65 million displaced people worldwide, of which 25.9 million are refugees (UNHCR, 2019). Worldwide, 20.4 million refugees are under the auspices or protection of UNHCR, while 5.5 million Palestinian refugees are under the United Nation's Relief and Works Agency's mandate (UNHCR, 2019). The UN defines a refugee as an individual who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country" (UNHCR, 1951). Therefore, refugees are persons forced to flee their country of origin to a host country due to conflict and persecution.

After escaping from their home countries, approximately 40 percent of refugees reside in urban settings while most of the remaining 60 percent live in camps designated for refugees (Berg, 2012). The UNHCR works with 138 host countries and various partner agencies to consider the best of three durable solutions for these refugees: (1)

voluntary repatriation, (2) integration in a nearby host country, or (3) resettlement in another country (UNHCR, 2019a; UNHCR, 2019b). Refugee processing specifically for resettlement is a lengthy process that requires at least two years, and less than one percent of refugees will be processed for resettlement in developed countries like the United States, Canada or Australia (UNHCR, 2019b).

The United States has Resettlement Support Centers (RSCs) overseas to help with processing refugees for resettlement. Once they have been referred by the UNHCR, refugees are screened and background checks are completed. The RSCs prepare refugees for interviews conducted by the Department of Homeland Security's US Citizenship and Immigration Services (DHS/USCIS). Next, DHS/USCIS conducts interviews with refugees and makes a decision whether or not the refugee applicant will be resettled in the United States. This step is known as refugee status determination interviews and helps decide if an applicant is eligible for resettlement. If an applicant is denied during this process, this decision cannot be appealed. However, their case can be reconsidered if new information becomes available. If approved, the applicant is considered to have conditional approval for resettlement contingent on passing medical examinations and security vetting checks.

The U.S. mandates medical screening for tuberculosis and selected sexually transmitted infections (STIs). If an applicant tests positive for TB, resettlement in the U.S. will be delayed until completion of medical treatment. Prior to 2010, refugees who tested HIV positive required a Class A waiver before U.S. entry. The waiver alerted U.S. medical providers to their underlying health condition and need for follow-up. This

waiver is no longer required. Concurrent with medical screenings, the applicant's profile is also undergoing security checks in many federal and international databases. If the applicant passes this phase, travel arrangements will typically be coordinated with the International Organization for Migration (IOM) and US resettlement agencies. In addition, the RSC organizes sponsorship assurance to the US in collaboration with the nine federally recognized resettlement agencies to assure that an agency is willing to accept the case for resettlement. Once assurance is completed, RSC provides cultural orientation for applicants to help give them an idea about life in the US, and travel arrangements are made. To offset travel cost to the United States, refugees are awarded an interest-free travel loan. Upon arrival to the United States, one of the nine federally recognized resettlement agencies works with local partner agencies to welcome the refugee and provide resettlement assistance (Refugee Council USA, 2019). The UNHCR works with partner agencies to provide basic health services to the refugees while they are residing in a host country. The 1951 Refugee Convention, of which the U.S. is a signatory, is a key document that formed the basis of UNHCR work; it stated that forcibly displaced persons should have the same access to healthcare services as citizens of the host countries (Refugee Convention, 1951). However, not all countries are signatories to the 1951 Refugee Convention and thus dictate their own rules on what types of services, if any, refugees are allowed to access. Infectious diseases are the main health concerns in low-income host countries, while chronic conditions are the main health concerns in high-income countries (UNHCR 2019c). When refugees reside in camps, they are separated from the general population so that UNHCR and partner

agencies refugees can provide services to them in a localized area. In urban settings, however, UNHCR faces unique challenges when assisting refugees who have often relocated to the host country on their own and who are also navigating rules and regulations of the host country (Grabska, 2006; Yotebieng, Syvertsen & Awah, 2018).

There is continuation of health services after resettlement in the United States (U.S.). This attention to their overall wellbeing is designed to address some of their unmet physical and mental health needs that result from fleeing unrest, disaster and persecution (Mishori, Aleinikoff & Davis, 2017). Many refugees lack the skills to navigate a new healthcare system and this makes it difficult for them to access care, which often results in deterioration of their already poor health (Woolhandler & Himmelstein, 2017). Practical stressors like financial constraints, legal status change, fragmented families and households, lack of culturally appropriate service providers and language barriers also limit access to care for refugees (Dow, 2011; Langlois, Haines, Tomson & Ghaffar, 2016). These stressors also delay timely and appropriate care (Morris, Popper, Rodwell, Brodine & Brouwer, 2017).

Brief History of Immigration Policy in the United States

The United States has a history of successful refugee resettlement. Prior to 1875, there was no federal immigration regulations; instead, immigration restrictions were dictated by individual states (Utržan, Wieling & Piehler, 2018). However, in 1882 the U.S Congress implemented the Chinese Exclusions Act to limit the number of Chinese individuals entering the country (Utržan, Wieling & Piehler, 2018). This prohibited entry of Chinese laborers amidst mounting socioeconomic concerns (Kanazawa, 2005). The

first legislation enacted for refugees was the Displaced Persons Act of 1948 (Utržan, Wieling & Piehler, 2018), developed in response to the millions of people displaced at the end of World War II. This Act allowed the entry of two hundred thousand Europeans to the U.S. for resettlement (Starkweather, n.d.). In 1975, the Indochina Migration and Refugee Assistance Act permitted resettlement of one hundred thirty thousand refugees from South Vietnam, Laos and Cambodia after the end of the Vietnam War (Haines, 1996).

These policies gave rise to the current United States Refugee Program (USRP), which was begun in 1975 to set quotas for refugee admissions from selected regions of the world. Five years later, the Refugee Act of 1980 led to the creation of a permanent and systematic refugee admissions program which is administered through the U.S. Department of State/Bureau of Population, Refugees and Migration and Department of Health and Human Services/Office of Refugee Resettlement (Bon Tempo, 2008; Anker, 1981; Office of Refugee Resettlement, 2019). Each year, the Department of State admits tens of thousands of refugees from conflict and war-torn regions. The USRP has a partnership with the U.S. Federal Government, nine non-governmental agencies or resettlement agencies and various partner agencies to help facilitate the refugee resettlement process (Utržan, Wieling & Piehler, 2018). Since 1975, the U.S. has resettled over three million refugees fleeing persecution from conflict areas worldwide (U.S. Department of State, 2017).

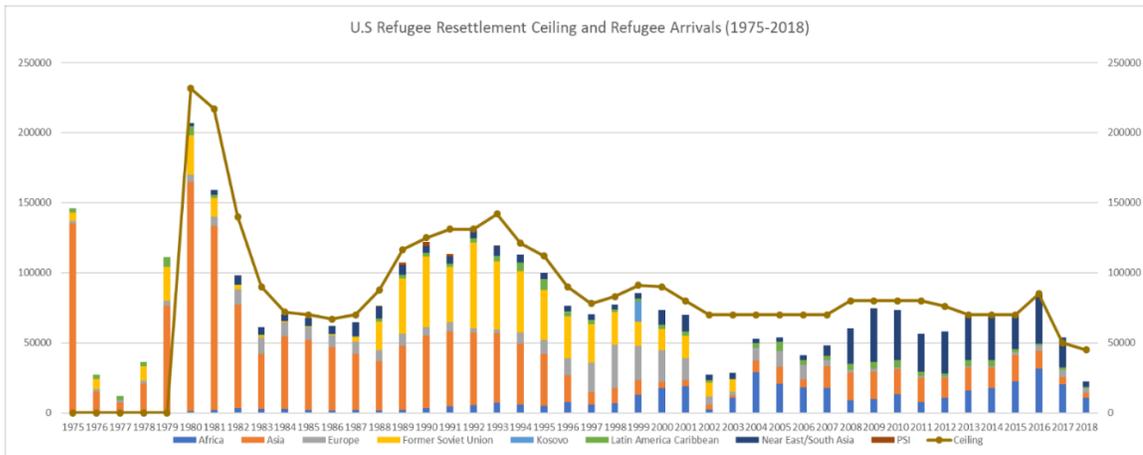
Two major events that have impacted the USRP were the September 11, 2001 terrorist attacks and the 2016 Presidential election. The 9/11 terrorist attacks, perpetrated

by foreign-born persons legally in the U.S., led to a number of changes in immigration policy such as revised visa policies and revamped security procedures. Although none of the 9/11 perpetrators were refugees, following the attacks there was also a temporary moratorium on refugee resettlement, resulting in admittance of only 27,508 refugees at the end of fiscal year 2001. This number was significantly lower than the seventy thousand arrival admission ceiling for that year set by the Department of State (Iyer and Rathod, 2011; Migration Policy Institute, 2003).

Another significant event for immigration policy occurred 15 years later. The 2016 Presidential election led to an increased polarization of immigration policy. Almost immediately after the election, the new administration signed into effect two Executive Orders (EOs) that were largely antiimmigrant and impacted quotas for refugee arrivals and resettlement. The first of the two EOs titled *Protecting the Nation from Foreign Terrorist Entry into the United States* (2017) restricted immigrants from specific Middle Eastern countries—Iran, Iraq, Libya, Somalia, Sudan, Syria and Yemen—from entry into the U.S. for ninety days (Office of the Press Secretary, 2017; Office of the Federal Register, 2017; Liptak, 2017). Although this Executive Order received criticism from many human rights groups, the Supreme Court of the United States upheld a revised version of this EO (De Vogue & Stracqualursi, 2018). The second EO, *Resuming the United States Refugee Admissions Program with Enhanced Vetting Capabilities* (2017), set new and stricter baseline regulations for screening people seeking to gain entry into the United States, including refugees (Office of the Press Secretary, 2017; Kopan & Landers, 2017; Gonzalez, 2017; Office of the Federal Register, 2017).

These two EOs have incited antirefugee rhetoric in the popular press and endangered the U.S standing as a safe haven for refugees (Benjamin, 2017). For the fiscal year 2018, the refugee admittance ceiling was forty-five thousand (Office of Refugee Resettlement, 2017), significantly lower than the ceilings set for 2017 (fifty thousand), 2018 (eighty-five thousand), and 2019 (seventy thousand) (Office of Refugee Resettlement, 2017). For fiscal year 2019, thirty thousand has been set as the refugee resettlement ceiling (Wroughton, 2018). However, given the history of disparity between refugee ceilings and refugee arrivals, it is anticipated that many fewer refugees will be resettled. The chart in Figure 1 shows refugee ceilings and actual arrival numbers from 1975 to 2018.

Figure 1. United States Refugee Resettlement Ceiling and Refugee Arrivals from 1975 to 2018



Sociopolitical Climate and Access to Care

The combination of the current political issues and the moods of society is commonly known as the sociopolitical climate. In 2019, many refugees are living in fear due to a sociopolitical climate that is generally unwelcoming to them (Miller, Hess, Bybee & Goodkind, 2018). The recent nationally implemented legislation as previously described has further exacerbated this problem. The current immigration policies (e.g., travel ban and historically lowest number of arrivals) have resulted in increased psychological stress and a noted decrease in access to health services despite continued eligibility (Novak, Geronimus & Martinez-Cardoso. 2017; Mutambudzi, Meyer, Reisine, et al. 2017; Philbin, Flake, Hatzenbuehler, et al. 2018; Artiga & Ubri, 2017; Nichols, LeBrón & Pedraza. 2018; Williams & Medlock. 2017).

Access to healthcare is the ability to obtain health services in a timely manner in order to achieve the best health outcomes (Institute of Medicine, 1993; Bodenheimer & Grumbach, 2012). Access to care in the United States is defined in three stages: (1) gaining entry into the health system typically through health insurance coverage, (2) accessing a place for health services provision or geographic availability, and (3) accessing a healthcare provider with whom the patient is comfortable communicating or establishing a personal relationship (Healthy People 2020, n.d.; National Healthcare Quality Report, 2013). Vulnerable populations such as refugees, racial and ethnic minorities, young children, elderly, the socioeconomically disadvantaged, and those with certain health conditions (Waisel, 2013) are known to have less access to healthcare.

Vulnerable populations have decreased access to care in comparison to the general population, despite greater risk factors and higher morbidity and mortality (Joszt, 2018). Furthermore, social factors, such as the sociopolitical climate, are stressors that can lead to lower access to care and care utilization (Krieger, Huynh, Li, Waterman & Van Wye, 2018). Low healthcare access of refugees (Mishori, Aleinikoff & Davis, 2017), coupled with a generally unwelcoming political climate, is a disruption set to further exacerbate already poor health outcomes and subsequently challenge efforts to improve health in refugee populations.

Access to Care for Refugees

Prior to entry into the United States, refugees undergo a mandatory health assessment to detect any conditions that may pose a public health threat in the United States (Mishori et al., 2017). Within thirty-ninety days of arrival, the Centers for Disease Control and Prevention (CDC) recommends a medical examination focused on general health and wellness, though record keeping is at the discretion of state and local health departments (CDC, 2013). Due to missed routine medical care and a history of hardship from war-related trauma and famine, refugees consistently present with high rates of infectious diseases [e.g., tuberculosis, hepatitis, intestinal parasites (Lifson, Thai, O'Fallon, & Mills, 2002; Mishori et al., 2017; Morris et al., 2009)], as well as nutritional problems and chronic diseases [e.g., musculoskeletal pain, and mental health conditions (Biegler, Mollica, Nicholas, Chandler, Ngo-Metzger, Paigne et al., 2018; Mishori et al., 2017; Morris et al., 2009)]. These contribute to poorer health in resettled refugees. It is

unclear whether these conditions continue for years after resettlement because the health of refugees is not routinely assessed after the initial arrival period.

The U.S. immigration and health policies inform what health services newly arrived refugees are qualified to access and influences their post-resettlement health status. Upon arrival in the United States, refugees as lawful immigrants are eligible for Medicaid, a need-based joint federal and state health insurance program, for a period of eight months (Office of Refugee Resettlement, 2019). In addition, resettlement agencies assist refugees with social services provisions and support through cash benefits, English language classes, and housing assistance. Within a year after arrival, the resettlement agency financial support is terminated and refugees are expected to become economically self-sufficient. Although refugees can re-apply for Medicaid and other social benefits, approval is not guaranteed and eligibility varies by state (Office of Refugee Resettlement, 2019).

Refugees who attempt to navigate the complex U.S healthcare system often encounter an unfamiliar environment that contains cultural, linguistic, and socioeconomic barriers which limit their healthcare access (Crosby, 2013; Wagner, Burke, Kuoch, Scully, Armeli & Rajan, 2013; Wong, Schell, Marshall, Elliott, Babey & Hambarsoomians, 2011). In fact, access to care is the most frequently expressed need among recently arrived refugees (Mishori, Aleinikoff, Davis, 2017; Crosby, 2013; Wagner, Burke, Kuoch, Scully, Armeli & Rajan, 2013; Wong, Schell, Marshall, Elliott, Babey & Hambarsoomians, 2011; WHO, 2010; Langlois, Haines, Tomson & Ghaffar, 2016). Even when low cost and culturally appropriate local health services are available,

shifting immigration policy instills fear and uncertainty in refugees, and ultimately disrupts access to care services (Miller, Hess, Bybee & Goodkind, 2018). Hence today's refugee newcomers are confronted with navigating both the unwelcoming and health decision making that are now contextualized within fear of further persecution and deportation. Furthermore, researchers collectively agree that increased primary healthcare access contributes to improved health outcomes, i.e. a lower prevalence of chronic conditions such as diabetes, hypertension, cardiovascular diseases, some cancers, emotional distress and other mental health conditions (Crosby, 2013; Wagner, Burke, Kuoch, Scully, Armeli & Rajan, 2013; Wong, Schell, Marshall, Elliott, Babey & Hambarsoomians, 2011; WHO, 2010; Langlois, Haines, Tomson & Ghaffar, 2016).

Community Health Workers: A Primary Health Access Intervention

Community health workers (CHWs) are a primary healthcare access tool of an intervention commonly used with vulnerable populations. In 1978, the World Health Organization (WHO) pushed for an increase in the utilization of Community Health Workers for community level provision of essential health education and clinical services (World Health Organization, 1978; United States Agency for International Development, 2010). The WHO recommended that CHWs should ideally be members of the communities where they work, knowledgeable about their communities' needs, and endorsed by the communities for their activities. They should also be supported by the general health system, but not necessarily as a part of its organization, because they typically have less training compared to skilled healthcare professionals (Frankel & Doggett, 1992). This definition presented CHWs as unskilled workers with short and

focused training that allows them to enter the workforce quickly (WHO, 2008).

“Community health worker” is now used as a catch-all phrase for the approximately one hundred job titles that encompass CHW roles (Sabo, Allen, Sutkowi & Wennerstrom, 2017). These include outreach worker, health promoter, lay health navigator, outreach educators, lay health advisor and community health aides, to name a few.

Erb (2012) organized the roles of CHWs in the United States into four main categories: access, education, advocacy and service delivery. Within access, CHWs connect different populations to the healthcare system by assisting individuals with enrollment in health insurance and coordinating medical appointments and healthcare referrals. In the capacity of education, they carry out health promotion, disease prevention and help to reduce the burden of chronic diseases. Additionally, CHWs are resource connectors and provide information about programs, resources and services, and communicate eligibility criteria. In regards to advocacy, CHWs serve as community advocates because they communicate with the larger health provider community about needs and preferences of the smaller community and help to build community capacity. Lastly, CHWs assist with service delivery by providing routine screenings and social support. Although CHW roles are delineated into these four broad categories, their work often intersects across all four (Erb, 2012).

Challenges for CHWs

There are limits to the utilization of CHWs as a community health intervention. The need for ongoing monitoring and training is a hallmark of community health worker programs. However, failure to consistently implement both has been cited as a

contributing factor in the failure of CHW programs over time (O'Donovan, Ahn, Nelson, Kagan & Burke, 2016). Another challenge is the failure to set clear boundaries and expectations within the different healthcare systems to help prevent CHWs from the burden of being tasked with more than was agreed upon. Furthermore, there is a lack of adequate compensation for CHWs - they generally earn low wages, or are employed as contractors. Finally, the diversity of CHW roles is often a disadvantage because it complicates the process of creating uniform training components for subsequent formal certification (Bovbjerg, Eyster, Ormond, Anderson & Richardson, 2014). Most importantly, the formality of certification may threaten the very core of CHW work, i.e., being flexible and adaptable in meeting unique needs of disadvantaged communities; and, inadvertently introducing power dynamics and strained relationships between CHWs and members of the communities that they serve.

CHWs Serving Refugees

Community health workers have thrived in remote areas where they provide access to care for populations and communities who are often missed by typical United States healthcare systems (Arvey & Fernandez, 2012). CHWs serve in settings where outcomes are defined and easily measured, such as with persons living with type II diabetes (Lujan, Ostwald & Ortiz, 2007; Rothschild, 2014), or where the outcomes are slower to accomplish such as with persons who need support to become physically active (Ayala, 2011). CHWs serving refugees must broker between their communities and the wider network of healthcare professional systems, connecting refugee populations to care through culturally appropriate health communication and support strategies (Arvey &

Fernandez, 2012; World Health Organization, 2008). The provision of culturally and linguistically appropriate healthcare has been upheld by researchers and practitioners as an evidence-based method for reducing health disparities and bridging gaps in healthcare provision (Mishori, Aleinikoff & Davis, 2017; Nunnery and Dharod, 2015; Mirambeau, 2012).

Culture can be defined as a people's way of life. According to Burke and colleagues (2009), culture is the method by which people make sense of their world. As such, culture often dictates what is considered normal or abnormal and often serves as a moral compass. CHWs navigate aspects of culture that are often unspoken and unapparent to outsiders. These efforts often permeate beyond country of origin, language and ethnicity. Culture is a nuanced understanding that helps inform people's way of life, including their health beliefs. CHWs are instrumental in either challenging those beliefs or strengthening them to effect positive health behaviors. CHWs' insider information is essential to understanding, for example, the culturally preferred method of receiving information, such as one-on-one interaction compared to group interaction. In addition, in sensitive matters, such as violence against women, CHWs can delineate or appropriately dispatch a female CHW to deliver health information rather than a male CHW to speak to women at risk. Subtle nuances in culture are important to know and take into account early in program planning (Burke, 2009). Overall, in serving as culture navigators, CHWs become recognized as natural helpers and leaders in their community.

Natural Helper Model

The Natural Helper Model is useful for characterizing CHWs as natural helpers or “lay people to whom others naturally turn for advice, emotional support and tangible aid” (Israel, 1985). This definition posits natural helpers as trusted leaders in the community. The hallmark of this model is the utilization of natural helpers to gain access to hard-to-reach populations and their social networks (Israel, 1985). Since refugees are a vulnerable population, the success of any public health intervention aimed at reaching them would depend on culturally appropriate programs that include community involvement. Previous literature lends support for refugees being more trusting of “natural helpers” from their own community and more comfortable participating in a health program when such persons assist them (Johnson, Ali & Shipp 2009; Nunnery & Dharod, 2015).

The Natural Helper role of CHWs (i.e. leveraging insider knowledge of indigenous community systems for assistance) facilitates their ability to become a bridge for communities navigating complex American social and health systems (Langlois, Haines, Tomson & Ghaffar, 2016; Arvey & Fernandez, 2012; WHO, 2008; Mirambeau, 2012; Nunnery & Dharod, 2015). Leveraging these talents requires an understanding of where and how best to align and insert multifaced strategies in these uncertain times in immigration policy. For many refugees, the ability to interact with someone with shared language, social cues and demographic background (Nunnery & Dharod, 2015) can become a channel for boosting participation in help-seeking health behaviors. CHWs are instrumental in developing culturally and linguistically appropriate intervention materials

targeting help-seeking health behaviors and change (Dharod, Croom & Sady, 2013). Many studies have reported greater success with CHW intervention than non-CHW intervention for behavior change associated with diabetes prevention, cancer screenings, and hypertension management (Bird et al., 1998, Islam, Zanowiak, Wyatt, Kavathe, Singh, Kwon & Trinh-Shevrin, 2014; Fedder, Chang, Curry & Nichols, 2003; Islam, Zanowiak, Wyatt, Chun, Lee, Kwon & Trinh-Shevrin, 2013).

Gaps in the Literature: The Missing Perspectives of CHWs

As the U.S continues to admit refugees, CHWs will increasingly be a bridge or guide to helping refugees gain access to the healthcare system. The task that lies ahead is to figure out what happens between CHW deployment, their efforts to increase refugee health access and evidence of positive health changes among those they help (Brownstein et al., 2005; Mirambeau, 2012). Several studies have documented the refugee health access issues from the perspective of service providers (Griswold, Zayas, Kerman & Wagner, 2007; Morris, Popper, Rodwell, Brodine & Brouwer, 2009; Zhang, Ornelas, Do, Magarati, Jackson & Taylor, 2017), as well as refugee clients themselves (Agbemenu, Volpe & Dyer, 2018; Herrel, Olevitch, DuBois, Terry, Thorp, Kind & Said, 2004; Lipson, & Omidian, 1992; Sharif, Biegler, Mollica, Sim, Nicholas, Chandler, ... & Sorkin, 2019). However, only a few studies in the United States have examined the perspectives of CHWs working specifically with refugees.

An ethnographic study conducted by Lipson, Weinstein, Gladstone & Sarnoff (2003) in California examined healthcare experiences of refugee CHWs from Bosnia. These CHWs were interpreters and provided social support for the refugee communities.

The CHWs identified the need for an increased budget for them to serve as interpreters for healthcare facilities utilized by refugee communities. In addition, they expressed the desire to conduct thorough orientations within communities in order to detail for them how to navigate the healthcare system and present them with accessible healthcare options. Finally, they addressed the lack of language and culturally appropriate outreach programs for prevention, an important public health measure.

The above study underscored the importance of examining CHW perspectives and experiences because they work directly with refugees and are dedicated to their health and wellbeing. The CHW perspective is important because (1) we lack extensive documentation of how CHWs distinctively and differentially serve refugee populations, and (2) these perspectives may be a gateway to better understanding how to systematically allocate and deploy resources for improved refugee health outcomes. Overall, insights from CHWs would be useful for program administrators and personnel who plan and fund programs that address refugee health needs.

Importance of This Study

This qualitative dissertation study focuses on understanding how CHWs affiliated with The University of North Carolina at Greensboro's Center for New North Carolinians in Greensboro, NC, work to improve access to healthcare for adult refugees. In conducting this study, I hoped to learn from CHWs the specific details or construction of their roles, how they perceive their roles, and how they propel refugee communities towards better health access. This study brings attention to refugees, a population often overlooked by American health systems and whose first and often only line of access to

healthcare is through CHWs. In that regard, this research departs from the status quo of looking at client or provider perspectives, as it aims to identify and operationalize CHW strategies that bridge the gap between their communities and access to the U.S. healthcare system. This study presents new and substantive information as it incorporates CHW voices into the discourse on refugee health and highlights their efforts in improving healthcare access for refugees. This study will use a constructivist grounded theory approach (Charmaz, 2014) to construct an informal theory to explain how CHWs connect refugee communities with access to the healthcare system. Results from this study will help to inform future evidence-based programming to strengthen the CHW workforce.

CHAPTER III

METHODOLOGY

Research Questions

- How do CHWs who work with refugee communities in Greensboro, NC connect refugee clients with access to the healthcare system?
 - How do CHWs perceive their role?

Research Design

I selected community health worker (CHW) participants working in Greensboro, North Carolina because Greensboro is one of the largest hubs for refugee resettlement in North Carolina. Furthermore, Greensboro is equipped with the infrastructure to help propel refugees and immigrants towards self-sufficiency, with resettlement and support agencies. The University of North Carolina at Greensboro's Center for New North Carolinians (CNNC), and its affiliated CHWs, will be the focus of the dissertation. The purpose of my study was to obtain a better understanding of experiences, perspectives and perceptions of CHWs at the CNNC whose primary role was to assist adult refugee clients in gaining access to the healthcare system. The Natural Helper Model informed my inquiry and selection of CHWs as key informants. I conducted a constructivist grounded theory study and collected primary data from community health workers (CHWs) through individual semi-structured interviews.

Grounded theory is a rigorous qualitative research method that leads to an informal theory specific to the data (Charmaz, 2014). Grounded theory is used for theory generation in a manner where data is methodically collected and simultaneously analyzed (Charmaz, 2014; Noble & Mitchell, 2016). Researchers generate strong grounded theories using rich data sources and a variety of data gathering strategies: for example - interviews, field notes, and written documents. The types of data collected by the researcher depends on the research questions posed as well as his or her ability to gain access to the sources (Charmaz, 2014). Through an inductive process, researchers analyze and organize empirical data into analytic categories and check their theoretical interpretations (Charmaz, 2014). Data collection and data analysis are concurrent and engage the researcher in an iterative process that is very different from traditional research methods where data collection and data analysis are separate. Grounded theory favors: data analysis over description, freshly generated theory over extant theory, and purposeful data collection over a large initial sample (Charmaz, 2014). In grounded theory, researchers use an inductive and iterative process to collect and analyze data on a specific topic; consistent with other qualitative research methods, generalization is neither a goal nor an outcome. Furthermore, grounded theory helps to explain a studied process with theory and explains properties of the categories within the theories (Charmaz, 2014), and thus qualifies as an appropriate qualitative approach for me to study CHWs.

Within grounded theory, I selected constructivist grounded theory (CGT) by Charmaz (2014) as the ideal lens with which to approach my dissertation study. Charmaz

argues that neither data nor theory are discovered in the text or analysis; rather, researchers construct grounded theories (Charmaz, 2014). Researchers using CGT take into account their subjectivity and social locations, past and present involvements, interactions with other people, their perspectives and research practices, and collect rich data sources to generate theory (Charmaz, 2014). Researchers also situate their analyses within the context of time, place and inquiry of interest and aim for an abstract understanding of a research topic (Charmaz, 2014).

In reality, human beings are active participants in the world around them and they are constantly negotiating social interactions, and our constructions of reality originates from our interactions and social processes (Charmaz, 2014). Not surprisingly, individual interviewing is the most common data collection method used by researchers conducting a constructivist grounded theory study. This type of interviewing consists of gently guided, one-sided conversations that delve into the perspectives of the personal experiences of the participants (Charmaz, 2014). Alongside individual interviews, researchers use questionnaires to collect accurate information about demographic and background characteristics to help assemble a chronological occurrence of events (Charmaz, 2014). Investigating the interactions between people and their social environment through interviews is a helpful tool for researchers who are investigating how people are navigating a new social environment, such as CHWs who are connecting refugees to the complex U.S. healthcare system. In this study, I used a questionnaire to collect demographic information, and used individual interviews to uncover CHW experiences linked to connecting refugees with the healthcare system.

CGT also has unique data analysis techniques such as memo writing, coding, theoretical sampling, theoretical saturation and constant comparison, which I describe in the data analysis section. Through analysis, categories and analytic codes are developed such that pre-existing conceptualizations are not used (Noble & Mitchell, 2016). Categories generated are then coded and refined, and more data is collected and analyzed. Lastly, concepts are integrated into a theoretical framework that helps to explain the social process or research topic (Charmaz, 2014, p. 189).

Setting

The setting of this study was Greensboro, North Carolina, an area known for successful refugee resettlement. In 2018, North Carolina was seventh among U.S states for refugee resettlement. The most popular regions of arrival were from Congo, Burma, Ukraine and Eritrea (Payne, 2018; Refugee Processing Center, 2018). However, refugee arrivals in North Carolina, as nationwide, are beginning to plummet: in 2018, there were 1050 refugees, compared to 1280 in 2017 and 3719 in 2016 (Payne, 2018, Kaplan, 2018). In Guilford County, where Greensboro is located, the county population is approximately five hundred thirty-three thousand, of which ten percent is foreign-born and approximately ten thousand residents are refugees (United States Census Bureau, 2013-2017). Resettlement agencies in partnership with the Federal Government and support agencies assist refugees with resources to rebuild their lives. The University of North Carolina Greensboro (UNCG)'s Center for New North Carolinians (CNNC), is dedicated to bridging newcomer populations with existing communities through direct service provision, research, and training (CNNC, 2019).

The CNNC's Immigrant Health Access Project (IHAP) focuses on providing access to healthcare for refugees and immigrants in Greensboro. For nearly two decades, CNNC programs have promoted integration and access to education, health, social services, legal counseling, employment training, and economic development for refugees and immigrants. IHAP, funded by Cone Health Foundation, aims to eliminate language and cultural barriers when accessing health services for adult immigrants and refugees. Each year, IHAP connects five hundred to six hundred adult refugees and immigrants to the healthcare system (CNNC IHAP, 2019). From a public health perspective, the provision of culturally and linguistically appropriate services are critical to prevent, detect at early onset, and address disease-specific treatment in underserved populations. The IHAP program seeks to assist these communities in accessing the healthcare system by helping them find suitable health insurance options and connecting them with a primary care clinic. IHAP typically uses six community health workers (CHWs) and two health coordinators to provide access to care services for refugees and immigrants in the greater Greensboro area. CHW positions are created based on needs of the CNNC clients, and those interested can apply once the position is advertised through the CNNC, the community, or UNCG's human resources page. CHWs are selected based on the best candidate that fits the job description.

The CHWs serve as interpreters and cultural brokers between their communities and the service providers. This helps reduce barriers to accessing and maintaining contact with the healthcare system. They are trained by shadowing more experienced CHWs for a few months. They are provided with a CHW model designed by CNNC; the

model includes useful resources for their duties. They are required to complete a day-long interpreter training offered through the CNNC to help equip them during their interactions with clients and service providers. They also attend monthly meetings for IHAP CHWs and staff, which sometimes consists of additional trainings to help them provide resources for clients; for example, a guest speaker at the meeting would provide updates on statewide Medicaid benefits and how those updates will affect their refugee clients.

I have been a graduate research assistant with the CNNC since January 2016. My roles include administrative support for grant writing, and program planning, implementation and evaluation. In January 2017, I began working with the CNNC director, IHAP staff, and CHWs to coordinate IHAP activities. Although IHAP has changed extensively in its nearly twenty years of existence, it has continued to utilize CHWs to connect refugee and immigrant adults to primary healthcare (CNNC IHAP, 2019). IHAP program activities include community outreach, safety net enrollment, health system navigation, coordination of services, information and referrals, and language access (CNNC IHAP, 2019). The current program staff consists of two full-time coordinators and six quarter time CHWs who reflect the diversity of the refugee and immigrant community and client base. Collectively, they speak fourteen languages.

In this study, I limited my inquiry to CHWs who work with refugees because refugees are a unique population requiring special support, especially in the current sociopolitical climate. Changes to health and immigration policy landscapes are occurring rapidly at both local and national levels. Accordingly, leveraging relationships

of trust with refugee communities is essential to ensuring access to care and improving population health (Nunnery & Dharod, 2015; WHO, 2008). In Greensboro, as it is nationwide, refugee communities face increased fear and potential family separation due to shifts in immigration policy. Furthermore, annual reports from IHAP have indicated dwindling instances of refugee outreach owing to increased reluctance of refugees to utilize services designed for them. My dissertation was the next logical step in examining efficiency of CHW practice and perspectives on how to improve access. Overall, conducting my dissertation gave me the opportunity to contribute to a more culturally responsive local health system and help to alleviate health disparities for refugees.

The CHW participants often originated from the same countries as the refugee communities that they serve and with whom they share common culture and language. I conducted individual interviews with them to gain a better understanding of their experiences and perspectives on their roles. My goal was to generate an informal theory to aid in better understanding how CHWs did their job and their perceptions on strategies and challenges in connecting refugee communities with the healthcare system. I hoped that by documenting CHW voice experiences it would help inform improvements and support for needed efforts to increase health access for refugees.

Participants and Data Collection

The CNNC director provided me with a list of sixteen current and former refugee CHWs who worked with the CNNC to connect adult refugee clients with access to healthcare. From this pool, I recruited a purposeful sample of ten participants via email,

in person, or through the telephone. Seven of the ten participants worked with IHAP at the CNNC, and three of them were undergraduate students working with the CNNC to complete an internship for their degree program. To help capture the diversity of refugee populations served through the CNNC and IHAP, the participants were CHWs who served refugee clients from Asia and Africa – this is because at the time of my dissertation CHWs were only serving refugees from these two regions of the world. It was important to note that the CHW participants worked with IHAP in the capacity of student intern, IHAP contractor, and full-time IHAP/CNNC staff member because this affected length of time worked as well as their roles and responsibilities. I screened for this information during recruitment and was cognizant of this during the interview process and data analysis.

The data collection methods that I used were demographic questionnaires and interviews. The demographic questionnaire is a type of informational interview used in CGT to generate facts to help construct a sequence of events (Charmaz, 2014, p. 57). I used it to create a profile of CHWs since they had served at different times and in various refugee communities. Immediately after completing the demographic questionnaire, I conducted an individual interview with each CHW participant. I recruited CHW participants using the following criteria: minimum age of eighteen years, current or previous partnership with the CNNC to assist refugee clients with access to care, and willingness and capacity to provide voluntary informed consent. (See data collection and purpose list in Table 1 below). After the initial interviews, I conducted follow-up

interviews with a few participants to gain a better understanding of their perspectives as a CHW.

Table 1. Rationale for Data Collection Methods

Data collection method	Purpose	Sample size
Demographic questionnaire	To gather accurate responses on demographic questions and details such as time period served as a CHW, and groups of refugees served	10 CHWs
Individual interview	To explore the perspective on the personal experience of each CHW in connecting refugees to the healthcare system	10 CHWs

Theoretical Sampling and Theoretical Saturation

Theoretical sampling is a process by which a researcher makes a decision about what additional data is required to move the theory generation process along (Charmaz, 2014). It allows researchers to produce more data to confirm or oppose categories identified in previous coding (Charmaz, 1990; Noble and Mitchell, 2016). For example, during coding of individual interviews, I took into account the different perspectives of CHWs due to diversity in communities served, capacity served and length of service. After conducting the first ten interviews and coding the data generated, I found that the CHWs had different types of training and various methods of gaining trust within the community. Given this insight, I read the CHW training manual guide being developed at the CNNC to help me learn more about the CHW scope of work. I used information

learned from this guide to probe for more information from CHWs during follow-up interviews.

I requested follow-up interviews through a strategic two-fold process. First, I deliberately made an effort to include the different types of CHWs working with CNNC. Second, I especially sought out the CHWs who were eager and willing to share more about their experiences. In the end, I conducted follow-up interviews with a student CHW, a contract CHW and two full-time CHWs. During these follow-up interviews, I asked about how they perceived their roles, how they interacted with the refugee communities served, and what types of training they had received after being hired as a CHW, and the ways the training impacted their role.

With theoretical sampling, data analysis informs new data collection; however, theoretical saturation signals the end of data collection and data analysis. At this point, gathering more data will not add any new theoretical categories to those formed with previous data collection and analysis. Theoretical saturation is a crucial period for CGT researchers because it takes into account the skills of the researcher in using collected data and data analysis to systematically answer research questions posed (Charmaz, 2014, p. 214). I continued the interview transcript analysis process until I reached theoretical saturation, or the stage whereby the data produces a theory fit for the data (Charmaz, 2014, p. 214).

Demographic Questionnaire

On the day of the individual interview, I asked each CHW participant to complete a demographic questionnaire. It included information on age, sex/gender, current or

previous work with IHAP, languages spoken, country of origin, highest level of education, length of years in the U.S, and employment status. Aggregate results from this questionnaire allowed me to create a profile of CHW participants and have a better understanding of the extent to which they served refugee communities. (See the questionnaire in Figure 2 below).

Figure 2. Demographic Questionnaire

Demographic Questionnaire				
What is your age group?	<input type="checkbox"/> 18-24	<input type="checkbox"/> 25-35	<input type="checkbox"/> 35-44	<input type="checkbox"/> 44+
What is your sex/gender?	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other/prefer not to answer	
Are you current or former IHAP CHW?	<input type="checkbox"/> current		<input type="checkbox"/> former	
How long, have you worked with refugees?	_____ less than one year	_____ years		
How long have you worked as an IHAP CHW?	<input type="checkbox"/> 1-2 years	<input type="checkbox"/> 3-5years	<input type="checkbox"/> 6-10 years	<input type="checkbox"/> 10+ years
Which languages do you speak?				
What's your country of origin?				
What is your highest level of education?	<input type="checkbox"/> Less than high school	<input type="checkbox"/> High school diploma	<input type="checkbox"/> College degree	<input type="checkbox"/> Higher than college degree
How many years have you lived in the U.S.?	_____ years			
Outside IHAP, do you work:	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time	<input type="checkbox"/> Student	<input type="checkbox"/> Not employed/Other

Interviews

I conducted individual intensive interviews with a sample of ten CHW participants who linked eligible refugees to the healthcare system. The interview questions covered role delineation in addition to their perspectives and experiences as CHWs. I asked what steps they would take when trying to connect a new refugee to healthcare access. Next, I asked questions to help me assess the challenges that they experienced and how they navigated those challenges. In conducting the interview, I concentrated on the broad topic of CHW roles and delved deeper into other topics brought up by the participants that were important to understand the CHW role. It was important to me to interview this diverse group of CHWs because they served various refugee communities and in different capacities. Interviewing them individually and aggregating the results as a mixed group allowed me to delineate differences and similarities in perspectives.

I arranged the interviews with CHWs in a location that was comfortable for them to talk and relax. The interview was guided by broad and open-ended questions (Turner, 2010) where the participant did most of the talking (Charmaz, 2014, p. 9.3). Utilizing this approach gave me flexibility when asking questions and probing for clarification and in-depth responses based on participant responses. The interviews were audio-recorded with consent from each CHW. I informed them verbally and in the recruitment script that I would contact them again for member checking; in addition, I informed them that if selected for a follow-up interview, I would reach out to arrange the interview as well as conduct a member check. The member checking was a time for me to verbally review

the contents of the interview with them to ensure accurate representation. Member checking and follow-up interviews took place at separate times. I used the transcription software application Otter.ai to transcribe the interviews, and used the software application Box for data management and retrieval (Otter.ai, version 1.0).

I wrote a memo summarizing each interview. Next, I used CGT coding guidelines to code each interview transcript. Next, I wrote memos to summarize and synthesize each interview. I then conducted member checks (Carlson, 2010) with each CHW, in person or by telephone, to ensure I had accurately captured the contents of the interview through a verbal review of the interview summary. During these approximately thirty minute encounters, I ensured that we were both in agreement with the contents of our conversation. I stored all memos, coding notes and member check notes in the study folder in Box.

I conducted all ten interviews first before requesting a follow-up interview with any CHW. I requested a follow-up interview with four CHWs who had the most to share about their experience. As indicated above, I conducted member checks with each CHW after I had written a memo summarizing his or her interview. If I conducted a follow-up interview, this was the process I took: conduct interview, code and analyze interview, request follow-up interview, conduct follow-up interview, and conduct member check of both interviews.

Table 2. Individual Interview Guide

Individual Interview Guide
<ol style="list-style-type: none">1. From my experience studying community health workers, I have found that there is a lot of confusion about what community health workers actually do! How do you introduce yourself as a CHW to people in the refugee communities that you serve?2. How do you connect with refugees who are new in the community?3. Starting from the beginning, can you describe the steps you would take when working with a new client?4. How about during a second or third contact with a client, what type of services would you provide after the first contact?5. Can you tell me more about how you would follow up with clients after you have helped them to connect with the healthcare system?6. There are a lot of success stories that have been recorded with CHWs working with refugee clients. Can you reflect a bit on your own experience as a CHW and please share with me one success story from your experience?7. Thank you for sharing that. How did you feel about your role in creating that success story?8. Let us now turn to barriers, because there are success stories alongside barriers in the CHW field. Can you reflect on your experiences and please share one barrier that you have experienced?9. How did you handle or navigate that barrier?10. You mentioned earlier that you have worked with refugees for (<i>length of time</i>) and been a CHW for (<i>length of time</i>). What events led to you becoming a CHW?11. Tell me about the strengths or skills that you have developed or discovered through serving as a CHW?12. Given your CHW experience, what advice would you give a new CHW? And why?13. Is there something else you think I should understand about being a CHW?14. Is there anything you would like to ask me?

Data Analysis and Interpretation

Data analysis and data interpretation are interchangeable because they occur simultaneously in CGT. As stated previously, CGT uses iterative data analysis procedures. Data analysis begins very early, often alongside data collection. Coding,

memoing, constant comparative analysis, theoretical sampling, theoretical saturation and situational analysis are processes and tenets in CGT. Although I described them individually, I used them simultaneously during data analysis. I used constant comparison to organize codes, categories and concepts from the data. Theoretical sampling helped me to develop targeted follow-up interview questions to better understand unique perspectives gathered from the individual interviews.

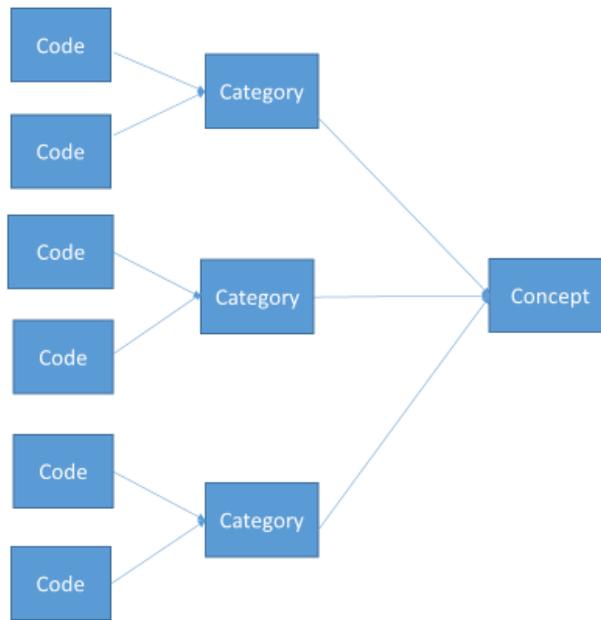
Coding and Memoing

In CGT, early data analysis often consists of coding and memoing to help the researcher build theory (Oktay 2012, p.53). I conducted initial, focused and axial coding to analyze the interview transcripts (Charmaz, 2014). Initial coding consisted of a review of the transcript to delineate meaningful units of analysis related to CHW experiences and perspectives. During focused coding, I reviewed and refined the codes and categories generated during initial coding. Finally, I conducted axial coding by reviewing the codes and concepts identified in initial and focused coding, consolidating them to broad concepts and identifying any new theoretical insights. Data analysis allowed me to group the codes into categories and consolidate categories into concepts.

Coding is an adventurous process because the researcher does not know which codes will be generated and how they will merge into concepts and categories (Oktay, 2012). Figure 3 shows the CGT coding figure. Memoing is a process of detailed note-taking that allowed me to document my thoughts on various ideas along the data collection and analysis process (Oktay, 2012, p. 68). While it started very early in the

data collection process with writing a memo of individual interview summaries, I wrote memos throughout the data analysis process to document my thoughts and unique cases.

Figure 3. The Constructivist Grounded Theory Coding Process



Constant Comparative Content Analysis

Constant comparison is a basic method in CGT that allows researchers to compare and contrast similarities and differences in data (Oktay, 2012, p. 17). The data drives the groupings of conceptual categories. I conducted constant comparative content analysis of interview data to group codes, categories and concepts. Specifically, I compared interviews within and across individual interviews and capacity served (i.e., intern, contractor, fulltime staff). To ensure validity/trustworthiness, I used quotes directly from CHWs participants so that readers could hear from participants in their own words, and I used member checking to ensure that I was accurately interpreting the expressions of

participants. Conducting the constant comparative analysis allowed me to examine the extent to which CHWs have linked eligible refugee individuals to healthcare and help move closer towards developing theory out of the empirical data.

Ethical Considerations

I obtained approval for this study from the Institutional Review Board (IRB) at the University of North Carolina at Greensboro. I also obtained informed consent from each CHW participant prior to conducting individual interviews. I gave each CHW participant a ten dollar gift card as compensation for his or her time.

By using a constructivist grounded theory lens, my approach was influenced by my own experiences, perspectives, and interactions, and my research interpretation was ultimately a construction of the world around me (Charmaz, 2014). My four-year tenure with the CNNC influenced the types of questions that I asked in initial and follow-up interviews because I had learned about CNNC's strengths and weaknesses. Furthermore, this background knowledge equipped me to tailor interview questions to uncover topics that yielded new insights. I also used terminology familiar to participants (Charmaz, 2014, p. 100), such as "clients" to refer to refugees with whom the CHWs were working (see interview guide in Table 2).

My role as a graduate research assistant was a strength, however, the benefit was limited to my administrative role, compared to the full-time staff, student intern and contractor CHW positions of my participants who worked directly with refugee clients. My role as a graduate research assistant may have introduced power dynamics, or at the very least, perceived power dynamics between me and the CHWs who participated in this

study. To navigate this and reduce the influence of power differential of the researcher, I intentionally made an effort to value the time and willingness of the participants to participate in my research study (Sturm & Antonakis, 2015; Anderson & Galinsky, 2006; Fast, Gruenfeld, Sivanathan, & Galinsky, 2009). I did this by listening attentively, unpacking their perspectives, and asking follow-up questions to clarify concepts that I did not understand. In addition, I treated the participants, their world and the interview situation, with respect (Charmaz, 2014, p. 62).

Limitations

There are a few limitations to consider in this study. Given that CNNC only deployed CHWs for the most populous communities, there are refugee communities within Greensboro who are not being served; some examples are Somalis, Ethiopians and Eritreans. As an organization, CNNC's inclusion criteria regarding outreach may need to be addressed in the future by allocating resources towards expanding the CHW intervention to include more refugee communities. In this study, however, I focused only on the refugee communities being served by CHWs through the CNNC.

Another limitation is sample size. Although I used a selected sample which did not include all past and current CHWs, I selected CHW participants who reflected the unique refugee communities served through the CNNC. Moreover, documenting CHWs experiences and perspectives on working to connect refugees to the healthcare system was valuable especially in Greensboro, which is an area equipped with agencies that facilitate refugee resettlement.

Expected Outcomes from Study Methods

My study approach is predicated on the Natural Helper Model which posits that there are informal helping networks within every community (Israel, 1985). Since CHWs are natural leaders in their communities, conducting individual interviews with them afforded me the opportunity to dig deeper for a better understanding of their unique perspectives. Completion of this study's methods allowed the opportunity to document CHW efforts to increase health access in the Greensboro refugee community. I expected to learn how CHWs connected specific refugee communities with the healthcare system. In the future, I hope that knowledge gained from my study will be useful in the development of future evidence-based and community-engaged CHW trainings and programs to improve health outcomes for refugees.

CHAPTER IV

THE WHEEL OF MY WORK: MAPPING COMMUNITY HEALTH WORKER ACCESS TO CARE PROCESSES FOR SERVING REFUGEES

Abstract

Community health workers (CHWs) are trusted community leaders and public health workers dedicated to promoting the health and well-being of community members. CHWs, who share similar language and culture, work with refugee communities that are often missed in traditional United States health systems. CHWs help refugees gain access to healthcare through culturally appropriate strategies. However, the scope of their work is largely unknown in the peer-reviewed literature. This qualitative research study used a constructivist grounded approach to examine the extent to which CHWs helped refugee clients gain access to the healthcare system. Data was collected through interviews with a purposeful sample of ten CHW participants affiliated with a health access program in Greensboro, North Carolina. The diagram derived from this study provided schema of CHW perspectives and experiences with connecting refugee clients to the healthcare system. Further research incorporating CHW voices is recommended because CHWs are instrumental in improving the health and well-being of refugees.

Introduction

Refugees often experience difficulty navigating the complex United States healthcare system because they are navigating resettlement challenges such as financial

constraints, legal status change, and language barriers which further limit healthcare access (Langlois, Haines, Tomson & Ghaffar, 2016). Community health workers (CHWs), who typically share the same language and culture with refugees, help connect them to healthcare by using culturally appropriate strategies (Arvey & Fernandez, 2012; World Health Organization, 2008). These CHWs are cultural brokers and an essential public health workforce invested in improving the health of refugees (Mirambeau, 2012; Nunnery & Dharod, 2015). Furthermore, they are leaders and liaisons between small refugee communities and larger communities, moving refugees along a continuum of resources that provide healthcare access, utilization and continuation (Nunnery & Dharod, 2015).

The literature on refugee health has consistently focused on refugee patients (Sharif, Biegler, Mollica, Sim, Nicholas, Chandler, ... & Sorkin, 2019) or professional healthcare providers such as doctors and nurses (Morris, Popper, Rodwell, Brodine & Brouwer, 2009), omitting CHWs who are a bridge between the two and are key trusted leaders essential to the refugee network. To better characterize how CHWs connected refugee clients to healthcare, a constructivist grounded theory (CGT) approach was applied to data collection and analysis that involved semi-structured interviews with a purposive sample of ten CHWs affiliated with the University of North Carolina's Center for New North Carolinians (CNNC) in Greensboro, North Carolina, a region known for its successful refugee resettlement program. The CGT approach allowed generation of an informal theory to fulfill the purpose of this study: to better understand CHW experiences and efforts in connecting eligible refugees with healthcare access.

Methods

Approach

In this study and in accordance with a typical constructivist grounded theory, data collection and data analysis occurred simultaneously (Charmaz, 2014). Data were collected to examine the experiences of the CHWs in connecting refugee community members with access to the healthcare system and to generate an informal theory to help explain CHWs' results . The CHW participants had previously connected eligible refugees with healthcare services in Greensboro, NC and were viewed by the community as trusted helpers from within the community that are cultural brokers between their community and outsider institutions (Israel, 1985).

Sample

Eligible participants were at least eighteen years old, had previously served or were currently serving as a CHW at the CNNC, and were willing to participate. The director of the CNNC provided me with contact information for CNNC CHWs and I recruited participants by email, telephone or in person. I conducted formal interviews with ten current or former CHWs affiliated with the CNNC and then conducted follow-up interviews with four of them. Interviews took place at various locations in Greensboro, North Carolina: coffee shops, a library, an office, and a nail salon. Five participants were from Africa and five participants were from Asia. Six were former CHWs and four were current CHWs. They had served as CHWs in the capacity of staff, student intern, or contractor CHW. Two CHWs were male while eight were female. Table 3 contains further details on the demographic characteristics of the CHW participants.

All interviews were conducted in English. The mean interview time was thirty minutes and ranged from twenty-four minutes to forty minutes. The mean interview time for the follow-up interviews was thirty-two minutes and ranged from twenty-three minutes to fifty minutes. In addition to formal interviews, I had informal conversations with other former CHWs, not included in this study, to ask about their experiences as CHWs. This information helped me to better understand their roles and responsibilities.

Data Collection Procedures

My position as a graduate research assistant for four years (2016-2019) with the CNNC facilitated my recruitment of CHWs for the study. Prior to the beginning of the study, I had interacted with or worked directly with most (twelve of the six-teen potential participants on the list provided to me by the CNNC director. This pre-established trust built through prior knowledge and interaction facilitated the recruitment process because I felt more comfortable approaching potential participants for the study. After recruitment, I found that I had worked directly with, or at least met, all ten CHW participants prior to the study.

All study procedures were approved by the University of North Carolina at Greensboro's Institutional Review Board. Data collection occurred from April 2019 to October 2019. During each interview, each participant and I completed the demographic questionnaire, then I conducted the interview using the guiding questions. I audiotaped the interviews with permission from the CHW participants using the software application tool Otter.ai (Otter.ai, version 1.0). The interviews followed the open-ended questioning format characteristic of constructivist grounded theory with prompts to precipitate further

discussion. All ten interviews were transcribed, and the resultant transcripts were used for coding and analysis.

Table 3. Community Health Worker Demographic Characteristics N = 10

Community Health Worker Demographic Characteristics N = 10	
Average age 30.5	Range 19-45
CHW status, N (%)	
Former	6 (60%)
Current	4 (40%)
Type of CHW	
IHAP full time staff	3 (30%)
IHAP contractor	4 (40%)
Student (intern/AmeriCorps member)	3 (30%)
Length of time in U.S. (years)	
1-10 years	5 (50%)
11-20 years	5 (50%)
Region of origin N (%)	
Africa (Burundi, Central African Republic, Eritrea, Rwanda)	5 (50%)
Asia (Burma, Nepal, Vietnam)	5 (50%)
Sex, N (%)	
Male	2 (20%)
Female	8 (80%)
Education status	
High school diploma	4 (40%)
College degree	5 (50%)
Higher than college degree	1 (10%)
Employment status	
Full time	4 (40%)
Part time/Student	6 (60%)

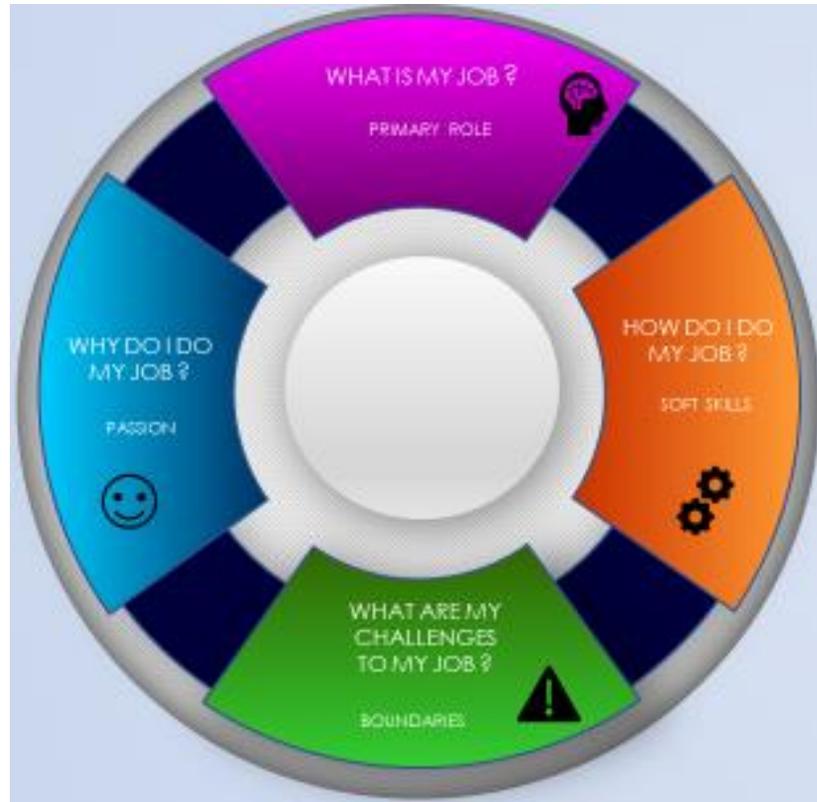
Data Analysis

To analyze the interview data, I utilized the data analysis method recommended by Charmaz (2014). First, I coded the interview transcripts immediately after completing the interview. I delineated insightful quotes and used gerunds to describe each quote and

wrote a memo for each participant. After analyzing participants separately, I wrote memos that compared the interview transcripts of the three types of CHWs: student, contractor and full-time staff member; I delineated similarities and differences in experiences. I then analyzed across all participants and grouped experiences that were similar and consolidated the data. I also captured some unique experiences within the different themes and unique experiences that were outside the themes that had emerged. Finally, I wrote memos to help explain the context of the emerging themes and eventually narrowed down to recurring themes across the transcripts.

Results

Figure 4. Map of Community Health Worker Access to Care Work



Overview

Through the coding process, four main themes were identified (as depicted in Figure 4) to represent the collective experiences of CHW participants in connecting refugees to the healthcare system: why do I do what I do, what is my job, how do I do my job, and what are challenges to my job.

Why Do I Do What I Do?

Personal experience as a refugee and love for the community were two main reasons that led participants to become CHWs. They were passionate about giving back to their community through serving as a CHW.

Refugee Background. The refugee status of some CHWs influenced their passion for serving as a CHW. For example, Barbara was a refugee and recalled arriving in the United States without knowing how to speak English and without any extended family members. She adjusted by learning English and establishing a social support group:

Well, I am a refugee myself. I just think I'm just seeing all the systems that we have to navigate that people know we have to talk to and it's just hectic, so I wanted to be there that way, like I know the steps because I've been through them and I'm also competent to help to connect them.

Similar to Barbara, Heaven arrived the United States as a refugee. Heaven's approach to her CHW role was heavily influenced by the cherished assistance her family received from refugee resettlement agencies and supporting partners, which motivated her to extend the same kindness and helpfulness to newly arrived refugees. Rachel also arrived in the United States as a refugee. She had unrealistic expectations of the U.S.

being a “place where there is milk and honey” such that all good things were available all the time and to all people. The harsh reality, she found, was that everybody did not have equal access and refugees often were not aware of all the resources that they were qualified to access because they were simultaneously adjusting to all the pressures of living in a new country. Rachel took it upon herself to serve as a guide for clients and advised them on how to set realistic expectations when adjusting to living in the U.S.

Love for Community. Some CHWs mentioned the community as their motivation for serving as a CHW. They enjoyed interacting with community members and serving as an integral link connecting them to the healthcare system. For example, Joan’s passion stemmed from her experience as a community leader:

For my past, I used to work with community...before I came here.... I love to work with the community even if it's hard.

This quote suggests that she had deep ties with the community, despite some challenges that she may have faced. Similarly, Baba’s passion originated from his experience in the humanitarian field for almost ten years, specifically working with refugees and refugee organizations in a host country while he was awaiting resettlement in the United States. After arriving in the United States, he continued in the humanitarian line of work as a CHW, attesting to his love for the community. Likewise, Prakriti explained that community members inspired her to do more and keep going. She envisioned working in a larger capacity beyond her CHW role to connect more people to the healthcare system in the United States and beyond.

For all participants, leveraging their linguistic and cultural skillsets to provide CHW services for community members was a rewarding experience that allowed them to build stronger relationships within the community. Their experience working with communities in country of origin or refugee status in the U.S allowed them to gain valuable skillsets that helped them during their tenure as CHWs.

What is My Job?

To understand how CHWs defined their role, it was important to first examine how they interpreted their role. There was variation in how participants interpreted their role as CHWs, and this was influenced by the type of CHW that they were. Full-time IHAP CHWs and intern CHWs had a broader interpretation of the CHW role that included resource connection with more distal health needs. However, contractor CHWs and student/AmeriCorps member CHW bound their roles specifically around helping clients gain access to the healthcare system due to time constraints within their type of CHW role.

Type of CHW and Interpretation of Role.

Full time CHWs: Emma and Baba. Emma defined her role broadly as a resource connector for the health needs of the communities that she served. For Emma, health meant: (1) a state of general wellbeing, (2) having access to health insurance (e.g., Medicaid or Medicare) and resources such as the orange card, a local program in North Carolina that helps to connect clients to a primary healthcare home, and (3) the ability to prevent future health deterioration through establishment of a primary care doctor at a primary healthcare home; having a primary cared doctor will ideally prevent clients from

seeking basic healthcare access at an urgent care facility or an emergency room. Emma mentioned these three factors as health, and this definition helped her define her role, which then guided her on how to set boundaries on services that she could directly provide for her clients.

For Baba, his definition of health can be inferred to mean any issue that affected the client's wellbeing:

It depends on the client and what the client needs if the client is facing a lot of health issue it's not only health issue as community health workers. It's like also the support and also giving them the resources that they need from the daily life like for example, if they contact me to just be in the hospital with the client and I took the client and I will talk with the client building rapport. The client will tell me I have a problem, for example for my food stamp, I don't have food stamp, and I will try to follow up like with their like to refer them to people who are helping or I will work with the client to just make sure he got the food stamp because like health has a lot of things related to health. So, I will be sometimes I see it as case management but it's not like case management as case management but like I will work to help him in every aspect of his life.

Based on his interpretation, being a CHW meant that he provided social support (“be in the hospital with the client”), and access to resources for daily living (e.g., food stamps) which constituted case management, where the client is the case and the CHW is the case manager that provides resources (“to help him in every aspect of life”). In other words, if an issue was important to a client, it was also important to Baba and he provided support in the most appropriate way. Emma and Baba interpreted their roles more broadly and approached health holistically to include access to the healthcare system in addition to social support services.

Contractor CHWs: Heaven and Burmerican. Most contractor CHWs spent a few hours a week at community centers strategically and conveniently placed close to apartment homes where refugees resided, to help connect refugee clients to the healthcare system. None of the contractor CHWs gave a clear definition of health. However, they clearly defined how they interpreted their role when introducing themselves to the community.

Heaven described her CHW role to the community members as someone who is trained to assist clients with health needs (e.g., medical billing, connecting them to a primary healthcare home), a resource connector (“intersection between two things”) and an interpreter (“I can help with interpretation if needed”). She tried to bind her role within health but including the term resource connector opened up opportunities to assist with distal health needs, which were an issue that appeared to make the CHW role overwhelming for her and other CHWs. She did not quite describe what health meant but used the term “health related” to guide how she interpreted her CHW role. Similar to Heaven, Burmerican typically gave an informal introduction to community members:

There is not a term for CHW in Burmese and Nepali. I say that I help to...navigate the healthcare system. I always assume that I am an interpreter. The term gives people an idea of what I am.

In addition, to help community members have a better understanding of his role, he included part of his interpretation of the CHW role in his introduction.

Student CHWs: Prakriti, Rachel, and Barbara. Prakriti interpreted being a CHW as a fluid role with the main focus of advocating for members in the community.

Meanwhile, Rachel embodied her refugee identity which often led her to identify her CHW role more broadly as a way to help members in her community meet the different health and non-health related needs that they presented with upon resettlement (e.g., food, clothes). Barbara, however, was an AmeriCorps member which was similar to contractor CHWs because it was a paid position, but she was also a student like Prakriti and Barbara. She had a strict definition of health and viewed her role as a resource connector specifically for health needs.

Access to the Healthcare System. Despite various interpretations of the CHW role, participants collectively saw themselves primarily as a resource to help connect clients with the healthcare system. This essentially translated to cultural brokering between their refugee communities and the broader community to assist clients with health insurance access, service provider appointments, and access to resources to meet health related needs. CHWs communicated health information to clients, such as explaining how to take their medication correctly or how to refill their prescriptions. CHWs also taught clients how to independently access the healthcare system to help promote self-sufficiency. Emma made a unique analogy to help explain her CHW role. She saw herself as a mother and her clients were her children.

They tend to want you to walk, walk with them holding their hand...guide them and point them direction, they want you to walk along with them. And I can't do that with one person...imagine, you know, now they have a doctor, now they, they know what medicine they're taking, like a feeling like they can do it on their own, like seeing them. And you like you...like a mother who had a baby, who's raising a child? teaching them, I mean, been holding the holding them all along, and then you start seeing them to walk on their own. They would come back and, you know, ask for help. Well, you know, ask for guidance. Yeah. just knowing someone behind them.

Clients were indeed needy when they first arrived as a refugee, similar to a baby that could not walk; however, through working with them, teaching them how to access the healthcare system and introducing them to services that they qualified to access, they gradually gained more independence. Emma saw this interaction as a mother teaching a baby, another participant saw it as training clients to independently access the healthcare system. Overall, CHWs were a bridge between their refugee communities and the larger community of service providers.

How Do I Do My Job?

CHWs identified skillsets helpful in carrying out their role. Communication skills and gaining trust were the most commonly mentioned skillsets. As liaisons between clients and the larger Greensboro community, they discussed the need for them to possess and utilize culturally appropriate communication skills. Meanwhile, trust was crucial in helping to build relationships with current clients and in connecting with new clients.

Communication with Clients. The CHW role necessitated a partnership between CHWs and clients. Some CHWs were physically located at the community centers which facilitated their interaction with clients. Sometimes they went door-to-door to meet new clients, meet with established clients via home visits, or gain new clients through word-of-mouth referrals from community members. As previously noted, when introducing themselves to the community, most did not use the CHW term because it did not exist in the languages that therefugees spoke. They instead gave an informal introduction and explained the services that they could provide. This technique helped community members have a better understanding of their role, made CHWs more

approachable and subsequently helped CHWs build rapport with the community members.

Gaining Trust. CHWs leveraged on their role as cultural brokers in order to build trust with clients. For example, Barbara indicated that sharing a language opened the door for a trusting working relationship with the client, and with more interaction, the trust grew between her and the client:

I think in the community once you speak the person's language, there is an instant connection of trust between you and that person, and the more services or the more guidance you offer them, the more they going to let you see, and sometimes they're just so...they want, need that assistance, so anybody who is willing to help they, will give them the time.

All CHWs echoed Barbara's sentiments and agreed that building trust was an important part of their job.

What Are the Challenges to My Job?

Although CHWs felt equipped to handle the capacity of their role, they encountered some unique challenges. Two main challenges were setting boundaries and navigating the complex healthcare insurance system. Boundary setting was important because flexibility of their roles and strong relationships with clients presented the potential for clients to burden and overwhelm them with needs. Secondly, their best efforts to provide the best access, utilization and continuation of healthcare for clients did not always work out as planned.

Boundaries. Since access to healthcare was the main role of CHWs in this study, all CHWs made an effort to bind their interaction with clients within healthcare access as often as possible. However, it is important to mention that the type of CHW did not only influence how CHWs interpreted their role, it also affected and how they set boundaries within the CHW role. For full-time CHWs and intern CHWs boundaries between them and clients was non-evident owing to their interpretation of the CHW role as flexible. However, contractor CHWs and AmeriCorps member CHW who defined their roles specifically around helping clients gain access to the healthcare system, elaborated on the importance of setting boundaries with clients based on the ten hours per week allotted to them for CHW work. For example, AmeriCorps member Barbara explained that clients sometimes wanted her to become “their personal caseworker” and essentially assigned her duties beyond her CHW role:

I think if you make it clear at the get-go that know what you are going to do, and you try to limit the personal interactions with them. It'll make it a lot easier for you to say no and they accept it. But if you keep saying, you know, saying yes to everything they want, and all of a sudden now you're saying no. It's like, 'What happened? You did it before, what's the matter?'

From her experience and the experience of most CHWs, failure to be transparent about duties within their roles caused confusion and could blur lines of professionalism between them as paraprofessionals and their community members as clients. Similarly, some CHWs explained that some clients asked for assistance with tasks beyond the CHW role (e.g., transportation to the grocery store). They collectively attributed this to the level of trust and comfort they felt with CHWs because they welcomed them into their

homes for home visits and often interacted with them informally as community members. They agreed on the need to be firm in rejecting requests beyond the CHW role because it freed them to help more clients gain access to the healthcare system.

Health Insurance. CHWs viewed health insurance as a tool to connect clients along a cascade to help improve their health and well-being. However, they also felt frustrated while connecting clients with health insurance at a systemic level. Due to variety in health insurance coverage, some refugees did not have full coverage and sometimes needed to pay for health services out-of-pocket after the eight month refugee Medicaid ended. For example, Sue explained that she felt bad because her attempts to connect her clients with a primary care doctor sometimes resulted in them getting stuck with large bills because of the limits of their Medicaid and the difficulty in extending it.:

The thing is that okay when we talk about health, we encourage them establish family care doctor and then interpret, and then after that the bill come back that is frustrate me, I don't want to hear that because everybody doesn't have Medicaid you know, everybody doesn't have insurance and it's not 100% paid for. When bill come back, I don't want to hear that, I feel bad that look like I'm the reason make them have to owe something, they happy to go to the doctor to checkup and then they'll come back.

The responsibility and guilt that Sue and other CHWs felt were due a systematic issue that they had no control over. However, they discussed working quickly and thoughtfully to ensure clients gained access to the healthcare system because reapplication for health insurance after the eight month period did not guarantee partial or full coverage for clients.

Discussion

This study used CGT to explore the experiences of CHWs in connecting refugee clients with the healthcare system. Results identified and examined the interaction between contextual factors within the scope of CHW work, leading to the development of the CHW map shown in Figure 4. Central to the map are factors that explained how CHWs carried out their primary role of providing refugee clients with healthcare access. This study provided an insider view into CHW experiences and perspectives on providing healthcare access to refugees.

CHW efforts have been reported in previous qualitative studies (Lipson, Weinstein, Gladstone & Sarnoff, 2003; Mirza, Luna, Mathews & Hasnain, 2014; Nunnery & Dharod, 2015). CHW efforts have been instrumental in helping refugees navigate the U.S healthcare system that is often confusing and difficult to access. CHWs provide language and cultural skillsets that provide a gateway for refugees to engage with the healthcare system in a manner that allows them to utilize it and engage in health promotion. CHWs are trusted leaders and a first point of contact in many refugee communities. CHWs engage with refugees in a manner that outsider institutions and persons are not able to (Lipson, Weinstein, Gladstone & Sarnoff, 2003; Mirza, Luna, Mathews & Hasnain, 2014).

Unlike previous studies, our findings suggest the perspectives of CHWs in providing access to healthcare must be considered to plan effective future trainings for CHWs, and in constructing CHW programs targeted at improving refugee health. CHWs in this study were community members and often lived and worked in the same

community as their refugee clients. They have gained knowledge about the healthcare system and are useful resources who educate and empower refugees (Mirza et al., 2013). Their unique perspectives are valuable because of their close relationship to the community (American Public Health Association, 2009) and could help inform programming designed to improve health outcomes. Furthermore, they could help advise program administrators on how to allocate resources and subsequently carry out program intervention to reach target population and program goals.

Limitations

This study contained key limitations. I (the lead author) interviewed the CHWs from the most populous language groups served by the CNNC, based on the list given to me by the CNNC director. There are smaller refugee populations that could benefit from CHW services; however, due to budgetary constraints and smaller population size, these populations are not being served by CHWs through the CNNC. Secondly, due to my role as a current graduate research assistant at the CNNC, my follow-up questions may have been more intensive with individuals that I had interacted with for a longer duration due to my privileged knowledge of their background and experience compared to others who I had interacted with the least. However, the interview guide helped to frame the questions asked and helped to ensure a level of uniformity across interviews. Finally, student CHWs were by definition time-limited positions; this affected their scope of work and their relationships with clients. However, I did not explore this during the interviews, but I would recommend that future studies delve deeper into these topics to have an enhanced understanding of the CHW roles. Despite these limitations, the

findings of this study are important and contribute to our knowledge on the perspectives of CHWs who work primarily with refugees and play a key role in helping them to access the healthcare system.

Conclusion

Using constructivist grounded theory, a theory was developed using data collected to help explain how CHW participants in this study connected refugee clients to the healthcare system. They served as liaisons between refugee communities and the larger Greensboro community. They identified skills that they found useful in their roles and explained challenges they experienced within their roles. Overall, they enjoyed their job and found it rewarding.

This study was innovative because it centered on the experiences and viewpoints of CHWs in their own words. Findings from this study can be used to tailor future interventions for CHWs working with refugee populations in the United States. In addition, it will ideally assist in better defining promising practices to ultimately reduce the existing burden of poorer health outcomes in refugee communities and inform enhanced training of CHWs. The findings from this study are particularly important because CHWs are an instrumental group who work to improve the health of refugee communities.

CHAPTER V

“IF THERE'S A WAY I COULD HELP, I WILL DO MY BEST”: COMMUNITY HEALTH WORKER PERSPECTIVES ON ROLE ENACTMENT

Abstract

Utilization of Community Health Workers (CHWs) is a culturally appropriate and effective strategy to help bridge access to healthcare gaps in refugee communities. CHWs are trusted and trained public health outreach workers who typically share language and culture with the refugee communities they serve. CHWs connect clients with the healthcare system through culturally appropriate health communications. Thus, gaining a better understanding of CHW perspectives and experiences within the scope of their work could be instrumental in improving refugee health. In this qualitative research study, we used a constructivist grounded theory lens to examine how CHWs, affiliated with a program in Greensboro, North Carolina, promoted access to healthcare within refugee communities with a special focus on how the CHWs interpreted their role. Data was collected through semistructured interviews with a purposeful sample of ten CHW participants. Knowledge gained from this study was used to develop an informal theory to describe how these CHWs improved healthcare access for refugee clients.

Introduction

Community Health Workers (CHWs) have been effectively utilized to improve and empower communities to actively participate in health promotion and health

education (Arvey & Fernandez, 2012). CHWs are leaders in their communities. They are public health workers who often possess similar language skills, cultural heritage and a thorough understanding of the community served compared to non-members of the community (American Public Health Association, 2009). Previous studies have demonstrated that refugees were more trusting of members from their own community and thus more likely to participate in a health program when such persons helped them better understand program components (Johnson, Ali & Shipp 2009; Nunnery & Dharod, 2015). In fact, they are often the first and most trusted contact that refugees have with the healthcare system upon arrival to the United States. Therefore, CHWs are key liaisons between the community and the healthcare systems; subsequently they are a vital workforce and are advocates that help outsider institutions gain a better understanding of the health and well-being of refugee communities.

For decades, CHWs have used their skillsets to move refugee communities along a continuum of healthcare service access and utilization. Nevertheless, little attention has been invested into the perspectives of how CHWs do their work, how they perceive their role and how they carry out their roles. Accordingly, the purpose of this qualitative research study was to utilize a constructivist grounded theory to examine how CHWs promoted access to care within the refugee communities they served in Greensboro, North Carolina through the University of North Carolina at Greensboro's Center for New North Carolinians (CNNC). In the previous chapter, the full CHW map was explained. However, this chapter delves into the role of CHWs, their interpretation of the CHW role and how it guides or guided their work.

Methods

Setting

This study took place in Greensboro, North Carolina from April to October 2019. Each participant had served or is currently serving as a CHW with the CNNC. Each participant selected a pseudonym at the beginning of the interview and the researcher used the pseudonym for the duration of the interview. At the completion of the interview, each participant was given a ten dollar gift card as a compensation for their time.

Sample

I (the lead author) interviewed ten community workers who were affiliated with the CNNC. Five participants were of African descent while the remaining five were of Asian descent. The study included both male (two) and female (eight) CHWs. Each participant had served (six) or was currently serving (four) as a CHW. They served in the capacity of contractor, full-time staff or student intern. The CHW contractors were part of CNNC's Immigrant Health Access Project (IHAP) program and were allotted to work ten hours a week with refugee clients. The IHAP staff members performed CHW duties as part of their full-time employment status with the CNNC. The student interns worked with the CNNC to fulfill internship requirements specified by their degree programs. Eligibility criteria included being at least eighteen years old and having CHW experience with refugee communities. My role as a graduate research assistant at the CNNC (2016-2019) empowered me to recruit ten participants by telephone, email or in person. I was

able to do this because I had built rapport with almost all of them by working directly with them through IHAP or by interacting with them at the CNNC.

Data Collection Procedures

All study procedures were approved by the university's Institutional Review Board. I collected data from participants through a demographic questionnaire and an individual interview. Each interview was conducted in English because all CHWs spoke English and were multilingual, although English was not their first language. I worked with each participant to complete the demographic questionnaire, and I used guiding questions to conduct the interviews. The interviews were open-ended with prompts to encourage further discussion, a method characteristic of constructivist grounded theory. All participants were agreeable to answering any follow-up questions that I had based on what I had asked them during the interview. In addition, I conducted follow-up interviews with four participants based on need for further clarification on information provided during the first interviews.

I audiotaped the interviews, with permission of the CHW participants, using the software application tool Otter.ai (Otter.ai, version 1.0). All ten interviews were transcribed, and the resultant transcripts were used for coding and analysis. Through using Otter.ai, I was able to have the interview audio recorded and transcribed simultaneously (Otter.ai, version 1.0). However, I reviewed the transcripts and made edits as necessary because I found some errors in the transcripts, which could be attributed to noisy interview settings or the fact that none of the CHWs were native English speakers.

Data Analysis

I recorded answers to the demographic questionnaire questions and used them to build a narrative profile for each CHW to help elucidate their CHW experience. I utilized the data analysis method recommended by Charmaz (2014) to analyze the interview data. I conducted constant comparative analysis across participant experiences and within participant experiences and consolidated the data into manageable concepts. I coded the interview transcripts to delineate insightful quotes and then I coded the transcripts multiple times to narrow down the most thought-provoking quotes. I then wrote a memo describing of the context of each quote from individual CHWs. I also analyzed horizontally or across participants to capture collective experiences and unique experiences.

Profile of CHWs

Heaven is a female CHW in the 18-25 age group. She is a former CHW with six years of experience working with the refugee community and three years as a CHW connecting them with the healthcare system. She is from Eritrea and speaks Arabic, Tigrigna, Tigre and English. She is a student working on her college degree and has lived in the United States for five to ten years. She is a former refugee.

Emma is a female CHW in the 25-35 age group. She is a current CHW and full time IHAP staff member with ten years of experience working with the refugee community and one to two years as a CHW connecting them with the healthcare system. She is from Vietnam and speaks Jarai, Rhade, Vietnamese and English. She has a college

degree and has lived in the United States for ten to twenty years. She is employed full-time.

Baba is a male CHW in the 35-44 age group. He is a current CHW with nine years of experience working with the refugee community and one year as a CHW connecting them with the healthcare system. He is from Central African Republic and speaks Fula, Sango, French, Arabic and English. He has a college degree and has lived in the United States for about one year. He is employed full-time. He is a former refugee and worked in a refugee camp prior to being resettled in North Carolina.

Joan is a female CHW in the 25-35 age group. She is a current CHW with one plus years of experience working with the refugee community and one to two years as a CHW connecting them with the healthcare system. She is from Burundi and speaks Swahili, Kinyarwanda, French, Kirundi and English. She has a high school diploma has lived in the United States for five to ten years. She is employed part-time. She is a former refugee and worked in a refugee camp prior to being resettled in North Carolina.

Barbara is a female CHW in the 18-25 age group. She is a former CHW with four years of experience working with the refugee community and one to two years as an intern and CHW connecting them with the healthcare system. She is from Eritrea and speaks Arabic, Tigrinya and English. She is a student/working on her college degree and has lived in the United States for five to ten years. She is a former refugee.

Rachel is a female CHW in the 25-35 age group. She is a former CHW with five years of experience working with the refugee community and one to two years as an intern and CHW connecting them with the healthcare system. She is from Rwanda and

speaks Swahili, Kinyarwanda, French and English. She has a college degree and has lived in the United States for ten to twenty years. She is employed full-time. She is a former refugee.

Prakriti is a female CHW in the 18-25 age group. She is a former CHW with seven years of experience working with the refugee community and one to two years connecting them with the healthcare system. She is from Nepal and speaks Nepali, Hindi and Urdu. She has a college degree and she is a current student. She has lived in the United States for ten to twenty years.

Savannah is a female CHW in the 35 to 44 age group. She is a former CHW with ten plus years of experience working with the refugee community and connecting them with the healthcare system. She is from Vietnam and speaks Jarai, Rhade, Vietnamese and English. She has a college degree and has lived in the United States for about twenty years. She worked as a community health worker first and then as a staff member with IHAP. She is employed full time.

Sue is a female CHW in the 44+ age group. She is a former CHW with seven years of experience working with the refugee community and one to two years connecting them with the healthcare system. She is from Vietnam and speaks Vietnamese, Montagnard and English. She has a medical degree from Vietnam and has lived in the United States for ten to twenty years. She is employed full-time.

Burmerican is a male CHW in the 25-35 age group. He is a current CHW with almost two years of experience connecting refugee community members with the healthcare system. He is employed part-time. He is from Burma/Myanmar and speaks

Burmese, Nepali, Hindi and English. He has completed high school and has lived in the United States for one to five years.

Reflexivity

Constructivist grounded theory was used as a lens to explore CHW experiences. It allowed me (lead author, Nneze Eluka) to account for my subjectivity given my interaction with most of the CHW participants during my four-year tenure at the CNNC as a graduate research assistant involved in administrative support of IHAP. I was interested in working with CHWs for several reasons. As a graduate research assistant at the CNNC, I had assisted in implementation of the IHAP program beginning in February 2017. I had seen both the strengths and weaknesses of the program both from the perspectives of the CHWs during the monthly meetings and from the perspectives of the program staff during my day-to-day work at the CNNC. It is important to note that I was an insider as part of the administrative team for IHAP and had access to program evaluations and benchmarks, but I was an outsider because I was not a CHW and thus did not share this experience with the CHWs.

Although CNNC and IHAP served both immigrants and refugees, CHW efforts within the refugee community were more defined in comparison to CHW efforts in the immigrant community. Furthermore, refugee health advocacy became a passion for me because my role as a graduate research assistant exposed me to national and local refugee issues, policies and advocacy. In addition, I decided to focus on CHWs, not refugee clients, because they were more accessible to me through IHAP, and I could speak to them without needing an interpreter. Thus, I decided to conduct this study to learn more

about CHW experiences and solicit their insights on how they interpreted their role as trusted community leaders and bridge connectors, and how this role interpretation guided their practice.

In conducting my dissertation study, I recognize that my tenure at the CNNC as a graduate assistant may have influenced my research process. In fact, according to constructivist grounded theory, data and theory are constructed by the researcher through interactions with social processes (Charmaz, 2014). I had the privilege of working with many of the CHWs that became my participants, and I selected to conduct follow-up interviews with participants that were eager to share more about their experiences and provide me with a deeper understanding on their perspectives and experiences. Their willingness to participate in my study may have been due to my prior interactions with them and due to a trust that I had built with them by being part of CNNC and IHAP specifically. Overall, my dissertation afforded me the wonderful opportunity to leverage on my experiences working closely with CHWs at the CNNC. It is my hope that this research will help to inform future practice of CHW programs that reach refugees, and most importantly, include the perspectives of CHWs within such programs.

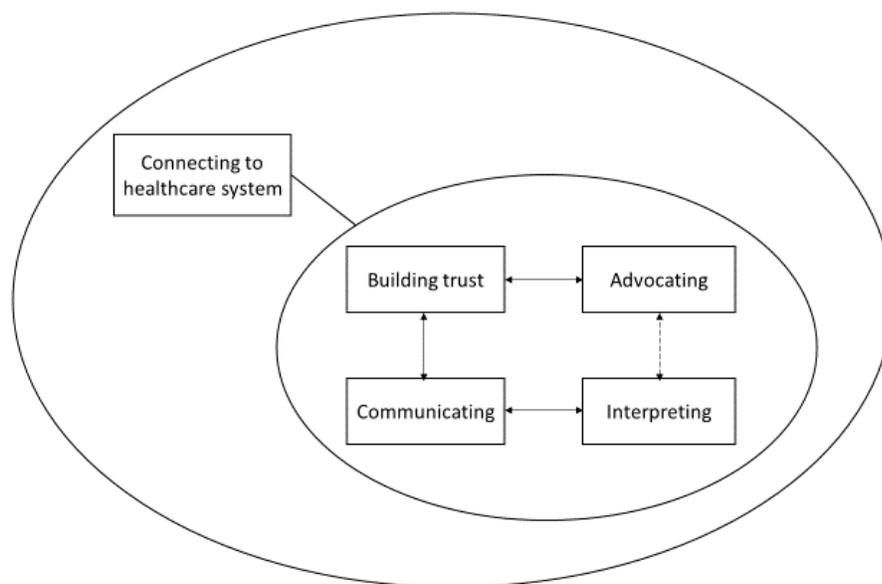
Results

This study aim was to describe and understand how these participants carried out their role as CHWs. I also examined how they interpreted their role and compared interpretations across all participants to identify important contextual elements. Furthermore, how they interpreted their role was connected to how they carried out their roles as CHWs. Therefore, it was important to understand how they interpreted their roles

because it allowed for a deeper understanding of their perspectives and experiences as CHWs. There were some similarities in interpretation of the CHW role within the different types of CHWs. The full-time staff members and CHW student interns had a broader definition of their CHW role and thus were willing to connect clients with distal health needs. On the other hand, contractor CHWs were generally stricter when defining their roles and bound it within access to health needs.

Despite similarities and differences in role interpretation, CHWs defined their primary role as assisting refugee clients in getting connected with the healthcare system. Within that role, they collectively defined themselves as interpreters and advocates. Furthermore, they identified communicating and building trust with clients as essential components that facilitated their interactions with clients (Figure 5).

Figure 5. Interpretation of CHW Role



Communicating

CHWs viewed communicating with refugee clients as a crucial starting point in the map shown in Figure 4. They reflected that being a CHW provided them with an opportunity to spark conversations with community members. They noted that if they did not initiate conversations, they would not be able to find out what was going on in the community or strategize how they could help. Getting to know clients—starting with simply their name and the health services they could provide—was valuable because in their experience, many refugees found that accessing the U.S healthcare system was a complicated challenge. CHWs reflected that the ability to serve as a point of contact and a resource connector was a cherished experience that provided a gateway into building trust with clients.

Building Trust

CHWs noted that building trust could take time because, although refugees were resilient, they had been through so much such that it could be difficult knowing who to trust. Fortunately, CHWs possessed language skillsets and shared culture with their clients. This helped facilitate their sensitivity to the refugee experiences and was necessary for building trust. CHWs found that being friendly and social helped them to build rapport and trust with new refugee clients. Some CHWs noted that speaking the same language with a refugee client was already a sign of trust and with more interactions, more trust was built.

CHWs indicated that they knew they had built up trust when clients opened up with them about intimate details that they would typically not tell other people. This

could mean letting their guard down and telling CHWs how they really felt. For example, Emma reflected on the process of trust building with her clients:

If that's something that they struggle [with], or...feel stress about, I want to hear their struggle, I want to hear their stress. Also, if there's a way I could help, I will do my best to connect them to resources out there. Let's say there's someone who have stress, you know, then the clinic like help with that, things like that. So yeah, it's stressful hearing the story...but again, I don't really kind of say, oh, I don't want to hear that. You know, stay professional and listen, and be friendly. So you could remain the trust between you and the patient.

She, like all CHWs, reflected on the importance of maintaining trust gained with clients by offering support and avoiding being judgmental about what they shared with them. They collectively agreed that a good strategy on maintaining trust was being respectful of their stories and empathizing with them. CHWs saw the importance of building trust with clients as a springboard into advocating for them.

Advocating

CHWs interpreted advocating as providing guidance and support for clients beyond the refugee community and within the larger Greensboro network. While many CHWs in this study worked with newly arrived refugees who were, as a group, most in need of support, CHWs reflected on their desire to propel them to navigate the health system independently. For example, they would teach clients how to make their health appointments, how to take their medication and how to fill their prescription. They shared their excitement in instances where their clients were able to self-sufficiently gain access to resources that they had previously relied on the CHW to help them access.

For example, Baba gave examples of his measures of success in helping his clients gained more independence:

When the client can take an appointment by himself. When the client can go and say, I need an interpreter, I don't speak this language, when the client can get an appointment ahead and address and does not ask me, 'how can I go there?' [they] can use the GPS to go there and like meet their needs. So when a client get bills, knows how to pay...if the client has Medicaid or any insurance, know how to tell them my insurance will cover this. So in that part, I feel the client is self-sufficient. And also, then the client can find someone in the community. Like because I'm one, but community, [there are] a lot [of] people in the community. So if he or she can navigate the community and resources and get what you want in the appropriate way or like a good way, he or she doesn't need me. So I know that the goal is met.

Similar to Baba, most CHWs noted that not all clients achieved the goal of independence at the same time. However, they worked to build individual and community capacity by increasing their health knowledge.

CHWs also emphasized the skillfulness of discerning the difference between advocating with clients as a form of social support and advocating with clients to help strategize next steps. In some instances, CHWs found that clients just needed someone to talk to and they would step in and fulfill this role. CHWs also noted instances where they would advocate for clients by helping to understand their health challenge and then work with them on figuring out a manageable next step to take towards solving the challenge. One such next step would be providing interpretation services between clients and service providers.

Interpreter

As interpreters, CHWs were able to use their language skills to communicate with clients and facilitate communication between clients and service providers. CHWs saw interpretation as the most essential component of their work because it was through this means that they were able to connect clients to much needed health resources. CHWs explained many instances where they delivered health information using culturally appropriate terms and concepts to ensure client comprehension. This subsequently resulted in improved healthcare access and utilization for clients. For example, Joan shared a story where she conveyed an important message to a client by interpreting a doctor's note for her:

When she saw me she asked me 'can you help me', I said 'okay'. So I checked the paper and there was no medicine. Because when she went to emergency room, the doctor found out she's pregnant and she has some issues she needs to go to see the women hospital and when I explained to her, she understands, she says 'ok, oh, I'm pregnant'. She didn't know because she doesn't know English. So I told her 'you're pregnant, that's what the doctor didn't give you any medicine. You have to go to women's hospital.'

Joan's story and similar stories of CHWs interpreting for clients helped to show how communication, trust and advocacy were essential for CHWs in connecting refugee clients to the healthcare system.

Discussion

CHWs are an important part of the health work force often ignored in the literature.

They are community advocates that are instrumental in linking communities with healthcare access (Oliver, Geniets, Winters, Rega, & Mbae, 2015). Obtaining the perceptions of CHWs about their work is important because they are experts in their communities and liaisons between the larger communities and their smaller communities. They navigate between both by using a set of skills that is often unique to them and characterized by a high degree of discretion and informality (Nunes & Lotta, 2019). Previous studies have reported that CHWs are often faced with situations and unforeseen circumstances where they negotiate outcomes by utilizing skillsets gained and sharpened through experience in the community (Nunes & Lotta, 2019).

CHWs have thrived and served their communities through community support, connections with service providers, and personal investment and efforts (Oliver, Geniets, Winters, Rega, & Mbae, 2015). In this study, we did not find any evidence of Lehmann & Sanders' differentiation (2007) between generalists and specialists. In fact, all CHWs involved could be seen as generalists because they acted as specialists in helping refugee clients get connected to the healthcare system. However, their role extended beyond this because they sometimes provided resources to meet distal health needs of communities served. They were especially knowledgeable about community needs and useful resources to meet those needs.

Other studies have reported on the limited resources of CHWs (Nyamhanga, Frumence, Mwangi, Hurtig, 2014; Oliver, Geniets, Winters, Rega, & Mbae, 2015; Sharma, Webster, Bhattacharyya, 2014;). However, for CHWs in this study, being a CHW was not simply a matter of resource allocation, but also an issue of

maintaining professionalism, negotiating how to build trust, and navigating how to help clients utilize health insurance within a given window of time. These skillsets may not be provided with CHW training but were voiced by CHWs in this study as necessary in helping them carry out the scope of their work. Therefore, these CHWs were constantly negotiating between their time, funding allocated for their work, and their primary responsibility.

Limitations

There are a few key limitations in this study. First, each CHW spoke an average of three languages in addition to English, and English was not a first language for any CHW. I did not consider that some may have felt more comfortable or been more conversant if I had interviewed them in a language other than English. I did not ask this question or consider it in the beginning of the study based on the assumption that each CHW was an interpreter and therefore relayed information to community members from English to a native tongue, and vice versa. Second, the CHWs may have participated because I had established trust with them and this may have influenced their responses positively or negatively, although I assured them that their participation would not in any way affect their contract with the CNNC now or in the future. Other CHWs who did not agree or were not able to participate may have had unique perspectives that are not covered here. Furthermore, although a majority of CHWs working with the CNNC are females, more males should be included in future studies. Finally, my experience as a graduate research assistant has influenced the way I conducted the study and my interpretation of it.

Conclusion

This study utilized a constructivist grounded theory to explore the experiences of CHWs working with refugees to connect refugees with the healthcare system within a program in Greensboro, North Carolina. This study made a connection between how CHWs interpreted their role and how this interpretation guided how they did their job. Although there are key limitations, this study included voices of CHWs - the CHWs are integral in bridging gaps in access to care for refugees who are navigating the complex U.S healthcare system. Incorporating their perspectives and experiences in future programming is crucial in helping to provide a better understanding of how they do their job and identification of key resources that will help strengthen the CHW workforce. It is hoped that the findings from this research will help to inform future CHW programs tailored to assist refugees in gaining access to the healthcare system.

CHAPTER VI

DISCUSSION AND IMPLICATIONS

Restatement of Purpose

The overarching aim of this dissertation study was to examine how CHWs affiliated with a program in Greensboro, NC, promoted access to care within the refugee communities that they served. This aim was achieved through a qualitative research study and a constructivist grounded theory approach.

Key Findings

Even though natural helpers are not designed as an intervention tool to replace healthcare providers, natural helpers are expected to bridge communications and coordination of services between refugees and healthcare services (Scott, 2009). In my dissertation, studying CHWs as natural helpers helped me to have a better understanding of how CHWs bridge gaps in access to care for refugees. Refugees looked up to CHWs as leaders and relied on them as a source of information, and their knowledge and guidance often encouraged refugees to take responsibility for their own health and reject ideas of ignorance and helplessness (Scott, 2009). In addition, CHWs as an intervention tool tailored by CHWs who were often refugees themselves led to a consideration of the tendency for refugees to value collaborative interactions with them as members of the same community; this fostered a partnership between CHWs and refugees that was based on trust and mutual respect. It is my hope that health access services delivered by CHWs

as natural helpers will allow refugees to better use health services that are available to them. In addition, past evidence has indicated that refugees are more trusting of people who share the same culture and language. Sharing these qualities allowed refugees to identify with and relate with natural helpers and their health messages.

An informal theory was developed to help explain how CHW participants in this study were able to connect refugees to the healthcare system. The diagram revealed key concepts of CHW work: communication with clients, gaining/building trust, advocating and interpreting; these ideas flow in a logical manner, but are interconnected in duties of CHWs. The challenges identified were on setting boundaries with clients and on navigating the intricacies of healthcare insurance. Setting boundaries was identified by all participants, but each dealt with this challenge in different ways such as working with clients solely to help them gain access to the healthcare system versus helping clients with distal health needs such as providing resources to help them find food. However, health insurance was beyond their control, making it tougher to pinpoint how they handled it, but they collectively wished for an extended coverage for their clients. The concepts identified in the diagram are important because they were identified by CHWs and helped to meet the goal of incorporating CHW voices in my dissertation.

Despite its key limitations, it is hoped that findings from this study will help inform and tailor interventions using CHWs to promote health access with refugee populations in the United States. Furthermore, it will ideally assist in better defining promising practices to enhance the training of CHWs as they work to reduce the existing burden of poorer health outcomes. This study highlights the importance of CHWs

experiences and the need to include CHWs voices in future program planning aimed at improving refugee health and wellbeing.

Significance of the Study

In this study, it was necessary to incorporate CHWs' voices, perspectives and experiences regarding their healthcare efforts within refugee communities because they were trusted key informants within their communities and were experienced in connecting community members with the larger healthcare system. Furthermore, CHWs may hold the key to helping researchers, practitioners and healthcare providers unpack how to address poor health outcomes in refugees because the CHWs are dedicated to building capacity within refugee communities and serving as liaisons between refugees and the larger community. This study departed from the status quo of looking at refugee or professional healthcare provider perspectives, as it aimed to examine the scope of work of CHWs who provide a bridge between their communities and the U.S. healthcare system.

Recommendations and Future Research

In this study, English was not a first language for any participant. However, I interviewed all of them in English. I recommend that researchers conducting future studies should ask CHWs which language they feel comfortable being interviewed in, to ensure that they are able to express themselves freely without being conscious of their pronunciation. Secondly, since the majority of CHWs in this study were female, I recommend that future studies attempt to have more balanced male and female representation. Lastly, CHWs serving refugee communities not included in this study

should be considered because they may have unique perspectives different from the ones reported here.

From a practice perspective, I recommend an evaluation of CHW programs to better allocate and maximize CHW efforts. For example, coordinators of the IHAP program can consider expanding the hours for current CHWs, or hiring more CHWs to better serve larger refugee communities. It may be more feasible to do the former because CHWs in the field have already gained trust with the communities. Overall, re-evaluating program structure with close attention to CHW voices should be tackled by program coordinators in order to strategize the best solutions to help facilitate CHW efforts in fulfilling program goals.

Finally, this study incorporated CHW voices. These voices are visibly missing in the literature because access to care for refugees has focused on the healthcare provider or refugee client perspective. Yet, it is CHWs who bridge gaps in access to healthcare, by being community advocates, community first responders and resource connectors. It is hoped that this dissertation research study opens the door for future research focused on the CHW perspective and will include them in decision-making affecting health and wellbeing of refugee communities. After all, CHWs belong to the refugee community and are invested leaders and stakeholders.

Epilogue

This research process has been by far the most strenuous thing I have ever done. This is because prior to my dissertation study and throughout my graduate study, I identified as a quantitative researcher. However, when my dissertation committee and I

found that a qualitative study was the best way to answer the research questions that I posed, I spent countless hours trying to make sense of how to carry out a primary qualitative research study. The research process was difficult, but I am glad that I undertook it and challenged myself to step outside my comfort zone. As a result, I grew personally and professionally, and I am a more competent researcher because of it.

For the past four years, my role as a graduate research assistant at the Center for New North Carolinians (CNNC) has been part of my identity. I am grateful that in January 2016, Dr. Holly Sienkiewicz gave me the opportunity to serve. She then continued renewing my contract for four years. I feel so fortunate to have worked with individuals at the CNNC who are incredibly passionate about meeting the needs of refugees and immigrants, showcasing their resilience, advocating for them and providing support. This is especially important during these times of shifting immigration policy in the United States. The past few years have been a wonderful journey and everyday has been an adventure. Most importantly, my dissertation topic and dissertation study arose from my experiences at the CNNC and was completed because of the CNNC. I lack the words to express my gratitude.

I am especially grateful to all the CNNC CHWs who participated in this study. I am indebted to them for sharing with me their experiences and perspectives. This study was about them and it is my hope that their voices are heard throughout the study. I will forever remember the dedication and compassion that they put into their work and the sacrifices that they made so that members in their community could have improved access to health. I do not take their time and attention for granted because it is often

stretched to capacity as they play different roles, personally and professionally, aside from being a CHW.

As my people, the Igbo people of Nigeria, say, and I am loosely translating, “no matter how nicely a person dances, he or she is dancing to the tune of the drummer”. I am thankful for my drummers, namely my dissertation committee, who beat the tune that I danced to and carried me through. I am grateful to my mentor, Dr. Sharon Morrison for patiently guiding me throughout this process. I am especially grateful to Dr. Tracy Nichols, Dr. Jennifer Erasquin and Dr. Holly Sienkiewicz for their dedication to my success.

After a wonderful five years, my time at UNCG has come to an end. I am grateful to all who have mentored me during this period and for the many lessons learned. I am happy to see the end of this chapter in my life and I welcome new and exciting opportunities to utilize the skillsets that I have gained. Finally, I look forward to continuing learning, growing and realizing my full potential.

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APPENDIX A

EMAIL RECRUITMENT SCRIPT

Hello (insert name of individual),

My name is Nneze Eluka and I am the principal investigator (PI) of this study. I am a doctoral candidate at the University of North Carolina at Greensboro's Department of Public Health Education. I am contacting you because the CNNC director, Holly Sienkiewicz, recommended you as a potential participant because you are a current or past community health workers who worked with the CNNC to connect adults with the healthcare system.

The purpose of my dissertation study is to document the extent to which community health workers connect refugee adults with the healthcare system in Greensboro, North Carolina, with a concentration on strategies used and negotiation of barriers encountered. Results will be used to inform improved future community health worker programs.

Potential participants are current or past community health workers who have worked with UNCG's Center for New North Carolinians to connect adult refugees with the healthcare system, are at least 18 years old and have the willingness and capacity to provide voluntary informed consent.

The data collection methods that I will use in this study are demographic questionnaire and individual interview. The questionnaire would contain questions such as age and length of time being a CHW to help create a de-identified CHW profile. During the interview, I will ask each participant questions about his or her experiences as a CHW.

The questionnaire and individual interview will be completed on the same day and will last about 1 hour, 2 hours maximum. Both will be conducted through the phone or in a location selected by each participant.

I will offer each participant will be offered a \$10 gift card as a token for participation.

Do you think that you would like to participate in this study? If so, please email me to let me know that you are interested so that I can go ahead and save your information, and get in contact with you. If not, thank you for reading. If you would like to take time and think about it, please contact me via telephone at (919) 518-5577 or via email at nneluka@uncg.edu. Thank you.

APPENDIX B

IN-PERSON RECRUITMENT SCRIPT

Hello (insert name of individual),

My name is Nneze Eluka and I am the principal investigator (PI) of this study. I am a doctoral candidate at the University of North Carolina at Greensboro's Department of Public Health Education. I am contacting you because the CNNC director, Holly Sienkiewicz, recommended you as a potential participant because you are a current or past community health workers who worked with the CNNC to connect adults with the healthcare system.

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APPENDIX C

TELEPHONE RECRUITMENT SCRIPT

Hello (insert name of individual),

My name is Nneze Eluka and I am the principal investigator (PI) of this study. I am a doctoral candidate at the University of North Carolina at Greensboro's Department of Public Health Education. I am contacting you because the CNNC director, Holly Sienkiewicz, recommended you as a potential participant because you are a current or past community health workers who worked with the CNNC to connect adults with the healthcare system.

The purpose of my dissertation study is to document the extent to which community health workers connect refugee adults with the healthcare system in Greensboro, North Carolina, with a concentration on strategies used and negotiation of barriers encountered. Results will be used to inform improved future community health worker programs.

Potential participants are current or past community health workers who have worked with UNCG's Center for New North Carolinians to connect adult refugees with the healthcare system, are at least 18 years old and have the willingness and capacity to provide voluntary informed consent.

The data collection methods that I will use in this study are demographic questionnaire and individual interview. The questionnaire would contain questions such as age and length of time being a CHW to help create a de-identified CHW profile. During the interview, I will ask each participant questions about his or her experiences as a CHW.

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Do you think that you would like to participate in this study? If so, I can go ahead and save your information so that I can get in touch with you. If not, thank you for listening. If you would like to take time and think about it, please contact me via telephone at (919) 518-5577 or via email at nneluka@uncg.edu. Thank you.

APPENDIX D

INDIVIDUAL INTERVIEW GUIDE

1. From my experience studying community health workers, I have found that there is a lot of confusion about what community health workers actually do! How do you introduce yourself as a CHW to people in the refugee communities that you serve?
2. How do you connect with refugees who are new in the community?
3. Starting from the beginning, can you describe the steps you would take when working with a new client?
4. How about during a second or third contact with a client, what type of services would you provide after the first contact?
5. Can you tell me more about how you would follow up with clients after you have helped them to connect with the healthcare system?
6. There are a lot of success stories that have been recorded with CHWs working with refugee clients. Can you reflect a bit on your own experience as a CHW and please share with me one success story from your experience?
7. Thank you for sharing that. How did you feel about your role in creating that success story?
8. Let us now turn to barriers, because there are success stories alongside barriers in the CHW field. Can you reflect on your experiences and please share one barrier that you have experienced?
9. How did you handle or navigate that barrier?
10. You mentioned earlier that you have worked with refugees for (length of time) and been a CHW for (length of time). What events led to you becoming a CHW?
11. Tell me about the strengths or skills that you have developed or discovered through serving as a CHW?
12. Given your CHW experience, what advice would you give a new CHW? And why?
13. Is there something else you think I should understand about being a CHW?
14. Is there anything you would like to ask me?

APPENDIX F

IRB INFORMATION SHEET

Project Title: Community Health Worker Strategies to Increase Access to Healthcare for Refugees

Principal Investigator: Nneze N. Eluka

Faculty Advisor: Sharon D. Morrison, PhD

What is this all about?

I am asking you to participate in this research study that aims to examine how community health workers connect adult refugees with the healthcare system. You are a potential participant because of you have worked as a community health worker. This research project will take approximately three hours of your time spread out in five to six sessions, and will involve your participation in an individual, in-depth interview and potentially a follow-up individual interview. Your participation in this research project is voluntary.

How will this negatively affect me?

No, other than the time you spend on this project there are no known or foreseeable risks involved with this study.

What do I get out of this research project?

There are no direct benefits to you. The community might benefit from the results obtained and these results may be used to improve future community health worker programs.

Will I get paid for participating?

Yes. You will be offered a \$10 gift card as a token for participation.

What about my confidentiality?

We will do everything possible to make sure that your information is kept confidential. All information obtained in this study is strictly confidential unless disclosure is required by law. We will take measures to ensure confidentiality i.e. we will not ask for any identifying information, we will use pseudonyms, we will store data (audio recordings and transcripts) in a password-protected folder in UNCG Box. Because your voice will be potentially identifiable by anyone who hears the recording, your confidentiality for things you say on the recording cannot be guaranteed although the researcher will try to limit access to the recording as described in this section.

What if I do not want to be in this research study?

You do not have to be part of this project. This project is voluntary, and it is up to you to decide to participate in this research project. If you agree to participate, then at any time in this project you may stop participating without penalty.

What if I have questions?

You can reach Nneze Eluka at (919) 518-5577 or nneluka@uncg.edu or faculty advisor Sharon Morrison at (336) 334-3243 or sdmorri2@uncg.edu to ask anything about the study. If you have concerns about how you have been treated in this study call the Office of Research Integrity Director at 1-855-251-2351.

APPENDIX G
PERMISSION LETTER



March 18, 2019

Melissa Beck, MHA, CIP
Associate Director
Office of Research Integrity
University of North Carolina at Greensboro
2718 Moore Humanities & Research Administration
Greensboro, NC 27402

Dear Ms. Beck,

The UNCG Center for New North Carolinians (CNNC) is committed to the health and well-being of all immigrants and refugees. As part of this commitment, we support the dissertation research of Nneze Eluka that includes interviewing community health workers (CHWs) affiliated with the Immigrant Health Access Project.

This letter provides permission for Ms. Eluka to conduct interviews with current and previous CHWs, analyze the data, and disseminate findings for her dissertation study. Although Ms. Eluka's research is independent of the CNNC, I approve her using the CNNC as a site to recruit CHWs for her study. IHAP staff and I are supportive of Ms. Eluka's research aimed at constructing a theory on roles and strategies of CHW participants to help inform future evidence-based and culturally-appropriate interventions utilizing the CHW model. I understand the project proposal will be reviewed and approved by UNCG Institutional Review Board for Research Involving Human Participants prior to data collection.

If you need further information in support of this project, please contact me by phone at (336) 334-9814 or by email at h_sienki@uncg.edu.

Sincerely,

A handwritten signature in black ink, appearing to read "Holly Sienkiewicz".

Holly Sienkiewicz, DrPH
Director / Research Scientist
UNCG Center for New North Carolinians