Abstract

More than 58,000 refugees were resettled in the United States in 2012 according to statistics from the United Nations High Commissioner for Refugees (UNHCR, 2013), and up to 70,000 people are slated to be resettled by the end of 2013. These numbers will likely increase as those fleeing persecution from areas such as Syria, the Central African Republic, and the Democratic Republic of Congo begin a new life here (UNHCR, 2013). The state of North Carolina received 2203 refugees in 2012 (North Carolina Department of Health and Human Services, 2013), and was allotted resources to resettle approximately 4000 people in 2013 (Office of Refugee Resettlement, 2013). North Carolina’s refugee population continues to grow, with resettlement and state agencies struggling to secure adequate resources and develop programs to keep pace with increased needs.

The refugee resettlement process is complicated and fraught with challenges for both refugees and for the agencies involved in their resettlement. There is much to accomplish during a short time, making the resettlement process intense. The State Department funds a ninety-day period during which resettlement agencies assist refugee clients in becoming self-sufficient. These agencies work with refugee clients to cultivate skills in financial literacy, housing, English skills, employment, and health care. While there are common barriers across areas, each area has unique challenges as well.
Barriers to health care for refugees include but are not limited to language, availability of interpreter services, financial costs, transportation, issues of insurance, cultural barriers, and issues of health literacy.

For many refugee clients in North Carolina, improved health literacy is essential to improving both personal health and the ability to navigate the North Carolina health care system. Improved health in the refugee population benefits both the individual and the community. Resettlement agencies are working on innovative ways to address and improve health literacy for their clients, as effective methods will become even more important as North Carolina’s refugee population increases. The use of health classes or health workshops is one such effective method for improving health literacy. In this paper I will examine the methods implemented by a Durham, North Carolina resettlement agency to improve refugee health literacy and will provide recommendations for further development.
In memory of my father, George Andrew Scoville. Your love and belief in me provided the strength needed to see this to completion.
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List of Abbreviations of Agencies and Jurisdiction

HHS: Health and Human Services, U.S. Department of (Federal)
IOM: Institute on Migration (International)
NCDHHS: North Carolina Department of Health and Human Services (State)
ORR: Office of Refugee Resettlement (Federal)
PRM: Bureau of Population, Refugees, and Migration (Federal)
UNHCR: United Nations High Commissioner for Refugees (International)
USCRI: United States Committee for Refugees and Immigrants (Federal)
USRP: United States Resettlement Program (Federal)
VolAg: Voluntary Agency (Federal/State)
Introduction

There are currently 15.2 million refugees globally, according to the United Nations High Commissioner for Refugees (UNHCR, 2013). Of those 15+ million people, many are able to receive support until it is safe for them to return home. Still others are able to remain in the country they fled to. A very small percentage—less than one percent—are resettled in third countries, including the United States, with the U.S. taking in over half of this one percent group and the rest distributed among the other resettlement countries (Bureau of Population, Refugees, and Migration, 2013). Of the 58,238 refugees sent to the United States in 2012, 2203 were resettled in North Carolina. North Carolina was allotted resources to resettle up to 4000 refugees during 2013, a significant increase over the 2203 refugees resettled in North Carolina in 2012 (Office of Refugee Resettlement, 2013).

The goal of the domestic refugee resettlement program is to assist individuals in becoming independent quickly. Barriers to resettlement complicate the process, and exist for both the refugee client and the resettlement agency. Among the areas focused on (financial literacy, employment, language skills, housing, and health care), health care presents several challenges. Barriers to health care include language, finances, insurance coverage, transportation, and health literacy.

Agencies that work with refugee clients are continuously seeking ways to overcome barriers and facilitate growth and self-sufficiency for the clients. One method increasingly used by agencies that assist refugees in North Carolina is the use of Health
Classes or Health Workshops to increase knowledge, teach skills, and improve health literacy. Methods utilized to improve refugee health literacy by World Relief, a Durham refugee resettlement agency, will be examined and discussed in this paper.
Background

The Refugee Experience

Refugees are people who have been persecuted and displaced from their homes, who literally flee for their lives and are often unable to return to their country of origin, their old homes and their old way of life. A refugee is defined by the UNHCR’s 1951 Refugee Convention as 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, 2013). They face persecution, discrimination, torture, and the threat of death based on race, ethnicity, religious beliefs, or political opinions.

Of those more than 15 million refugees, most will receive assistance until they can safely return to their home country, though it may take years. Some refugees are granted permission to remain and repatriate in the country that they fled to, and a very small percentage—less than one percent, or 1.52 million in 2012—are resettled in third countries because it is simply too dangerous for them to return home. In 2012 the United States received approximately half of these third-country resettlements (Bureau of Population, Refugees, and Migration, 2013).

The process of being awarded refugee status is long and difficult (see Appendix A). It begins when a person who has fled to another country or a camp for displaced people registers with the UNHCR and applies for refugee status. Once that status is
approved, a resettlement plan is created, and referrals to appropriate agencies are made. For those referred to the U.S. Resettlement Program, there is a pre-screening process, an interview with officials from the Department of Homeland Security or the U.S. Customs and Immigration Service, fingerprinting, and security clearance procedures. After approval for resettlement in the U.S., the refugee client is referred to the Institute on Migration (IOM) for medical clearance exams, and is assigned to one of the voluntary agencies (VolAgs) in the United States that works in resettlement. The IOM then arranges final travel arrangements. The average for this process is 12-15 months, but it can take many years (Bureau of Population, Refugees, and Migration, 2013).

The people fleeing persecution and applying for refugee status come from all over the world, but approximately half are from Asia and about 28% are of African origin. They vary widely in background, experiences, education, and living conditions. (UNHCR, 2103) Many live in refugee camps for years, some are born in the camp, and some are born and then grow old in the camps waiting for resettlement. Many refugees have not had experience with a structured health care system, and have had little to no formal medical care. The only type of medical care some may have had was a field hospital or clinic that took hours or days to walk to.

They arrive in the United States, exhausted, bewildered, and ill-prepared to assimilate quickly. The resettlement process works to prepare refugees for independent living as they begin their lives over again in a new country.
The Resettlement Process

Nine voluntary agencies (VolAgs) are approved to work with the federal Office of Refugee Resettlement, a division of the U.S. Department of Health and Human Services. World Relief is one of those agencies, and has twenty-three offices in the United States, including offices in High Point, North Carolina, and Durham, North Carolina. In addition to World Relief, three other refugee resettlement agencies work in the Raleigh/Durham area: Church World Service, USCRI (US Committee for Refugees and Immigrants), and Lutheran Services Carolina. The World Relief Durham office, smallest of the four Raleigh/Durham agencies, began work in refugee resettlement in 2007 and has resettled increasing numbers of refugees in Durham, Orange, Wake and surrounding counties. Of the 2203 refugees resettled in North Carolina in 2012, approximately 200 refugees were resettled by World Relief Durham.

In most states, including North Carolina, the resettlement process in the receiving or host community begins prior to the refugee client’s arrival (see Appendix B). Once a resettlement agency is notified of the refugee’s arrival date, housing is secured and set up, health screenings are set up at local health departments, and U.S. ties and volunteers are contacted. Orientation to living in the United States begins immediately upon arrival, with case specialists going over safety features of the house and making sure the client knows how to use the stove, fridge, toilet, and shower; how to lock the door, and how to contact emergency services and the case specialist. More detailed orientation sessions and program enrollments typically begin the day after
arrival. The process of resettlement is intense. According to the Office of Refugee Resettlement’s *Refugee Resettlement 101* tutorial, the U.S. Resettlement Program’s goal is “self-sufficiency within eight months”; however, the initial phase of the resettlement period that is funded by the State Department is only ninety days. Within those first ninety days, agencies are tasked with helping refugee clients learn financial literacy, learn English quickly, obtain a state I.D., obtain required health screenings, and gain employment. North Carolina refugee clients are also enrolled in Medicaid, Food Assistance programs, and placed in programs that supplement income such as Refugee Cash Assistance for single adults or Matching Grant Programs for six to eight months or until they are employed (North Carolina Department of Health and Human Services, 2013; Office of Refugee Resettlement, 2013). North Carolina requires adults in refugee families to enroll in TANF (Temporary Assistance for Needy Families), which carries a work requirement. While the objective measure and validation of what constitutes “self-sufficiency” is subject to debate, it generally implies that a refugee client can obtain employment, earn enough to sustain housing and a basic standard of living, can navigate the area with public transportation, is actively learning English, and can access necessary services such as health care and social services. Each refugee resettling in North Carolina receives initial Reception and Placement funding in the amount of $925.00 from the State Department for a ninety day period. Cases may remain open beyond ninety days to ensure self-sufficiency in areas such as employment or health care. The resettlement agency utilizes funds from additional grants when necessary, as well as relying on volunteer assistance.
Refugee clients’ experiences, educational levels, cultures, and backgrounds vary widely. Some clients move quickly through the initial period and gain employment and independence quickly, while others struggle with one or more area and require additional resources and time. In addition to the enormous challenge of learning a new culture and starting a new life, other barriers to independence include:

--Language: Some refugee client may be illiterate in their own language, or may struggle with learning basic English.

--Transportation: Though refugee clients may be placed in housing near bus lines, they still have to learn to navigate bus routes, timing, and how to get to and from destinations. Depending on a resettlement agency’s policy, refugees may be housed near factories, or within walking distance of their resettlement agency. For refugees with medical issues, transportation issues can be quite difficult.

--Financial literacy: For many refugees, learning a new currency system, setting up a bank account, balancing a check book, and paying bills on a monthly basis is very difficult and takes several months to learn. For some, the concept of writing a check and mailing it to the appropriate agency before the due date is utterly unfamiliar, and navigating late bills and medical collection agencies can prove impossible. Some refugee clients arrive without any experience with a currency system, requiring intensive teaching and assistance.

--Health Literacy: Consider how difficult it can be for the average American citizen to establish primary medical care, understand and utilize health insurance benefits (or lack thereof) and understand medications/pharmacies. For a refugee client with no
prior health care system experience, this can sometimes prove to be the area where self-sufficiency is a struggle and may take many months, or may simply not be attained.

The resettlement process can be likened to a preceptor guiding a new professional, or a parent preparing a teenager for independence. The work of facilitating a refugee’s successful navigation of a new culture involves a delicate balance. The agency personnel strive to provide as much information and facilitate as much skill as they can in a short time period, without creating dependency. There is a bit of a sink-or-swim mentality, for funds and resources are limited. The goal is to see each client become self-sufficient enough to create and sustain a decent life for themselves. There are volunteers and local agencies that can provide assistance during this transition, but the fear of a refugee client failing or getting lost in the system lurks in the back of each case specialist’s mind. The area of health care has proven to present challenges on a consistent basis. Refugee clients struggle to establish and maintain primary medical care, and many have difficulty with the concept of appointments and follow-up care. There are many unique barriers to health care for the refugee population.
Barriers in Refugee Health Care

Refugees arrive in the United States from many different countries. They bring with them the experiences and cultures of their home country and perhaps the country they fled to. They bring with them the cumulative effects of years of persecution, fear, and neglect. They come from busy urban centers and from the bush, they are young and old, they are healthy and injured or ill. They are farmers and they are professors. Some are overjoyed and talkative; others are silent, fearful, and withdrawn. Many leave behind spouses, children, and parents. Many arrive with only one change of clothes and the large white IOM bag containing the documents they will need. It is no wonder, then, that the widely varied experiences and cultures they come from can also create various barriers to obtaining health care. Barriers to establishing health care for refugees arriving in the U.S. and in North Carolina exist for both refugee clients and the resettlement agencies and health care facilities that work with them. The most common barriers include language issues, transportation, health insurance, knowledge of the health care system, and health literacy (Eckstein, 2011; Reavy, Hobbs, Hereford, & Crosby, 2012).

Language issues present challenges for all involved. It can be difficult to locate clinics and health care providers that offer either on-site medical interpreters or a language-line phone service. Often, a clinic may have a language line system and a practitioner does not know how to utilize it, and the system is not available at check-in/registration or in ancillary services such as the Lab. A client may be conversational
in English, but the subtleties and details found in medical conversations make effective communication difficult, so it is best to rely on professional interpreter services. Sometimes a family member or community member will volunteer to interpret, but this creates problems with patient confidentiality and accuracy. Another language issue is that some languages simply do not have words for English medical terms or conditions, and so the concepts can be difficult to convey. Finally, some refugee clients are afraid to question medical practitioners or ask for further interpretation, and simply say, “Yes” to everything, creating a situation in which the practitioner does not get an accurate clinical picture and the client does not receive appropriate treatment. In 2009, a new clinical care model for refugees was successfully piloted in Idaho that incorporated the ecological model and cultural safety principles to address this issue (Reavy et al., 2012).

Once a clinic is found that offers or accommodates language services, the resettlement agency must ensure that they accept Medicaid patients and will offer a sliding-scale fee schedule if the refugee client becomes uninsured. The concept of insurance, Medicaid, and clinic fees/billing must be explained clearly to the refugee client during orientation sessions and reinforced by case specialists periodically. In addition, the clinic will need to be accessible by public transportation so that the client can keep appointments. The availability of appointment times can be a challenge for refugee clients who work twelve-hour shifts or night shifts, or have a long commute and are only available in the evenings or on weekends. Asking for time off for medical appointments can mean the loss of employment. The refugee client is then placed in the position of choosing between medical care and employment.
Another barrier to adequate medical care is knowledge of the health care system in North Carolina. For many refugee clients, a field hospital or refugee camp clinic addressed all health care needs. The concept of established care with one particular clinic, a medical “home”, is completely novel and unfamiliar to many refugees, and consequently, the concept of making appointments and keeping them is a skill they must learn. It is also important to explain the difference between the Emergency Department, an Urgent Care Center, and a Primary Care Clinic, and to explain when each might be needed or accessed.

Health literacy refers to “an individual’s capacity to obtain, process, and understand basic health information and services” (Geltman et al., 2013). In light of this definition, improving health literacy for refugee clients can reduce the barriers of language needs, transportation/access issues, health care system knowledge, and personal health literacy in regard to one’s own medical care. Increasing refugee health literacy during the resettlement phase is one way to address these challenges, and to improve the likelihood of a client becoming self-sufficient in accessing and participating in medical care.
Health Literacy in Refugees

Implications of Low Health Literacy Levels

Low health literacy levels in refugee clients affect not only the refugee client and his or her family, but also the surrounding community in many ways. Multiple studies show correlations between low health literacy and poor oral health (Geltman et al., 2013), effective, comprehensive medical care (Eckstein, 2011; Mancuso, 2011), and completion of important preventive health services (Morrison et al., 2012). The refugee population has been shown to have a higher prevalence of chronic disease burden than other immigrant populations in the U.S. (Yun et al., 2012). In addition to chronic diseases, refugee clients in the U.S. are at a higher risk for increased rates of infectious diseases such as tuberculosis (Liu et al., 2012) and complications from parasitic diseases such as neurocystercercosis from *T. solium* infection (a central nervous system involvement of pork tapeworm infection) (O’Neal et al., 2012). Low health literacy impacts the understanding of disease processes, the need for screening services and appropriate follow-up, and compliance with treatment. Though all U.S.-bound refugee clients are screened for communicable diseases such as tuberculosis, hepatitis B, syphilis and other sexually-transmitted diseases prior to departure (Centers for Disease Control, 2012), they must keep initial health screening appointments and follow-up appointments for appropriate treatment of any conditions diagnosed after arrival in the United States. Without adequate health literacy, chronic and infectious diseases can go untreated. The burden of untreated chronic disease will adversely affect personal
health, employment capacity, and financial security. It may also lead to overuse of Emergency Department services and increased medical costs. Infectious diseases, left untreated, will damage the health of the refugee, and may affect the health of his or her family, and the surrounding community. Some conditions such as hepatitis A or parasitic infections are food-borne, and many refugee clients find work in food service or food-processing plants. Infectious diseases that are untreated or incompletely treated present a valid threat to both the client and to community health.

By increasing health literacy levels, clients can begin to understand how important it is to keep follow-up appointments and complete treatments, and what the potential consequences of untreated conditions might mean for them. Increased preventive and primary care can reduce the use of Emergency Departments, increase employability and productivity, and prevent complications. Increased health literacy will also assist refugees in better navigating health care facilities, understanding insurance, and in establishing medical care with a designated provider or clinic, i.e., a medical home.

**Methods for Increasing Health Literacy**

There are many methods that can be used to facilitate increased health literacy in the refugee population. In many states, including North Carolina, Health Departments and clinics utilize medical interpreters and written materials translated into the refugee’s native language. The majority of U.S. resettlement agencies provide health orientations with continual reinforcement and assist the refugee in obtaining an initial health screening appointment, and often assist with linkage to a primary care
provider. However, given the volume of information a refugee must absorb, the pace and intensity of the initial ninety day resettlement phase, and the task of adjusting to an entirely new culture, retention of health-related information may be suboptimal.

One method that is used increasingly by North Carolina agencies that work with refugees is the Health Class or Health Workshop, and can take various forms. Church World Service in Durham partners with the University of North Carolina’s Refugee Health Initiative, and UNC students provide home visits with refugee clients. During the regular visits, the students and an interpreter assist clients in learning how to access and establish medical care (Church World Service RDU, 2012). Duke University’s Duke Refugee Aid organization launched a new program this year aimed at providing workshops to increase refugee health literacy (Duke Refugee Aid, 2012). World Relief in Durham, North Carolina developed a Health Class program and examined ways to improve Health Orientation sessions.
Case Study: World Relief Durham

During the 2012 fiscal year, World Relief Durham implemented a new program aimed at increasing health literacy for newly-arrived refugee clients. During 2012, both total numbers of refugee arrivals and the number of refugees with significant medical needs increased. The shift from a relatively healthy population to one with more significant health issues required not only increased linkage to medical care but also required increased efforts to facilitate self-sufficiency in clients accessing and staying in care. The resettlement process was examined to determine optimal times for access to a majority of recent arrivals. Potential time periods and methods were identified by the health care coordinator and the resettlement director. The Health Orientation and Health Assessment process, typically done by the health care coordinator within a week of arrival, provides individual time with each refugee client and an interpreter. Another optimal period was immediately following the required weekly Employment Skills class. Most of the recently arrived refugee clients would be in the office and have interpreters already present for each language need.

Health Orientation/Health Assessment

The Health Orientation was redesigned to include information on the North Carolina health care system, Medicaid, the Health Screening process, transportation to clinics, and any medical issues the agency was already aware of. It was also utilized as an opportunity to establish a connection and a working relationship with each client.
The Health Assessment, an individualized medical screening questionnaire, included sections for past and current medical history, medication, allergies, and untreated illness/injuries. It was revised to include a section for surgical history and a more detailed past medical history. The review of systems section was revised to provide a comprehensive review of all major systems and detailed documentation of any positive symptoms. Mental health issues and substance abuse issues were also included as brief screening questions. These revisions allowed for a more thorough history and more detailed clinical assessment, both useful when linking refugees to appropriate medical care.

By gauging the refugee client’s responses and comfort level during the Orientation and Assessment process, a rough indicator of health literacy could be obtained, and areas where literacy seemed low could be brought to the case specialist’s attention. For example, a refugee client who was well-versed in his or her medical history and had obtained medical care in an urban setting would require less intervention than a client from a rural area who could only name vague symptoms and had never received formal medical care. Increased needs for improved health literacy were then addressed by both the case specialist and the health care coordinator. Though subjective in nature, the Health Orientation and Assessment provided a good starting point for assessing and increasing individual refugee health literacy.

Health Classes

The second and more objective method was the implementation of weekly Health Classes. An initial format for the classes was designed in June 2012. The health
care coordination intern worked with office staff to determine salient health education needs and optimal times and settings to conduct the classes. The initial proposal (see Appendix C) was approved by the resettlement director, and class topic modules were developed using available online resources from the Refugee Health Information Network, the Cultural Orientation Resource Center, the U.S. Committee for Refugees and Immigrants, Health Roads Media, and the Center for Applied Linguistics (see Appendix C).

Using the above resources and input from World Relief staff, six topics were identified:

-- Nutrition (Child and Adult)
-- Dental Care (Child and Adult)
-- Women’s Health, Child Care
-- Navigating the U.S. Health Care System
-- Visiting the Doctor and Pharmacies

Primary countries of origin were identified for the Durham office refugee client population as Burma, Iraq, Democratic Republic of Congo, Somalia, South Sudan, and North Sudan. As class topics were developed, dietary and cultural factors for each group were taken into consideration and incorporated. Written materials for hand-outs and take-home materials were obtained in English and relevant language translations using the above-mentioned online resources. The format proposal, class module templates, hand-outs and written materials, and visual aids were organized into a centrally-located binder for office use.
It was determined that the most effective time to conduct the Health Class would be immediately after the Employment Skills Class. The majority of refugee clients are required to attend a minimum of eight weeks of Employment Skills training during the initial phase of resettlement. World Relief Durham resettles clients in Durham, Orange and Wake counties, but a significant portion of clients are in Durham or Orange County. For Wake County and some Orange County clients, Employment Skills training takes place at the clients’ home, but a significant number of clients in Durham and Orange County attend class at the World Relief office. Each refugee’s language need is met by having interpreters for each language present for class. Therefore, a significant portion of newly-arrived refugees and their interpreters would already be present in the office, providing the best opportunity to reach the most people. Health Class was presented as an optional class, and it was made clear that though Employment Skills training was required, attendance at Health Class was not required but that all were welcome and encouraged to attend.

The first Health Class was offered in July 2012, and served as an introduction to the format and goals of holding the class. It was also a time for the health care coordinator to ask refugee clients what they hoped to gain from Health Class and to ask for ideas on topics and class format. Knowing that some cultural factors might inhibit refugee participation and questions, this was also addressed. The health care coordinator let clients know that this was their class, and that the goal was for them to participate and get as much out of the class as they needed, and to feel free to ask questions or add information. The atmosphere was then set as one that encouraged discussion and facilitated exchange.
Health Classes were held on a weekly basis and over the course of a few weeks, the staff found that not only did everybody stay for Health Class, refugee clients continued to attend Health Class after they had completed their eight-week Employment Skill training. The first few months of Health Class were fluid, as the health care coordinator and the refugee clients tried different topics and approaches to see what worked best. For this initial period, the goal was to impart adequate information to clients, answer questions, and gauge response and feedback. At the end of each class, the health care coordinator asked for feedback from both refugee clients and interpreters. As clients and interpreters became more comfortable and interactive, an effective format for the Health Class emerged.

Through collaboration with refugee clients, interpreters, and the health care coordinator, it was determined that a group setting arranged in a circle enhanced far more participation than a lecture hall-style setting. Some structure was needed to keep everyone focused, so it was requested that personal health care issues be discussed individually after class. Introductions were done at the beginning of each class, and a sign-in sheet was circulated. This helped the group learn each other’s names, practice writing their names in English, and tracked attendance. Relevant hand-outs in each language were circulated. The topic was introduced, and the health care coordinator and interpreters worked together to present a small section, have it translated to the clients, visually gauge comprehension, and continue to the next section. Prior to each topic presentation, the health care coordinator asked refugee clients what their experience or normal customs were for each topic, i.e., “Tell me about dental care in your home country.” “Tell me your thoughts on what a healthy meal is.” The class
facilitator then used those responses along with personal examples to make the topic relevant. After the topic was covered, question-and-answer sessions followed. At the end of each session, the health care coordinator asked for feedback on the topic and for further topic ideas. After Health Class, the health care coordinator was available to meet individually with refugee clients to answer questions or assist with health-related issues.

The original six topics were presented at least once except for Women’s Health, as there was not an opportunity to meet with the female refugee clients separately. Transportation, interpreter availability, child care, time, and cultural issues were a barrier to a separate Women’s Health Class. It quickly became apparent that the most well-received topic was Nutrition, followed closely by Dental Care and Navigating the U.S. Health Care System. The Child Care module was not met with much enthusiasm. Refugee clients requested information on latent tuberculosis and on the Health Screening process, so those topics were added, as well as a class on seasonal influenza and the flu vaccine.

As discussions with refugee clients and interpreters continued, the Health Class topic modules developed into eight areas that were well-received and garnered the most discussion and questions:

--Nutrition I (basic nutrition, healthy diets, cooking methods)

--Nutrition II (shopping and cooking on a budget, navigating grocery stores, reading labels)

--Dental Care
The format of the Health Class and the regular meeting time and place developed into a setting for exchanging information not only between the health care coordinator and refugee clients, but also between clients from different countries. The atmosphere of shared learning facilitated comfort in asking questions about class topics and for refugee clients to ask about individual health issues and needs. It quickly became routine that the Health Class would last an hour, and then another hour would be spent in individual consultation to answer questions, solve problems, and address needs. It also became clear that there was a need to develop and standardize methods to help refugee clients increase health literacy in relation to making/keeping appointments and follow-up care. These issues were addressed by the health care coordinator and the case specialists, and steps were taken to develop effective methods such as written appointment cards with maps and bus routes attached, and letters from World Relief Durham explaining the mandatory nature and importance of Refugee Health Screening appointments for refugee clients to give to their employers and schools.
The Health Class format and topics continue to be a work-in-progress, and are currently being standardized into materials that any staff member or intern can access to effectively facilitate class. World Relief Durham currently serves as a site for students from the Watts School of Nursing to obtain their Community Health/Underserved Population clinical experience, and the nursing students have been instrumental in the continuing development of the Health Class and associated materials. Through their work, the Nutrition Class module has grown to include a “grocery store field trip”. Nursing students, refugee clients and interpreters take a trip to a local grocery store where healthy choices, reading labels, and cost-saving ideas are demonstrated.
Conclusion

Given the increasing numbers of refugees who will be resettled in the United States, the need for increased health literacy, and the short amount of time resettlement agencies have with each client, Health Classes offer an effective method to evaluate refugee clients’ health literacy and facilitate improvement on an individual level. The example of the implementation, response, and initial modifications to the Health Class format by World Relief Durham provides a platform for further development of a formal Health Education protocol and for evaluation methods.

Strengths: The first year of Health Class offered insight into best practices for ensuring refugee client participation and for developing a format that is well-received and accessible. Requesting and incorporating refugee client input resulted in class topics that were relevant and useful to refugees. Creating an atmosphere of shared learning and placing as much importance on refugees’ experiences and contributions as the class material was key; refugees reported feeling respected and comfortable, and the shared dialogue model led to increased individual consultations for assistance with health issues. The environment of mutual respect and building of relationship based on mutual experiences facilitated refugee clients’ comfort in contacting the health care coordinator outside of class time for assistance. The combination of shared learning, a comfortable and mutually respectful atmosphere, along with access to the health care coordinator for advice resulted in increased dialogue, increased requests for assistance
with health issues and medical appointments, and increased participation in class, all markers of improved health literacy.

*Weaknesses:* Though the initial implementation of Health Classes was felt to be successful and resulted in positive feedback from refugee clients, increased attendance, and increased discussions, it also highlighted the need for essential changes and further development. The topics required standardization (i.e. not taught ‘off-the-cuff’) and needed to be organized into a format that could be accessed by World Relief staff, interns, or nursing students so that anyone could teach Health Class at any time. Each module required additional visual aids, and development of Power Point presentations to accompany them. Attendance needed to be tracked carefully as well. The individual discussions after Health Class tended to become a crowded free-for-all. Given the scarcity of time and increased work load of case specialists and health care coordinators, those discussions should be scheduled or conducted one-on-one in a private setting. Organization and standardization of Health Class topics will be key to ensuring the sustainability of this format, as well as adequate funding.
Recommendations

Methods for Evaluation

In addition to addressing the above-mentioned areas of Health Classes needing improvement on a practical level, an essential recommendation is the development of evaluation tools. While the initial Health Class format used at World Relief, Church World Service, Duke Refugee Aid, and other organizations is proving valuable, the need exists for objective collection of data to determine if these classes significantly increase refugee health literacy. The goal of increased refugee health literacy needs to be met for improved health of the individual, the community, and subsequently, the financial health of the individual and the community. Increased health literacy will also reduce burdens on health care agencies and refugee case specialists.

If it can be shown with statistical significance that the Health Class format does indeed increase refugee health literacy, these findings will aid in providing stakeholders with information to grant increased funding for further development and distribution of this method. However, if it is shown that while useful, refugee health literacy is not significantly increased using this method, Health Classes can still be used as a tool to assist in assimilation, build relationships, and offer information, but will not be as heavily prioritized or funded as other interventions.

Evaluating the effect of the Health Class format on refugee health literacy will involve several approaches. Development of tools will be needed to assess health literacy levels at baseline, after the completion of Health Classes, and perhaps six
months after the refugee client’s case is closed, to determine the effect of the classes on a long-term basis. Assessment tools will need to be simple to use and easy to assimilate into the Health Orientation. Health Orientations and Assessments are carried out by a variety of staff, from interns to case managers with varying educational and health care backgrounds. There are time constraints for all staff members involved in resettlement, necessitating a simple, user-friendly format. The assessment tools will need to provide quantifiable data; specifically, they should provide a way of ‘scoring’ health literacy for each refugee and a corresponding scale. An additional benefit of utilizing an objective assessment tool with a scoring system would be the ability to provide different levels of educational materials to refugee clients based on their initial health literacy score, making the process more efficient and productive. The evaluation of Health Class effectiveness would need to be studied across agencies to control for variables such as differences in teaching format, number of clients in attendance, differences in cultures represented, and types of material presented.

In theory, a grant would be applied for to create an assessment tool to measure health literacy levels over time, to analyze collected data, determine the statistical significance of the data, and examine the objective effect of the Health Class format on refugee health literacy. Those findings would then potentially lead to funding for development of a model that could be standardized and distributed across resettlement agencies in North Carolina and the U.S., providing a Health Class program that is sustainable and reproducible. One possibility would be to include development of evaluation methods and required funding into existing health service grant applications.
The Role of Public Health Leadership

Opportunities abound for public health involvement and leadership throughout the refugee resettlement process and efforts to improve refugee health literacy. The position of Health Care Coordinator at refugee resettlement agencies is not always filled by a person with medical or public health experience. Those educated in Health Behavior or Health Education would greatly benefit the agency and the refugee clients. Consulting with health policy specialists and biostatisticians would be essential in developing a grant proposal, evaluating the Health Class format, and analyzing the results. Equally important is the need for Public Health Leadership. Refugee resettlement involves agencies from Federal and State levels to county Health Departments; it involves grant proposals, policy evaluation and changes, an understanding of the refugee experience from a Global Health perspective, and an understanding of the U.S. health care system. Refugee resettlement also requires an understanding of epidemiology on local and global levels. Those in refugee resettlement must have a commitment to meeting the needs of underserved populations while also maintaining the health of the community. Refugee resettlement and health care is quintessentially interdisciplinary, and requires public health leaders that can work among and between disciplines, agencies, and systems to achieve positive, sustainable results.
Appendices

Appendix A: Obtaining Refugee Status/Placement
Appendix B: The Resettlement Process
Appendix C: Proposed Health Class Format
Appendix A: Obtaining Refugee Status/Placement

How do Refugees Get to the United States?

UNHCR, U.S. Embassy, or an authorized non-governmental organization (NGO) can refer the refugee to the U.S. Refugee Admissions Program (USRAP)

The regional Resettlement Support Center (RSC) prepares a case file.

An officer from the Department of Homeland Security's U.S. Citizenship and Immigration Services (DHS/USCIS) conducts an interview with the individual to determine if s/he qualifies as a refugee under U.S. law.

If the case is approved, the applicant and his/her family undergo medical examination, security clearances, and a cultural orientation program.

In the U.S., the Department of State's Bureau of Population, Refugees, and Migration (PRM) works with Refugee Resettlement Agencies to plan the final resettlement location.

After the refugee and his/her family pass all security clearances, they depart for the U.S.

Local resettlement agency staff meets them at their destination airport and takes them to their new home.

Resettlement agencies and other refugee service providers provide the refugee with initial Reception and Placement support and services such as case management, assistance learning English, and help finding a job.

Source: Bridging Refugee Youth & Children’s Services (BRYCS)
Refugee Health Technical Assistance Center | www.refugeehealthta.org
Appendix B: The Resettlement Process

* US Resettlement Program
  State Dept/PRM funds the initial Reception & Placement (R&P) phase for overseas arrivals

* HHS/ORR funds Refugee Cash and Medical Assistance, and other social services programs to all eligible persons

* States manage federal grants to volags and other CBOs under ORR’s Refugee Assistance Programs

* Local grantees provide services to clients, and fulfill the requirements of all ORR grants

* “Self-sufficiency within eight months” is the goal of the USRP

* Access to mainstream services is one indicator of this self-sufficiency

Appendix C: Proposed Health Class Format

World Relief Durham—Health Classes/Group Sessions

Format:
Sessions will be held with groups of clients, with an interpreter present for each language need, and a session facilitator. Classes would be best held before or after ESL classes or job classes at the World Relief Office to ensure reaching the largest number of clients. Other options might include being held at the community center of an apartment complex, at a church that ministers to a large group of World Relief clients, or even at a client’s home where there is adequate space. Settings outside of the office will reinforce building community. Having groups with clients from different countries may also help build relationships and community. The exception might be the Women’s Health session—this would need to be held with only women present. Sessions may last 30-60 minutes.

Sessions will begin with an introduction, a moment for questions, and then a brief presentation of the topic with visual materials. Some modules will have group work with activities to role-play, practice, or brain storm together. The session will conclude with time for Q&A, discussion, and handing out take-home materials. When facilitating sessions, encourage clients to reach out to and learn from established refugees and members in their communities.

Materials:
--Large room with adequate seating and lighting
--Table
--Flip chart, markers, paper, pencils
--Visual aids/posters/USCRI materials
--Session outline/notes
--Activity outlines
--Take-home materials—PCP Visit form, PCP/UC/ED fridge card, brochures

Resources:
RHIN: Refugee Health Information Network
(http://www.rhin.org/Default.aspx)

COR: Cultural Orientation Resource Center
(http://www.cal.org/co/domestic/toolkit/Complete_Curricula/index.html)

USCRI: US Committee for Refugees and Immigrants
(http://www.refugees.org/resources/for-refugees--immigrants/health/healthy-living-toolkit/)

Healthy Roads Media
(http://www.healthyroadsmedia.org/)
CAL: Center for Applied Linguistics
(www.cal.org)

Topics:
-- Nutrition (Adult & Child)
-- Dental Care (Adult & Child)
-- Women’s Health
-- Child Care
-- Navigating the US Healthcare System: PCP/UC/ED & Consent/Waivers
-- Visiting the Doctor & Pharmacies

Primary Countries-of-Origin for WR Durham Clients:
-- Burma
-- Democratic Republic of Congo
-- Iraq
-- North Sudan
-- Somalia
-- South Sudan
(Also Afghanistan, Bhutan, and Vietnam)

Module Development:
A general topic module will be developed with background information, examples, and group activities or discussion. Materials from resources will be incorporated and cited. A profile for each country of origin will be created as a rough guideline for language, cultural, and religious factors to consider. Each module can be adjusted for cultural factors during presentation if necessary and take-home materials will be available for translation.

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References


http://www.healthyroadsmedia.org/


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