The Refugee Community Partnership: An Empowerment Evaluation

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Abstract
The Refugee Community Partnership is a non-profit organization located in Carrboro, NC. This paper reviews the social context of refugee resettlement, establishes a connection between social isolation and negative mental health outcomes and evaluates the program structure of RCP. Key findings include an improvement in social network structure as a result of participation in Refugee Community Partnership and a renewed direction for program improvement.

Introduction
Non-profit organizations intending to partner with and support refugee populations must be informed by a mix of historical context, social theory, and input from the community (Samimi, n.d.). Refugee Community Partnership (RCP) developed from an established community need and in partnership with refugees primarily from Burma living in Chapel Hill and Carrboro, NC (Decker & Ellenson, 2007). This organization has never undergone a formal evaluation and currently seeks to identify strengths and opportunity areas in partnership with the refugee community of Chapel Hill and Carrboro through the lens of an empowerment evaluation (Fetterman, 1996).

Evaluation Questions
What are the core activities of Refugee Community Partnership?
How well are they performing in these core activities?
What is the community’s perspective on the program?
Is the organization positively impacting social isolation?
**Background**

While all refugees are admitted to their country of resettlement due to a collective trauma, their identities vary by country of origin, ethnic background as well as other factors. It is imperative that historical context inform policy and social services (Samimi, n.d.).

The majority of refugees involved in Refugee Community Partnership come from Southeast Asia. They come to the United States from India, Malaysia and Thailand after fleeing their homeland of Myanmar. This review will refer to Myanmar as Burma, consistent with the United Nations policy of not recognizing the name Myanmar imposed by the military junta. Many refugees refer to their country of origin as Burma in solidarity with the pro-democracy movement (Fike & Androff, 2016). When refugees from Burma first arrived in 2000, the majority consisted of political activists and students. More recently refugees from Burma mainly consist of ethnic and religious minorities persecuted by the brutal government. As of 2015, refugees from Burma composed 19% of the total refugee population in the United States (Fike, 2016).

**How Refugee Community Partnership was Formed**

Refugee Community Partnership was created based on gaps identified in an action-oriented community diagnosis conducted by a graduate team in the Health Behavior & Health Education department at UNC Chapel Hill in conjunction with the Orange County Health Department (Decker & Ellenson, 2007). When this diagnosis was conducted in 2007 only 250 individuals from Burma were living in Chapel Hill and Carrboro. Current estimates report around 1,000 refugees from Burma in the area. The report was well-informed but was not meant to be definitive. The researchers attended community gatherings, and conducted focus groups and 40
individual interviews. From the data, the team identified twelve themes within the community. Four themes were selected and discussed at length at a community forum, thus expanding on the community feedback on these key themes.

The first theme explored was adult education. As with any new arrivals in a foreign land, a key priority for self-sufficiency is proficiency in the native language. Many individuals in the community expressed frustrations with the language acquisition process. Multiple participants stated that they lacked access to ESL classes because class schedules conflicted with work and family life. The difficulty in maintaining the motivation to learn English was also identified as a barrier, especially since any community members were employed in jobs that did not require English skills.

The second theme identified was community organization. The community identified a lack of organization which impeded their ability to help newcomers and improve the lives of their community members. Individual opinions varied on how exactly to establish this organization, but the majority agreed it would be beneficial in many domains. From the team’s perspective, various ethnic groups had successfully organized separately but there was a lack in overall organization that transcended ethnic and religious barriers.

Health knowledge was the third theme identified and discussed in the forum. The group identified a lack of knowledge about the U.S. healthcare system and described how to access it as a barrier in achieving and maintaining health. Self-care including hygiene and dental care was brought up as a concern by the community. Community members did not speak much of primary
care physicians but did express understanding or experiencing the need to seek emergency services in some situations. The team interpreted this as perhaps the result of a lack of understanding about the health care system and how to navigate it. Service providers echoed this idea, adding that they are often the ones giving instructions about dental hygiene and personal care. Due to language and cultural barriers the providers expressed feeling overburdened and underprepared for this task. The group proposed creating training courses and utilizing lay health workers to relay information in culturally accessible ways.

The fourth and final theme addressed in the forum was interpreter services. The major concern identified with this theme was the lack of interpreter services in Chapel Hill and Carrboro and its effect on service access by members of this community. Both community and service providers expressed their frustration regarding the diminished quality of care caused by communication difficulties. Community isolation and its impact on outcomes will be explored further in later sections.

Overall, this report’s results and themes of concern still remain prevalent nine years later, as evidenced by concerns from volunteers and the community itself. This evaluation focuses on how the Refugee Community Partnership can continue to address these same themes in a manner that is directed by the desires of people from Burma living in Chapel Hill and Carrboro, through a lens of community partnership.

History of Burma
The root cause of the refugee outflow from Burma began in 1885 with the colonization of Burma by the British (Fike, 2016). The colonial governance exacerbated existing ethnic tensions. In accordance with the trend of colonial rule, colony borders were created based on the desires of the colonizing forces and ignored existing boundaries and ethnic lines. Incorporating religious and ethnically diverse people into one geographic unit increased the tension between the ethnic minorities and the majority Burman population. These tensions festered and grew, bubbling under the surface until Burma reached independence in 1948. Aung San, a nationalist leader, worked to foster cooperation among Burma’s ethnic groups throughout the 1930s and 1940s (Fike, 2016). Aung San and his political allies were assassinated in 1947, ending the legacy of ethnic alliance. The power vacuum that resulted from Aung San’s assassination moved the country towards a violent civil war, the effects of which can still be seen today. A coup in 1962 intensified tensions as a military junta took power and began to rule as a dictatorship. Tensions rose to their height in 1988 when political repression and economic failure resulted in public protest. During these protests the junta (intending to suppress the popular opinion) killed an estimated 10,000 people. Multiple attempts to reinstate democracy have seen little success. After the bloodbath protests in 1988, democratic elections were permitted but subsequently crushed when the popularly elected National League for Democracy was prohibited from taking power (Fike, 2016).

Because of strict dictator rule, human rights and democracy have had a grim history within Burma. The Burmese military often uses physical and sexual violence as control mechanisms over the ethnic minorities (Sungkyu & Cornwell, 2015). Human rights organizations have well documented evidence of violations including but not limited to disappearances, torture, sexual
slavery, forced labor, destruction of places of worship, and use of child soldiers. It is for these reasons that the United States and other nations accepting refugees have seen a steady influx of refugees from Burma over the past decades. For the purposes of this report, the history of Burma has been boiled down to key events. However, when partnering with this population it is critical to consider the long and complex history of its people. One example of a common misstep those without a familiarity to the history often make is referring to all individuals from Burma as Burmese. Many of the ethnic minorities prefer to be identified by their ethnic group (for example the Karen) in lieu of being associated with the government that has oppressed them (Decker & Ellenson, 2007). The Action Oriented Community Diagnosis encountered this identity conversation and observed that many individuals identified with a combination of their ethnic, religious and political identities. This led researchers to identify the entire community as “people from Burma living in Chapel Hill”.

**Social Isolation**

Social support organizations are essential in the resettlement process, but they are often underfunded and only present in a minority of resettlement locations. The U.S. resettlement policy focuses on economic self-sufficiency as the primary indicator of successful integration (Fike, 2016). This policy imperative disregards the psychosocial needs of newcomers. The push to acquire employment ignores essential components of successful community integration. A well-rounded definition of community integration consists of three crucial and synchronous steps: 1) physical integration 2) social integration and 3) psychological integration (Sungkyu, 2015). As it stands, government programming does not provide the resources nor the person-time necessary to accomplish these three steps.
Social support is essential to successful integration and community building. Loneliness or social isolation have been proven to negatively impact community integration. Perlman and Peplau (1981) define loneliness as “the unpleasant experience that occurs when a person’s network of social relationship is deficient in some important way either quantitatively or qualitatively.” (Kashyap, 2014). The deficits mentioned in the definition of loneliness likely fall into one of the following categories according to Weiss (1973): a) attachment b) social integration c) nurturance d) reassurance of worth e) sense of reliable alliance, and f) guidance in stressful situations (Kashyap, 2014). Munib, working with South Asian communities in Australia, found that emotional isolation and social detachment contribute to psychological distress. A study on Tibetan refugees revealed that refugees born and raised in Tibet experienced higher social and emotional isolation than those that left Tibet before their teens (Kashyap, 2014). Similarities can be drawn between this situation and that of refugees from Burma (the primary focus population of this program evaluation). Refugees from Burma experience protracted stays in either refugee camps in Thailand or urban areas in Malaysia. Thus the majority of those arriving are leaving in their mid-thirties, increasing the prevalence of isolation as their social networks are dismantled.

**Social Networks**

Social capital and social networks are key intangible resources utilized in community integration and contribute to a “successful” resettlement process. Social capital is used in multiple disciplines and can be applied to explain social dynamics. In immigration scholarship, social capital is primarily utilized to describe the web of connections and mutual obligations that develop among people (McMichael & Manderson, 2004). Two specific forms of social capital
are identified in the literature; bonding capital and bridging capital (McMichael, 2004). Bonding capital refers to the day to day interactions that strengthen group bonds whereas bridging capital refers to the new interactions that create links to be exploited. Social capital theory has been adapted to health research to explain the ability for social networks to help prevent disease. Multiple studies have linked strong social networks to positive mental health outcomes. While social networks appear to predict positive effects on health (including mental health), it is evident that social capital is not easily established nor transferred in the resettlement process (McMichael, 2004).

**Mental Health**

Mental health considerations are of the utmost important for war-affected individuals. Mental health outcomes impact the “success” of resettlement measured either from the economic perspective of the current US refugee policy, or by the more inclusive definitions of community integration proposed in the previous section (Sungkyu, 2015). Refugees consistently exhibit higher rates of mental disorders than those in the non-war affected population (Bogic, Njoku, & Priebe, 2015). A comprehensive literature review found that refugees are up to 14 times more likely to have depression and 15 times more likely to have PTSD than non-war affected individuals11. Traumatic experiences ranging from killings to detention and loss of social networks can affect individuals’ psychological function for generations (Kashyap, 2014). According to the World Health Organization in 1999, an average of more than 50% of refugees present mental health problems (Kashyap, 2014). The increased prevalence in the refugee population is linked to both pre-migration experiences as well as post-migration conditions. These post-migration stressors include separation from families, economic difficulties,
inadequate housing along with other issues of community integration. In a systematic literature review on the long term mental health of war-refugees, researchers found that exposures to traumatic experiences and post-migration stress were most consistently linked to higher prevalence of negative mental health outcomes. Post-migration factors were more strongly associated with depression than with PTSD rates. This research supports the theory that refugee resettlement policy and reception influence mental health outcomes.

Refugee Resettlement History

The 1951 United Nation Convention and Protocol Relating to the Status of Refugees provides a clear, universally accepted definition of a refugee. A refugee is defined as: “any person with a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion” (Fike, 2016). The United Nations High Commission for Refugees has since identified three durable solutions for asylum seekers; 1) Voluntary repatriation to home country 2) Local integration in country of asylum and 3) Resettlement to a third country. When possible it is preferred for individuals to return to their home country; however, this is generally impossible and solutions two and three are implemented. Once screened and selected for resettlement (a process that should not be minimized but for the purposes of this paper shall be skimmed over) the policy governing their resettlement is determined by the destination country.

The United States Refugee Admissions Program (USRAP) was created in 1980. Since then, the United States has consistently been a leader in refugee resettlement, settling 70% of the world’s refugee population being resettled in 2008 (Columbia, 2010). However, USRAP hasn’t been
seriously overhauled since its creation. This causes problems as the demographics of those being resettled and their needs have shifted. USRAP has made a commitment to resettling the most vulnerable, and therefore in the majority of cases, the most needy individuals. From a moral standpoint this is an admirable goal; however, the actual policy goals restrict the amount of personalized resources provided to address these individuals’ complex needs.

The first policy conflict is with the established policy imperative of economic self-sufficiency as early as possible (Fike, 2016). This imperative stems from a lack of resources for the overwhelming number of refugee applications and a political push for newcomers to contribute to the economic success of the nation. In the Refugee Act of 1980, the goals of the resettlement program are clearly defined and emphasize this economic motivation stating the goals to: “provide for the effective resettlement of refugees and to assist them to achieve economic self-sufficiency as quickly as possible”. The Office of Refugee Resettlement (ORR) echoes this sentiment aiming to assist refugees in becoming “integrated members of American society” (Columbia, 2010). The Columbia SIPA report identified critical gaps in evaluation and monitoring of the resettlement program. The report highlights the lack of a stakeholder responsible for measuring long-term outcomes of resettled refugees. Therefore there is no hard evidence that the economic imperative is successful in the long-run. Short term data collection may make this program appear successful initially as most refugees are able to obtain jobs within the first few months. However, if other social needs are ignored in favor of quick job placement, these jobs will most likely be lost. This concept is evident in the healthcare utilization data from refugees.
In the United States refugees receive healthcare coverage for the first eight months post-arrival. Usage data has shown that during these initial months refugees have high utilization rates yet these numbers drop off after this period ends. While healthcare insurance and provider options do exist there are many barriers to accessing these resources including; cost, language barriers and transportation issues (Wright, 2016). In Wright and Dahlimi’s study, approximately one out of every 5 refugees reported poor health due to lack of access during the first and second year after arrival. Their study attributes the high unemployment rates among refugees to the poor access to healthcare within this population (Wright, 2016). Much of this long-term data is not captured and therefore isn’t informing updates to policies to improve long-term success of refugees. To policy makers viewing the data it will appear that job placements are successful and thus further support the policy imperative of economic self-sufficiency as a priority. ORR staff openly recognizes this shortcoming (Columbia, 2010). The focus on quick employment also gives refugees little agency over the services they receive and provides little leeway to match skills with employment. Supplementary services are decided in essence by lottery. There is no standardization across voluntary agencies (volags) and regions. Support and resources are guided by the organizations that operate in a certain area introducing the element of randomness (Columbia, 2010).

Evaluation Design
This evaluation utilizes empowerment evaluation (Fetterman, 1996) as a tool to identify strengths and weaknesses, create action plans, implement change and evaluate the impacts of these changes in an iterative process designed to empower community members. The evaluation will begin with identifying the mission, vision and values of the organization, and then move on
to creating baseline measurements of core program activities. Following the baseline diagnosis, key points of action will be identified. All the tools utilized in this evaluation will focus on increasing community buy-in and leadership.

**Organization and Community Participants**

The evaluation will focus on the work of Refugee Community Partnership, a 501(c)3 community-driven organization dedicated to building a holistic and comprehensive support infrastructure to relocated families. Refugee Community Partnership (RCP) began as a student project in the Sociology Department at the University of North Carolina at Chapel Hill. The first year was spent building relationships with refugee individuals, learning about their experiences, and talking with local stakeholders. In 2008, the Orange County Health Department alongside UNC School of Public Health conducted a community assessment of local refugee communities. This assessment informed RCP’s focus areas.

Addressing tangible barriers-- such as housing and employment-- only addressed a small portion of the puzzle. The founders had a general critique of the traditional service delivery model and saw a need for a model more focused on relationships in which refugees -- a group typically excluded from decision-making -- drive the actions of the organization. The idea was to build something contradictory to the Nonprofit Industrial Complex, or the idea that non-profits constrained by funding requirements are forced to align their actions with funding requirements instead of fulfilling their original mission (Samimi). In summary, RCP aims to take a systems thinking approach to understanding and addressing the barriers refugees face in rebuilding home here.
The systems thinking approach is based on the understanding that we cannot just provide a simple service (i.e. homework help) and expect an improvement in academic performance. The social support aspects are equally as important; how socially supported or isolated do they feel? Are they feeling anxiety during the school day? Is our mode of learning at odds culturally with what they are used to? Another example: how can we expect a worker to file a complaint about their supervisor if they have a fear of authority figures? Or get exercise outside of they have a fear of public spaces? Basically, if the factors that influence a refugee's circumstances are interconnected and dynamic and make up an entire system, then the solutions must be systemic, as well.

Refugee Community Partnership currently incorporates 40 refugee families (177 individuals), 66 volunteers, an executive board, executive director, 7 program staff members and 3 family liaisons. Thirty-five of these volunteers are new additions to the team who have joined the program in the Fall of 2016. Staff has also grown within the organization to include the 5 new program staff positions funded by federal work study grants through the University. These changes have necessitated a thorough evaluation of the structure and effectiveness of programming.

Participants and Sampling Methods

Feedback and input was sought from all levels of the organization in three distinct groups: refugee community participants, community volunteers, and program staff. Refugee community participants included established community leaders who have working relationships with RCP as well as families that participate in the program. Community volunteers were approached on an
individual basis and had the option to deny consent to participate. Program staff participated
during a regularly scheduled bi-weekly staff meeting.

Data Analysis Methods

Input was collected from these groups in a variety of manners. Two focus groups were
conducted; one with refugee community members and a second with program staff and board
members. Input from volunteers was gathered through interviews to accommodate varying
schedules. The evaluator conducted activities and facilitated discussion following the guidelines
given in empowerment evaluation, interview guidelines and focus group literature to elicit the
desired insights.

Focus Group with Participants

This evaluation utilized a multiple-category focus group design (Merriam, 2015). This variation
is traditionally used to conduct sessions with several audiences. In this case, the various
audiences include: parents, teens, and program staff. Separating the groups in this way will
minimize any intimidation from one group about speaking in the presence of another group.
The focus group conducted with parents and community leaders was the most anticipated portion
of this evaluation. Due to time constraints, language barriers and the many demands placed on
refugee adults these group conversations were few and far between. Since RCP’s inception a
large group conversation had not been facilitated due to logistic issues. The focus group was
scheduled for RCP’s “field day” event. Arabic, Burmese and Karen interpreters were in
attendance. This event was largely geared towards the children but included food and picnic
tables for parents to relax and converse at while their children were occupied. This event
typically draws around 100 participants and is unique in that it incorporates full family
participation. The executive director of RCP and the evaluator brainstormed the most important topics of discussion. A general guide for the conversation was created but ultimately the conversation flowed in a natural way and the guide was solely utilized for directing the conversation. Key quotes from the group discussion have been pulled to highlight findings and summarize the outcomes. Appendix section I contains the initial focus group guide.

Focus Group with Staff

The focus group with program staff was conducted during a bi-weekly staff meeting. The evaluator led the group through a series of exercises intended to elicit honest and saturated responses. First the evaluator requested all group members to list activities they believed that RCP’s volunteers engaged in with their RCP family. This list can be viewed in the Appendix section II. Next, program staff was asked to list what activities are conducted by program staff or “central activities of RCP”. The group created a collective list which was compiled and checked for duplicates. They were later asked via google form to vote for the five “most important” activities of program staff. Ten of the “most important” activities were then put to a vote via another google form that all volunteers were invited to respond to. Volunteers were asked to anonymously rank RCP’s performance in the top 10 most important activities (as listed by the program staff): event planning, overseeing volunteer and family relationships, checking in with families, establishing avenues for communication between volunteers, program staff and families, brainstorming and implementing new projects, sharing community resources, communication with volunteers, collaborating with other stakeholders that interact with refugee populations, orienting new volunteers to RCP’s philosophy and program, follow up with RCP
volunteers, and arranging carpools. This survey and its results are located in Appendix section III.

Interviews with Volunteers

Interviews followed a flexible interview guide that allowed for expansion on certain topics according to the volunteer’s interests and concerns (Merriam, 2015). The complete interview guide is located in Appendix section IV. The interviews were conducted over an average of fifteen minutes and targeted volunteers of varying ages, genders, and length of experience with RCP. Key quotes and themes from the interviews were pulled and used to support conclusions made in the discussion.

Findings

Findings are organized first by group reporting the information (volunteer or refugee community member) and then into thematic sections. Refugee Community Partnership partnered with a UNC Public Policy team that conducted an impact assessment of the organization. The team synthesized their findings into key categories. Anecdotal evidence to support these thematic groups is provided in italics and was sourced from either individual interviews or the focus groups.

Refugee Community Members

**Resettlement Challenges** These are challenges commonly identified in the literature and in the group as difficulties faced upon resettlement in the United States. Challenges are largely
individualized but some themes emerged throughout conversations. Challenges marked with asterisks are ones that cannot be realistically addressed by RCP volunteers.

1. Cultural reconciliation and adaptation

Many individuals expressed concern over their adaptation of the American culture and how this new culture might clash or conflict with their customs and ideas. This culture clash was illuminated most poignantly by the following quote:

   *The American people are mentally caged and imprisoned, that’s what my existence here feels like.*

This woman continued to express to the interpreter how at odds she felt with the culture here. Throughout conversations with refugee community members this idea of culture clash came up repeatedly. Program staff has similarly identified this as a common theme that arises specifically around the topic of diet. There is a large diet acculturation that occurs upon arrival; new foods, new eating customs, new budgets. The idea of the mental cage however was a new addition that was referenced multiple times throughout conversations and will be explored further in the discussion. For example, one participant remarked:

   *These groups are important. We need for the parents to realize that our culture is important. We can see that the kids are losing our culture, our food and our customs. It is important that we have more community gatherings.*
A common sentiment seemed to be shared; it is very important for children to maintain their culture. There is a clear pull for children to participate in school activities and acculturate to fit in with peers. This action results in children rejecting their parents’ “traditional” ways for the ways of their peers. Parents expressed a lack of time to spend with family and their community leading to less and less time to practice traditional religion and cultural habits and customs. They also expressed a concern for the material nature of American society:

“You have freedom here if material things are what you want, not if emotional, spiritual and mental freedom are what you’re seeking.”

This quote speaks to the contrasting core values of American society with that of many refugee populations. Another woman echoed this sentiment, saying that she never realized how poor she was until she had things. She realized that she used to be content with very little and now in America feels that life is about accumulating things. Families are set on a track where they are constantly relying on assistance to keep up with standards and customs that are unfamiliar to them. This disconnect leads to the sense of emotional loss of freedom.

2. Isolation

Isolation from one's own community was a commonly identified theme. One individual mentioned that we are all a big family (indicating the RCP volunteer as well as her neighbors from Burma). However, the very real demands of minimum wage jobs, rent, food and language learning prevent many from being able to support their own community. This burden was multiplied for community members that spoke English and their native language. These
individuals are relied upon by many and often face burnout and are unable to effectively help everyone. One respondent stated:

At first we felt the isolation too even from our own community, everyone is always working to support themselves and that consumes all of their time. We can only help each other so much. My brother was here when we moved and he was here for guidance and support. He told us where to apply for jobs and made suggestions but he has his own family too and he works. I don’t know what I would have done without him but he was pretty much all I had.

I think if I hadn’t known anyone here I would have gone crazy. We couldn’t go out to do anything, we couldn’t speak the language. It felt like I was a blind person. It felt like I was caged. It’s like a mental isolation. Of course the caseworker was there but that relationship ends when the work is done.

What stood out most to program staff was the continuous usage of the theme of imprisonment. Most commonly stated as:

...like a mental imprisonment.

This idea of mental imprisonment and living in a cage are the metaphorical representations of social isolation and the mental health impacts it has on a person. This feeling of being trapped was explained to us as being the result of being in an unfamiliar place with limited language
abilities and little to no family. The individual may be able to physically access the space but it is as if they are restrained. This idea of feeling “like a blind person” is indicative of feeling as if a basic sense of understanding your surroundings has been removed and you are suddenly forced to exist without this critical tool that the person has always had.

2. Language Barriers

This theme came up in both volunteer interviews and conversations with the refugee community. Language barrier is often the most thought of challenge faced upon resettlement. The effect this barrier has on mental health outcomes and overall health is often underestimated. Multiple participants indicated that being unable to express themselves led them to shy away from community engagement because of the frustration and occasional dangerous situations it can provoke. Attempting to speak with someone and having them get frustrated or raise their voice in response to the limited English proficiency can be intimidating and uncomfortable. As two women explained:

*I have so many things I want to say. I feel trapped. It feels like everything is bubbling up inside. It wants to get out but it can’t.*

*[My volunteer] understands me. When I go out to places and try to speak to them everyone looks at me and says ‘What? What?’ They don’t understand me. [My volunteer] is used to the way I speak and if I can’t get the words out she knows what I am saying because we understand each other.*
4. Career Prospects

The theme of employment was echoed repeatedly by numerous participants. Many spoke of their desires to advance in careers or return to their previous profession indicating that language was a barrier to that. One individual looking for employment was hesitant to work in the typical setting as a dishwasher due to the limited English exposure at the job. Many jobs available to refugee folks involve mindless tasks and don’t allow for interactions with others that might improve English proficiency. Multiple respondents addressed this theme in their responses:

*We asked our caseworker if we could go back to Malaysia. When we first got here we had assistance for three months but those months were passing quickly and we could not find jobs.*

*We receive job training before we come from the UNHCR but the second we speak in an interview and cannot speak English it does not matter. The opportunity ends there.*

*The biggest obstacle was work. We started applying to jobs as soon as we got here. We weren’t hearing back from jobs and we were being rejected. So our biggest worry was next month we have to pay our own bills and we haven’t found a job yet so what are we going to do. At that time we were going crazy because there was a deadline.*

5. Fear and Trauma**

While fear is often a result of prior trauma and experiences, resettlement itself can be a source of trauma for refugees. During the community meeting the fear of eviction was discussed openly. Many volunteers echoed these fears, commenting on the conversations they had with their RCP
family. Rent for “affordable housing” is hardly affordable on a minimum wage job. Many families face the very real fear that they may be evicted and end up homeless in this new country. There is a sense of rush and intimidation at the idea of being self-sufficient in three months. This trepidation coupled with the ticking tock of the caseworker’s contract instills a fear from the initial resettlement. As one put it:

_We’re still trying to learn everything. In the midst of all of that, the worry about not finding a job constantly was stressful. We were afraid, we heard from other people that if you don’t pay your rent you will get kicked out of your house. So we were worried about that happening and having nowhere to go._

6. **Connecting to resources**

Resource connection can be through direct knowledge provision or through the empowerment that comes from knowing one can access information and learning tools should they need to. While volunteers can provide direct resources and information they also work through the process with families. Through resource sharing, individuals can learn how to seek out information for themselves the next time. This is an empowering activity because it also allows individuals to feel confident that they won’t be taken advantage of. For example, if they receive a phone call saying the IRS demands money they have a source they can go to and inquire about this demand.
[Our volunteer] connects us to many resources we wouldn’t know existed. While we can get help from our own community, they all are struggling to keep up with work, sleep and family so they often do not have time. RCP has been our source of consistently accurate information.

RCP helped me with the forms and things the school sent home. That was a burden lifted. When we first got here and our child started school anything he brought home we couldn’t understand. Another thing for example, if my son was sick I’d have to call school and it’s not a direct phone call... you have to go through the phone options and press one or two. That was another obstacle.

Having them in my life has been really helpful and I’m really grateful to have them in my life because not only have they helped me do things like read mail but they have been that intermediate of me learning what resources are there. Learning how to do simple things like learning how to get somewhere or how to get groceries from the store. Simple things like that that we have to re-learn. [my volunteer] doesn’t just visit me on the days she’s scheduled to visit me, I’m able to depend on her. She would take time out of the scheduled time to take me to the store or something. I feel like they’ve done more than they’ve needed to. They have helped me learn these things. Especially when we were moving there were a lot of letters involved and moving schools for our son.

7. Reciprocity

Service provision can leave the recipient feeling powerless and dependent. Many individuals expressed the benefits of the assistance volunteers could provide but on top of that expressed the
friendship they felt. In a friendship the service is reciprocal, it is give and take. These same thoughts were frequently expressed, with families offering to cook their traditional food for their volunteer or inviting them to festivals and events.

I’ll never forget them and the times we have had together. You’ve given me strength not only because you’re someone I can go to when I don’t know something. That’s empowering, but also just the time we spend together is a source of strength. One day I want to do something for you. For now that’s in the form of cooking for you. That’s my small token of thanks for now.

Perceptions of RCP

Interestingly, yet unsurprisingly, perceptions of RCP varied family to family. The perception of RCP depended largely on the relationship between the volunteer and the family. In situations where the volunteer mainly tutored the children, volunteers were treated as tutors or teachers (service providers). In pairings where volunteers frequently visited the home, took families on outings and attended family gatherings they were viewed as friends or family. In newer arrangements the volunteer was often viewed as a guest. This theme highlighted a gap in understanding of RCP and its volunteers.

Volunteers

Themes were extracted from individual interviews with volunteers. Themes identified as needing more attention from volunteers and program staff are identified with asterisks.

Academic help
Many volunteers identified homework help as their main area of support. Volunteers actively pursue communication with teachers and are able to bridge the gap between the parents and the school. Most volunteers spend about half of their time with the family working on schoolwork.

**Help with English**

Second to academic help, the most common request is for ESL tutoring. Individuals who have experienced trauma may feel more comfortable receiving tutoring in a one on one setting. Transportation barriers are prohibitive to ESL class attendance.

> While I work with the kids on homework, my partner works on common phrases with the mom if she is home from work.

**Relationship building/combatting social isolation**

One of the most critical parts of RCP is providing social companionship and experiences for very isolated populations. Volunteer response indicated this priority:

> Each week we end up spending time talking. It’s easy with the kids around, conversation flows easily. This built up over the years. I think we lucked out, the mom in our family is very outgoing.

> For us it’s like an extended family. Our family is not here in Chapel Hill but its like we have another family here with us. [Their son] got an award at school and we went and cheered him on. We come over here and they cook us food and we get to experience some of their culture. It’s very much a family atmosphere and it’s comforting and something we both enjoy.
We go home and we talk about all the funny things the kids did and how much fun we had. We are always thinking about when we can see them again and when we could go to the park with the kids.

...As soon as we walked in [the first day] the youngest daughter jumped into my lap. Immediate integration. If the family had been more standoffish, I see it being more awkward. We were lucky to get a very friendly family with outgoing kids.

Dealing with family-specific issues

Three months after families arrive they are cut off from their resettlement agency. This means that case specific problems are left unresolved. It can be incredibly difficult for individuals to seek out the answers when they do not speak English and are unfamiliar with the area. Volunteers play a critical role in case management and can work informally to identify solutions with the family.

Communication with parents/ adults***

Multiple volunteers indicated their eagerness to connect more with the parents in the family. Some volunteers expressed concern that the parents only saw them as tutors for the children. The volunteers hope to build a relationship with the parents as well and are seeking guidance for how to do so.

Perception of Bridge Builders***

Perhaps contributing to the hands off approach of the adults is the pervasive perception that they volunteers are simply “teachers” for their children. This misclassification may be born out of the
large need for tutors and the convenient supply of volunteers. While volunteers are happy to provide this support many yearn for larger roles and feel they could be helpful in other ways.

Communicating goals and expectations

Volunteers have indicated feeling unsure about what they should be doing in their weekly visits. Some have strong goals they are working towards with their families (i.e. learning to drive) but others have lofty goals that they are struggling to meet.

Data from Surveys of Program Staff and Volunteers

Table I contains the voting results of RCP program staff. Staff voted anonymously on the brainstormed list of “Activities of RCP”. The top choices are listed above. The team will utilize this list in conjunction with the ratings given by volunteers in Table II to consider its priorities in making programmatic improvements.

Table I: RCP Activities Ranked by Program Staff

<table>
<thead>
<tr>
<th>Activities Central to RCP</th>
<th>Votes</th>
<th>Rank (Most Important to Least Important)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organize Events</td>
<td>6</td>
<td>1st-Tied</td>
</tr>
<tr>
<td>Oversee Volunteer and Family Relations</td>
<td>6</td>
<td>1st- Tied</td>
</tr>
<tr>
<td>Checking in with Families</td>
<td>5</td>
<td>2nd- Tied</td>
</tr>
<tr>
<td>Orient New Volunteers to RCP’s Mission and Philosophy</td>
<td>5</td>
<td>2nd- Tied</td>
</tr>
<tr>
<td>Collaborating with other</td>
<td>4</td>
<td>3rd- Tied</td>
</tr>
</tbody>
</table>
Table II presents the evaluation results of RCP’s performance on select activities. The activities selected were the top ranked “most central” activities by program staff. RCP received high votes for “Very Effective” in three main categories: Organizing Events, Communicating with Volunteers and Establishing Avenues for Communication between Volunteers Program Staff and Families. Three categories received the most “Needing Development” votes: Overseeing Volunteer and Family Relationships, Orienting New Volunteers to RCP’s Mission and Philosophy, and Collaborating with other Stakeholders who Interact with Refugees. These results support the qualitative findings presented above and will be explored below.

Table II: RCP Activities Evaluated by Volunteers

<table>
<thead>
<tr>
<th>Activities Central to RCP</th>
<th>N/A</th>
<th>Very Effective</th>
<th>Capable and Effective</th>
<th>Somewhat Effective</th>
<th>Needs Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholders who Interact with Refugee Populations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication with Volunteers</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>3rd-Tied</td>
</tr>
<tr>
<td>Sharing Community Resources</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>3rd-Tied</td>
</tr>
<tr>
<td>Brainstorming and Implementing New Projects</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>4th</td>
</tr>
<tr>
<td>Establishing Avenues for Communication between Volunteers Program Staff and Families</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>5th- Tied</td>
</tr>
<tr>
<td>Arranging Carpools</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>5th- Tied</td>
</tr>
<tr>
<td>Following up with RCP Volunteers</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>5th- Tied</td>
</tr>
<tr>
<td>Task Description</td>
<td>Score</td>
<td>Priority</td>
<td>Time</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>-------</td>
<td>----------</td>
<td>------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Organize Events</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Oversee Volunteer and Family Relationships</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Checking in with Families</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Orient New Volunteers to RCP’s Mission and Philosophy</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Collaborating with other Stakeholders who Interact with Refugee Populations</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Communication with Volunteers</td>
<td>1</td>
<td>8</td>
<td>8</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Sharing Community Resources</td>
<td>4</td>
<td>4</td>
<td>8</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Brainstorming and Implementing New Projects</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Establishing Avenues for Communication between Volunteers Program Staff and Families</td>
<td>2</td>
<td>9</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Arranging Carpools</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>
Discussion

This empowerment evaluation process revealed a great deal about the organization, its people and its participants. Key findings revealed that there is a disconnect between what families think RCP does and what RCP actually does, the community feels that RCP does combat social isolation, and all parties agree that current infrastructure is lacking the support for clear communication about goals and expectations.

Amongst the themes and data presented in the findings the team noticed an overall lack of clarity regarding what RCP is exactly and what its volunteers do. When the Public Policy team conducted their interviews - which did not include RCP representatives - they had difficulty explaining to families who they were. However, when individuals’ names were mentioned families were able to identify the program. This brought up a discussion among program staff regarding RCP “branding” and a debate about the need for group distinction. While on one hand brand identity is essential to growing the organization (and at this point it has reached far past a handful of volunteers), does brand identity take away from the purposeful mutual relationships that RCP has helped foster? This question remains unanswered at the current time but sprung up as a result of these discussions and findings and will continue to be pursued by the organization and its participants.

Another key finding was the repeated imagery of mental imprisonment. The frequency with which this idea appeared organically spoke emphatically to the traumatic lived experiences of resettlement. As supported by the literature review, refugee resettlement brings its own set of
traumas and negative mental health impacts. These findings from the literature were present in our own small sampling of the community. While it is acknowledged that RCP volunteers alone cannot provide sufficient support to address the trauma and fear that exists in many refugee communities, it does appear that Social isolation is very much a reality for some refugee persons. Furthermore, RCP’s model is having real impacts on feelings of social isolation in the community.

The third key finding sets a priority for RCP improvement. In both interviews and survey results, volunteers indicated that they do not feel that RCP provides adequate interpretation and communication avenues between the families and themselves. They yearn for more opportunities to speak via an interpreter with the family about goals and priorities. Addressing this gap in infrastructure would also address the confusion among families about what exactly their volunteer is and what that relationship can look like.

**Evaluating this evaluation**

Utilizing empowerment evaluation in this setting provided a unique opportunity to further emphasize RCP’s guiding principles of working alongside refugees in pursuit of mutually beneficial and supportive relationships aimed at alleviating social isolation. Empowerment evaluation holds true to those principles and incorporates all voices into the evaluation. An unexpected benefit of using this tool was that volunteers who originally did not feel as incorporated into the organization’s core had the opportunity to voice their opinions. In some cases the information we heard from the community were things that we had heard before from one individual, but had never realized were commonly-held opinions. In other cases, and in some cases completely new information was discovered. This evaluation allowed for the organization to compile diverse data that will inform decisions made in the future.
While this evaluation painted a bleak picture of the resettlement process, one comment shared with us by a community member shares a positive insight into the hope she has for the future:

_We had extremely hard lives before being resettled in the U.S. so all of this “new” is not all bad, gaining a new community family, an overall better environment and an opportunity for a restart on life is refreshing and a good thing, too._
Appendix:

I. Parent and Community Leader Focus Group Guide

Goals: Redefine RCP, Get Community Buy-in, Assess opinions/outcomes from RCP, Establish future conversations

1. Define RCP
   a. Establish connection between A and the volunteers and the program as a whole
   b. Emphasize that RCP is “community run”... what does this mean?
   c. Give examples (N.P.’s experience with her volunteers)

2. Talk about M and C’s roles (community leaders)

3. Inquire about priorities of the group
   a. What are the most pressing “needs”?
   b. How can these be addressed?

4. What have their experiences with their volunteers been like?

5. Does discussion in this type of setting work? Could we have “board meetings” at community gatherings?

II. Activities that RCP Program Staff believe Volunteers engage in with their families (compiled list)-- items listed multiple times across program staff are indicated by “xNumber”

- Create relationships between refugee community and chapel hill (x4)
- Take kids to fun outings-- ice cream, movies (x3)
- Stay in contact with families-- visit, facetime, phone calls
- Participate in field days (x3)
- Assisting with college applications
- Book club meetings
- Communicate with kid’s teacher/school (x2)
- Play board games with kids
- ESL classes for family (x3)
- Translate homework/bills
- Sports practice-- helping kids get involved in extracurricular activities
- Cook food with families
- Assists in reading mail
- Liaison between family and other organizations (x2)
- Learning about cultures (x3)
- Provide homework help (x2)
- Ensuring that everyone feels included
- Women’s empowerment groups (x3)
- Workshops-- self defense, resume writing

III. Volunteer Survey on Efficacy of RCP’s Top 10 most important activities

IV. Interview Guide

**Thank you & Introduction:** Program evaluation for RCP for honors thesis

**Introduction to RCP:**

1. How did you first hear about RCP?
2. When did you join?
3. What made you want to join RCP?
4. Did you have any concerns about joining?
5. What was the onboarding process like?

**Volunteer Experience:**

1. How did you feel during your first visit? Can you describe it?
2. Do you feel supported as a volunteer?
3. What are your thoughts on the events that RCP hosts that you’ve attended?
4. What resources, if any, do you use to find support?

Opinions

1. You mentioned ___ as your reasoning for joining RCP, are those still the reasons you’ve continued with the program? Do you have additional reasons now?
2. Has your perception of RCP changed from when you first heard about it to now (while you’re in the program)?
3. Would you recommend RCP to a friend?
4. What might have helped you feel more prepared/ supported during the process?
5. Do you have any recommendations for how to improve RCP for future volunteers based on your own experience?
6. What do you see your relationship with your family looking like after you leave the program?
References:


