USING PHOTOVOICE AS PARTICIPATORY ACTION RESEARCH TO IDENTIFY VIEWS AND PERCEPTIONS ON HEALTH AND WELL-BEING AMONG A GROUP OF BURMESE REFUGEES RESETTLED IN HOUSTON

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BY

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DEDICATION

This dissertation is dedicated to all individuals who “owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside of his nationality” (United Nations Refugee Agency, 2012).

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ABSTRACT

ADRIAN E. YAM

USING PHOTOVOICE AS PARTICIPATORY ACTION RESEARCH TO IDENTIFY VIEWS AND PERCEPTIONS ON HEALTH AND WELL-BEING AMONG A GROUP OF BURMESE REFUGEES RESETTLED IN HOUSTON

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The main purpose of this study was to understand the views and perceptions of health and well-being among a group of resettled Burmese refugees in Houston, Texas. People from Burma are among the largest number of relocated refugees in the state of Texas, yet relatively little is known about their health status. Through participatory action research and Photovoice, the study explores topics such as the resettlement process, their everyday challenges and what is needed to improve their livelihood from an ecological perspective. Increased attention focusing on these topics is important to consider for a better understanding of the resettlement experiences, the process of adjustment, and integration into American society, and advancing the nation's health status.

The study employed qualitative research methods consistent with participatory action research, and convenience sampling for the identification of participants that fit the established inclusion criteria. The study was guided by empowerment theory and utilized a collaborative approach in viewing individuals as active participants and experts in their lives. Research participants were able to capture images that represent different aspects

of health and well-being years after resettlement. Through an in-depth discussion via focus groups guided by the Principal Investigator (PI), an initial contextualization of information started to emerge. Data analysis included the transcription of audio recordings and the identification of emerging themes and categories. NVivo Pro 11 Computer Assisted Qualitative Data Analysis Software was utilized to classify, sort, and arrange unstructured data for the qualitative analysis. The thematic analysis followed the social constructivist approach and focused on adhering to "their own voices" and understanding "their own stories" to deconstruct complex data. Results indicated three emerging categories and a discourse on the role of community agencies in enhancing all systems that sustain health and well-being. The study discovered a pronounced need for systems that sustain family well-being and financial stability, safety, and preventive education and understanding health and health-related material. Additionally, the continuous role of community agencies was seen as crucial and included the inclusion of Burmese staff, identification of Burmese community leaders, as well as intentional and culturally sensitive outreach programs.

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CHAPTER I

INTRODUCTION

The United Nations Refugee Agency (commonly known as UNHCR) defines refugees as individuals, as, "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside of his nationality" (United Nations Refugee Agency, 2012). In 2008, two-thirds of all refugees who resettled into the United States were from Burma, Iraq, and Bhutan. The resettlement experience can be described as a step in the process of surviving another stage of losing a personal connection to one's mother country and the difficulties faced in adjusting to a new life in a foreign society. For refugees, the resettlement experience is further complicated by the psychological necessity of attempting to heal after surviving destructive emotional effects that result from fleeing a war-torn country (Barkdull, Weber, Swart, & Phillips, 2012; Kenny & Lockwood-Kenny, 2011; Kok, Low, & Lee, 2013).

In particular, Burmese individuals are often forced to flee to a neighboring country in close proximity to Burma before arriving in the United States. Because of this mandated detour, being admitted into the U.S. for a Burmese refugee may take several years. While waiting to be admitted into the U.S., the interim can be difficult for refugees. Likewise, the emotional well-being of these individuals is distinctly vulnerable due to their unique experiences related to their forced separation from their family. Burmese

refugees encounter crises even after fleeing Burma. Enduring the transition between the host country and the U.S., Burmese refugees often endure hardships such as being forced to hide over the period of several years, which keeps them in isolation. They are harassed, receive threats to their personal well-being, and often their transition, as they flee from Burma to their host country as they await the U.S. immigration authorities to accept them as refugees, interrupts their education. Moreover, survival in general becomes trying as they suffer from a lack of food and/or fresh water while in exile, and are forced to survive in poverty because of homelessness or lack of adequate shelter. In addition, refugees face circumstances more violent than ones listed above. They may also become the victims of mass killings and suffer the disappearance of immediate family members. Even apart from the burden of survival in exile and some of the extreme cases involving mass killings, refugees are also subjected to threats, and some are tortured, raped, and sexually abused as well (Allden et al., 1996; Fuertes, 2004; Munene, 2013).

As public health officials, it is crucial that we better understand the health and emotional well-being of Burmese refugees who are in the process of resettling and adjusting to a new way of life, in a foreign country. Not only do these refugees need to conquer a labyrinthine system of healthcare support, but they also need to know how to make sense of an entirely new reality. In thinking about the adjustment process, we should note that this new reality they now find themselves in would have seemed unfathomable and even unimaginable to them before they were forced to flee their country of origin. For many refugees seeking asylum, their struggle to survive does not

stop there. Resettlement is only one hard-won but intermediary step on the way to reaching what could be described as a final optimum state of health and well-being for refugees.

Resettlement is an arduous process for all immigrants and refugees as they all face important challenges while trying to survive and eventually reach a state of stability. In addition to trying to establish a routine and to acquiring knowledge in order to be able to navigate the healthcare system that would ensure a decent standard of health and emotional well-being, they also are faced with the task of starting over. This means within an unfamiliar setting they must acquire a new language, secure a suitable shelter, continue their formal education, raise a family, and obtain employment in a new place. Our current support systems in place report that Burmese refugees gradually do become more self-reliant and independent as they continue to adapt to their surroundings in which they resettle and stabilize (Kok et al., 2013). However, as a result of resettlement, in reality, many refugees reside in low-cost apartments, live in social isolation, and may feel that can only interact with other similar diaspora populations. Additionally, they may not seek healthcare services when they need them. Even after they culturally assimilate, theses populations experience higher levels of poverty due to unemployment and underemployment. Thus, the unique challenges that affect refugees in the process of resettlement concerning their overall health and well-being is not only of utmost importance for healthcare professionals in order to know how to respond, it is also crucial that we understand how they perceive these challenges by listening to their personal

stories, narrated in their own voice. Thus, there is a pressing need to understand the challenges faced by Burmese refugees. Understanding their perspectives will go a long way in determining how to strengthen the systems that support the overall health and well-being of these refugees who have resettled in the United States. This study was created with the intention of providing insight into the health-related challenges Burmese refugees face. These insights can provide further understanding, which will help healthcare professionals understand and strategize in order to come up with better methods that could enhance the overall quality of life of refugees, as they resettle in the U.S. This study was designed to ensure cultural appropriateness while recognizing the strengths and assets of their established community. Therefore, the utilization of theoretical principles of participatory action research (PAR) along with empowerment theory guided the design and execution of this study (Green & Kreuter, 2005).

Purpose of the Study

The purpose of this study was to identify the perceptions and views on health and well-being among Burmese refugees, who relocated to Houston, TX, using Photovoice as an instrument for participatory action research.

Research Questions

The following questions guided the action research:

1. What perceptions do Burmese refugees, who resettled in Houston, TX, have about their current health status and level of well-being?

2. What perceptions do Burmese refugees, who resettled in Houston, have about community agencies and policies [currently in place] that offer support for improving their health status and level of well-being?

Delimitations

The study had the following delimitations for study participation:

1. Only Burmese refugees who have lived in Houston for at least 3 years were selected for this study.
2. Only Burmese refugees who used English as their primary language were allowed to participate in the study.
3. Only Burmese refugees between the ages of 18 and 65 years of age were considered to participate in this study.
4. Only those Burmese individuals who voluntarily signed the informed consent for this study were considered participants to this study.

Limitations

The study had the following limitations:

1. Convenience sampling was used to include Burmese refugees resettled in the metropolitan area of Houston. The results portrayed in this study reflect the experiences specific to this sample of the population. Results do not reflect the experience of all refugee populations.
2. The data collected for this study primarily relied on self-reported information. This type of data collection is subject individuals' bias and errors.

Assumptions

The following assumptions were made in order to conduct the study:

1. Participants were able to understand and comprehend the questions developed for this study.
2. Participants were able to collect and share information based on their life experience accurately.

Definition of Terms

Refugee - A person who flees his or her country of origin through a well-founded fear of persecution for reasons of race, religion, social class, or political beliefs (Merson, Black & Mills, 2006).

Photovoice - Participatory action research, (PAR) that provides research participants cameras to capture photographs representing aspects of their daily living in order to produce and encourage knowledge, and a better understanding of personal and community issues (Killion & Wang, 2000).

Health - A "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 2013).

Well-being - Considered a positive outcome, is "multidimensional in nature and include social, emotional, spiritual, environmental, occupational, intellectual and physical wellness" (University of California, Riverside [UCR], 2014).

Empowerment Theory - Defined as "an active participatory process through which individuals and communities gain greater control, efficacy and social justice" (Rappaport, 1987).

Importance of the Study

Qualitative research has the capacity to offer insight into complex health issues such as those experienced by Burmese refugees who resettled in Houston. The results of this study will contribute to the limited existing library of information available on factors that influence the health and well-being of refugees. By incorporating PAR into this study, we were able to visually identify factors that, if corrected, could enhance the target population's overall quality of life. Furthermore, these findings can be used to develop programs and health education strategies further influencing entities, advocating on behalf of refugees, which can be applied to improve the resettlement process for refugees.

CHAPTER II

LITERATURE REVIEW

According to Merson, Black, and Mills (2006), the imperative to address the needs of refugees is a growing concern. Increasingly, the crisis associated with the resettlement process grows in urgency and complexity. The circumstances of refugees when fleeing, awaiting U.S. approval, and finally, in resettling are humanitarian crises. These crises result from a combination of factors arising from complex issues, which affect the surrounding civilian populations. Among other things, refugees are affected by war or civil strife, food shortages, and population displacement, resulting in an excess of mortality on a daily basis. According to Refugee Health, a technical assistance center, nationals of Burma, Iraq, and Bhutan accounted for over two-thirds of all refugees resettled in the United States in 2008. In 2012, as the total number of refugees resettling in the U.S. was growing, 10,000 of these refugees were Burmese (Refugee Health Technical Assistance Center, 2012). Many of these refugees face multiple challenges that hinder their overall health and well-being such as responding to the demands of adjusting to a new culture, navigating systems that require competency in communicating in an unfamiliar language, not to mention the difficulties of trying to understand beliefs and practices different from their own. Additionally, refugees are expected to survive and thrive in a distant country (United Nations High Commission on Refugees, 2015)

while employment, education, and healthcare continue to be major obstacles for these refugees (Kenny & Lockwood-Kenny, 2011).

The United Nations High Commission on Refugees (UNHCR) recognizes the following scenarios for refugees: 1) voluntary repatriation, 2) local repatriation to the country of asylum (typically a country next to the country of origin), and 3) resettlement to a third country (UNHCR, 2013a). Because of the continued internal violence, refugees from Burma are unlikely to return home and often resettle and remain in a third country (Kenny & Lockwood-Kenny, 2011). The Karen, Karenni, and Chin refugees from Burma are the sub-populations that are most in need of protection, after having been displaced from their country of origin (Fuertes, 2004; Refugee Health Technical Assistance, 2013).

Upon arriving in the United States, refugees must forge a new life as the integration process starts to gradually unfold. Typically, the country offering asylum expects refugees to seek employment and become self-sufficient in a very short time (Kok et al, 2013). Most of the barriers they face relate to past traumatic experiences of war, such as the scars of emotional trauma and having to flee their country because they fear for their lives (Fuertes, 2004). In addition, typically, upon arrival refugees receive basic housing, a modest financial allowance for up to eight months, and three months of basic case management intended to help refugees find employment (Catholic Charities, 2012). Assistance provided to refugees may also include training for certain job skills and referrals to community agencies that are able to cater to needs other than employment,

such as food and clothing. Burmese refugees are a diverse group, and their individual experiences, beliefs, practices, and needs along with their views on health and well-being are varied (Refugee Health Technical Assistance, 2012). A review of available literature on these issues points clearly to the imperative of overhauling the current systems in place for the development of public health initiatives and policies in order to foster integration thus well-being for all vulnerable populations (Barkdull et al., 2012; Merson et al., 2006; Smith, Stephenson, & Gibson-Satterthwaite, 2013; Vandiver, 2009).

Refugee Crisis

The constant flight of individuals from places of extreme danger has shaped world history, culture, and the international socio-political environment. One becomes a refugee because he or she is forced to make the decision to escape from war-torn regions. This decision results from the realization that his or her life has been disrupted to such a degree that he or she can no longer endure daily life in his country of origin. Fleeing becomes the only viable option because it fosters the possibility of life free from these dangers, in the hopes of resettling into a situation of increased safety and a new opportunity for the continuation of a normal life once resettled.

Historically, resettlement is how countries and nationalities are formed. Even several years after the end of World War II, Europe saw a continued influx of thousands of people fleeing internal armed conflicts, organized ethnic cleansings, and civil wars. Unfortunately, these conflicts still exist today in many regions of the world. According to a United Nations (2015) report, when one looks at any place of armed conflict, one

sees infants, children, women, and men – entire families even – packing any and everything they can fit into bags and broken down carts, walking long distances in search of basic safety. In the spirit of humanitarianism, a few countries came together to develop initial international policies and procedures in an effort to streamline support for refugees fleeing their country of origin. This meeting led to the 1951 Convention Relating to the Status of Refugees led by the United Nations High Commission on Refugees (UNHCR), (United Nations High Commission on Refugees, 2001).

Those attempting to expatriate, as refugees, must be recognized as a "refugee" in status in order to receive aid from a host country, as defined and governed by the UNHCR. The United Nation's legal definition of the term "refugee" is any individual who flees, "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, and is outside of his nationality" (United Nations High Commission on Refugees, 2013a). This definition outlines the selection process and general procedures refugees face, regarding how and when they enter and/or remain in a host country. Fitting within the guidelines of this definition determines not only the level but also the types of support refugees can expect. Once a refugee meets the UN definition for status and has successfully met the requirements of the host country's screening process, only then can he resettle.

In 2015, the UNHCRs' Blue Key Campaign estimated 51.2 million individuals were displaced worldwide (UNHCR, 2013b). Out of 51.2 million individuals, a total of 25.9 million (10.4 million classified as refugees and 15.5 million classified as internally

displaced) received some form of assistance from the UNHCR. While there was a margin of error that inflated these figures, making them appear higher than they really are (because of the parameters set and how a “displaced person” is defined) nevertheless, three-quarters of the entire refugee population was supported with assistance from the UNHCR, across 26 different countries. Additionally, it was estimated that around 49% of the 51.2 million refugees were women and girls, who were seeking resettlement in a third country (a country subsequent to their temporary settlement in a host country). Worse still, 46% of the 51.2 million identified as refugees were under the age of 18 (in 2015).

Keeping in mind that nearly half of the identified refugees (or “displaced persons”) in 2015 were women and girls under the age of 18, we need to understand the plight that all those seeking asylum face should they decide not to flee. Refugees face multifarious and deadly consequences should they choose to remain in their country of origin. Consequences involving political oppression, civil war, political conflict, ethnic oppression, and injury from living in heavily conflicted areas are among the many dangers they face. Moreover, refugees forced to leave their home countries due to unsafe conditions and ensuing threats of war find it difficult to eventually return to their home countries within their lifetime. Understanding their local experiences by gaining insight into their personal struggle and situation from which they escape remains critically important for future research (Kok et al., 2013).

Brief Profile: Burma/Myanmar

Burma is one of the most biologically diverse countries in the world and the most ethnically and linguistically diverse nation in Asia. With over 100 distinct ethnic groups, Burma is also one of the largest countries in mainland Southeast Asia. Burma's neighboring countries are China to the north, India to the northeast, Laos to the east, Thailand to the southeast, and Bangladesh to the west (Amnesty International, 2015). Burma shares a coastline with the Andaman Sea and the Bay of Bengal between Bangladesh and Thailand.

Figure 1: Map of Burma (Myanmar)
Courtesy: Dive the World

Figure 2: Location of Burma (Myanmar)
Courtesy: World Atlas

Throughout the nineteenth century, Burma consisted of a diverse population of ethnic minorities organized into city-states or kingdoms (UNHCR, 2015b). Britain conquered and ruled Burma for a period of 62 years (1824-1886) and incorporated the nation of Burma into their Indian Empire. In addition, Japan briefly occupied Burma during World War II. Up until 1937, India administered Burma when it became a self-governing British colony. In 1948, Burma gained full independence from the British Commonwealth, thereby adopting a parliamentary Westminster style of government.

With a population of over 55 million people, Burma is home to over 100 minority groups. The largest ethnic groups are the Burman, Shan, Karen, Rakhine, Karenni, Wa, Wahoo, Chinese, Indian, and Mon. Among these, the largest ethnic minority groups are the Burmans which make up at least 68% of the total population, followed by the Shan who make up 9% and the Karen who make up 7% of this population (Central Intelligence Agency, 2015). Burmese is the official language in Burma; however, ethnic minority

groups also have retained their own dialects and languages. The country is divided into seven states (Chin, Kachin, Kayah, Kayin, Mon, Rakhine [Arakan], and Shan); the capital of Burma is Rangoon, while the administrative capital is Nay Pyi Taw. Finally, when considering religious and cultural practices, the UNHCR estimates that 89% of Burmese are Buddhists, followed by a large number of Christians (mostly Baptist and Roman Catholics), Muslims, and Animists (UNHCR, 2011).

Conflict in Burma

Soon after Burma gained independence in 1948, a civil war erupted across the country. This internal conflict lasted from 1948 to 1962. Subsequently, a political vacuum was created in the wake of civil war. Therefore, against the newly installed regime, a significant number of ethnic minority groups took up arms in Burma. One such uprising occurred in 1962 when the military-dominated Burma Socialist Party installed General Ne Win to power. This coup overthrew the standing president, President U Nu. The result was the installment of General Ne Win as the new president of Burma. Shortly after President U Nu was removed from office, the coup, led by General Ne Win immediately abolished the Union of Burma Constitution.

As a consequence, there were no democratic elections in years to come. The oppressive regime ruled by General Ne Win meant little freedom of expression, and limited free association (Williams, 2011). Between the 1960s and 1970s, Burma became further disordered by clashes between the military and academic sectors, in addition to onslaught of constant protests demonstrated by the workforce and the religious clergy.

These demonstrations were in response to the abolition of the constitution and growing oppressive military presence in Burma. Without the protection of the Union of Burma Constitution, any Burmese citizen who dared to challenge the ruling party was detained, tortured, and/or killed.

As a result, the economy gradually deteriorated under Burma's ruler General Ne Win. In fact, in September 1987, General Ne Win cancelled currency notes wanting declaring only 45 of 90 kyat in circulation (Narang, 2011). Ne Win's declaration meant that most Burmese lost their savings overnight. Soon after, Burmese citizens protested in response to the economic crisis he had created. The political unrest did not stop there.

One event that sparked public outrage and thus assured more demonstrations to come occurred in March of 1988. On this day, Phone Maw, an engineering student, was shot dead by the military during a student-led protest in the city of Rangoon. His murder generated wide-scale protests by students, ordinary citizens, civil servants, and many revered monks (British Broadcasting Corporation, 2013).

Then, on August 8, 1988 (known as 8-8-88), another historic event took place. On this day, hundreds of thousands of Burmese marched across the country demanding democracy or at least a form of government that elected leaders through civil processes. This triggered several large protests that spread throughout the country in the following months, which were led by Aung San Suu Kyi. Kyi was the public persona for oppressed Burmese citizens. As a public figure, he was the face of democracy. In September of 1988, soldiers fired against a large crowd of protesters in the city of Rangoon, killing

thousands of them while others were carried away in trucks never to be seen or heard from again (British Broadcasting Corporation, 2015). In response to the call for democracy, the ruling military government announced new legislation organized by the State of Law and Order Restoration Council (SLORC). However, rather than stemming the violence in Burma, this new legislation agitated an already tense situation, resulting in another nationwide deadly protest; in which, again, the ruling party killed thousands of demonstrators.

While the rhetoric of the SLORC was meant to "ensure peace and tranquility," it only added to the culminating devastation and rising number of civilian causalities. It was soon realized by demonstrators that the peace the legislation meant to ensure was actually a move for further oppression because the main objective of SLORC was to ensure peace by outlawing pro-democratic demonstrations (Anderson, 2000). As a symbolic gesture for more control, in 1989, the military-run government changed its nation's official name from Burma to Myanmar. As a means of further political resistance, the Burmese have since stated that the dictatorship had no legitimacy therefore no right to change the name of the country to Myanmar (Burma Centrum Nederland, 2010). As a policy, the U.S. continues to maintain its public disapproval of the anti-democratic coup even now, in that it will only refer to the country as Burma (in most contexts) (U.S. Department of State, 2012).

SLORC, then, promised that elections would be held again citing new legislation that was decided upon by elections, held on May 27, 1990. However, SLORC lost this

election. Nevertheless, the incoming regime soon made modifications to election regulations, which guaranteed that SLORC was to remain in power anyway, regardless of the election results (National League for Democracy, 2013). Moreover, SLORC's powerful reach resulted in the house arrest of Aung San Suu Kyi, the main democratic political figure and leader of the National League for Democracy (NLD). Aung San Suu Kyi endured this politically sanctioned house arrest for a period of 10 years (National League for Democracy, 2013). Some of Aung San Suu Kyi's remaining supporters (or remaining NLD leaders) were put in jail, while others were disappeared, leaving the rest to flee the country.

In 1998, the regime (SLORC) renamed itself the State Peace and Development Council (SPDC). Accordingly, SPDC held a convention in order to design, draft, and establish a new national constitution. As to be expected, many Burmese regarded this constitution as further "military dominance of any future government and [further] marginalization of Burma's ethnic minorities" (Burma Campaign UK, 2009).

For the duration of years under SPDC's control, from 1998 to 2010, until elections were held once more, the new face of the SPDC regime (also referred to as a junta) seized total control of the Burmese economic, social, and political identity. In 2010, elections were held once more, and it was during this time when Thein Sein (a former key member of the military junta) was elected and took office in March 2011. President Sein soon began to be seen by the Burmese as a reformist due to several of his political actions. For starters, while in office, Sein garnered favor from the people by freeing

political prisoners including Aung San Suu Kyi. He also permitted free speech again. What's more, he offered a more stable path to social mobility by including Burma in more international investments. President Sein also negotiated imposed sanctions, thereby spreading the ideals of modernity throughout Burma. However, despite the goodwill displayed and international attention paid to Burma and President Sein for these new initiatives, the Burmese Army still retains a stronghold in all political negotiations. And, the army still holds a majority of the significant seats in parliament – essentially, ruling from behind the scenes (Burma Campaign UK, 2011).

The military's influence became undeniable in 2015 when the NLD, led by Aung San Suu Kyi, won the majority election of total seats in the national, state, and regional parliaments by a landslide (United State Department of State, 2016a). However, the person appointed to the President's seat was none other than Htin Kyaw, who holds strong ties to the Burmese military. Essentially, today, the same political and economic authority remains in power that was formerly installed by the SPDC regime (originally SLORC) (Burma Centrum Netherland, 2013).

Effects of War

As defined by the World Health Organization (WHO), wars are becoming more complex and widespread in societies where authorities endorse the use of violence through their own initiatives and actions (WHO, 2002). According to the 2014 report from the Stockholm International Peace Research Institute (SIPRI), 76 state-armed conflicts, involving at least 1 state, 18 conflicts involving wars, and 44 state conflicts

with no projected path to resolution were documented (SIPRI, 2014). The report was consistent with the guideline set by the Uppsala Conflict Data Program (UCDP) in that it defined an armed conflict as one that "contested incompatibility which concerns government and/or territory where the use of armed force between two parties, of which at least one is the government of a state, results in at least 25 battle-related deaths" (UCDP, 2014).

The effect of war on a nation is a complex phenomenon. War causes interruption and the breakdown of society at all levels, breaking down infrastructure that provides the necessities for any civilized society. In fact, wars have profound and lasting effects that go beyond what one can perceive without actually living his life constantly threatened by them. Among other atrocities, these losses include: displacement of peoples, death, injury, illness, and a breakdown of health services, educational systems, and a constraint placed on the supply of goods, furthering economic decline (Devakumar, Birch, Osrin, Sondorp, & Wells, 2014). The effect of war causes disruption and a breakdown of society at all levels, which have a pervasive affect on a society. Because of wars' lasting effects, it may take several generations for a society to rebuild and overcome the damage. This is why we should recognize the one aspect most in need of critical attention: the long-term effects and the overall well-being of survivors. Even in the best of circumstances, societies stricken by war take many generations to rebuild after the fighting has stopped.

Violence affects all levels of society, and its effects are multifaceted. In the last decade, a worldwide trend was noted in the increasing number of conflicts, affecting a greater number of non-combat individuals or civilian population. One report estimated that 90% of causalities related to armed conflicts in Burma were civilian deaths (Levy, 2002). However, in Burma there arises a difficulty in ascertaining an accurate estimate of civilian casualties. This is due in part to the social violence created by the distortion of media and access to accurate public records. In fact, foreign access to data on civilian casualties remains limited because the Burmese government controls how these estimates are measured and released as public information and accordingly distorts media coverage (Project Ploughshares, 2015). Despite limited access, it is estimated that hundreds of thousands have died in the ensuing conflicts, and that 3,000 of these deaths were confirmed as civilians who were killed while protesting (Project Ploughshares, 2015).

Violence targeted at women is often heightened in times of conflict. Women and children are at higher risk associated to combatant and civilian injury (Devakumar et al., 2014). This may include an intentional form of violence such as rape, human trafficking and prostitution (Lindsay-Curtet, Holst-Roness, & Anderson, 2004). These atrocities affecting women are the consequences of broken social structures that would otherwise provide women and children with basic human rights protections, including their safety and providing them with essential needs. Rape, human trafficking, and forced prostitution suffered by women and children are inherent strategies of domination found in all wars as a strategy of domination. As a point of comparison, these atrocities

suffered by women and children have been well documented in relatively recent armed conflicts in Rwanda, the former Yugoslavia, and Kosovo (Watt, 2006; Watts & Zimmerman, 2002). Similarly, the internal conflict in Burma has had similar consequences. In 2012, the United States Department of State reported on the many cases of rape of Burmese women and children by military and security personnel in the Kachin, Shan and Rakine states. This report also revealed the kidnapping of women and children, who are taken and then sold into sex slavery by military installation (United States Department of State, 2012b). It is no surprise that these incidents were not investigated fully by the Burmese government.

Schools have also been affected by war. Schools were either targeted intentionally or accounted for as causalities of collateral damage. When schools are not safe from war, the result is the disruption of the educational systems in place. It can affect how schools are run and the infrastructures that support them. Yet, wars and internal conflicts may have another serious effect, in which children, no longer part of a school system, begin fighting and serving those in power in conflicted zones. Because of this common phenomenon of war, a specialized agency of the United Nations was formed called the United Nations Educational, Scientific, and Cultural Organization (UNESCO). UNESCO reported that in 2003 there were approximately 300,000 children serving in 30-armed conflicts worldwide (UNESCO, 2012). In 2002, the group Human Rights Watch estimated that 20% of the 350,000 Burmese soldiers were children under 18 years old (Human Rights Watch, 2002). The total number of 350,000 Burmese soldiers makes the

Burmese Army one of the largest armies in Southeast Asia (Human Rights Watch, 2002). Children are recruited against their will with force, intimidation, and violence to join the armed forces. Once deployed, they are expected to combat opposition groups as well as civilians. As young adults, they continue to deal with the effects of these experiences (Kline & Mone, 2007).

Of significant importance for this study are the overall health conditions of a people during and after armed conflicts. As mentioned, war commonly demolishes health infrastructures, making it impossible to sustain a well-organized health delivery system. Mock et al. (2004) point out that the lack of health delivery systems is significantly correlated with poor health, malnutrition, and extreme poverty with women, refugees, and orphaned children being the most vulnerable. As of 2012, evidence shows that an estimated 1 million children were malnourished, and between 9% and 12 % of those children suffered severe malnutrition contributing to mortality rates (Zhao et al., 2012). In fact, children under the age of 5 years are rated as the highest mortality demographic in Southeast Asia due to severe malnutrition (Zhao et al., 2012).

In addition, Burma also suffers a significant health problem related to infectious diseases, such as malaria and tuberculosis, and a lack of basic healthcare further compounds these health issues (Zhao et al., 2012). Family planning and women's health also remain gravely affected by conflict. Limited access to reproductive healthcare services has resulted in limited access to health and safe-sex education, knowledge about and possession of contraception, as well as maternal and abortion services. The continued

lack of basic healthcare for women has resulted in unsafe abortions, and an unusually high maternal mortality of 200 per 100,000 live births in 2010 in Burma (United States Department of State, 2012b).

Armed conflicts result in the displacement of a people either by the threat or force of violence. Countless individuals, families, women, and children have no choice but to flee from their homes and communities. As of September of 2013, the United Nations Office of Coordination for Humanitarian Affairs estimated around 100,000 Burmese displaced as a result of 40 years of internal conflict in the Kachin and Shan States of Burma (United Nations, 2015). In addition, there were around 140,000 displaced in the Rakhine state, including Rohinga, Kaman Muslims, ethnic Rakhine, and Maramagyi Buddhists (Unites States Department of State, 2012b). Displacement results in major complications associated with homelessness, little access to clean water and proper sanitation, interrupted access to health services and education, food crises and restrictions imposed on movement by officials. However, in most cases, the government and relief agencies were unable to meet the basic needs of this population (Ee, 2009).

Resettlement

The UNHCR Resettlement Handbook (2013b) defines resettlement as the "selection and transfer of refugees from a State in which they sought protection to a third State which has agreed to admit them -- as refugees -- with permanent residence status." Furthermore, under international law, these host countries have agreed to provide protection, grant equal access to rights as though a citizen, and provide a system of

integration to the new culture of incoming refugees. Most frequently, the response to mass population movements is the establishment of settlement or refugees camps (Merson et al., 2006). These camps are usually kept within the borders of the neighboring country. Typically, refugee camps can host anywhere from a few hundred in small camps and up to more than 20,000 residents in large camps, and in some cases up to 300,000 persons, as is the case for the camp in which Rwandan refugees in Zaire resided in 1994 (Merson et al., 2006).

Resettlement to a third country has distinct characteristics. Most host countries heavily burdened by a large number of refugees may not have the infrastructure to integrate these individuals. Others have distinct political views about refugees. For instance, some host countries such as Thailand do not recognize Burmese refugees in their territory, thus making resettlement elsewhere urgent for these people. International policies on refugee resettlement recognize three durable solutions to the current political issues blocking refugees from asylum. These solutions are based on the notion that in order to end the cycle of displacement and turmoil certain decisions must be made. These policies favor the most viable solution on a case-by-case basis. Thus, one of the options referred to as "voluntary repatriation," which serves the function of returning refugees to their countries of origin with dignity and with provisions that will ensure that they have the benefit of national protection and safety (UNHCR, 2013b). This is a free and informed decision made by the refugees themselves. Another option is referred to as "integration." Integration is a durable solution in that it is an opportunity for the refugee

to be able to integrate legally, socially, and economically in a country of asylum (usually a neighboring country). In the case of integration, the host country has agreed to provide permanent residency and national protection for the refugee. Many individuals who were born in refugee camps may opt for this solution as well. Others may decide to opt for local integration instead of voluntary repatriation because of severe trauma they experienced in their country of origin.

The last durable solution is resettlement. This solution is in itself not a right of the refugee; it is when the refugee is transferred from the country of asylum to another state that has agreed to provide permanent settlement, path to citizenship, and offer national protection (UNHCR, 2013b). Most of the refugees who seek and qualify for resettlement are individuals whose safety cannot be guaranteed using the aforementioned options. However, these durable solutions are attempts to restore a sense of routine within these vulnerable populations when applied separately or in combination. Caritas, an organization highly involved in resettlement of refugees, reported an average wait time of at least 17 years for resettlement to take place for the refugee in the country chosen as a final destination (Caritas, 2014).

Path to Resettlement

According to the UNHCR Resettlement Handbook (2013b), the most vulnerable subgroups among refugees are prioritized for resettlement. International guidelines outline the following subcategories into stages of urgency as follows:

- Legal and/or physical needs of the refugee (including refoulement: threat to life or freedom if returned to home country).
- Survivors of torture and/or violence (prevent further trauma, increased risk of trauma, no treatment available).
- Medical needs (with no treatment available in country of origin).
- Women and girls at risk (heightened risk because of gender).
- Family reunification (families are separated by international borders and even continents).
- Children and adolescents at risk.
- Lack of foreseeable alternative durable solutions

The most vulnerable populations may not be vocal and may remain invisible in refugee population. Therefore, proper identification of the most vulnerable remains the most important element to maintain fairness and integrity of any resettlement project. The 2013 Resettlement Handbook by UNHCR acknowledges the tools and methodology to identify cases and needs. Proper documentation of each case is tracked including important information for large groups that includes refugee determination, registration and classification. A comprehensive individual assessment is utilized to determine a refugee's history and other identifying risk factors such as: forced separation from family, the reasons they had for going into prolonged hiding, the presence of sexual harassment or abuse, interrupted education, lack of proper nutrition, existing threats to self or family, lack of shelter, forced isolation, forced relocation, and in extreme

circumstances: the experience of mass killings, disappearances of immediate family members, torture, rape or sexual abuse (Allden et al., 1996; Fuertes, 2004; Munene, 2013; UNHCR, 2013b).

Resettlement needs are an integral part of international policies. Yearly reports on resettlement trends are projected for operational and strategic planning to determine need and provide humanitarian assistance. These projections are then disseminated to the 26 countries that have a refugee resettlement program (UNHCR, 2013b). In 2012, over 69,000 individuals departed to those 26 countries. Of those 26 countries, the United States, Canada, and Australia provide 90% of global resettlement opportunities. As a result, in 2012, over 53,000 individuals started a new life in the United States. The five largest resettled groups were refugees from Burma, followed by Bhutan, Iraq, Somalia, and the Democratic Republic of Congo. They departed from countries of asylum such as Nepal, Malaysia, Thailand, Turkey, Jordan, Arab Republic of Syria, as well as Lebanon, Kenya, Ethiopia, and Tunisia (UNHCR, 2013b).

Refugee Health and Well-being

One of the most important aspects of survival for every human being is the ability to adjust, adapt, and thrive. Moreover, the ability to enjoy health and general well-being is the result of the complex interplay of many factors, including the emotional, physical, social, financial, and political systems that create a sustainable infrastructure. When this infrastructure is nonexistent for refugees, their experience is referred to as complex humanitarian emergencies. This lack of infrastructure was further defined by the Centers

for Disease Control and Prevention (CDC) as a "situation affecting large civilian populations which usually involves a combination of factors including war or civil strife, food shortages, and population displacement, resulting in excess mortality" (Burkholder & Toole, 1995, p. 1013). Therefore, resettled refugees, especially those who have suffered the brutal effects of conflict, require a thorough analysis of life after the initial experience of devastation. Burmese refugees are civilians who survived the effects of the destruction of communities, which devastated lives as a result of war. Consequently, the infrastructure that once supported and sustained their livelihood is close to nonexistent.

Rebuilding their lives in a distant country with social, cultural, and political values differing from their own requires a strong sense of well-being and belonging to ensure their success. Thus, one premise that would ensure their success after resettlement involves a consideration of their mental-health status, as it is linked to overall health and functioning. Mental health is defined by the Word Health Organization (WHO) as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2013). Furthermore, central to the three durable solutions identified by the United Nations related to the humanitarian assistance to refugees, is the concept of self-reliance. Self-reliance as defined by the United Nations is the "social and economic ability of an individual, a household or a community to meet essential needs (including protection, food, water, shelter, personal safety, health and education) in a sustainable manner and with dignity" (UNHCR, 2013b). The path

towards self-reliance is a personal and hard-won journey for each refugee. Countries granting resettlement opportunities have systems in place to alleviate suffering and limit adverse effects on the health of these populations (Merson et al., 2006). Local integration to a new society is based on the quality of health and well-being for this special population. The World Health Organization recognizes that the effects of war have a long lasting intergenerational effect on the capacity to cope with social, health, and mental health crises (WHO, 2003a).

The Report to Congress for the year 2012 by the Office of Refugees Resettlement (ORR) placed strong emphasis on preventive health for survivors of trauma among other important issues (United States Department of State, 2012). In addition, the report concluded that refugees are still facing a difficult path towards self-reliance and therefore suffer from a high unemployment rate of 16% as compared to the 8% affecting the general U.S. population (United States Department of State, 2012). Furthermore, the effects of unemployment on refugees translates into 40% with no medical insurance, 61% still relying on Supplemental Nutrition Assistance Program (SNAP) for basic food needs, and 24% still receiving some form of cash assistance from a program. In addition, the language barrier they face is a major factor that influences the overall health of this population. They may arrive already disadvantaged. Refugees who had the least amount of education were refugees coming from Africa and South/Southeast Asia, which was only 8 years of school prior to their arrival (United States Department of State, 2012). Integration involves the ability to learn the American way to navigate the health,

economic, cultural, and education systems. Hyman and Guruge (2002) found that new immigrant women faced the greatest difficulties in adopting and maintaining their healthcare as a consequence of systemic barriers. Moreover, suicide rates have risen among refugees who came from South East Asia (Wu, Chen, & Yip, 2012). Consequently, the Office of Refugee Resettlement has started to put in place initiatives that move beyond general health for resettlement programs by including mental health and suicide prevention awareness, screening and strategies, and overall mental healthcare post-resettlement.

Overview on Health Status of Refugees and Minorities

The gap in healthcare disparity starts even before the refugee arrives in the host country. Many Non-Governmental Organizations (NGO) delivering services in refugee camps have limited resources and trained health professionals, and rely on training refugees for day-to-day operations (Banki & Lang, 2007). Furthermore, Banki and Lang (2007) stated as these factors appear "the risk of public health crisis in the camps arises." These factors include a lack of preventive health, a lack of basic sanitation services, extreme poverty, and limited resources. These systemic obstacles prevent progress toward optimum preventive healthcare and early intervention, thus resulting in unnecessary morbidity and mortality.

Historically, minorities in the United States have experienced tremendous gaps with regards to overall health and wellness when compared to the mainstream population. In the United States, minorities commonly have less access to healthcare. This condition

has been linked to factors such as practitioner barriers, care system barriers, health beliefs and behavior, as well as cultural differences (Tripp-Reimer, Choi, Kelley, & Enslein 2001). Minorities also suffer from higher mortality rates linked to low socioeconomic status (Centers for Disease Control, 2010). Moreover, socioeconomic status is also related to educational attainment, access to health and education services, and employment opportunities (unemployed and underemployed) (American Psychological Association, 2012).

Of significant importance are the factors shared between poverty and health disparities associated with minority groups. In the United States, poverty is seen as the leading cause of health inequality. Merson, Black, and Mills (2006) view poverty as a social determinant of health. This is because poverty translates into fewer opportunities for progress in many areas that include education, employment, access to housing and transportation, health, and nutrition. Inadequate housing is related to disproportionate levels of chronic health issues related to race, ethnicity, morbidity, mortality, and disability that prevent minorities to properly enjoy access to preventive medicine and healthcare education that would significantly enhance their level of health, wellbeing, and social equality (Centers for Disease Control, 2013).

The health conditions of Asian Americans have distinctive characteristics. They are comprised of a racial identity defined as having origins from ancestors in eastern Eurasia, Southeast Asia (including Burma), and the Indian Subcontinent (India, Pakistan, Cambodia, China, Korea, Malaysia, Vietnam, Japan, Philippines, Thailand). In 2011,

there were an estimated 18.2 million Asian Americans in the United States (United States Census Bureau, 2011). They accounted for at least 5.8% of the total population, and the largest diaspora groups can be found in: California, New York, Hawaii, Texas, New Jersey, and Illinois (United States Census Bureau, 2011). Asian Americans and Pacific Islanders (AAPI) are a very diverse group. They originate from almost 50 countries and speak over 100 languages and also possess varied cultural backgrounds, beliefs, and traditions (Perez & Laquiz, 2008). Each group has a unique immigration pattern into the United States that includes refugees fleeing violence and armed conflicts.

Asian Americans have distinctive health and well-being trends. In 2010, up to 19% of this group relied on public health insurance and around 18% were reported as uninsured (the highest uninsured group were Vietnamese with 25% followed by Chinese with 13% and Filipinos with 11%) (United States Department of State, 2012). Furthermore, Asian Americans have the highest rate of coronary artery diseases (CAD), occurring at a rate that is 4 times higher than the general population (Louie, 2001). This risk is associated with high blood pressure, high cholesterol, and obesity. The Centers for Disease Control (2013) reported that cancer, heart disease, stroke, and unintentional injuries are the leading cause of death in Asian Americans who generally have higher risk for the following: chronic obstructive pulmonary disease, liver disease, hepatitis B, HIV/AIDS, smoking, and tuberculosis (CDC, 2013). Other important factors are parasitic infections; the highest number of all malaria cases in the United States occurs among the Southeast Asians (Ackerman, 1997). On the subject of mental wellness, the

Center for American Progress (2015) stated that Southeast Asian refugees have higher rates of suffering from post-traumatic stress disorder connected with past traumatic experiences that led to their immigration to the United States. Asian-American suicide rates are notably higher than the general population especially among Asian American women between the ages of 65 and 84 (American Psychological Association, 2015).

Although Asian Americans have been regarded as a "model minority," they continue to face many healthcare barriers. The myth of the model minority ignores the existence of institutional barriers that prevents upward economic and social mobility (Robbins, Chatterjee, & Canda, 2006). These barriers include language: a significant amount of Asian Americans do not speak English fluently, making it difficult to adjust and acculturate in the U.S. For example, in 2010, over 70% of the Asian American population in the United States spoke a language other than English at home (Office of Minority Health, 2010). Many recent Asian immigrants still do not fully understand the Western biomedical model. This means that their view differs from the highly acculturated individuals, who are more open to embracing and receiving treatment from this model. Because they are a diverse group, there is an array of cultural beliefs and traditions that differ from the mainstream culture. Overall, their health beliefs and well-being are based on Eastern medical principles that honor energy forces, folk remedies, and traditional healing practices (Lee, 2009; Louie, 2001). Thus, limited access to these traditional remedies once they arrive in the U.S. is a cause for concern. Lin-Fu (1998) indicated that many Asian immigrants were uncomfortable with procedures like blood

sampling, hospitalization, and pelvic examinations. Another contributing factor to their lack of adjustment to the U.S. model includes the effects of racial discrimination. Lee (2009) found that perceived discrimination based on language and race prevented Asian American youths from seeking services for mental health (services were not delivered in their language). From a culturally sensitive perspective from which we should view this minority group, it is essential that we honor their individual behavior and perceptions, environmental factors, as well as existing social support networks (Perez & Laquiz, 2008). For example, in some Asian American groups, the avoidance of hot-cold, staying warm, eating, and resting well, routine of physical exercise, sleep, as well as resting are associated with good health and well-being (Hyman & Guruge, 2002). Such protective factors in Asian American culture also include tradition, honoring extended family, group orientation and welfare, and modesty and formality (Perez & Laquiz, 2008).

Participatory Research

Participatory action research strives to achieve change of important individual and societal concerns through direct awareness. A distinct characteristic of this research approach is the equality of involvement of the community, where the element of study resides. This innovative approach to community research and involvement has been defined by Reason and Bradury (2006) as a "democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes grounded in a participatory world view." In assessing views and perceptions of a community, it is crucial to take into consideration the context and the environment in which they dwell.

They have a unique worldview influenced by personal and collective beliefs, traditions, history, and cultural values. Reason and Bradbury (2006) emphasized that the structural changes brought upon by this approach to research can affect the individual, interpersonal relationships as well as the local community. Furthermore, it has the ability to promote a critical dialogue and knowledge about community issues through discussions (Wang, 2007). This perspective enables a more accurate account of the specific collective needs, concerns, strengths, dreams and realities of the population. The information generated and the knowledge produced through participatory action research serves as an educational experience since it facilitates further understanding. At its highest point, this research modality incorporates participant-generated data to understand and interpret phenomena and recommend change at the policy level where applicable (Given, 2008).

Furthermore, the concept of decision-making is central to participatory research model. Local people have the opportunity to decide on pressing issues as well as jointly choose what concerns to address, and come together to discuss the possible origin of these issues. Moreover, this decision-making capacity results in having a voice in reshaping their community (Fuertes, 2004).

Moreover, participatory action research validates the community empowerment theory. It is dire to understand the association between morbidity and perceptions regarding community issues such as well-being, health, housing, education, safety, and financial well-being. Thus, attention is given to the social-action process, the community's connections, and importance of critical thinking as well as the development

of personal and social capacity, and the transformation of power relations (Vandiver, 2009). With this approach, people are not seen as objects to be studied and listened to but seen as engineers able to identify their concerns, construct their projects, discover solutions, and transform themselves and their reality through this process.

Participatory Action Research with Refugees

Participatory action research approach has been used in different settings with various issues, and diverse populations. When applied to refugee populations, it is considered an innovative approach that enables a better understanding of their specific concerns while engaging them in a process of gradual empowerment. Wieland et al. (2011) described a project with refugee women where the focus was centered on the design and implementation of a fitness and nutrition program based on socio-cultural factors. This study highlighted the importance of proper experimental design, making sure that the cultural preferences of a study's participants' were included and understood. Another study by Dona (2007) demonstrated the importance of the role that subjects play when using a participatory approach in order to examine their total involvement in the production and reproduction of knowledge. Participatory action research has also been used to collaborate with refugees regarding health promotion strategies. For instance, participatory methods have been applied with Somali refugees to understand their experience in the United States healthcare system as well as their reproductive healthcare needs (Johnson, Ali, & Shipp, 2009).

Lastly, Ellis et al. (2007) implemented a participatory action research study that focused on the ethical research methods of Somali refugees' mental health. Ellis faced the challenge of assessing important ethical considerations when studying less commonly researched populations, who uphold different cultural standards and values that differ from what we are used to in America.

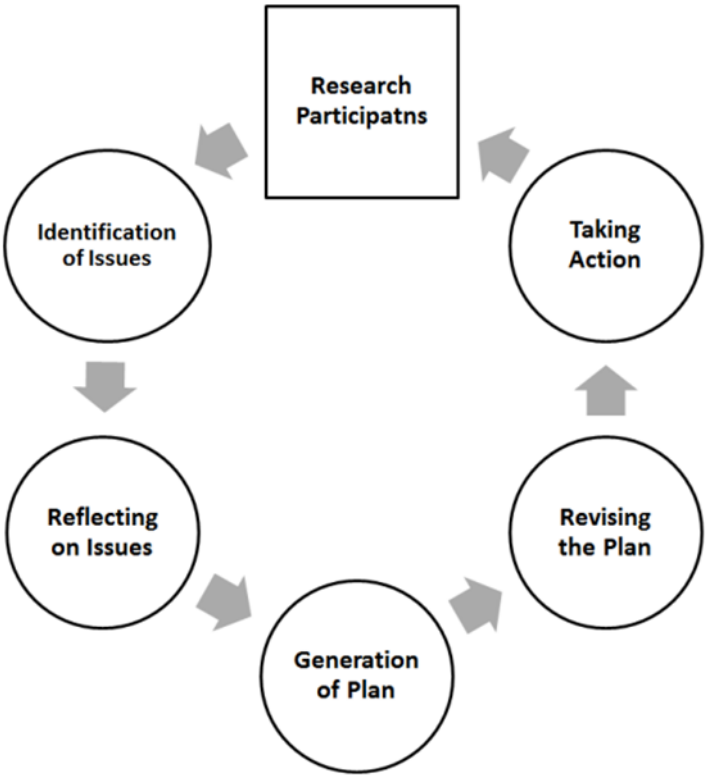

Figure 3: Participatory action research process

Photovoice as Participatory Action Research

Participatory action research has the capacity of engaging communities through a grassroots approach of critical discussions and strong connection within participants. The participatory approach is decisive in contextualizing knowledge and information arising

from a particular community and culture. Consequently, information gathered is incorporated and tailored as appropriate for health promotion and educational activities to fit their needs. The contextual data generated from participatory action methods cannot be captured through the use of other traditional quantitative-data-generated methods (Monsen & Van Horn, 2008). The incorporation of visual methods allows the collection of in-depth knowledge of a community through the eyes of its members. In visual research approaches, pictures may be used as a source of data, as a method of data analysis, and a means for data representation (Given, 2008). The visual items are related the topic of the research theme.

Photovoice is considered participatory action research that provides research participants cameras to capture photographs representing aspects of their daily living in order to produce and encourage knowledge, and a better understanding of personal and community issues (Killion & Wang, 2000).

The utilization of photographs is a direct influence in being able to broaden an observer's understanding of the participants' lives outside of the research context (Given, 2008). Thus, photography is a form of communication that enables messages to be shared and produces in-depth information. As this new information is explored, it eventually enriches and adds to the current existing knowledge of the topic being examined. The utilization of Photovoice as a primary participatory research method allows for the collection of raw, unfiltered, current data that come from the context of the community at hand. Additionally, the integration of the flow of cultural norms, concerns,

and views are collected that would otherwise be missed using other research methods. The Photovoice process gives ample opportunity to frame the strengths and needs of the community through its participants. The visual aspects of these images are powerful in its ability to offer a tangible representation of life as it is experienced from the eyes of the beholder. For example, refugees from Burma photographed aspects of their daily routine while living at a refugee camp in the Thailand/Burma border. The photographs, personal stories and narratives went beyond what was expected (Allden et al., 1996).

Theoretical Foundation of Photovoice

Photovoice is linked to critical consciousness, feminist theory, and photo documentary (Given, 2008; Wang & Burris, 1994). Photovoice is grounded on strong participation and engagement from members of a particular community. Thus, it creates a sense of empowerment since participants are able to have a voice in the research process. Consequently, Photovoice is consistent with empowerment education as developed by Paulo Freire (Freire, 2014). This empowerment is related to the process by which participants are able to move to the highest level of consciousness. Freire identified three levels of consciousness that impact a subject's interpretation and subsequent behaviors related to an individuals' existence (Freire, 2013). At the magical levels of consciousness, the individual adapts passively; remains silent and does not question the superior structure or forces. They accept their life as it is. In the naïve consciousness level, a gradual insight of individual problems and social conditions arise; however, there is no connection between these conditions with outside structures. At the

highest level referred to as critical consciousness, a connection is established between an individual's condition and the existing socio-economic structure. This reflective process empowers the individual. Through discussions of their own reality, the individual is able to create knowledge and meaning and is able to be an engaged participant. As a result, a higher level of personal accountability and capacity for individual choice arises.

Photovoice draws from feminist theory the principle of empowerment while giving voice to marginalized populations. Originally, feminist theories centered on women's experiences and an appreciation for their commitment to securing changes. This approach advocates for socio-political change achieved from the perspective of women, designed by women, in ways that empower and honor women's intelligence as well as their participation and knowledge grounded by their experience (Given, 2008). Consequently, Photovoice illustrates these components of promoting healthier communities through participants' photographs, illustrating what is important to them. Furthermore, the use of cameras and the consequent collection of photographs permits them the inherent authority of knowing these populations allowing them to represent what is significant to the participant instead of what an outside expert may think is important. This insightful experience enables critical dialogue, permits a genuine representation of the community, respects their cultural values and gives them the power to create new knowledge and understand the role of outside institutions.

For photo documentary, participants have the task of taking pictures of those hard to reach places and/or populations. Historically, the main objective was to inform

through “visual representation”. This method is characterized by presenting social issues in visual form. Examples of this method include photo elicitation, and a photo diary (Denzin & Lincoln, 2011). As synthesized by Stryker, documentary photography can be referred to as “the things to be said in the language of pictures" (Carnegie Library of Pittsburg, 2014). This type of visual research centers on naturally occurring phenomena, which can have greater significance for research and plan development. In addition, the focus is not necessarily on the image itself but is related to the perception and the attributed meaning and significance of the image (Denzin & Lincoln, 2011). Furthermore, both methods include processes to understand the relationship between the images and what they represent. Photo documentary shares a common ground with Photovoice in the areas of use of media, construction of images and establishing a context for the visual data (Denzin & Lincoln, 2011).

Photovoice Methodology

Photovoice is a specific technique whereby participants can identify, represent and enhance their community (Wang & Burris, 1997). The Photovoice process includes the use of cameras for participants to capture visual images related to a specific topic. These visual images serve as evidence of what is significant and meaningful for the person capturing the image.

Photovoice has a process and a structure. Wang and Burris (1997) summarize the three main goals of this method as follows:

- to enable people to record and reflect their community strengths and needs,

- to promote critical dialogue and knowledge about important community issues through large and small group discussions of photographs, and
- to reach policymakers.

Being highly flexible and adaptive, Photovoice has been used in different settings, in diverse cultural contexts and with an array of social issues including public health topics.

There are various examples of research using Photovoice, including: researching the influence on environmental factors on mental health within prisons (Nurse, Woodcock, & Ormsby, 2003). It is also has been used as a method of facilitating deliberation in a rural population to improve health status (Downey, Ireson & Scutchfield, 2009). It has been used with vulnerable populations addressing disparities in health promotion among people with intellectual disabilities (Jurkowski & Paul-Ward, 2007) to examine sexual health issues by non-gay identified African American men who have sex with men (Kubicek, Beyer, Weiss, & Kipke, 2012); and used in community building among youths, adults, and policy makers (Wang, Morrel-Samuels, Hutchinson, Bell, & Pestronk, 2004). Caroline Wang and Mary Ann Burris (1997) have been credited for the development of this method of inquiry as they used it to enable Chinese village women to photograph their everyday health and work realities (Wang & Burris, 1997).

Photovoice methodology includes specific procedures. The following procedures are involved in the process (Wang, 1999):

1. Selection and recruitment of leaders from a target audience of policy makers or community.

The central principle in this stage is the understanding that changes can happen when key stakeholders are involved. Community leaders are able to make recommendations based on what is important to the community.

2. Recruitment of a group of Photovoice participants.

Participants must come from the target community. They are considered experts and are instrumental in exemplifying how issues are experienced in their everyday lives. They must meet specific sampling criteria related to key demographics, age, race/ethnicity, gender, and similar elements based on the project.

3. Introduction of Photovoice methodology to participants and facilitate group discussion.

This session is recommended to familiarize participants with Photovoice as a participatory action research method. Roles and responsibilities are discussed as well as clarification for any questions about the methodology.

4. Obtain informed consent.

Researchers must be aware of participants' well-being when using Photovoice. All risks must be explained as well as steps to minimize them. Facilitators must explain the consent form thoroughly. This includes answering any questions related to the methodology, research process and the ethics of taking pictures of people.

5. Pose initial theme for discussion.

Research participants may wish to discuss examples of potential images to be captured. The importance of this process is the opportunity to start thinking critically of the theme/topic as it relates to individual and community experience.

6. Distribution of cameras and training on how to use them.

Cameras are given to participants for basic training on how to capture photographs. Wang (1999) advises to keep it simple to increase creativity and minimize inhibition: keep fingers out of the camera's eye, place sun at their back as much as possible and to avoid putting the subject or object of interest in the middle for each picture.

7. Establishment of time for taking pictures.

The recommended timeframe for taking pictures is one week. This is followed by a timeframe for picture selection and the final group discussion.

8. Meet to discuss photographs.

This portion of the methodology involves three stages: selection of pictures, contextualizing/storytelling, and initial codification of themes, issues or theories. These stages are what drive the group discussion. Photovoice allows for participants to discuss one or two photographs that are most significant to them. The frame for image photo discussion is based on the SHOWed acronym:

(1) What do you **See** in this picture?

(2) What is really **Happening**?

(3) How does this related to **Our** lives?

(4)**Why** does this problem, situation or strength exist? and

(5) What can we **Do** about it?

The themes, issues or theories will arise from the participants' discussion.

9. Plan format (with participants) to share photographs and stories.

It is recommended that participants and facilitators plan a format to disseminate findings. This process of information sharing hopes to heighten awareness of critical issues among community leaders and eventually attains significant changes at the policy level.

Constructivist Approach

The collaborative approach in learning from communities involves the premise that people need the opportunity to share their voice in creating resolutions that shape their livelihoods. By sharing ownership through participation and decision-making, they are no longer viewed as a category. When Photovoice is applied in research processes, the data emerging from discussions involve participants defining themes, issues, trends and concerns. This approach enables adherence to viewing data as an emerging theory instead of fitting information into a predetermined framework. This practice enables the research process to listen and understand communities as they establish meaning and construct what matters themselves (Wang & Burris, 1997).

The constructivist approach infused in qualitative research focuses on the socially constructed character of lived realities (Holstein & Gubrium, 2008). These realities are constructed in communities and are able to transform society. Constructivism holds that reality is constructed in the mind of the person and that reality is not viewed as an external singular entity (Hansen, 2004). This is of utmost importance when using this

approach in focus groups: the constructivist position adopts a hermeneutical approach which supports the embedded meaning in everyday life experiences, which is brought to life through the reflective process (Sciarra, 1999). Rather than implying a theory that explains the social process, this approach emphasizes the reflective process being generated through the dialogue between the researcher and the individual. Viewing participants as experts in their lives and communities entails an adherence to the data being generated without a prearranged agenda.

Constructivism pays attention to the interaction between the researcher and the entity or object of inquiry. Thus, the knowledge emerging is uncovered between the researcher and the participant. This method of inquiry can be traced back to German philosopher Immanuel Kant. According to Mannion (2002), Kant's position was that "reality is not an ordered universe waiting to be perceived by the human mind. Rather, the human mind takes the chaos out there and structures it into the reality we perceive." This method of thinking aligns with the central tenet of constructivist thinking: that you cannot separate or divide the objective reality found in research from the participant's reality who is experiencing, codifying, and making sense of the world (Mannion, 2002).

Furthermore, the constructivist approach is characterized by the co-creation of the meaning of lived experiences (Ponterotto, 2005). This is of particular importance when working with vulnerable populations such as refugees. Qualitative research focusing on describing and interpreting of experiences of this population will take into consideration the context where connection and collaboration are present. In this sense, the

conceptualization of language and the generation of knowledge will drive this learning process (Anderson, 2005). Each research participant is able to share his or her understanding, awareness, personal views and interpretation of his or her valid realities. The constructivist approach as a method of inquiry has the ability to bring awareness of significant elements that would otherwise remain hidden, thus unearthing potential for critical change.

Empowerment Theory in Participatory Action Research

Instrumental to health education and advocacy with vulnerable populations such as refugees is the application of approaches such as participatory action research (PAR) and community based participatory action research (CBPAR). Based on the principles of self-determination, equity, and social justice, these approaches have the goal of bridging the gap between the researcher and the research participant (Maiter, Simich, Jacobson, & Wise, 2008). These innovative research designs presume the power inherent within each individual and community to assess their own strengths and needs and to act upon them (Minkler & Wallerstein, 2003). Participants are able to reflect on their reality, objectively discuss their experiences, and intentionally engage in a decision making process. Interwoven in these processes is the theory of empowerment. Empowerment theory can be defined as "an active participatory process through which individuals and communities gain greater control, efficacy and social justice" (Rappaport, 1987). Thus, empowerment theory is aligned with action, practice, and application.

Empowerment theory is highly interrelated with the dynamics of discrimination and oppression (Robbins et al., 2006). Most of the perceived and tangible barriers are connected with a group having little access to resources. The lack of these resources results in significant disparity as it relates to health and overall well-being. In this sense, social change is necessary, and as a process, and can be engaged in when individuals are able to express the breadth and depth of their life burdens (Wang, 1999). Consequently, the process of empowerment is linked to gaining individual and communal goals and aspirations. For these to happen, the identification of societal structures and barriers need to be recognized. Yassour-Borochowitz (2004) stated that these can be identified through a relationship that is reciprocal and based on high ethical standards between the researcher and participants. Through this connection, a higher perspective of life experiences can be unearthed, resulting in the group feeling empowered.

Empowerment is a personal development process. Therefore, it is distinctively individual as well as an ongoing practice. This course of action involves people gaining information about themselves and the willingness to involve others (Lord & Hutchinson, 1993). Rappaport (1987) also equated empowerment with personal control: "by empowerment I mean our aim should be to enhance the possibilities for people to control their lives." Whitmore (1988) went further in her definition of empowerment as a personal process and includes the following:

a) Individuals understand their needs better than anyone else,

b) All people possess strength, upon which they can build,

c) Empowerment is a lifelong endeavor and

d) Personal knowledge and experience are valid and useful in coping effectively. Research methods that uncover the voices of the community can be transformative for the individual. It offers the opportunity of transitioning people to a sense of increased participation in their lives as well as uncovering their qualities, experiences, interests, and dreams.

Finally, empowerment is seen as a process for an equal distribution of power both in interpersonal relationships and in institutions throughout society (Stromquist, 1995). From this authors' point of view, empowerment is multidimensional and includes areas from the cognitive, psychological, economic issues to further reaching political components. While the cognitive component includes the understanding of self and the conditions that result in dependence, interdependence, and autonomy; the psychological aspect involves the decision-making processes whereby individuals can act at personal and societal levels to improve their conditions (Stromquist, 1995). The economic and political levels involve participation in society to increase financial autonomy and the ability for analysis of sociopolitical climate to improve civic engagement (Stromquist, 1995). This model of empowerment aligns with Photovoice methodology since it initiates by framing the research topic and eliciting insight on its effect on participant's lives and generates possible solutions at societal levels. Thus, all levels of the theory are touched through the research process.

Conclusion

Resettlement and integration to a new society are highly influenced by a range of dynamic factors, including the ability to benefit from quality of health and a sense of overall well-being. Research has shown the importance of individual factors such as former refugees' ability to learn the new language, continue with personal life goals and the ability to become employed as well as navigate societal systems that support these factors. Years after their arrival in the United States; nonetheless, many refugees still find themselves adjusting to the host culture and navigating an ever-changing multicultural society. Many of them are still on their way to fulfill critical areas related to health, education, employment and connection to the community. This is a gradual and sometimes lengthy process in achieving self-reliance and independence (Kok et al., 2013).

Of equal importance to understanding the resettlement process is the ability to listen to the voices that shape that experience. When goals, dreams and interests are achieved, healthier communities emerge with a strong sense of security, belonging, and cultural pride. This contributes to the vision of Healthy People 2020: a society in which all people live long, healthy lives and the goal of achieving health equity, eliminate disparities, and improve the health of all groups (Healthy People, 2013).

While many studies have focused on the immediate refugee experience, this research aims to build on the narrative of post-resettlement status in areas of health and well-being. By focusing on their personal experiences, this research brings participatory

action research to a new level of engagement. It seeks to understand personal factors, challenges faced by Burmese refugees, as well as systems that sustain their quest for leading a healthier lifestyle in their new country.

CHAPTER III

METHODOLOGY

The purpose of this action research study was to identify the perceptions and views on health and well-being among a group of Burmese refugees relocated to Houston, TX using Photovoice as an instrument for participatory action research.

Population and Sample

Burmese refugees between the ages of 18 and 65 who have lived in Houston for at least 3 years dictated the selection of sample characteristics. Photovoice methodology recommends a sample size between 6 to 10 participants. Consequently, 10 volunteer participants were identified between area community services agencies, and 6 individuals followed through with all aspects of the project. Their ages ranged from 22 to 45 years of age; 4 were female and 3 were male. All of them were Burmese and voluntarily participated in this project. These individuals followed through in all of the proposed activities: information session, training on use of camera, signing of consent forms, taking photographs, and focus group participation, where pictures were displayed, discussed, and interpreted.

Setting

The study took place in the city of Houston, TX. According to the Department of Health and Human Services (2013), Texas accepted the largest number of refugees in 2012, and refugees from Burma were the second largest group to migrate to the United

States. Most refugees relocate to major cities such as Houston; therefore, the research was designed to take place in this city.

Sampling Procedure

The nature of the study included distinct sample characteristics, which resulted in the utilization of convenience sampling. Therefore, agencies, organizations and business that serve the Burmese population relocated in Houston were contacted via email communication, phone calls and personal meetings. These were: The Hope Clinic, Houston Independent School District, and Amaanah Refugee Services. Principal Investigator (PI) debriefed each individual agency on the process and requirements of the research. At least three face-to-face meetings were established. The Recruitment Flyer (Appendix B) and Recruitment Script (Appendix F) were shared with these agencies to aide in the identification of possible participants. Potential participants were routed to contact PI for further debriefing and setting a time/date for training and orientation. The Interview and Focus Group Session Guide (Appendix G) was used to guide this initial conversation.

Protection of Human Rights Participants

The Texas Woman's University Institutional Review Board (IRB) approved the study in the spring of 2015. After IRB approval, this researcher started formally contacting and actively networking with agencies that serve the Burmese population in Houston. In August 2015, the PI was able to establish the voluntary participation of at least 10 individuals. Of this sample, 7 went through the mandatory orientation session

and training. All participants signed the consent form and confidentiality agreement form: Consent to Participate in Research (Appendix B) prior to the initiation of the study. Individuals who began the study were informed that participation was strictly voluntary, and that they could withdraw from the study at any time for any reason without any penalty

Research Procedures

Orientation and Training

This first meeting took place during the last week of August 2015. This was an opportunity for developing rapport with study participants, building relationships based on trust while being culturally responsive to any important need and/or request from the group. The first item discussed was a brief explanation of Photovoice. Attention was given to adhering to the definition of Photovoice as a participatory action research that provides research participants cameras to capture photographs representing aspects of their daily living in order to produce and encourage knowledge, and a better understanding of personal and community issues (Killion & Wang, 2000). Participants were coached into taking an active role in identifying what they want to portray (photographs) as part of the research questions: objects, places, and/or subjects. In staying consistent with the theoretical framework of Photovoice participants were asked to take as many photographs as they deem important, however; it was also explained that they would participate in the final selection of pictures that best represented their perceptions on health and well-being.

Secondly, the purpose of study was explained: the identification of factors that influence the health and well-being of refugees, and the incorporation of participatory action research (PAR). The consent form was explained in detail including participants' expectations regarding time commitment and confidentiality during the study. It was made clear that these items were included and contained in the Consent Form and Confidentiality Agreement (Appendix C). After all question/concerns were answered about the purpose of the study and the Consent Form, all participants signed the form. The PI also mentioned that he would be available to answer all questions/concerns at all times during the research process. His contact information was included in the consent form. Individuals were informed that participation was strictly voluntary and that they could withdraw from the study at any time for any reason without any penalty.

A List of Mental Health Counselors and Support Groups (Appendix I) and List of Health and Related Service Organizations (Appendix J) was distributed and explained to each participant. These tools were distributed to aide in cases related to health, legal, housing, and employment, including crisis and emergencies.

A brief training in the proper use of the cameras was given covering basic items: charging the camera, use of zoom, power, use of flash, focusing. The PI also demonstrated how to use the cameras followed by a hands-on use section by participants.

In this section of the training, the process of picture taking related to the purpose of the study was emphasized: participants taking pictures of their everyday life as it relates health and well-being. Additionally, PI and participants contributed to a short

brainstorming activity to elicit initial ideas of what perceived elements related to the status of health and well-being could be photographed. This activity is also consistent with the proposed Photovoice activities outlined by Wang (1999). This provided a space for participants to share initial ideas about their perceptions on the research topic and to develop rapport among the group.

It was clarified that captured pictures could range from scenery, to objects, persons, and situations. It was reiterated that they would take full control of what pictures they wanted to capture and the amount of pictures to be taken. This was followed by a thorough discussion and explanation of obtaining permission and signature of Consent to Photograph Subject Form (Appendix D) should participants choose to photograph an individual. This included the use of Script for Taking Pictures of Persons (Appendix H), which is consistent with seeking permission and explaining the purpose of the study before photographing an individual: pictures were taken only of those individuals who voluntarily signed the consent form.

Additionally, another form was introduced: Consent for Publication of Photographs (Appendix E). Participants are the owners of the pictures captured, and their consent to use them as part of the study was obtained. This practice aligns with other studies where Photovoice has been used.

Finally, the PI led a short discussion for the next steps: the timeframe for picture taking, the selection of pictures from each individual and the focus group discussion. Participants were given one week to take pictures that would fit the purpose of the study.

The PI also mentioned that he would meet with each individual to make the final selection of pictures to be used in the focus group. Each individual would give the date and time for this activity. PI agreed to adhere to each participant's schedule. Additionally, the group agreed to have the focus group in the next two weeks. This period of two weeks gave enough time for the PI to gather all selected pictures in preparation for the activity.

Data Collection Process

Picture Taking Segment

The seven participants were given seven days to take pictures. Each participant received a notebook to use for writing notes connected to the photographs. The use of the notebook was not mandatory, and it was not expected for it to be submitted as part of the research design. During the timeframe of the picture taking portion of the research, member check-in was done through a follow up call. This was done to increase the validity and consistency of the research process. All members reported that they were doing fine, as no significant issues or concerns were reported.

Selection of Pictures

After the picture taking phase, the PI met with each participant individually to review all pictures taken. The PI asked each individual to select the pictures that would be used in the pool for an in-depth discussion during the focus group. This was followed by the selection of at least four pictures taken by each individual. These selected pictures were then downloaded into the PI's computer.

Focus Group

Participants were welcomed to the focus group session. All seven participants arrived on time. The group sessions took place at the Amanaah Refugees Services and Neighborhood Centers Inc. facility in the Southwest area of the city of Houston on August, 2015. The total time for Photovoice group discussions took 3 hours and 15 minutes. There were two 10-minute breaks embedded into the session. Selected pictures were projected on a screen using a laptop and projector. The session was audio recorded and later transcribed by PI.

PI recapped the purpose of the meeting and opened the floor for any last minute comment/and or concerns. Time for any questions and/or concerns was given. There were no questions. Next, a brief overview of the confidentiality agreement regarding the sensitive information that may arise from the discussions and the signed consent form was referenced. It was mentioned that individual pauses and breaks during the session was allowed and encouraged.

The PI, using the photographs taken by each participant, led the in-depth focus group discussion. The PI started the inquiry by posing probing questions to encourage elaboration of responses. This was the process by which initial contextualizing of the pictures took place: what it represented to the individual that took the picture followed by general input from the group. This inquiry process followed the SHOWeD method outline of the Photovoice methodology (Wang, 1999):

(1) What do you **S**ee in this picture?

(2) What is really **H**appening?

(3) How does this related to **O**ur lives?

(4)**W**hy does this problem, situation or strength exist? and

(5) What can we **D**o about it?

Through this group dialogue and photo analysis, contextualization of the pictures began to arise, the codification of ideas emerged as well as the identification of themes and theories (Wang, 2007). The PI, taking notes of emerging themes using a flip chart, supported this. Using the flip chart assisted in the identification of themes and topics for the group. This was used to enhance the studys' authenticity and consistency. This method was followed until all photographs were discussed as a method of following a consistent protocol for internal and external validity and reliability. The final section of the focus group included concluding remarks from participants. The PI concluded the session by thanking all of the participants and remained in the building for any additional individual comment or concern.

Data Collection Method

The data collection method used was Photovoice. It is a participatory action research method that provides research participants cameras to capture photographs representing aspects of their daily living in order to produce and encourage knowledge, and a better understanding of personal and community issues (Killion & Wang, 2000). Participants take an active role in identifying what they want to portray (photographs) as part of the research questions: objects, places, and/or subjects. The theoretical

framework of Photovoice includes the following concepts: images can teach, photographs can inform and influence policy, community members creating the images are experts in their lives, those with the ability to create change must be involved, and it has the power to promote individual/community action. Caroline Wang and Mary Ann Burris (1997) have been credited in developing this method of inquiry to enable Chinese village women to photograph their everyday health and work realities (Wang & Burris, 1997).

Phototovoice is also considered a culturally appropriate research methodology as the photographs are captured by the participants to and reflect their particular worldview (Wilson et al, 2007). It has been used to research the following relevant topics: the influence on environmental factors on mental health within prisons (Nurse et al., 2003); as a method of facilitating deliberation in a rural population to improve health status (Downey et al., 2009); with vulnerable populations addressing disparities in health promotion among people with intellectual disabilities (Jurkowski & Paul-Ward, 2007); to examine sexual health issues by non-gay identified African American men who have sex with men (Kubicek et al., 2012); and in community building among youths, adults, and policy makers (Wang et al., 2004).

Data Analysis

Analysis of data was executed by PI. The data analyzed emerged from the discussion of all 18 pictures during the focus group. The discussion session in its entirety was digitally recorded and then transcribed verbatim by PI. The thematic analysis followed the social constructivist approach. Creswell (2007) stated that this theory

focuses on the complexity of data emerging from the subjects as part of their worldview. The analysis of the qualitative data was done using NVivo Pro 11 version; a Computer Assisted Qualitative Data Analysis Software. This software has been used widely to classify, sort, and arrange unstructured data in qualitative studies (Walsh, 2009). To improve the study's validity; member checking, triangulation of data collection methods through the literature review, inclusion of expert viewpoints from peer-reviewed articles, and implementation of a consistent Photovoice methodology was observed.

Summary

The purpose of the present study was to get Burmese refugees resettled in Houston, Texas to share their views and perceptions on health and well-being through a Photovoice project. The study was designed to determine the factors that influence and enhance the overall quality of life of the resettlement experience as well as to identify strategies for entities advocating on behalf of refugees. To determine these factors, Nvivo Pro 11 software was used to analyze unstructured qualitative data gathered through a focus group discussion.

CHAPTER IV

RESULTS

The main findings from this research are summarized under significant headings corresponding to views and perceptions on health and well-being. A constructivist approach was applied for the identification of significant emerging themes.

The results of this qualitative study consisted of constructing new knowledge and concepts evolving from the interaction of individuals, contextualizing their life experiences through dialogue and the discussion of images. Transcripts of the focus group discussions with resettled Burmese, photographs captured by participants, highlights from conversations with experts on the topic of resettlement, and field notes were used to conduct the analysis. The aggregation and disaggregation of data was conducted using the NVivo11 Pro software. The primary source of data came from six participants that fit the inclusion criteria for this study: 1) of Burmese origin, 2) resettled in Houston, 3) between the ages of 18 and 65, 4) have lived for at least three years in the United States, 5) command of the English language, and 6) voluntarily consenting to participate.

The methodology used for data collection is consistent with Photovoice protocol as presented by Wang and Burris (Wang, 2007). Guided discussion followed the SHOWeD method (Appendix G). Principal Investigator (PI) met with participants and conducted an orientation session to introduce the study. At the end of this session, each

participant voluntarily signed the consent form and received a camera. A short demonstration on how to use it, and its role in the Photovoice project of capturing images related to health and well-being was given during the orientation session. Consistent with Photovoice methodology, participants were guided with a short brainstorming session to identify potential images of what represents health and well-being for them. Initial ideas that emerged were safety, medication, finances, employment, and transportation. These preliminary ideas seemed highly related to achievement and maintenance of optimum health and well-being. These factors potentially pose as barriers for the topic of analysis. One week was allowed for participants to capture images, making sure to gain written consent of other individuals who would be included in photographs. Pictures could be persons, objects, and/or places. It was explained that it was the participants who controlled what images to capture.

Of the seven initial participants, six took place in the focus group activity. There was a minimum of at least 18 images captured. All participants selected for their pictures to be included in the focus-groups discussions. Eighteen images that illustrated the research topic were discussed. These pictures were uploaded in NVivo11 Pro software and integrated in the final data analysis. A few pictures were cropped and utilized in this section to illustrate pertinent findings related to health and well-being as perceived by the Burmese people who have resettled in this country. The focus group discussion included the contextualization of images through the showed method. The inquiry had the objective of eliciting views and perceptions on health and well-being. It included

dialogues on how these concepts affected the topic being researched, consideration of why the problem exists, and what solutions were perceived as relevant.

The focus group discussion was audio recorded for a total duration of approximately 3 hours and 15 minutes. These were then transcribed into a text format. This was followed by importing the text document into NVivo Pro 11 software. Other sources imported included images, field notes and anecdotal summaries from meetings with experts in the refugee resettlement field. This software assisted in managing documents, organizing emerging themes, exploring data, coding themes and developing new concepts on health and well-being from the data collected.

Summary of Themes

The final analysis was done by the PI following the constructivist approach by honoring the important concepts emerging as created and perceived by participants. The top 5 themes served as nodes under the Nvivo analysis process: (a) Family Well-being, (b) Financial Well-being, (c) Health Literacy, (d) Health Education, and (e) Community Engagement. The following diagram depicts emerging Nodes and Codes in Nvivo 11.

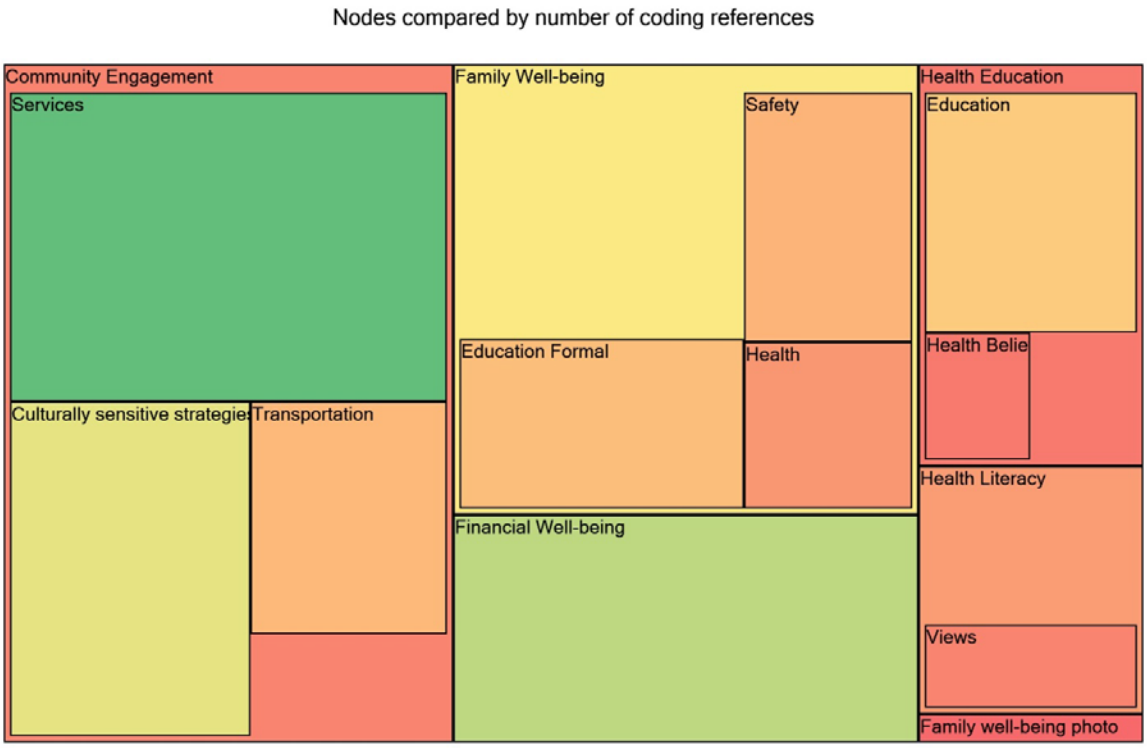

Figure 4: NVivo Nodes by coding reference

Further audit of information from the audio transcripts revealed specific concepts that surfaced from the PI's understanding and experience while interacting with data and the research participants. The following table summarizes those concepts that are embedded in further discussion within this chapter.

Table 1:
Emerging Themes and Codes

Family Well-being and Financial Stability	Ability to understand disease and health related material. (Health Literacy)	Safety/Preventive Education (Health Education)	Community Engagement
Family Safety	Healthcare System	Nutrition Education	Social Isolation
Access to education	Knowledge of health topics	Lifestyle factors	Community participation
Employment	Locating health institutions	Understanding Risk factors	Connection
Sanitation	Filing applications	Patient education	Adjustment process
Living conditions	Knowledge about insurance coverage	Awareness	Outreach activities
Finances/Financial stability	Locating health services	Family Planning	Cultural competency
Language	Nutrition labels	Educational Activities	Case Management
Services	Following prescriptions	Dissemination of health literature	Community integration
Income	Understanding insurance polices	Attitude and behavior	Living conditions
Adjustment	Understanding risk factors	Community participation	Cultural differences
Family literacy	Sharing Personal health history	Nutrition	Refugee organizations
Parenting	Lifestyle factors	Healthy cooking	Trust
Transportation	Health Insurance		Social Capital
Basic needs	Benefits: Medicaid		Transportation
Mental health			Women's group

Data analysis regarding the overall perception of current health and well-being elicited many issues. These were shared in combination of narratives of personal experiences, description of family living conditions, as well as examples of perceived characteristics of the larger Burmese resettled community. Through the guided

discussion of photographs, four predominant categories closely related to health and well-being were identified to include:

- *Family well-being including financial stability*
- *Safety/preventive education*
- *Ability to understand disease and health related material and*
- *Community engagement*

These themes are interwoven and are presented to support both research questions.

Research Question One

What perceptions do Burmese refugees resettled in Houston, TX have towards their current health status and level of well-being?

Figure 5: Family

Family well-being and financial stability. The most important emerging theme from data analysis was coded under Family-Wellbeing using Nvivo Pro 11 software. Transcribed statements, phrases, and sometimes entire paragraphs were coded under this node. The family well-being aspect ranged from employment and job skills, parent-child relationships, access to formal education, employment and training, current living

conditions, general financial well-being, transportation, basic needs, as well as language acquisition.

Employment. Beyond resettlement, it is perceived that many Burmese families are still struggling with securing gainful employment. Lack of employment is highly correlated with the ability to diligently provide nutritious food for self and family, secure monthly payments for shelter, and afford other day-to-day finances. Financial instability was seen as a problem that affected their overall health and wellness.

Concerns about financial struggles came were voiced various ways. Some of the comments were directly connected to income and the consequences of sustaining a family. It was mentioned that daily a child's demands had a great burden on parents. Even when both parents were working their combined income was not enough to provide for other life demands such as computers, smart devices, toys, new clothes, or even qualifying for credit cards. At the same time, the prices for these items were too expensive when their earning wage was seen as barely meeting living standards. Unfortunately, this was attributed to lack of gainful employment opportunities. These were validated by comments like the following:

"They can't pay that money; because they are a family of three and their high income is like 30,000…a year"; "Another thing I would like to add could be that Mom and Dad are working hard to pay the rent and the bills of the apartment…."; "Yes; low and only one person works to pay the rent."

Many households are seen to have up to three generations living together with only one person gainfully employed. Two members of the sample aligned with this finding at the time of data collection. From their perspective this condition is prevalent and true for many Burmese families.

Many Burmese as heads of households found it difficult to secure employment that would enhance access to better living standards. The group noted the lack of special skills that would make them marketable. One of them mentioned how many were employed in service industries and production lines. These included hotels, restaurants, and assembly lines. Several of them lack training and education to strive for better positions such as managers, administrators, or supervisors. One individual shared a personal story where individuals were interviewed and did not get hired by a local supermarket chain. She attributed this to her limited skillset and lack of training and education made worse by a linguistic barrier. It was commented that middle age relocated individuals were unable to secure better work positions as a result of not fluently speaking English. Furthermore, they also reported that in many households the only people employed were men.

Figure 6: Money

Financial stability. Financial stability was by far the most important aspect affecting the overall systems that sustain health and well-being as identified by study participants. This barrier to optimum health and well-being affects all subsequent themes under this category. Financial stability and the ability to feel connected to the community were perceived by the research participants as tightly correlated to being able to feel secure and safe. In order for individuals to benefit from a sense of health and security they need to perceive progress in established goals for themselves and their children. Feeling economically secure is also related to the ability to cope with adversity and overcoming these difficulties.

The following comment illustrates the perceived weight of working at minimum wage and unable to plan for a brighter future: "They are working at the $7.25. How long they working? Because we are already 45-50, so they can work 10-15 years, but here they have a life so if the community...if the community members are working with them directly then they will get…if they are low income they will get benefits. Each and every

student in the United States, so they need to continue their studies—we need to encourage them."

This participant further explained that family's future financial well-being was related to education. He focused on the second generation. Bridging the income gap for the next generation involved supporting the academic progress and plans for Burmese students in high school. From his point of view, these Burmese youths have the opportunity to lift up this community economically since they are being educated in the United States and are acquiring the language faster.

Furthermore, it implies establishing financial stability is somehow perceived as related to age. The opportunities for employment and the ability to save money and prevent falling into poverty appear to be of importance during these productive years. It is important to maximize their employment and career potential around this age bracket.

These remarks exemplify the possibility of establishing goals that support plans for themselves, their children, and families. Besides, community initiatives and programs that enhance career and job readiness and action agencies are esteemed as an important component of any refugee group. Community action agencies are instrumental in guiding refugee families in times of crisis and emergencies. They offer a baseline for accessing basic service relief resources such as food pantries, rent and utilities, legal advice, education, insurance, and other services such as tax preparation, banking, and education on home buyers' programs and basic budgeting. By simply having the

knowledge of being able to access these resources and systems of support, this capacity contributes towards a person's overall sense of wellness.

Figure 7: Children and computer

Parent-child relationships. At the core of family well-being are parent-child relationships. The quality of these relationships is regarded as integral to overall family functioning. These protective factors account for stronger bonds with family members, closeness with parents, and positive role models. Furthermore, a strong positive bond increases the sense of emotional well-being. When a lack of time begins to threaten these core family values, refugee families visibly recoil at the thought of this and attribute this to long hours at work and computer games or time on the Internet as contributing factors. The following comments that arose during discussions, which exemplified these topics were:

"The children can play outside under the supervision of the parents"; "As refugee parents, most never do that, because most of the parents they do not know how to take

care of their kids, so they mostly are not educated on how to control them the only thing can provide for kids so mostly they can only provide the kids is only getting the desktop computer"; "The kids they play outside of the apartment; each apt complex, parents allow them if they are in the house, they can play around with their friends. What they are done they come back and can play around, when they are done they come back and play on the computer until the parents let them stop or maybe if they go."

Two of the participants expressed their view that many children from these Burmese families living in large apartment complexes had less supervision. They could be seen playing in small groups around the compound. They stressed that there were many factors involved in this situation. These ranged from lack of parenting skills, to parents not knowing how to fully engage with children, to parents being culturally bound to the environment and community they trust.

Associated with this situation is the long-term concept of parenting education. One of the participants exemplified this situation by describing life as refugees before relocation. This narrative connected the present situation with life in refugee camps. He mentioned that living in refugee camps focused on survival and was seen by many as just a phase. However, this phase took up to twenty years in many cases. In such circumstances, they lived in communities that lacked access to formal education much less exposure to information on concepts of child development, supporting academic achievement, and the importance of social-emotional development during these years. At the same time, the entire community cared for children.

A participant noted: “These kids they are struggling with their homework-they sitting physically in the classroom but they don’t understand because the base is not there and the parents cannot help them so I don’t know if these kids how they will do will do when they go to higher classes— elementary; first, second grade, they come and go.” Additional observations arose regarding the parenting expectations. From this perspective, these young children are growing up in a country whose culture is different and may have distinct expectations from their parents. It was mentioned that parents sometimes are bold with how they manage behavior issues with their children, posing a burden on their family wellness: “Lot of people they speak to the children not good…like, a lot in America…some babies if the fall down, if they be like: “you ok? (sweet voice), but refugees be like: “what happened?” (rough voice, laugh)…they make the baby more sad…need to be: “you ok? (sweet voice)”. This posed an issue when educators contacted the families. Parents play an important role in the adjustment of their children to this society and needed support in doing it. Two participants shared that it was essential to teach Burmese parents on this topic.

Furthermore, they mentioned that many times the school invited them to parent-teacher conferences, and many of them did not know how to navigate the educational system and much less know how to respond to teacher’s request or how to inquire on behalf of their families.

Basic needs---shelter. The most frequent factor related to health and well-being was related to basic needs. Basic needs, in this context, are the ability in accessing decent supply of food and adequate shelter. These factors are important for survival and the ability to thrive in a different country and culture especially for relocated Burmese people. According to Maslow's (1943) Hierarchy of Needs, in order to achieve the highest level of human existence the most instinctive and physiological level of needs most be satisfied. Based on a few participants' views it seems common to see many Burmese people struggling to meet these needs even after six years of relocation. Many of the participants agreed that if these needs were covered, it would greatly improve the quality of life for these families. From their perspective this is related to employment opportunities and lack of access to training and education.

Figure 8: Unemployment

All participants agreed on the fact that many were still struggling to elevate their overall level of quality of life in different areas. They spoke about paying rent and not having enough money to pay for nutritious food and other miscellaneous items. Many of

them explained that by having minimum wage employment positions, they barely made ends meet. This is a recurrent trend amongst the Burmese resettled communities. In some communities there are members who have been unemployed for the past few weeks and others over a few months often relying on community organizations and churches to get adequate food for their families. The following experiences demonstrate the hardships faced by most vulnerable of the refugee populous:

"Dad works and the Mom may work"; "We have to think what we need to pay for first and then in what we need…if you have money, it is for diapers for baby. No phone…"; and "Yeah…they cannot buy a phone, because the money just goes to the rent and electricity—that's it…not enough."

These comments further illustrate the situation in which parents are striving to cover rent and utilities associated with shelter. One of the members explained that after all monthly expenses were met, there was hardly enough money for miscellaneous items such as new clothes and toys for children. She even described having seen families collecting toys that were thrown away by other residents and fixing them for their children. They further explained that they had not seen families venture to other areas of town for family leisure or exposing their children to educational experiences such as the local museums or the zoo. Visiting these establishments meant having enough finances to provide for these experiences and surmounting communication barriers that prevent them from being able to take advantage of the free educational experiences that are hosted by these public establishments.

Another area of significant importance was connected to the affordability of quality dwellings. They described the places where many were living as properties lacking basic maintenance and follow through from management regarding a renter's request. One of the examples shared was related to physical health and basic sanitation. They described cases where bed bugs were in many units in one of the participant's apartment complex. Several issues came up as part of this discussion.

First, a lack of knowledge contributed to many of the Burmese families on identifying this problem as a health issue. It was mentioned that a few thought they were mosquito bites from children playing in open areas. Additionally, the local elementary schools have identified this as a problem and have sought parent assistance to address this: "The leasing apartment there are there not only to collect the monthly rent but they should fix the problems what is inside the apartment like maintenance"; "I have seen the bed bugs and roaches come through the carpet."; "Every apartment has that—if you want to know that, turn on the light in the middle of the night—and they all come out and voila!—this is our place! You can see all the kitchen…"; "Children are sleeping at night with their parents or might be alone and the bed bugs and they go to school with all the rashes in their heads and the teachers see and ask what is happening and they don't know-- kids don't know about bed bugs and roaches—they think it is just an insect bite. So this needs to be taken care of for the refugee families…" The quality of physical living conditions can affect the sense of safety and protection. It is extremely important for at-risk populations such as infant and toddlers as well as pregnant women and the elderly to

live in safe environments. Being able to meet these basic living standards assures a better path to health and well-being.

Language. Language issues come up repeatedly as participants spoke about various issues surrounded to health and well-being. A few felt self-conscious about their command of the English language. The PI from the initial stages of the recruitment process experienced this. Even after many years of relocation, many Burmese people still found themselves having difficulty acquiring a strong command of the language. The majority of the research subjects felt that being able to speak English fluently was strongly tied to their levels of self-confidence as they interacted with their new environment. From this perspective, it was seen that a few potential participants who were perceived to speak English well declined participating in this study when it was explained that speaking, narrating, and describing photographs was to be expected.

Three of the participants were very vocal about this issue as to how it affected the overall health and well-being for individuals and families. They understood that learning English led to many possibilities. From their point of view, many Burmese people did not have enough time to dedicate to learning English. This was seen as a luxury because they had to dedicate most of their time working. Being gainfully employed secured funds for food, shelter, and clothing for their families. At the same time, difficulty communicating in English further compounded not being able to pursue better employment and education while also affecting other areas of family functioning such as

being able to assist with their children's primary education. The following narrative illustrates this phenomenon in their words:

"These kids they are struggling with their homework-they sitting physically in the classroom but they don't understand because the base is not there and the parents cannot help them so I don't know if these kids how they will do will do when they go to higher classes— elementary; first, second grade, they come and go." His view sheds light into the language barrier and how it affects understanding home-school connection. A few found it difficult to support their children when they could not read print material.

In addition, the language barrier had an effect in their health and health related services. It was stated that understanding medical terms proved to be difficult and interacting with health-related material such as prescriptions and warning labels as well as drug interaction. Basic literacy skills support understanding of health assessments such as results of mammograms, cervical screenings, and childhood preventive health progress, informed consent and discharge procedures. The lack of these skills negatively impact health and health related conditions for this population.

Transportation. A number of women mentioned that transportation was perceived as a barrier to health and well-being. Transportation is essential to connect persons to important life systems such as healthcare agencies and services, going to work, or attending school functions, especially in a commuter-oriented city here such as Houston. Lack of transportation impacts many important life systems.

Figure 9: Transportation

For example, a lack of transportation access significantly altered their doctor visits and access to local hospitals and community health centers. One of the research participants noted that many former refugees in her community had not learned how to drive and this was an issue in accessing these services: "Yeah, yeah…not enough transportation because they do not know how to drive…so we really need transportation…yeah; for parents or child to go to hospital. So if can go to classes to learn to drive but we need a car for transportation."

Transportation is essential to be able to keep appointments, meetings, and scheduled functions at school. One of the participants spoke about this from her experience in the community: "if the need to take babies to school they need to take bus or drive to meet the teachers—they need to drive themselves." In addition to this situation, she also mentioned not being able to keep up with scheduled wellness-child exams for her youngest daughter: "Like me, I don't have a car. I need to take my daughter to the clinic but I cannot go; that's why I need to check her teeth once a year…I

have not gone." Transportation as a barrier resulted in missed appointments, higher need to reschedule doctors' visits and postponed care consequently, interfering with an optimum sense of wellness.

The above scenario is related to complications when applying for a driver's license because of linguistic barriers. These issues come up in phrases like: "They cannot speak or read and write in English"; "We need to help them to learn a little bit of English, apply for ID for car, driver's license, benefits…", "A lot of people they do not know how to drive. Also, they cannot apply to get an ID for like a car…"

Applying for a driver's license meant studying and preparing for the exam. This required the ability to read and understand print material in a language not yet fully mastered in addition to the actual driving test. In the words of another participant, this was a two-level barrier: "They need to read and write for driver's license and they also need to learn how to drive." Moreover, there was the experience that because of the language barrier even calling a taxi got complicated.

Along with these issues, they also mentioned the support received by relocation agencies soon after their arrival. Services included a system that provided transportation to all social services agencies. This system enabled them to access these services; however, post allocation of this support left many refugees struggling to navigate the complicated and sparse public transportation system in Houston. Although they use the metro system of public transit, they did not know how to navigate a large city. After relocation, many had not ventured further than their communities: "Yes; they use the

Metro. We try the best we can to help each other and we need a lot of help but we need a lot of things. There are a lot of refugees here, but if they need to go somewhere they cannot go. They cannot speak or read and write in English." This situation is not uncommon and has been mentioned by an area health clinic staff. They have experienced Burmese people not feeling comfortable and getting confused when referred to a public hospital in the medical center. They had cases where refugees got lost using the public transportation system, and the clinic had to assign staff to take them to the hospital. Being able to use the metro system implies that a person has the ability to understand from a map a route, understand service lines, schedules, and the transfer system and finally being able to walk a short distance to the exact address.

Being able to stay connected through an adequate transport system is also indicative of financial stability. Part of the discussion on this topic included information related to jobs and salaries. Many of them had to carpool to get to their jobs since only a few either had vehicles and/or had leant how to drive. If the driver was unavailable, the rest needed alternate plans for that day. Not being able to finance a vehicle posed a barrier, which prevented these families from being able to secure a better job and higher paying salaries. One individual shared the following personal experience that exemplifies this issue:

"So just imagine, me and my husband. If I go to work, he cannot go to work…he takes care of the babies…If he goes to work, I cannot go to work…So, only one person works and you have to pay rent, electricity, you have to pay that so…how can we get a car? We

need more jobs with more money… Higher salary, so we can get a car? Only we get a little money. We work, but the salary is very low." Her family did not have a vehicle and mentioned not being able to strive for a better job because of transportation.

Safety and Preventive Education

Another section of emerging topics were related to general safety and preventive medicine. These areas are very critical on how participants perceive health and well-being. The concept of health can be very subjective and has different meanings to different people. Its definition will also vary from one community to another. Relevant categories from these participants were related to general health practices, safety, living conditions, and the need for understanding preventive education.

General safety. Regarding general considerations of health, a picture of a fire extinguisher was briefly discussed. From the standpoint of environmental safety and health, this item is necessary for any hazards associated with extinguishing small fires. It is also a requirement for apartment complexes to have a fire alarm system. This may include sprinkler systems, smoke detectors and portable fire extinguishers at strategic locations per regulations set forth by the fire marshal. However, not many people were familiar with these requirements and did not know how to use them in case of emergency.

Figure 10: Fire-extinguisher

One of the youngest participants was first to comment on the topic when the photo of the fire extinguisher was presented. She was familiar with its use; however, she did not know whom to contact in case a fire did indeed occur. This paved the way for further discussion on how Burmese people (and the general population) may not understand or underestimate the importance of environmental health and safety measures. One of the participants associated this picture with two parallel issues highly connected with health education: the importance of educating the community on the use of a fire extinguisher while understanding that fire extinguishers may be a novelty for Burmese people. He explained that its function could be a foreign concept to many members of

his community. This is because they come from refugee camps in a third-world country, where fire extinguishers were close to non-existent. They had not interacted with them and thus had no reference on how to properly use them. Even though they may have a general idea of its function, they still needed educational exposure to fully comprehend its impact in case of a fire. This would positively impact the health and well-being of an entire community.

He commented:

"Is it a fire extinguisher…you know from the picture but, ahh… the communities which that are settled new to Houston may not have seen before in their back country so, in the apartments or house each might have inside the apartment, but they do not know how to use it. So when come new, the case worker come, ……. they may not understand at that time and it is important if there is something; we have seen some houses or apartments that have burned because they do not have any idea what it is called so if something happens it goes back to their health."

Likewise, another participant emphasized the need for this type of preventive education for emergency situations and the well-being of young children. This was noted because many parents stay at home with infant and toddlers. If they felt confident in using a fire extinguisher in case of an emergency they would be able to prevent a disaster: "So even I do not know now still now, but how can we like- some of the parents that only stay with the kids only and they do not know still how to use, so it is not exactly related to health, but it is life; it is prevention…"

Furthermore, the need to educate the community arose from an incident where some apartment units where resettled refugees lived had burnt. An observation shared was that apartment management offices had the impression that residents were familiar with safety and preventive measures in cases of fires. The group felt that this was not the case and it was true for other immigrants living in their communities:

"But speaking of the refugee families, not only from Burma, but all over the world- I mean like third world country people you barely see fire extinguishers", "But even in a residential area, most of the refugee people go there, if it is a new home or new apartment they probably might put one (fire extinguisher) there but nowadays they don't because, because even from Mexico or Asia, if they put it close to the kids for them to reach out, they think that it is just think that it is a play around and ummm…even the families don't know and the leasing office did not let them know either because they think that the residents already know and…one apartment burned—I think two or three rooms burned and, they don't know how to use that and some apartments don't have it, so this picture can let the refugee community know that they should have, they should all have, along with the knowledge of how to use it and how that kind of thing can prevent about fire, disaster and ummm…some kind of knowledge, you know, just so they can take advantage of the picture…"

Living conditions. A healthy living environment is a precondition for a healthy family. At the same time, access to decent shelter has always been considered a basic need to be fulfilled for any human being. Once these basic needs have been achieved, individuals can strive for higher levels of self-fulfillment according to Maslow's hierarchy of needs. That means that general living conditions and its quality have an impact on health and well-being. From the general discussion, it appears that many Burmese refugees spend a lot of time inside their apartments. Many of them are stay-at-home mothers taking care of their young children. The following themes are illustrated by Figure 11.

Figure 11: Child safety

One of the participants took the lead in discussing his views on health related to housing quality. He expressed that many Burmese people live in substandard conditions.

This meant living in apartments in which the physical environments were not the best. This included the quality of the carpets, the level of maintenance by the management, and the type of furniture that existed inside dwellings. As shown in the picture above, the initial concerns were related to his assessment of cleanliness and the lack of access to improved living environments. The most pressing issue was related to condition of carpets and children's health. Since children are considered a vulnerable population attention should be given to this situation. This was a concern since these children were exposed to insect bites. These bites could then get infected, posing a greater risk for illness for these children. They also pointed out the quality of apartment interiors. The specific example was carpet conditions that in many cases were old, had not been replaced, and were very unclean. These posed a higher risk for insects, infections, and disease: "I have seen the bed bugs and roaches come through the carpet." "Every apartment has that—if you want to know that, turn on the light in the middle of the night—and they all come out and voila!—this is our place! You can see all the kitchen…" "Many children with insect bite."

Children spend a lot of time at home and are very prone to play inside of their apartment units. Constant contact with unclean carpets meant increased exposure to allergens, dust, dirt, bacteria, and even poor quality air inside dwellings. Exposure to poor indoor quality air can result from contaminated carpets, which may cause respiratory health conditions and negatively affect an individual's overall well-being. It was evident in this research group that the incidence of sickness related to young children

was due to staying indoors longer and being exposed to unclean conditions for prolonged periods of time. One of the comments summarizes this issue relating to infants: "If they are there with a baby and the young kids with a dirty apartment, not cleaning they are going to get all these diseases and illnesses." Additionally, "many have an environment that is not clean and the carpet, that dirty carpet can cause and that kid, like you know, trust me, they will be fooling around on the floor—so he maybe he probably might breath like some dirt and it can cause some him—for health—that's not good." Having a clean indoor environment improves air quality and has the potential of reducing allergies in children and improving the health and well-being for these families.

Similarly, another participant noted instances in which young children were sleeping in dilapidated and infected mattresses. They expressed their concerns regarding the children's beds:

"Children are sleeping at night with their parents or might be alone and the bed bugs and they go to school with all the rashes in their heads and the teachers see and ask what is happening and they don't know-- kids don't know about bed bugs and roaches—they think it is just an insect bite. So this needs to be taken care of for the refugee families…" This could easily be prevented through implementation of basic education in proper sanitation and access to preventive education. In this study it is evident that a few households are experiencing this form of pest infestation. Several participants also felt that the management staff was not engaged enough to offer pest control services or other treatment options and as a result did not contact management regarding the issue.

Educating the Burmese people about their rights and responsibilities on matters that affect their health and well-being should be of utmost concern.

Finally, it is also important to note that quality of living is directly correlated to income. All of the participants were familiar with the area where relocated Burmese and other refugees were placed. Most of these structures housed many of these families and were moderate in monthly rent prices. There were many instances where it was implied that these families were still struggling with monthly payments for basic needs including rent and affording basic utilities.

While most refugee families work long hours to provide for their basic needs, they still struggle financially:

"Another thing I would like to add, could be that Mom and Dad are working hard to pay the rent and the bills of the apartment so maybe they do not have time to set up the things. So it is their apartment—they pay the money, so they might think that maybe nobody comes to see this so they are always working; they come, they sleep, they go—because of lack of time."

It was also mentioned that clutter was another important item for safety under living conditions. The following comment exemplifies this view:

"Look at the cupboard—the cupboard is dirty and the mattress-if they don't use it, then they have to throw away because, you know, most of the apartments in this neighborhood what have I been seeing on some kids…they have a bacteria and when they bite it it's

going to turn red—some kids, it's crazy. So it's coming from…sometimes, like in the kitchen, very dirty—they do not know how to take care of it.

Figure 12: Living room

When clutter is present, it only increases the possibility of exposure to safety hazards and increases the chances of child injury. There were at least three participants that talked about the importance of this concern. Families have the added pressure to provide a living environment that is clean and ordered for them and their young children. A healthy and safe home environment is also essential to provide a safe atmosphere, enough space, ventilation, and comfort for inhabitants.

There appeared some concerns about the ability for some families to maintain proper order as illustrated by Figure 12. The image portrayed several random items left on a couch that were not yet shelved or put in their proper section in the household. It included items that looked like paper towels, ice cream, items of clothing, and diapers left on a couch in the living room. Participants commented:

"If this is really ice cream it is supposed to be inside the refrigerator; and not to be outside" and "If it is toilet paper also it is supposed to be in the toilet; not in the living room. And usually this is all about the health. I can see, uhh, the living room is supposed to like a living room."

Part of the discussion was about the possibility of also leaving medication and prescription drugs out in the open for easy access and possibility for young children to accidentally ingesting harmful dosages. Understanding the importance of placing medications out of the reach of children at the recommended temperature to ensure integrity of its components was mentioned:

"the picture is the location (medication) is not supposed to be there because the ahhh….some medicines, drugs have to be in a location that you go by the temperature."

Preventive education and medical care. The importance of education and awareness to promote healthy behaviors among refugees developed as an important node during the analysis. These themes are all interrelated and interconnected with other areas in this section.

Many saw the importance of educational activities and initiatives that would strengthen knowledge of preventive doctor's visits as well as the importance of medication treatment. It was a common perception that many refugees would benefit from understanding the importance of health maintenance activities. As Figure 13 was discussed, many important themes were identified. They have experienced instances where many members of the relocated community did not follow through with important

health related appointments. One of the participants shared that "paper is missing and they have to write it down so they will not miss the date and the time so that picture shows that."

He explained that even when they had received a doctor's note stating the information for the next visit (date and time); a few would still miss that appointment. From his point of view this was an area that needed attention in raising awareness to promote health and well-being. Furthermore, another participant stated that: "they use some information; because speaking of health they need the proper information and procedure" in describing needed attention given to written information on prescriptions and appointments slips.

Figure 13: Medication management

The need to follow the prescribed schedule for immunizations for children and infants was briefly mentioned. It was discussed that the concept of a scheduled and structured expectation for children's immunization could be a unclear concept for refugees. Burmese individuals came from refugee camps, where only basic services were given and the limited resources available may not have included intentional health

promotion strategies. As described by two participants: “When we lived in our country, we lived in a village so we did not have a clinic or hospital.” They also described that because of a very fragile health infrastructure, they were not able even to get a birth certificate. As these families start interacting with social structures such as school systems that require up to date immunizations they start to realize vaccinations are an important health issue. One of the participants explains:

“This is about the immunizations. Parents in the back country they didn’t have any idea that the children without immunizations they cannot go to school; parents did not know about, but here in America if a child does not get not get like to 7 years they are supposed to get some immunizations—the parents have no idea that the child needs to be able to sit in the classrooms.”

Other participants validated this comment. They thought that many had not associated immunizations with school settings. This fairly new concept may be discovered as these individuals interacted within such settings. Additionally, it was also mentioned that many of them did not know where to go to access these services. The following comment highlights another issue with immunizations:

“Parents should know that they have to take to the clinic and sometimes they do not have Medicaid so this is very important for the kids. Some parents don’t take them because they do not know where to go; which clinic takes Medicaid. Even if they have Medicaid they need know the source so they need to know about the locations so that would be helpful for families.”

All participants agreed that it was necessary to engage in educational activities in order to address the importance of childhood immunizations as well as the importance of following the required schedule for children in their early years. They needed to understand that these activities serve to prevent disease and keep their children safe, that immunizations are highly effective, and that it saves lives. At the same time, having a healthy child can also save time and money.

Figure 14: Food labels

Nutrition. The lifeline of these Burmese families depends on the acquisition of basic needs, which include proper nutrition. The participants believed that there must be initiatives, activities, and programs that would promote healthy habits such as proper nutrition. Apart from the day to day struggles related to acquiring better jobs and higher wages that would enable access to food, it was important to expose these families to a balanced diet that promote health and well-being. It was cited that many of these families prepare their own meals. Vital nutrition is needed to provide our bodies with energy,

important proteins, essential fats, vitamins and minerals. We need to consume a variety of foods to be able to provide those indispensable elements to the body. A few research participants shared the view that this was not necessarily happening:

"The Burmese community people they just stay home and cook every day. Today the same, tomorrow the same. They just make food but they need to learn how to make good food for babies' food…yeah…a lot of people need healthy food for the children." One of the participants described that many families will prepare the same food using the same ingredients almost every day. It was a common perception that children and families were eating the same prepared food for breakfast, lunch, and sometimes dinner. She also mentioned that this could be related to customs and culture.

At the same time, she shared that after living in the United States for more than six years, she had learned that children deserved proper nutrition to be able to develop and learn properly. Her perception was that many of these families were not exposed to healthy cooking classes and proper nutrition programs: "because they do not know how to cook healthy food, how to make a breakfast, a dinner, in the morning—breakfast-is the same thing as dinner…they cook same thing.… "

The group also mentioned that these educational activities were needed to guide young mothers and their children: "That is not healthy for the babies…so they can know better how to cook so the babies and family are healthy;" "We need to have a women's group to learn how to cook for the children." This implies the importance of caregivers to consume nutritious foods and to try new foods. This encourages young children to

increase their food options and enhances their eating habits and future food preferences. Parents can be a positive role model for promoting healthy nutrition. Proper nutrition information exposure improves the overall health and well-being for any community.

Mental health. The mental health status and emotional well-being of these refugees was another important topic that surfaced. Protective factors such as family bonds, sense of community, close-knit families, and other relevant issues affecting their emotional condition were identified. The psychological distress caused as a result of adjustment difficulties were related to mastering a new language, occupational issues, poverty, and social isolation. Years after relocation, these refugees are dealing with underlying emotional and relationship issues needed to be addressed in this area.

The most important topic was related to the stress of trying to learn English. This theme was prevalent and interwoven in nearly the majority of perceived barriers to acquiring health and well-being as well as preparation for the future. Many of the participants stressed that not being able to learn the language made them feel inadequate. They felt self-conscious about this aspect. For many, their first exposure to the English language only began when they arrived here in the United States. In their own words: "Just a few months. If they speak English, it is OK for them; but if no English, 6 months is not enough. The families' need more than 6 months. If we have agency like [name of relocating agencies], they need to connect with them until they no longer need help. They just help for 6 months and let them go and they still need help." It seems that the

six months of intensive support and guidance from resettlement agencies is inadequate for those who are learning a foreign language for the first time.

Even after many years of living in the United States, many were still in the beginning stages of mastering the language. This prevented them from securing better jobs and higher wages. This proved to be also connected to constant worry about the future for them and their children. Financial stability is also connected to an overall sense of well-being and a source of distress when basic needs are not met. One of them described how this can result in internalizing the situation while they should be externalizing it through connecting with others and sharing their situation, so that there is opportunity for community to provide support.

"Because they cannot read and write, so they cannot apply for jobs and just stay home. But we have to connect to them to know what problems they have, because we do not know what problems they have so we can fix problems for them. They still need help."

Additionally, there have been reports of serious mental health complications. One of the participants spoke about his experience and involvement in cases related to domestic abuse and severe mental health conditions including suicide attempts. He recalled that there were instances where police officers had been called to intervene in family disputes and arguments in Burmese households. It is important to note that there is the possibility of unprocessed emotional trauma paired with routine demands of living in a sophisticated society with great advances in almost every area. There is much stress related to decision-making and navigating social systems with little formal training and

exposure. The following excerpt illustrates the overarching factors contributing to this area:

"Now they cannot study—they cannot learn; they spent 20 years in the refugee camp in and they came to the US, so half of their lives is spent in the refugee life doing nothing. So, when they are 65 and above, how they will get citizenship studying the history of the US? That is why people are having problems now and why they are thinking so much and they are maybe thinking in the wrong way…issues of mental health. Like some of the Burmese lost their life; they commit suicide; like 24 I think so far. The reason they commit suicide; we don't know but this the things that is happening."

Finally, linguistic barriers prevented many from seeking specialized intervention when it came to issues of mental health. The constant worry and preoccupation related to financial stability was also highlighted: "Maybe they just worry a lot and they can get sick. Or they have no money and the rent is coming. Imagine…no job and I have to pay rent…how to pay next month's rent…they worry a lot and it makes the parents sick." If mental health services were requested, there were few professionals in the area that spoke their languages. A limited option for mental health and promotion of protective factors means that those who are suffering must suffer in silence.

Reproductive health. Two female participants also cited the need for family planning. They mentioned this issue as a much needed area of health education and awareness. They could clearly see the connection between the number of offspring and the quality of health and well-being available for the family. The intended outcome of

this topic is to promote health for mothers and their newborns as well as improve community health. Discussion initiated with attention given to mothers as a priority: "How do we help children, help Mom to help the baby, so everything is better…." As family leaders and caregivers, childbearing-aged women needed information on the importance of screenings, benefits of good nutrition, and general health conditions. It was mentioned that they needed to be targeted as a community. One of them visualized it as: "I see a women's group…women really need help…because they need Medicare…good insurance…how to take care of babies… Let them know a family plan; then, know step by step. If they know then little things that are not little will fix a lot of problems for us. We can know then better so we do not have a child every one and half years. Step by step…this will help fix a lot of problems for us."

She touched on relevant topics such as accessing and understanding insurance policies. By utilizing these services, they are able to provide a higher quality of well-being for their children starting with pre-natal care. The planned approach of family planning was mentioned since they have experienced families that could benefit from this knowledge. They stated that couples had many children in a short span; their ages were close and parents did not have enough financial means to provide for all of them. This translated into higher financial struggles. It resulted in mothers having no choice but to stay at home and take care of children. Having resources and education about family planning would improve the livelihood for them. Another participant shared: "After they go to family doctor, the doctor can explain how to help family with health. And when

they are healthy, they can get a better job and more money for the babies and the rent so they are better."

Understanding Health and Health-related Material

Another important section was related to understanding health-related material and making personal health decisions. The group spoke about topics related to understanding medication, ability to comply with self-care instructions, and the follow through with medical treatment. These are important elements to understand expert medical advice and therefore improve and maintain healthy individuals in the Burmese community. The ability to comprehend health-related material goes beyond a doctor's visit and includes understanding written prescriptions, medical treatment, as well as the ability to evaluate risks and benefits to be able to make a personal informed decision.

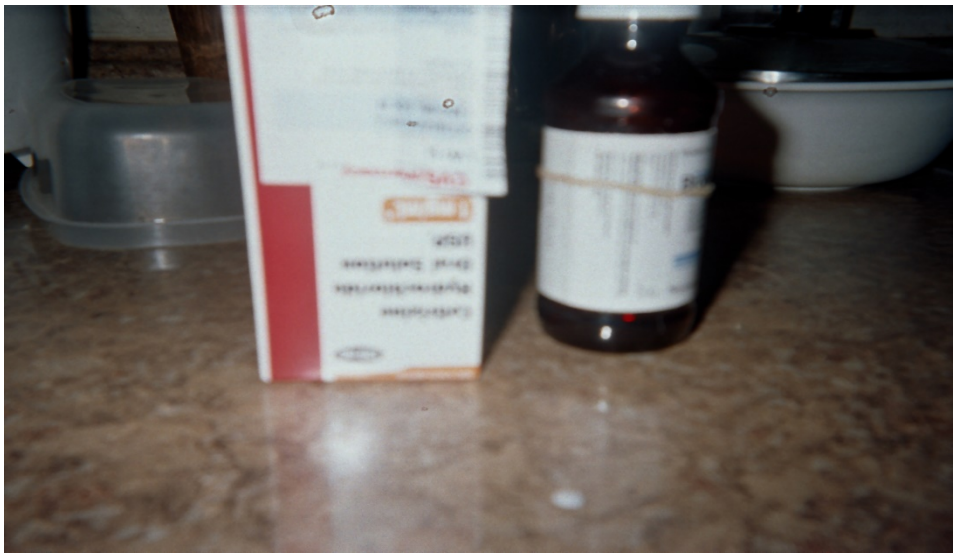

Figure 15: Reading prescriptions

Understanding labels. One of the aspects of life in the United States after relocation was the opportunity to access different community resources including health services. Figure 15 exemplifies the perception that there are many gaps to be filled in this area. All participants described behaviors that were consistent with gaps in health literacy. Due to this lack of health literacy, the Burmese people were not able to fully understand the importance of factual data on drug labels such as a prescription number, the attending physician, date the medication was filled, prescription number, specific directions for taking the drug, refills left, as well as dosage. The majority of participants had the perception that this level of patient education and awareness had not been mastered describing instances in which people got confused and were not able to correctly take medication according to the prescription. One of them described this issue by the following: "It is medicine…from my point of view…usually they have to take the medicines when they need it, but I can see that some of the families I can see they do not know what time to take, what is the dose. That is what I have seen…in the communities, some of the people do not know the timing to take medicines and that they need someone to help them."

Another participant further exemplified this problem from his personal familiarity with this issue in the community. He brought up the importance of storing medication in the recommended temperature and proper placement. It was perceived that many were not paying enough attention to the written prescription:

"Some medicines, drugs have to be in a location that you go by the temperature, so that means that the picture is showing that…ahhh…that they need proper information about where to keep it cool. So, some drugs are…even though the doctor prescription it does not matter if the go to Burmese doctor or other doctor…if they follow the procedure they should know where to keep that prescription. Sometimes, you know, how many pills they have to take daily, weekly, that kind of paperwork that comes along with the doctor prescription."

This translates into the need for health education strategies targeting improvement in knowledge, attitude and behaviors for targeted population. Not being able to fully understand the recommendation of a physician interferes with health and well-being especially when treating chronic health conditions.

One other participant shared a similar experience, except this time with her immediate family members. Because of the language barrier, her family members were unable to understand the language prescribed and became confused leading up to the end result of not following through with the prescription. As it is known, not following with the prescribed regimen of medications could result in serious health consequences. This inability to understand prescriptions was seen as a trend from the group's perspective. Even for those with some level of health literacy, navigating the medical system can prove to be a challenge. Health advocates have the basic obligation to ensure that systems are in place to be able to engage patients in this area and raise them to a self-

sustainable level. Limited health literacy increases individual health related errors such as mixing medications and over dose.

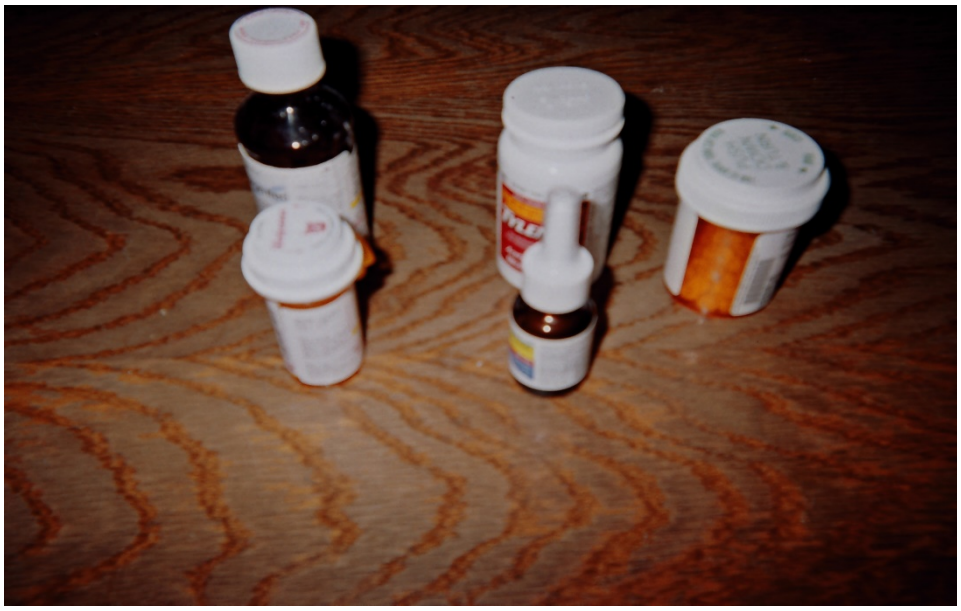

Figure 16: Medication types

Patient education. Another important node under health literacy was the ability to effectively follow doctor's recommendations beyond the office visit. This area of health literacy is highly connected with the ability to read, comprehend, and follow a doctor's recommendations. One of the participants shared her view on medication non-compliance. She explained that many individuals would start medication treatment and not adhere to the instructions soon after that. This non-adherence to medication regimes may result in health complications as well as treatment failure. She described the behavior as follows:

"Some people they just be like- just they get free but… where they get the medicine they be just like they throw it away; they don't keep like drinking… like they drink one

time…so they be just like…just get free…so they just be like…we get free, we get what we need…or we do not want to drink so, they just leave it there…"

The above implies a lack of understanding on how the processes of medication treatment and medicines work in the eyes of the Burmese resettled individuals, which illustrates the importance of education and exposure that would support health and well-being. She mentioned that soon after the first signs of recovery, they thought that medication was not needed. Thus, they would not finish the prescribed treatment. Moreover, she also shared that this behavior is directly correlated to the inexpensive price paid on some medications, which has effectively devalued the treatment in the eyes of the refugees. Formal education and resources are required to recognize the dangers of nonadherence with medication regimens, which is related to lengthy recovery, increased utilization of medical resources, and unnecessary additional treatments, higher expenses, and the breeding of multiple-drug resistant organisms feared by the medical community due to their lack of response to available antibiotics.

Nevertheless, another participant extended the importance of this topic as something that interferes with general health. From his point of view, people with chronic health conditions like diabetes need to understand the importance of medication management. Since their treatment may include intake of different types of medication at diverse times, it increases the possibility of confusion. Without properly understanding written recommendations, the likelihood of medication mixing can occur and result in health complications. This was a complication with co-occurring medical conditions. He

further explains, “I have seen in the community like if you have high blood pressure or diabetes, so on and so on—two or three medicines but health what they are doing is what medication they are supposed to take at what time—parents they are taking wrong medicines. Because they are supposed to keep in one place they do not the name and time. I have seen that they are taking the timing…they are taking wrong medicine at the wrong time when the, you know, four or five medications together.”

Healthcare system. The healthcare system in the United States can be difficult to navigate even for those who are familiar with how the system operates. Navigating this system is further complicated for those who cannot communicate their needs in their native language. Thus, Burmese refugees find themselves frustrated because they cannot navigate a system in a non-native language such as English, which further exacerbates their inability to navigate the system, a system that may already be too complex for native English speakers. Unfortunately, as a result, their health and well-being are further impacted by the individual’s ability to access and understand health-related material. A clear understanding of health-related materials includes: properly filling out multi-part forms, the ability to access health services, the capacity to locate healthcare providers, the skills to understand health insurance policies, as well as the understanding of consumer rights and responsibilities. Not being able to confidently navigate the myriad complexities of the health systems may add to the stress that relocated Burmese people have to deal with on a daily basis, which may cause them to forgo trying to navigate the system altogether. During the study, it was also noted that many Burmese people had not

interacted with formal health systems before, therefore they were unfamiliar with how insurance coverage worked on the basic level. A few of the participants even mentioned that in rural areas where they originally lived, there were no hospitals and/or clinics. There was no prior knowledge on how to navigate these formal health structures. Making matters worse, their country of origin does not provide documentation such as social security cards and birth certificates, something everyone in the U.S. must have to receive healthcare and other services. In their own words: "When we lived in our country, we lived in a village so we did not have a clinic or hospital so we do not have a birth certificate. No; we don't have no clinic, no nothing…no teachers… No nothing…we just live by ourselves in a little building, yeah…"

One of the primary barriers of being able to successfully navigate and gain a proper understanding of healthcare system in order to seek medical treatment was the language barrier. After relocation, their priority is to find a job as they are tasked with sustaining nuclear which often includes an extended family. They are not permitted enough time to dedicate themselves to properly learn English. Instead they learn conversational English as they navigate American society, which leaves out learning how to read and understand instructions on how and where to acquire prescription medications. As one research participant mentioned:

"Whenever the doc gives them prescriptions, even some people don't know where to collect medicines, the pharmacy-Walgreens, so that is some of the things…someone to help them in their own language…this is…ummm….I can see the language problem too

because whatever the doctor says, the community members may not understand and they need someone to help them." It was further explained that essential elements such as requesting a doctor's appointment, understanding the difference between primary care physicians and urgent care practitioners, as well as being able to understand access, care, and pay regarding an emergency room visit were part of problematic barriers to their knowledge about and behaviors that dictated their success in obtaining healthcare. As such, these are critical barriers in dire need of attention.

Many Burmese people were still learning how these systems operate: including 911 emergency networks for immediate assistance for ambulance, fire department, or police/sheriff's department. A personal experience was shared in which 911 services were accessed. Family members called for an ambulance, which resulted in the patient being hospitalized for at least two days at a local hospital. The hospital stay included many routine services, medical evaluations, and laboratory tests. This resulted in an unexpected exorbitant amount of money owed by the patient. However, the family was under the impression that subsidized state health insurance qualified them for free health insurance. The payment placed a heavy financial and emotional burden on them. From this perspective, this is an example of an area that is in need of community education for the Burmese population.

Furthermore, another participant took a picture that included prescription drugs and over-the-counter medications. He further explained that many of them lacked the knowledge regarding where medication could be attained, as even the concept of a

pharmacy was unfamiliar to them. Even though they qualify for free, subsidized, and/or reduced medication from Medicaid and Gold Card, they did not know how to obtain their prescribed medication or how to bill it correctly. They found it even more confusing when stores like Wal-Mart had an embedded drugstore inside the store. It was mentioned that many seemed familiar with stores like Walgreens for medication dispensation. However, many were unaware of the process involved in the steps to accessing these establishments for medication and requesting refills. This includes being aware of pharmacy's contact information, accessing their automated services, and the ability to navigate prompts in large part for them, as none have the option for choosing a menu in Burmese languages. In some instances they were unaware they had to contact the doctor's office for medication refill approval. This concern was connected to a lack of knowledge of accessing services and language barriers. The group mentioned this as a reason for great distress and one that resulted in unnecessary health complications.

Additionally, the healthcare system requires consumers to be fully informed of periodic changes and updates that affect health related decisions. This was briefly discussed in the cases of Medicaid, Medicare, and Supplemental Security Income (SSI). Many were unfamiliar with how to complete these forms. For instance, in the case of Medicare and Supplemental Security Income, it was mentioned that the interplay of barriers like language and age played an fundamental role in this issue: "elderly people they are supposed to get benefits like 65 and older they get SSI, Medicaid so they can help but these people 60-80% of the elderly people of the Burmese people they are

uneducated; they have never been to school in their back country; they don't know so." This situation included a lack of familiarity with the paperwork or understanding the application, eligibility, and how requirements are processed. It was stated that elderly Burmese people had difficulty processing and understanding what they needed to do in order to keep in compliance with Medicare and SSI requirements. In addition, the policies and procedures for these services were constantly being updated and many were unfamiliar with current requirements. Participants mentioned that qualifying for these services opened another set of concerns in understanding how to use these services. This included accessing providers that accepted Medicaid, understanding restrictions of these services, enrollment periods, what health conditions are covered and not covered plus long term care and disabilities. The interplay between Medicare and SS with the complication of age and disabilities is yet another area in which Burmese families need help to fully understand the navigation process. Thus, this results in the elderly being at an unnecessary disadvantage and greater risk for health conditions and disease. This frustration was exemplified during the discussion.

"So…this is very important and this is happening in the communities. The health issues--they have Medicaid and they don't know how to use it. They have to select the primary care physician and do not know how to do that".

This issue was also extended to Medicaid for children. Many families were not familiar with navigating requirements once they were able to qualify. This meant that many families were unable to get timely medical services for their children. One of the

specific problems that become problematic was the constant need to reapply for Medicaid after a set amount of time. This meant that within six to eight months services were terminated if reenrollment had not occurred. As expressed by a participant who spoke about Medicaid:

> "Generally what I think…they need help for a certain time like 6-8 months and then they stop because they have new families…they stop after 8 months. They have to extend the Medicaid for the kids; they have to apply for the food stamps. If they do not have Medicaid they have to go for the Gold Card…these are the things that they need help…I think this will help by community members can help. If there are community members that are willing to help the population, then they will not have a problem."

This testimony illustrates the complicated system that requires the constant attention and mastery of navigation and upkeep in order to sustain health and well-being. Even with the help of community agencies to guide them, there is still a major information discrepancy that refugees face, in that they do not understand but often cannot express this. Therefore, navigating healthcare service whether at the level of Medicaid or the local pharmacy needs to be explained in a way that they can grasp and understand the system. Finally, this problem extends to understanding and applying for Supplemental Nutrition Assistance Program (SNAP), commonly known as Food Stamps, which allows for families of low income households to access foods and other basic amenities (rent, utilities, transportation, and childcare).

Figure 17: Forgotten medications

Research Question Two

What perceptions do Burmese refugees resettled in Houston, TX have towards community agencies and policies that offer support for improving their health status and level of well-being?

Figure 18: Community trends

The assets and strengths of the community as well as potential areas of improvement were identified in various parts of the focus group discussions. Figure 18 illustrates important vocabulary that emerged from the inclusive of views and perceptions of the group in Nvivo Pro 11. The SHOWeD method addressed this question directly with the last question: "What can we do about it?" and the theme emerged naturally as photographs were presented and explored. During the discussion, most said that the possibility of a role that integrated Burmese staff into community agencies to support the relocation experience would be helpful because they would be able to bridge the gap and language barrier between the organization and the refugee community. The identification of leaders within the Burmese community will lead to the beginning of a positive chain-reaction of effects that will eventually lead to the community becoming self-reliant in supporting families, adjusting to the new society, community education, job training, and the establishment of women, advocacy, and support groups. Therefore, it is important to mention that these areas are to be perceived as critical and needed as experienced by the group. Words such as: "change," "refugee," "community," "organizations," and "Asian" were brought up by the group as significant.

Role of Burmese staff in community organizations. Burmese persons generally have an innate sense of connection towards other community members. Few become so involved that they are present in practically every community event that goes on around town. However, despite the involvement of the few, it is perceived by the focus group that there are still not enough Burmese individuals who are involved in the professional

fields such as healthcare and education. In this study, the research group seemed to have a working knowledge of the healthcare system, community organizations, services, and agencies that are available to enhance health, and well-being. At least half of the participants were actively involved in initiatives and programs that would enhance the overall well-being of relocated families.

When asked if they knew of other Burmese physicians, dentists or nurses in the community, one group member mentioned: "We probably have somewhere… We know some and they help; but it is not enough because we have a lot of Burmese… Not enough…we need more nurses or teachers from our country…to help us…a translator and everything." On several occasions the topic of linguistic barriers came to light. The group had experiences with many clinics that were unable to communicate with them because they simply did not have the staff that had the ability to speak any of the Burmese languages. This experience promoted a response of one group member: "If we can have more clinics, it's better. But, for me, if we can have more translators…for example, if I can go to clinic; that's good but, if she has a problem, who can tell them? They need a translator." This was also experienced with agencies working with recent refugees.

Burma, being a highly linguistically diverse country with different groups of refugees all of whom could be speaking a different dialect, poses unique challenges. As perceived by another participant when referring to a renowned community agency whose mission is to support arriving refugees, said: "For example, [relocating agency] we just

come from them, how are they going to help if they do not speak Burmese, how can they connect?" She further explained that although these agencies had made strides in securing personnel that could speak the language though there were still gaps: "A lot of people cannot speak Burmese; it's a different language: Kadai, Nepal…Kachin; they cannot speak Burmese, so we need more help… And Chin has 62 languages. And if they have a translator, even on the phone—it doesn't matter—to go to doctor, to apply for benefits—we need more translators so it will be better."

Identification of Burmese community leaders. Another important aspect connected to inclusion of people from Burma as staff in community organizations was the identification of Burmese community leaders to support and guide families as they adjust to this society beyond the first few years. An integral rational for this need was connected to culture and language. This was shared as a need to facilitate understanding among the group from "someone to help them in their own language" to help in navigating the new systems. Often, they needed a liaison. This was often someone from their community who had experienced the same situation and was able to empathize what they were going through. One participant mentioned that a permanent liaison would make a vast difference, from sharing personal stories on how to acquire a new house, to understanding and following physician prescriptions, applying for insurance, and even in learning how to properly navigate the local school system.

Furthermore, having an involved community member supporting Burmese families minimizes the following situation: "The language problem because whatever the

doctor says, the community members may not understand and they need someone to help them." The group explained that by having a regular support framework in place that is modeled after an active community support system is necessary to sustain a healthy sense of psychological and family well-being. A participant exemplified this by stating:

> "So if I am working for one of them, I am working for all people. So if I am paid to work for the communities, I can work because our people they won't share their problems—what is happening inside the home. So if someone is paid to work with the communities, they will go and visit the house; what is happening. They may not say in first visit, but on the second visit they will say slowly; they will listen to the person…so this is very important we need to have..."

He further stated that the needs of the community would go beyond the traditional work hours stipulated by community organizations. Thus, the need for more involvement of Burmese individuals in support of those unfamiliar with the system, especially in times of need, was a dire concern.

The establishment of these liaisons would play a significant role in raising community awareness and agencies supporting these families. After a few years of relocation, many of these families were still adjusting to American society and its demands. The discussion of Figure 11 (Living Conditions) included the importance of being sensitive about how these communities were perceived was discussed. The group felt that society needed to understand the living conditions of individuals who live in refugee camps. The following exemplifies this view:

"We can't fix it—we have to leave like that, because most of the majority that came here, they lived like that. If it's say three family members—mom and kids stay there—nobody comes visit there. So if you want to report, you take a picture—that is normal. So we cannot control; we cannot go and tell them that. So this thing is not, not the thing that—maybe, maybe you can give them for the knowledge that but, it does not matter-if you there and tell them, it is going to be like that. Because most of the people they are coming from worse than that—the place that they are coming from. Even though better than that here; surviving is way, way more important than cleaning the house; putting it in order. Maybe if the kids are educated—professional job, getting a house; yes. Do that…same thing; apartment—they are already thinking, their mind set is already telling them that it is temporary. They are going to move out anyway—that's the thing that they do; this is normal; so we cannot fix that even if we fix that, it is going to be happening." The importance of understanding their values was highlighted in this discussion. The vision shared of being sensitive and aware of this community was an issue of concern when discussing support for incoming refugees in the areas of understanding family values, views of early childhood education, behaviors connected to health practices, and adjusting to the city. These protective factors would greatly enhance the future of relocation and adjustment for these families.

Intentional Community Educational Programs

Language. Among other pressing needs, the group identified the need for planned and engaged intervention of community agencies in supporting basic needs for Burmese

families after relocation in specific areas. The key rational for this was related to not being able to fully understand the processes and requirements of social structures that sustain their livelihood. One of the greatest needs was related to learning English. A few participants mentioned that years after relocation they still did not feel comfortable with their level of spoken English. For most of them, their first encounter with the English language was upon their arrival in the United States. Exposure to the English language in refugee camps was rare. Upon arrival in the United States, there were some opportunities to learn English; however, the six-month constraint that was required for all Burmese immigrants to become self-reliant was too little time to effectively learn an entire new foreign language. "They just help for 6 months and let them go and they still need help." Another participant extended the conversation stating "So they need to help to connect the families after 6 months. Just a few months. If they speak English, it is OK for them; but if no English, 6 months is not enough. The families' need more than 6 months." From these comments, part of the role of community agencies is to design opportunities for the entire family to engage in mastering the English language.

Employment. Additionally, the group perceived the importance of finding opportunities for their families to get better jobs. The topic of job readiness and employment readiness arose several times during discussion. The group felt that many families were still struggling in finding jobs that would sustain their families beyond basic needs. Many of the participants knew of individuals who were unemployed during the time of data collection for this study. Comments that described the situation include:

"You need more education or you need more money or more services, what kind of things would help the most," "We need more jobs with more money…," "Higher salary, so we can get a car. Only we get a little money. We work, but the salary is very low." And the connection between mastering the language and securing a better paid position was mentioned: "also, we don't speak English right, so then they give us lower job, which pays low. Maybe $8 or $7.25." The group shared that many would go for interviews and would not get the job because they were not qualified and had little or no experience. Many of them settled for jobs in restaurants, service agencies, and manufacturing companies.

Education and training. Access to formal training and education was mentioned as a service much needed. Education played an important role for securing a better lifestyle and securing a path for the next generation to succeed. The entire group felt that formal education was extremely necessary. They saw the need to bring these resources and awareness back to the community. They also perceived that many families were not paying enough attention to this aspect. Two of the group participants shared that adult education and/or vocational training were nonexistent in the refugee camps from whence they came. Six years after relocation, they had the idea of starting their own business and needed formal exposure on how to set this up.

They felt that community agencies in general would need to be aware of the dynamics of the group. One of the participants explained that entire families were relocated to the United States as part of refugee services. He explains: "If the family is

coming today; like a family of three and the child is less than 13 years they might provide only one bedroom apartment. If the child is more than 13, they might put a two bedroom apartment." This meant that parents and/or guardians now needed to provide basic needs for their families. The first several years were spent developing that system of care and provision of those needs. Time for short-term education, certifications, and training were needed after they had somewhat sorted these basic needs.

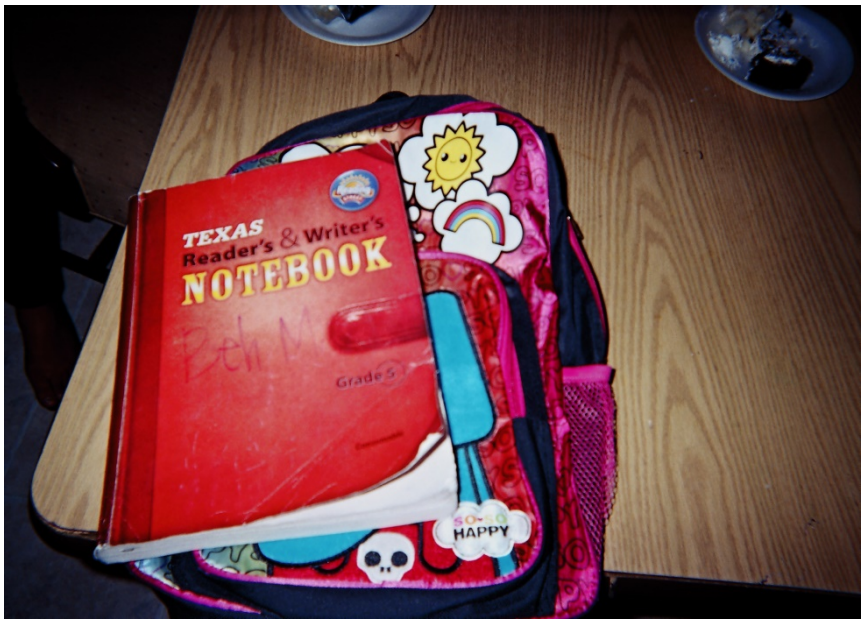

Figure 19: Education

Along with access to these educational opportunities for themselves; they also felt the need to educate parents on their role in supporting formal education for their children. This was an identified area of need. They shared stories where they perceived Burmese parents not being fully engaged in their children's education and academic path. This path included elementary, high school, and college education.

They thought that through formal education more Burmese people could gradually enhance the community. One of them stated, "We really need children to become doctors; to become teachers. There are not enough…we need more nurses or teachers from our country…to help us." Even though young people in high school generally understood the importance of education, it was their families who needed guidance on how to navigate topics like scholarship applications and requirements for financial aid. "Speaking of the high school, very few people that like education does not matter if the parents are not educated because they learn something, they realize they need education for their future life. Those kids who love to go to continue their education the agency and, even the US government is helping them, so the agency strongly recommends to help them the follow up program which means, educate them: hey student, if you really want to go to continue school, go to college there is a financial aid thing going on so all the agencies go there, reach our, help them, educate them, to get applications for the financial aid. Tell the parents you don't need to worry to pay for the school; with your income your kid does not have to pay any money for the school."

Likewise, another individual shared a personal story regarding the need for community academic preparation. From his point of view, many young Burmese are finishing high school and not continuing with college. Initiatives and programs to promote educational attainment were needed to impress upon the community the importance of higher education. As opposed to continuing their studies after high school, students were instead seeking out full time jobs, after graduating 12th grade in order to

support their struggling families. He commented: "Even the community members of my group; 60 students from 2008-2014…they graduated high school and only 9 are in college—where are the rest? They are working at the $7.25."

Path to citizenship. Not being fully aware of all of the rights and responsibilities after relocation is another important topic, as it relates to the path of becoming a future citizen of the United States of America.

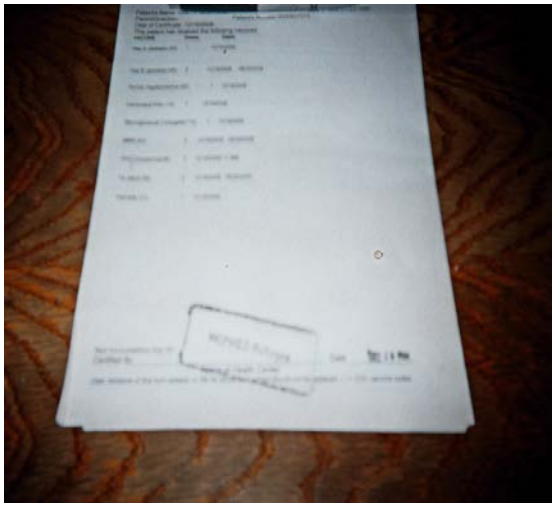

Figure 20: Forms and applications

Figure 21: Citizenship

This topic was relevant to their overall well-being as a former refugee. The individual that took the photograph depicted in Figures 20 and 21 shared in discussion the fact that many refugees arrived in the United States who may not have fully understood the benefits of being a resident or citizen. Both statuses, as resident or citizen, would qualify them for many services that would enhance their health and well-being. Whenever they are granted a green card, they are no longer considered refugees. The group shared that the green card was obtained one year after arriving. After receiving

their green card, their path to citizenship would start then. The application for citizenship could be initiated within the subsequent five years. Beyond the months of case management from the relocating agencies, many former refugees still needed support in comprehending that they qualified for Supplemental Security Income (SSI), Medicaid, Medicare, and other state and federal social services as a result of their new classification in the United States. However, many of them were not taking advantage of these services and were not fully aware of how these institutions work. As mentioned by one of them: "The thing is, the people who came to the United States they were given warranties in the back country. If you go to the United States now your refugee life is over; you are going there and are given citizenship. They were given wrong orientation and when they come here…they get, ummm….when get their residential. When day they arrive to the US they get their alien number from the day they arrive here and after one year they get the green card." Becoming a citizen involves being a resident first; then, one must follow up by submitting a citizenship application, which included supporting documentation and payment for attorney and immigration agency fees. Securing payment for these services was seen as a burden to the group turning to community agencies for support through reduced-cost application services.

It was also stressed that relocating to the United States was seen as a goal and a dream. While in refugee camps, many dreamed about restarting their lives in a distant country. As one of them mentioned: "That is a good thing about well-being of the refugee family because that, that…this picture—the passport is one of their goals; the

pursuit of happiness of the refugee people being here, because mostly they came from the camps- they don't have no place to go, so their goal is to become a United States citizen so they can get the benefits."

Living in the United States guaranteed a better life for them as well as a better future for their children. They could not relocate back to Burma, and they would not be safe in any of the neighboring countries. Their personal safety was guaranteed in this country: "Their goal and dreams—that is one of them. The people that came from there especially the Burmese, the Muslim; some people they wait for their citizenship so they can go anywhere in the world. Most of them are scared to go back to Burma or to travel the world with a green card, with the travel documents. So, for most of the refugee families that is their dream—to get that; to do that they need help".

In addition, the group felt that support was needed from community agencies and liaisons or members of the communities in these areas. Acting as liaisons, two of the participants were highly involved in guiding Burmese families on these matters. They felt it was not enough. Their vision was to engage with others who knew about the process: "So they go to the community people who know knowledge about it. So, this is a good example for them to achieve what their dream is to go along with that with whoever wants to help with that; I have been helping too, so you know."

They mentioned that having lived through this process themselves was overwhelming. As former refugees, they started the process in their fifth year of living in the United States. They were not fully aware that the process would include large

amount of fees, consulting with immigration attorneys, and countless documentation, apart from standard application procedures. Filing for other family members who had not mastered the language heightened their stress levels when asked to visualize the actual interview they went through. It consisted of conversational and written English as well as a civic test regarding United States history.

Figure 22: Women's participation

Women's Participation

Another issue where community agencies and/or initiatives were needed was in the area of Burmese women's participation. The group felt there was great need for women to be invited and empowered to participate in their community. Many were stay

at home mothers because they had no other choice, had no job skills, and were raising young children. As one participant described it: "I see a women's group…women really need help…because they need Medicare…good insurance…how to take care of babies…" They had the impression that education and guidance are essential in supporting women's overall health and well-being. These were in the areas of accessing insurance and social services such as Gold Card, Medicaid, and Medicare for elderly family members, family planning and even childcare or preschool services. The need for agencies to focus on these subjects meant understanding the population's point of view: "A lot of refugees they just take care of the babies at home, so when they go outside, a lot of people they don't understand because they are not used to go outside; that's why we need to make a community with women to help, to benefit from women." This individual also described other challenges faced by women: linguistic barriers, living and adjusting to a large city, not being able to read English signs, and not able to drive and getting familiar with public transportation.

Community integration was seen as a benefit for Burmese women. Two participants shared their own interests on this topic. One had the idea of initiating a women's group that would focus on educating them on parenting skills, nutritious cooking, and entrepreneurship skills. This last item was very important since in many households only husbands were employed. Women were also eager to get employed and had shared their dreams of starting their own business. However, they needed guidance and coaching on where to start. Another key area for community support was in

childcare. It was described that many women would not seek employment because of their young children. If there were free or reduced services for childcare and/or access to preschools beyond public schools, then they would have greater possibilities for attending job preparation and training seminars. Nevertheless, they also thought that this was possible if there were enough resources for this group. Their vision was summarized as follows: "The first thing is to connect them; let them know something for English…to meet each other to read a book or something …the community or something to call the community together—not everybody; those that have time, so we can read the book together and share together when we have problem. We can get together at somebody's house and share what you are worried about and think about."

Embedded was the need to support each other through understanding and being appreciative of each other. They thought that because the Burmese community was so diverse in customs, language, and religion that it was necessary for them to come together and support themselves as a community. The benefits would also enhance their overall experience as they recreated their new lives in this country. Another participant had the idea of initiating her own business in the near future. Her vision included specific behaviors and strategies that would help women and the community if organized connections were to be established: "So, maybe know how to fix your problem, so let's meet together. So, maybe you have a transportation problem and maybe someone can drive a car for me. Or maybe I cannot speak English, so someone can go with me to the school. So we can help each other in groups." At least one of the women in the group

was very active in a local agency that supports Burmese families after they relocate to Houston. The agency leads educational activities as well as promoting access to health and social services. This participant felt that there were many needs not fulfilled and challenges to be confronted. She felt that after six years of living in the city there were still many families in need. Her final thought was "If someone can please help the refugees, please come and help us; please help us until we need help and teach us how to remain strong, so please continue to help us refugees."

CHAPTER V

CONCLUSION AND RECOMMENDATIONS

Summary

The present participatory action research project using Photovoice with refugees from Burma relocated in Houston, TX served as an opportunity to explore and understand through their perspectives what is relevant for their future health and well-being as they integrate themselves to the North American way of life. Years after resettlement, former refugees are still adjusting and slowly assimilating into this society. The participants include six Burmese resettled individuals. They voluntarily signed consent for study participation. All individuals contributed meaningfully during the project.

There has been a shortage of research addressing the health needs of people from Burma that recognize distinctive contextual needs of such a minority group. Therefore, this study engaged these individuals in critical thinking processes as leaders and advocates for health and well-being for themselves and the community they represented. This was the initial phase of engagement and discussion of health promotion initiatives. All emerging themes are interrelated with one another. Additionally, the PI interacted with personnel from different agencies that served these individuals alongside refugee resettlement agencies. The software used to aid in qualitative data analysis was Nvivo Pro 11 software. Images and narratives were imported and inquiry initiated. A concise narrative of significant themes were identified, implications for health education and

promotion, limitations, recommendations, as well as areas of future research were presented.

Discussion and Implications

The state of Texas is home to a considerable large number of Burmese resettled refugees; many of them resettled as a consequence of conflict and victims of war. They slowly assimilate and integrate into their new reality in their new home. As they are incorporated into the American way of life, they also contribute to society's growth and stability. However, with a history of having endured extreme hardships, it is important to understand their path towards health and well-being. This evidence contributes to enhancing the systems and structures that support this journey through the identification of barriers encountered.

Research Questions

Research Question One

What perceptions do Burmese refugees resettled in Houston, TX have towards their current health status and level of well-being?

The PI concluded that the majority perceived and identified certain needs connected to health and well-being for Burmese people who have resettled in Houston. These needs are related to the following: family well-being including financial stability, employment, language acquisition, and a lack of exposure to preventive health information. These themes emerged through Photovoice. During in-depth focus group discussions, the participants constantly noted that that many of the challenges related to

health and well-being exist because of some level of poverty. From the group's perception, many households are still struggling to meet basic needs. When families live in such conditions, there is limited access to medical services and care, and limited access to education opportunities, so poverty also results in the possibility of unhealthy living environments and less probability of training/preparation for job and employment opportunities. Even though some level of poverty was identified as a central factor related to the research topic, all other emerging themes identified through images and discussions are interconnected with poverty and are interrelated to each other. Each factor appears to affect other areas of health and family functioning at different levels.

The most important factor was the ability of individual families to be able to provide for all basic needs. This proved to be a challenge when many households included nuclear and extended families with only one employed caregiver, proving to be a heavy burden on these individuals. When discussing photographs related to basic needs, many individuals stated the fact that many could benefit from systems that support those areas. They included financial literacy, education and jobs. This is consistent with reviewed literature for this project regarding the refugee experience and wellness. These studies also concluded that identified hardships included economic areas, medical services, education, and linguistic barriers. Moreover, this population appears to be more disadvantaged than other minority groups in the United States when compared. Resettled Burmese people have to quickly adjust to society and family demands and may not have the opportunity to retake their lives before the refugee camp experience. They are at a

higher risk for poor health including poorer mental health and lower levels of education. These are consequences of structural and linguistic barriers that affect life after resettlement. Taken together, these dynamics obstruct expectations of a better job and higher level of income that would increase financial stability and positively impact family well-being.

Education and financial stability are also related to better heath and access to health services. These factors impact outcomes of a well-informed individual consumer of health services and individual health decision. Level of education influences health literacy as well. Direct and comprehensive communication between physician and patient is crucial for ultimate positive health maintenance and health promotion. This problem was identified even after leaving a physician's office, as the average individual is not able to recall all information discussed during the visit much less the esoteric medical terminology. The concept of "poor health literacy" refers to the inability to understand and process basic health information and healthcare services needed to formulate an informed decision (Williams, Davis, Parker & Weiss, 2002). Based on the literature, the life of former refugees included low levels of health literacy since many of them start interacting and qualifying for standard and high quality specialized healthcare services until their arrival to a third country. However; because of interrupted schooling and a lack of academic preparation, many of them were unable to complete any form of formal education and training. Furthermore, the slow acquisition of the English language

poses a disadvantage for their health and well-being as it relates to the inability to understand written and oral health material written in a foreign language.

Figure 23: Maslow's Hierarchy of Needs

When the theory of Maslow's Hierarchy of Needs is applied to this population and topic, it contextualizes the findings in this section (Figure 23). It soon becomes obvious why Burmese resettled individuals still feel the need for guidance and assistance in order to achieve a sense of health and well-being. The theory emphasizes the fulfillment of basic needs, which include physiological needs, safety and security as the highest priority. These are the foundations for higher levels of human achievement related to sense of belonging and self-actualization (Maslow, 1943). The lowest levels are commonly known as food, water, shelter, and clothing. These concepts were exemplified by the group's participants and illustrated in many of the images taken and

discussed. They ranged from quality of family dwellings, having several jobs to provide for food and rent, to the inability to provide for other basic needs. This reality impacts the attainment of higher levels of functioning.

When staff from organizations and agencies with experience in the refugee resettlement area was asked to provide feedback on this analysis, they articulated ideas on areas in need of great support. Their recommendations were consistent with research findings, which included training and education for Burmese individuals on opportunities for first time home buyers, information on applying and qualifying for scholarships, and financial aid for themselves and their children, and design and delivery of English language courses at times that are pertinent for them (and not for the institution). These are systems that enhance sense of well-being for any individual. Furthermore, the provisioning of health services in close proximity to the community can help prevent future complications, which may include the delivery of preventative medicine and other mental health services. There is also a dire need for support in emotional, psychological and social well-being years after relocation.

Fostering health and well-being for these individuals requires a planned approach. Even when there is a gradual process of acculturation, which entails adopting certain behavioral patterns from mainstream society, it is important to acknowledge the existence of unique beliefs and perceptions rooted from a different country and culture along with the refugee camp experience that they carry with them. The need for eliminating health disparities for ethnic and racially different groups has been widely researched, with data

suggesting the inclusion of a culturally competent framework upon which refugees find familiar and can build upon. This framework includes organizational, structural and clinical components, and aligns with what the research discussion group had uncovered as critical focus points (Betancourt, Green, Carillo & Ananeh Firempong, 2003). Most of the sociocultural barriers for resettled Burmese individuals can be addressed based on this framework at these levels. Effectively, the demand for a regulatory framework places responsibility at the highest level of organizational leadership and management in order to help increase the availability and acceptability of healthcare services by minority groups (Betancourt et al., 2003). Decreasing structural and psychological barriers can also help support the health and well-being of this group, in addressing the perceptions uncovered by the focus group that hospital visits and tracking countless healthcare policies is a confusing and stressful process. These factors result in health burdens to consumers and pose a threat for preventive healthcare education and disease. The incorporation of navigators for patient support, simplification of forms, and support in understanding the structure and function of these systems are strategies that can support these vulnerable populations. Lastly, addressing clinical barriers that involve the patient and provider will eventually reduce post-clinical health complications such as improperly following prescribed regimens and recommended follow-ups. By educating both healthcare practitioners and patients, we can bring both persons to an elevated understanding of culturally sensitive topics. Many refugees have come from areas of Burma lacking a developed primary care healthcare system. Something as simple as

improving communication between physicians and patients will have a significant impact on health beliefs, attitudes, and psychosocial histories of each clinical experience. These examples are universal and can be adopted by any social service agency.

Based on the information generated from all sources of the project and by systematic data analysis using NVivo Pro 11, the following diagram (Figure 24) presents a logic model for this project. It outlines a systematic, integrated, and comprehensive approach to health and well-being based on ideas and themes emerging from data analysis.

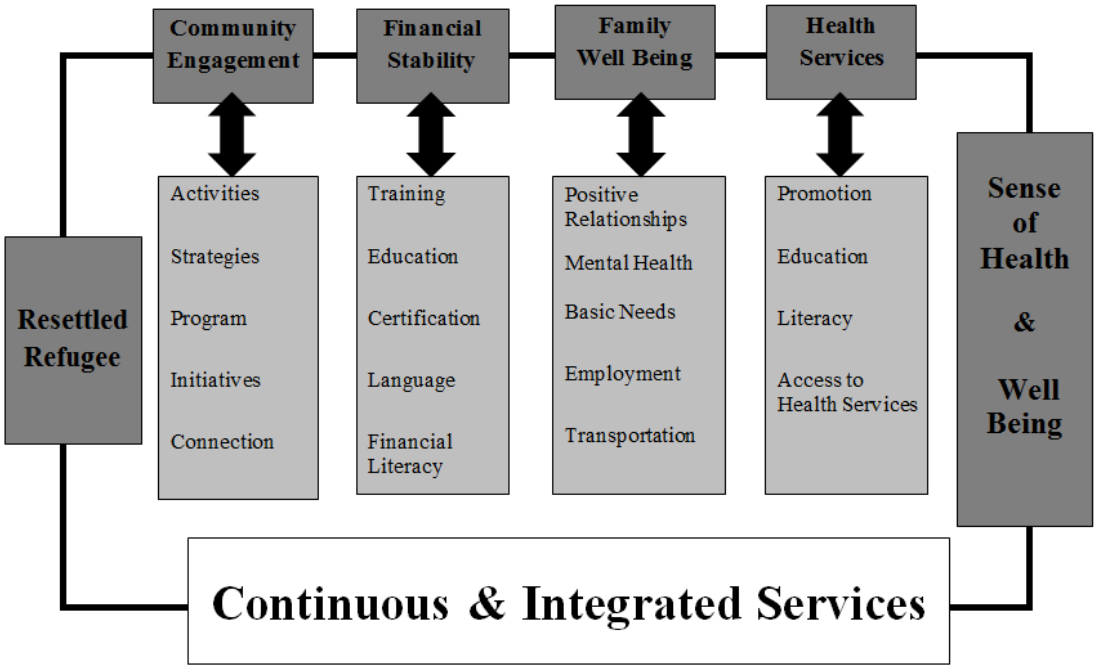

Figure 24: Logic Model of Systems that support Health and Well-being for study population.

The sense of optimum health and well-being is an ongoing process, and outcomes may vary with each attempt. However, outcomes are defined by the individual or community based upon their perception. Well-being is considered a positive outcome, is "multidimensional in nature and includes social, emotional, spiritual, environmental, occupational, intellectual and physical wellness" (University of California, Riverside, 2014). Our focus group managed to identify four essential pillars for success and well-being: 1) Financial stability, 2) Family wellness, 3) Community engagement, and 4) Health Understanding and Literacy. All of these pillars are intertwined and contiguous. When all four pillars are successfully built, they provide the foundation to positively impact the sense of health and wellbeing of all displaced Burmese refugee-immigrants.

Research Question Two

What perceptions do Burmese refugees resettled in Houston, TX have towards community agencies and policies that offer support for improving their health status and level of well-being?

The refugee resettlement agencies are at the forefront of organizational support and community engagement. The focus group acknowledged on several occasions the vision delivered by these agencies. They provided a warm welcome to new refugees, basic housing, food, and social services for the following six months. The research participants generally had a strong connection with these agencies and their staff. Example models of case management during these critical months include: job training and employment skills, learning the American culture, transportation, introduction to the

local educational system, the concept of insurance, and federal social services. The positive impact of these support agencies continues to be highly regarded years after resettlement.

However, community participation is not as simple as providing support and activities for six months and then moving onto the next case. It is a far more complex situation, especially for unique and special refugee groups. When social factors interfere with the elimination of health disparities, it is crucial to include the wisdom of community members in these initiatives. The attainment of self-reliance is sometimes a long-term process, particularly when involving the health of infants and children of low-income families and ethnic minorities. Generally, minority groups have higher rates of infant mortality and morbidity when compared with children and infants from white and middle class families (Shalowitz et al., 2009). The inclusion of skilled Burmese professionals to bridge the gap between the community and agencies/organizations will lead to the likelihood that these persons will utilize preventative medical services regularly and not only when health emergencies arises. Placing such individuals in social services and medical settings is emphasized and is consistent with research recommendations.

Additionally, the definition of health and well-being is very complex. Both definitions are holistic and include an ecological approach. None of the social and medical structures that sustain health and well-being can fulfill the needs for this population working in isolation. To finally reach a state of optimum well-being, all

dimensions need to be functioning and includes social, emotional, spiritual, environmental, occupational, intellectual, and physical wellness. Adjustment from a rural area to an urban life in one of the most advanced nations in the world can be a challenge. This may take years of navigating several systems to finally achieve a decent level of understanding. Thus, community agencies are tasked with tailoring interventions that meet specific guidelines for these individuals. They include understanding cultural and language barriers, views, perceptions and practices related to health, as well as being sensitive to the effects of enduring history of war and refugee camp experiences. Of importance is the latter when working with Burmese individuals. There are many traumatic unprocessed experiences in the community. At least two participants spoke briefly about fleeing minutes before their village was targeted and almost losing their lives in the process. Many elderly Burmese still hope to visit their motherland in the future. Fuertes (2004) validates this need for psychological first aid/counseling with traumatic experiences pre and post migration.

In addition, community agencies can create opportunities for a healthier life for these resettled populations. The people from Burma come from a highly multicultural society. Most of them described adjusting to the weather of the state of Texas because it is similar to where they came from. They also mentioned that many used to be farmers before the war and had owned property. This was different from living in a large city. Initiatives that take into consideration these two factors can enhance possibilities for employment and training in these areas. Many of them are eager to start working;

however, some do not understand the application and interview process and requirements that precede the acquisition of many jobs. This poses an additional barrier along with the language. As established earlier, their level of education is related to employment and health outcomes. Communication with community leaders validated this reality.

Participants in this study established the need for intentional health promotion activities. They vividly described experiences that exemplified difficulties in navigating the North American healthcare system, complications when attending doctor's appointments, the possibility of taking medication at inaccurate times, and mixing medications. These skills are very important when faced with multiple diagnoses and different medical treatments and intervention. These activities went beyond translating written medical material and providing translators. Healthcare administrators need to bring services to communities, in their language, through their people, and at times convenient to refugees in need.

Theoretical Application: Empowerment

The cognitive aspect of any empowerment approach starts with raising awareness of the discussion topic. Stromquist (1993) states that empowerment is a process and includes cognitive, psychological, economic, and political components. Being able to empower the individual, community, and political institutions at the highest levels presents those who are involved with the unique opportunity to change the world they are currently present in.

Through the process of community participation, an entire group of community members were able to utilize Photovoice to show their perspective of their story, voice their concerns, and become leaders in changing their lives for the better. This group of Burmese refugees guided an entire discussion on health and wellness through Photovoice and conversation, sharing their personal views and perceptions that they experience every day.

Through this study, we were able to identify barriers preventing the achievement of higher levels of education, health, and well-being. An overarching barrier identified was employment and linguistic barriers. The breaking down of these challenges starts with the identification of pertinent information to improve our understanding of the issue, and how to address it. This process enables us exposure to a diversity of opinions, providing insight into the phenomenon. Finally, by using this information that we have meticulously gathered, we are able to replace powerlessness with empowerment through a process of education and personal responsibility (Allen, 2012).

Empowering a community means paying attention to individuals as catalysts for change. In the case of Burmese individuals, it implies coaching them to uncover their strengths and possibilities. This process was touched in part by the Photovoice process of validating their experiences in a non-judgmental manner. This is consistent with the psychological aspect of empowerment theory that focuses on concepts such as self-esteem, feelings of blame, embarrassment, and isolation (Stromquist, 1995). This Photovoice project was the first step towards individual and social change with this group.

The uniqueness of this methodology has three main goals: record everyday lives, promote critical dialogue while acknowledging the strengths and weaknesses of the community, and reach policy change (Wang, 2007). Participants were able to drive the milestones of the project, which included dialogue, identification of issues related to the research topic, eliciting recommendations through reflection, and by having a platform where ideas and experiences were shared. In this process, participants were able to feel the privilege and the capacity to speak on behalf of their fellow community members. Through discussions of the images, they were able to reflect and establish the need for more funding and intentional activities and services for basic needs including economic stability to sustain a decent level of health and functioning. At the same time, they agreed that the benefits of organizational support was there, however; they identified that relying on each other was one of the most important aspects of community integration. This is consistent with empowering theory, which starts with individuals at grassroots levels with increasing awareness on specific issues.

The empowerment process includes a political and an economic aspect. The first is not limited to the understanding of the health issues surrounding our research topic. It takes into consideration the analysis of structural environments, barriers, and proposals to minimize them. This includes the possibility of mobilization for social change, and the possibility for these individuals to serve, and be represented in grassroots organizations, coalitions, and community projects addressing personal issues. The following table exemplifies these areas related to the process of empowerment (Stromquist, 1995).

Table 2
Application of Stromquists' Empowerment Theory for Photovoice Project

Cognitive Domain		
Levels of empowerment	Perceived Health Needs	Recommendations
Intrapersonal	Belief that personal health needs are present. Awareness that health and well-being can be better. Inadequate shelter	Education on resources available. Health strengths and needs assessment. Training on how to access services, understand oral and written medical prescriptions.
Interpersonal	Perceptions that many resettled families are in great need of health services. Impression that basic needs not met in many households.	Identify resources available. Able to access services. Identification of community leaders. Neighborhood initiatives Provide job training opportunities
Intuitional/Political	Idea that there is great need for community intervention for increased health services and education Limited access to health services	Community assessment. Interact with social and health services organizations. Break down linguistic barriers.

(continued)

Psychological Domain		
Levels of empowerment	Health Needs	Recommendations
Intrapersonal	Stress	Coaching
	Emotional issues	Counseling
	Family concerns and parenting	Long term mentorship
	Providing for basic needs	
Interpersonal	Social Isolation	Community integration
	Language barriers when accessing heath institutions	Social support groups
		Faith based institutions
	Not feeling connected with organizations.	Sensitize community members on protective and resiliency factors.
Intuitional/Political	Not feeling comfortable accessing services.	Ability to identify and trust community agencies
		Tailored and culturally sensitive health strategies.
	Not feeling connected to social services and medical institutions	Burmese people taking lead role in community agencies
		Fostering protective factors

(continued)

Political and Economic Domain		
Levels of empowerment	Health Needs	Recommendations
Intrapersonal	Not enough finances. Poverty Unemployment Underemployment Understanding rights and responsibilities in all systems that sustain health	Job readiness and training programs Extra funding for programs Individualized plans for financial stability. Support in navigating healthcare system, insurance coverage as well as patient education
Interpersonal	Not able to fully provide for extended families. Limited access to education opportunities. Many women unemployed Lack of opportunities for women to engage	Community participation Mentorship programs Small loans Group support in navigating healthcare system, insurance coverage as well as patient education

(continued)

Levels of empowerment	Health Needs	Recommendations
Intuitional/Political	Poverty	Scholarships or grants available,
	Few opportunities for small businesses	Existing coalition of agencies with same vision include and enhance grassroots organizations:
	Inability to access services from institutions.	Health promotion, health education, preventive health and any initiative that enhances attainment of basic needs.
	Great need for education in many areas (job, health literacy, education)	Adult vocational and education opportunities
		Inclusion of Burmese individuals as health experts in decision making.

Limitations of the Study

While this research was able to identify important factors and experiences that contribute to the overall health and well-being of a group of people from Burma after relocation, this study is not without limitations. This Photovoice project used convenience sampling of refugees from Burma resettled in Houston who met the proposed inclusion criteria; therefore, the results of this project have relevance for this specific population and for the topics discussed. These results cannot be generalized to other refugee populations. Nevertheless, the results can be utilized to convey an enhanced understanding of the lived experiences post relocation in the United States, provide a conceptual framework for increasing the overall health and well-being for this

population, identify gaps in existing services and increase possible solutions to these issues.

Another limitation was related to language. The study was conducted in English, and it may have excluded potential participants who are in the process of acquiring the basics of the language. During the recruitment process, a potential participant and a community stakeholder mentioned that many Burmese are able to speak English but may not always be able to read English. Consequently, future studies with similar populations may include translated recruitment written material along with English versions.

Additionally the time spent on the focus group discussions was limited. It was a challenge to convene all potential participants at the agreed location and for the required intended time. This is due to the fact that they came from different parts of the city and had to report to their weekend jobs, and also that they are paid hourly and had other family responsibilities. The PI honored this and discussions kept on track using the SHOWeD method.

Moreover, another limitation was connected to in-depth networking with the community. The PI was able to contact many organizations highly involved in refugee resettlement services along with long-term case management (social and health services). However, it was challenging to reach out to potential participants without a strong partnership with Burmese community representatives. The PI started by diligently immersing in Burmese community activities, attending refugee events, and meeting people from Burma in their settings: businesses, restaurants, clinics, neighborhoods, and

civic engagements. This delayed the establishment and securing the sample of voluntary participants.

Finally, there may have been an expectation of compensation for participating in the study. It was explained that participation was strictly voluntary and that their commitment to the study was to contribute a better understanding of the overall health and well-being after resettlement without monetary compensation. It is possible that if there was funding for participatory compensation, monetary incentive may have resulted in a greater pool of research participants during time of recruitment.

Recommendations

Enhanced Health Education and Health Literacy activities

Additional efforts were needed to address factors, which improve knowledge, attitudes, and skills, which work towards health and well-being for refugees after resettlement. It is important to note that health education is highly correlated to morbidity and mortality. Themes related to this topic were pervasive. It appears that many individuals from this community underestimate the value of preventive medical checkups such as mammograms, prenatal care, yearly wellness physical and dental checkups, as well as immunizations and adoption of lifestyle behaviors that promote overall well-being. Many of them were not exposed to health education strategies until resettlement. The idea associated with preventive healthcare education may still appear foreign. These initiatives can improve our understanding of personal factors that interfere with health behavior in this population. Additionally, health education

initiatives that include dissemination of healthcare material, education, and communication strategies aimed at improving self-efficacy associated with health are imperative for this group of resettled population.

In addition, strategies that target health literacy are highly recommended for this population. During the course of data analysis and disaggregation of information, significant themes related to this topic emerged. Healthcare literacy refers to the extent to which an individual is able to understand, assess, and communicate information regarding health in different contexts. This skill proves to be highly beneficial and crucial across the lifespan. Health literacy not only empowers these individuals but also enhances the overall well-being of this community as they integrate into this western medical model. It involves simplifying information in print material for increased medication compliance, adherence to medication schedule, understanding prescriptions and risk factors associated with treatment, reading and comprehending food labels and warning signs, as well as being able to fully describe symptomatology during medical visits. Health literacy becomes of greatest importance as these former refugees assimilate into this society that enable access to advanced medical practices that include at-home treatment, sophisticated medical devices, and equipment and simultaneous multiple drug treatment regimens.

Culturally Sensitive Community Services and Integration

The implementation of culturally sensitive and tailored interventions is strongly recommended for positive long-lasting health and well-being benefits. Years after resettlement, former refugees are still struggling with securing basic needs. The idea promoted from community members about self-reliance after six months proved to be a challenge at least for the group in this study. The definition of well-being is complex, and this unit of analysis involves taking into consideration individual views, experiences and perceptions. Relevance should be given to the special characteristics of these individuals as established through their narratives. Having spent many years in refugee camps resulted in lives interrupted and plans postponed, which included finishing their education and finding a career and profession including technical training or certification. These were close to non-existent for many. Designing language acquisition, job, and employment readiness programs while involving them into the process may positively impact their long-term well-being. Moreover, the inclusion of identified community Burmese leaders would enhance this strategy. There is progress in many agencies in employing Burmese individuals in their teams. However, the community would greatly benefit from more Burmese people at the forefront of programs, initiatives and activities that promote wellness targeting these communities. Additionally, it's important to consider that people from Burma come from different ethnic groups with diverse customs and distinct languages.

Additionally, a combined collaboration of established community agencies and grass roots initiatives would greatly enhance their long-term well-being. Years after resettlement, there was a sense of social isolation from community support. However, there was reassurance and comfort from social contacts among them. It is recommended that enhanced community support networks should be established to cover individual and family needs when they arise. The integration of formal and informal community initiatives can enrich opportunities for self-reliance and positively impact overall well-being. This would enhance their social capital, opportunities for psychological comfort from group, and sense of community integration. This is related to the resilience of resettled communities and the degree to which their connection to the community supports this resilience. From this intentional alliance for deeper community integration and support, many unmet needs and desires would be processed. These include such activities like learning English, childcare services, and financial literacy, access to health, and wellness opportunities as well as economic opportunity, education, and employment.

Community Based Participatory Research (CBPR)

It is highly recommended that further studies addressing these topics be implemented. Of particular importance is the inclusion of individuals from the community as co-researchers. This practice would enhance future program design and implementation when the voice of the community was integrated from initial phases forward. Community based participatory research increases the level of knowledge and understanding of the research topic in both research and participant. It includes shared

decision-making as well as the construction of new concepts and innovative ideas for community improvements. This approach has been implemented in understanding health disparities in underserved populations.

Conclusion

This study also confirmed similar findings done in other research projects and with data published in the local and international media. The resettled refugee has a long history that dates back to their land of origin. Being a refugee is not a choice. After fleeing, all areas of life are interrupted starting with one's health and sense of wellness. The hardships endured are many and are seen as complex humanitarian emergencies (Merson et al, 2006). The processes of adjustment, acculturation, and assimilation include unique outcomes when faced with securing basic needs such as food, housing, transportation, employment, and education. The level of optimum health and well-being is sustained when all these factors are integrated and available.

In conclusion, further research projects are recommended to study the proposed areas affecting the health and well-being of this population. The Burmese people are a distinct minority group within another minority group and many times are classified under "other" in many studies addressing the Asian population. Thus, it is important to reflect and understand that including their voices and participation is a path towards lessening structural and linguistic barriers and enhancing their health and wellness potential. It has been confirmed through participants in this project that many Burmese individuals are ready to represent their community. It is quite evident that studies that

include them in the planning process would enhance findings and benefit the literature and the community.

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Appendix A
Texas Woman's University Institutional Review Board Approval and Extension Letter

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Institutional Review Board
Office of Research and Sponsored Programs
P.O. Box 425619, Denton, TX 76204-5619
940-898-3378
email: IRB@twu.edu
http://www.twu.edu/irb.html

DATE: July 1, 2015

TO: Mr. Adrian Yam
Health Studies

FROM: Institutional Review Board - Denton

Re: *Approval for Using Photovoice as Participatory Action Research to Identify Views and Perceptions on Health and Well-being among a Group of Burmese Refugees Resettled in Houston (Protocol #: 18047)*

The above referenced study has been reviewed and approved at a fully convened meeting of the Denton Institutional Review Board (IRB) on 2/6/2015. This approval is valid for one year and expires on 2/6/2016. The IRB will send an email notification 45 days prior to the expiration date with instructions to extend or close the study. It is your responsibility to request an extension for the study if it is not yet complete, to close the protocol file when the study is complete, and to make certain that the study is not conducted beyond the expiration date.

If applicable, agency approval letters must be submitted to the IRB upon receipt prior to any data collection at that agency. A copy of the approved consent form with the IRB approval stamp is enclosed. Please use the consent form with the most recent approval date stamp when obtaining consent from your participants. A copy of the signed consent forms must be submitted with the request to close the study file at the completion of the study.

Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any adverse events or unanticipated problems. All forms are located on the IRB website. If you have any questions, please contact the TWU IRB.

cc. Dr. Roger Shipley, Health Studies
Dr. Kimberly Parker, Health Studies
Graduate School

TWU
TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Institutional Review Board
Office of Research and Sponsored Programs
P.O. Box 425619, Denton, TX 76204-5619
940-898-3378
email: IRB@twu.edu
http://www.twu.edu/irb.html

DATE: January 15, 2016

TO: Mr. Adrian Yam
Health Studies

FROM: Institutional Review Board (IRB) - Denton

Re: Extension for Using Photovoice as Participatory Action Research to Identify Views and Perceptions on Health and Well-being among a Group of Burmese Refugees Resettled in Houston (Protocol #: 18047)

The request for an extension of your IRB approval for the above referenced study has been reviewed by the TWU IRB (operating under FWA00000178) and appears to meet our requirements for the protection of individuals' rights.

If applicable, agency approval letters must be submitted to the IRB upon receipt prior to any data collection at that agency. If subject recruitment is on-going, a copy of the approved consent form with the IRB approval stamp is enclosed. Please use the consent form with the most recent approval date stamp when obtaining consent from your participants. A copy of the signed consent forms must be submitted with the request to close the study file at the completion of the study.

This extension is valid one year from February 6, 2016. Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any unanticipated incidents. All forms are located on the IRB website. If you have any questions, please contact the TWU IRB.

cc. Dr. Roger Shipley, Health Studies
Dr. Kimberly Parker, Health Studies
Graduate School

Appendix B
Recruitment Flyer

Texas Woman's University
College of Health Sciences, Department of Health Studies
Recruitment Flyer

Are you a refugee originally from Burma who has been relocated to the United States of America and now living in Houston?

If so, please contact us to learn about our research study to identify the perceptions and views on health and well-being of a group of Burmese refugees relocated to Houston, using photovoice as an instrument for participatory action research.

To qualify, you must:

1. Have lived in the city of Houston for at least 3 years.
2. Have acquired English as a second language.
3. Have voluntarily signed the informed consent for this study.
4. Be between 18 and 65 years old.

Participants will receive a digital camera upon completion of study.

For more information please contact:
Principal Investigator: Adrian Yam, M.Ed.
Email: iyam24@msn.com
Tel: 713.851.0823

Participation in study is strictly voluntary!

There is a potential risk of loss of confidentiality in all email, downloading, and internet transaction.

Appendix C
Consent Form and Confidentiality Agreement

Texas Woman's University
College of Health Sciences, Department of Health Studies
Consent to Participate in Research

Research Title: *Using photovoice as participatory action research to identify views and perceptions on health and well-being among a group of Burmese refugees resettled in Houston.*

Principal Investigator: Adrian Yam Email: iyam24@msn.com Tel: 832-251-7629
Adviser: Kimberly Parker, Ph.D. Email: kparker6@mail.twu.edu Tel: 940-898-2899

Purpose of Research

This forms asks for your consent to take part in a research study as part of Adrian Yam's dissertation at Texas Woman's University. The purpose of this study is to identify the perceptions and views on health and well-being of a group of Burmese refugees relocated to Houston, using photovoice as an instrument for participatory action research. Understanding these factors from your perspective is the main purpose of this study.

Description of Procedures

This project includes action research through taking pictures that tell a story and then discussing their meaning (photovoice). You will be asked to participate in an orientation session that may take up to 1.5 hours where you will receive a camera and a journal to aid in note taking (use of journal is not mandatory). You will be given 2 weeks to take pictures. Then, at your convenience; the researcher will meet with you to download pictures into his computer. At this point you will also select the pictures to be included in a group discussion. The group discussion will take approximately 3 hours and will be audio recorded. The reason for this recording is to provide a correct transcript of the discussions and to adhere to the accuracy of the information being generated. The total time commitment for this project is approximately 5.5 hours (1.5 hours for orientation, 1 hour for picture taking, 30 min. to download pictures and 3 hours for focus group).

Potential Risks and steps to minimize them

- Loss of confidentiality

No individual identifier will be used or linked to your pictures or responses during group discussions. As a study participant you will get a random number for demographic data and your name will not be used. To maximize privacy, this consent form includes a confidentiality agreement signed by all participants to minimize possibility of group discussions being repeated outside of the group. Additionally, all data material from study such as email communications, group discussions and photo sharing will be stored in a password protected laptop and encrypted flash drive. All electronic and hard copies will be erased and shredded within 5 years of study completion.

- Emotional Discomfort

These may be reactions such as anxiety, stress, sadness, potential emotional reaction related to memories connected to the refugee experience, stories linked to adjustment to new society and/or narratives related to traumatic experiences. Frequent breaks will be taken during group discussions to minimize fatigue/stress. Individual pauses and breaks will be honored throughout the process. A list of counselors and support groups in the area will be provided to you. The Principal Investigator will also provide individual referrals on

Initials: _____

a need bases. Moreover, as a research participant you have the opportunity to terminate the study without penalty at anytime

- Topic of a sensitive nature – related to the picture taking process of life and experience as a refugee.

As a study participant, you will guide the discussion topics throughout the research process. You will receive a referral list with information to access local support for any emotional discomfort that may arise during this process. At the same time, the Principal Investigator will be available to assist you for any individualized referral during this process; his contact information will be shared with you. Once more, potential participants will have the opportunity to terminate the study without penalty at anytime if you think it's necessary.

- Loss of anonymity-based on group discussion and photo sharing

At the start of the group discussion, the Principal Investigator will revisit the ground rules for the session which will include adhering to confidentiality and privacy regarding study participants and for the information being discussed. Furthermore, a confidentiality agreement statement is being implemented as part of the consent form to minimize this aspect.

- Loss of time

Detailed information about the required time for the study is included in this consent form. Principal Investigator will adhere to the proposed time for this study as much as possible. Furthermore, the Principal Investigator will also adhere to the timeframes that work best for you and the group participants. As a study participant you can choose to withdraw from the study at anytime without penalty if the demand is too high.

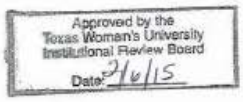
- Risk of Coercion

Participation is strictly voluntary and you should not feel obligated to take part in the study. No individual or agency can force you to participate. Furthermore, you can withdraw from this study at any time without any penalty. Your decision will be respected. If you feel that someone has forced you into participating in this research, please let the Principal Investigator know as soon as possible.

The researchers will treat you with respect and justice. Your voice will shape the research. The results of this study will be published in the investigators dissertation, however; no personal identifiers will be included.

Participation and Benefits

Finally, your participation in this study is voluntary. You may choose to discontinue participating in this study at anytime. There will be no penalty and your decision will be respected. By participating in this research, you will be contributing to the limited existing body of knowledge regarding health and well-being of refugees after relocation. You will have access to the results. *



Texas Woman's University
College of Health Sciences, Department of Health Studies
Consent to Participate in Research

Questions Regarding the Study

If you have any questions regarding your rights as a study participant, or any aspect of the research, you may contact the Texas Woman's University Office of Research and Sponsored Programs at 940.898-3378 or via email at IRB@twu.edu. If you have any questions about the study, please feel free to contact the researchers conducting this study; their information is on top of this form.

Consent and Confidentiality agreement

Your signature confirms your voluntary participation in this subject and that you will not share information discussed in the group with anyone outside of the group. By signing below, you confirm that you have read and understood this document. You will be given a copy of this signed document.

You will be given a copy of this signed and dated consent form to keep.

_____ _____

Name Signature

_____

Date

* Please send research results to:

Email address: _____

Or

Address: _____

_____

_____

Approved by the
Texas Woman's University
Institutional Review Board
Date: 2/6/15

Appendix D
Consent to Photograph Subject

Texas Woman's University
College of Health Sciences, Department of Health Studies
Consent Form for Subject Photograph

Project Title: *Using photovoice as participatory action research to identify views and perceptions on health and well-being among a group of Burmese refugees resettled in Houston.*

Person's Name: _____

Date: _____

Location: _____

I consent for my picture to be taken for this project. I understand that my picture may be used in print and/or display.

By signing this form, I agree that I am 18 years or older and that I have read and understand this form.

_____
Participant's signature

_____
Date

_____
Name of person obtaining consent

_____
Date

Appendix E
Consent for Publication of Photograph

Texas Woman's University
College of Health Sciences, Department of Health Studies
Consent for Publication of Photographs

Title of study: *Using photovoice as participatory action research to identify views and perceptions on health and well-being among a group of Burmese refugees resettled in Houston.*

I give permission for the chosen photographs to be used in any form of display; electronic, digital and print for the purpose of this study. I fully understand that my name will not be used in connection to these pictures, unless I agree to have it disclosed *. These pictures may be used and seen in print, copied, displayed and copyrighted. I understand that by signing this form I release Texas Woman's University and the principal investigator from any claims, actions, damages, or demands of uses indentified above. Finally, I attest that these photographs are originals and have not been published before in any form.

Title of photograph: _____

_____

_____
Signature

_____
Print Name

_____
Date

* I voluntary agree to have my name used in connection to this photograph.
Place initials here: _____

Appendix F
Recruitment Script (for individuals who have access to target population)

Texas Woman's University
College of Health Sciences, Department of Health Studies
Recruitment Script

Research Title: *Using photovoice as participatory action research to identify views and perceptions on health and well-being among a group of Burmese refugees resettled in Houston.*

Instructions for Recruiting Script:
Staff will introduce themselves, followed by a basic overview of the study and inclusion criteria. Next, will be a brief statement of study components and time commitment. It is recommended that staff is able to share their email address and phone number for further clarification. PIs information will also be shared with potential participants.

Sample Script:

Hello, my name is _____. I work at _____ organization. I understand there is a research study where you may be a good fit. This research is searching for Burmese refugees living in Houston (USA) for at least 3 years and use English as a second language to identify their views and perceptions on health and well-being. I am extending this invitation for you to consider participating.

Participation in this research includes attending a training session on the purpose of the study, basic training on using a camera, followed by taking pictures related to the purpose of the study (at your own time) and then attending a focus group to discuss those pictures as it relates to health and well-being. If you participate, the total time commitment for the complete study is around 5.5 hours.

If you have any questions or would like to participate in the research, I can be reached at *<phone number>* or *<email address>*.

At the same time; please free to contact the Principal Investigator:
Principal Investigator: Adrian Yam, M.Ed.
Email: iyam24@msn.com
Tel: 713.851.0823

Thank you for your time!

State your name: _____

Figure G
.Individual and Focus Group Discussion Guide

Texas Woman's University

College of Health Sciences, Department of Health Studies

Individual and Focus Group Session Guide

For interview:

(Welcome)

"Thank you for making time to speak with me today."

(Brief overview of inclusion criteria and purpose of study)

"We are searching for Burmese refugees living in Houston for at least 3 years and use English as their primary language. The purpose of this study is to identify factors that influence the health and well-being of refugees, and the incorporation of participatory action research (PAR) using photovoice."

(Statement regarding study process and time commitment)

"Specifically, this research will give you a camera to take photographs of your everyday living to identify those factors that influence your health and well-being. You will be able to take as many pictures as you like and will then select those for in-dept discussion at a focus group."

"Participation in this research includes attending a training session on the purpose of the study, basic training on using a camera, followed by taking pictures related to the purpose of the study (at your own time) and then attending a focus group to discuss those pictures as it relates to health and well-being. If you participate, the total time commitment for the complete study is around 5.5 hours."

(Relevance for study participation)

"I extend this invitation for your commitment to the study. Through your participation in this study, you will be contributing crucial information for the enhancement of programs and strategies for entities advocating on behalf of refugees while improving the resettlement process."

(Checking for understanding and questions)

"Do you have any questions? Are there any initial thoughts or comments on what was just mentioned?"

(Information for training session)

"If you are willing to take part in the study, please make sure you are able to attend the information session and training on (date, 2015), (time), Alliance for Multicultural Community Services, 6640 Hillcroft Avenue, Suite 411, Houston, TX 77081"

(Contact information)

Feel free to contact me at anytime for further questions/concerns:

Adrian Yam

Email address: iyam24@msn.com

Phone: 713-851-0823

For focus group:

(Welcome)

"Welcome to everybody. We really value your time and are very thankful for coming to the focus group today. Today we will discuss the pictures taken by you."

(Confidentiality)

"We'd like to kindly remind everyone that to protect the privacy of all participants in this activity, all transcripts will be coded with a personal identification number (no names will be used) and we ask that you not share what is being discussed in this meeting with anyone else."

(Logistics, time)

"The focus group/interview will last approximately three hours and we will audiotape the discussion to make sure that it is recorded accurately. Please feel free to take a break if needed, bathrooms are at the end of the hall, feel free to get some water and some light snacks. We will take a general break during the discussion."

(Check for understanding)

"Do you have any questions for us before we begin?"

(Purpose of study and discussion Process using SHOWeD method)

"Please take a look at the pictures. We invite the person who took the pictures displayed to share their initial thoughts keeping in mind how it relates to health and well-being as Burmese refugees. We will follow this printed outline:

(1) What do you **See** in this picture?

(2) What is really **Happening**?

(3) How does this related to **Our** lives?

(4)Why does this problem, situation or strength exist? and

(5) What can we **Do** about it? "

(The PI will facilitate the discussion and take notes on flip chart. Discussions of all photographs will follow using the SHOWeD method)

(Final comments/thanking for group participation)

"We are very grateful for your participation. It has been an honor to listen to all of the information discussed here today. Are there any final comments regarding this session or on any aspect of the study? I will remain in the room for a few more minutes for any additional comment. Thank you once more for coming".

Appendix H
Script for Taking Pictures of Persons

Texas Woman's University
College of Health Sciences, Department of Health Studies
Script for Taking Pictures of Persons

Research Title: *Using photovoice as participatory action research to identify views and perceptions on health and well-being among a group of Burmese refugees resettled in Houston.*

Instructions for using Script:
Script will be used only when taking pictures of persons. This guide will help in speaking briefly about the project, the use of the pictures and introducing the consent form. A short section for possible questions and recommended answers is also included. The contact information for PI will also be disclosed if necessary.

Sample Script:

"Hello, I am (state your name). I am part of a photovoice dissertation project where we are taking pictures.

We are taking a few pictures to show the health perspective of Burmese refugees resettled in Houston. We are taking pictures of people, places and things in our community that represent our views on health. These pictures will help identify issues that are important on this topic.

I would like for you to be in a few of my pictures. Would you mind if I took some photos of you for this project?"

(Note: people have the right to decline. If person does not agree- photographer will thank the individual).
If person agrees, photographer will thank them for agreeing. Photographer will proceed as follows:

"Thank you; before I take your picture I will need you to sign a consent form."

(Hand the Consent to Photograph Subject form and follow the instructions contained. Photo will be taken after the person has signed the consent form).

"You do not have to pose or even look at the camera. Just do whatever you were doing."

(Take the picture. Explain how you would like for them to be in the picture Finish by thanking them once more.)

"Thank you once for letting me take this photo."

Texas Woman's University
College of Health Sciences, Department of Health Studies
Script for Taking Pictures of Persons

Research Title: *Using photovoice as participatory action research to identify views and perceptions on health and well-being among a group of Burmese refugees resettled in Houston.*

Instructions for using Script:
Script will be used only when taking pictures of persons. This guide will help in speaking briefly about the project, the use of the pictures and introducing the consent form. A short section for possible questions and recommended answers is also included. The contact information for PI will also be disclosed if necessary.

Sample Script:

"Hello, I am (state your name). I am part of a photovoice dissertation project where we are taking pictures.

We are taking a few pictures to show the health perspective of Burmese refugees resettled in Houston. We are taking pictures of people, places and things in our community that represent our views on health. These pictures will help identify issues that are important on this topic.

I would like for you to be in a few of my pictures. Would you mind if I took some photos of you for this project?"

(Note: people have the right to decline. If person does not agree- photographer will thank the individual).
If person agrees, photographer will thank them for agreeing. Photographer will proceed as follows:

"Thank you; before I take your picture I will need you to sign a consent form."

(Hand the Consent to Photograph Subject form and follow the instructions contained. Photo will be taken after the person has signed the consent form).

"You do not have to pose or even look at the camera. Just do whatever you were doing."

(Take the picture. Explain how you would like for them to be in the picture Finish by thanking them once more.)

"Thank you once for letting me take this photo."

Appendix I
List of Mental Health Counselors and Support Groups

Texas Woman's University
College of Health Sciences, Department of Health Studies
Mental Health Counselors and Support Groups

Research Title: *Using photovoice as participatory action research to identify views and perceptions on health and well-being among a group of Burmese refugees resettled in Houston.*

Asian American Family Services http://www.aafstexas.org **713-600-9400**
9440 Bellaire, Suite 228, Houston 77036

Catholic Charities http://www.catholiccharities.org **713-526-4611**
2900 Louisiana (Main office), Houston 77006

Center for Creative Resources http://www.therapyhouston.org **713-461-7599**
816 Hawthorne St, Houston 77006

Chinese Community Center http://www.ccchouston.org **713-271-6100**
9800 Town Park Drive, Houston 77036

Family Enrichment Clinic http://www.familyenrichmentclinic.com **713-780-2833**
7100 Regency Square, Suite 136, Houston 77036

The Houston/Galveston Institute http://www.talkhgi.org **713-526-8390**
Main Office: 3316 Mount Vernon, Houston 77006

Legacy Community Health Services www.legacycommunityhealth.org **713-830-3000**
6441 High Star, Houston 77074

DAYA http://www.dayahouston.org **Helpline: 713-981-7645**
P.O. Box 571774, Houston 77257

University of Texas Mental Science Institute **Intake: 713-486-2525**
UT Psychiatry Outpatient Clinic
1941 East Road, Suite 2100, Houston 77054

Tzu Chi Foundation www.tzuchi.org **Main: 713-270-9988**
6200 Corporate Drive, Houston 77036 **MHMRA liaison: 713-970-8385**

Crisis Intervention of Houston http://www.crisishotline.org **713-527-9864**
Hotline: 713-HOTLINE/713-468-5463

United Way Information and Referral Services **Helpline: 713-957-4357 or 211**
50 Waugh Drive, Houston 77007 http://www.unitedwayhouston.org

YMCA International Services http://www.ymcahouston.org/ymca-international/ **713-339-9015**
6300 Westpark #600, Houston 77057

National Alliance on Mentally Illness **(NAMI) National Helpline: 800-950-6264**
http://www.nami.org **Local: 713-970-4419**

Appendix J
List of Health and Related Services Organizations

Texas Woman's University
College of Health Sciences, Department of Health Studies
List of Health Related and Service Organizations

Research Title: *Using photovoice as participatory action research to identify views and perceptions on health and well-be]ing among a group of Burmese refugees resettled in Houston.*

Alliance for Multicultural Community Services **713-776-4700**
6440 Hillcroft, Suite 411, Houston 77081 http://www.allianceontheweb.org
Health care access for refugees; interpreter program; immigration. Health care counseling. Adult education, employment training, vocational training, referrals to community agencies.

Asian American Family Services http://www.aafstexas.org **713-600-9400**
9440 Bellaire, Suite 228, Houston 77036
Serves the mental health needs of the Asian-American community. Provides bilingual and bicultural counseling, screening, referral and follow-up for social services, training, education, and advocacy; case management and interpreting/translation upon request. Court ordered parenting classes, substance abuse prevention program. Newcomer outreach, education & early intervention program for Asian American seniors. Psychological/psychiatric evaluations. Training for mental health professionals.

Ben Taub General Hospital, http://www.hchdonline.com **713-873-2000**
1504 Taub Loop, 77030
Must have Harris County Hospital District gold card. Free or sliding scale based on eligibility. Spanish and Vietnamese spoken. Emergency short term hospitalization. Clinic for outpatient and after care. Diagnosis for medications.

Bilingual Education Institute http://www.aetas.com **713-789-4555**
6060 Richmond Ave, Suite 180, Houston 77057
ESL instruction and Spanish courses. Provides citizenship classes for refugees upon qualification. Private/semiprivate lessons in a variety of languages.

Bering Dental Clinic **713-524-7933**
1427 Hawthorne, Houston, 77006
Basic dental health, preventive education, first come first serve basis, sliding scale.

Career & Recovery Resources, Inc. http://www.careerandrecovery.org **713-754-7000**
2525 San Jacinto, Houston 77002
Career counseling and testing. Education on interviewing and resume writing. Must be 16+. Career Helpline-Job Bank. Homeless Program does outreach to shelters. Various locations.

Center for Hearing and Speech http://www.centerhearingandspeech.org **713-523-3633**
3636 W. Dallas, Houston 77019
Audiology services, speech pathology, early childhood development and education for children with hearing impairments. Full hearing aid dispensary.

Children's Court Services Houston Area Women's Center www.hawc.org
713-528-6798 x 2255 or 2237
1010 Waugh, Houston 77019
Victim assistance program for children who are crime victims or witnesses to crimes, and their non-offending parents. Crisis counseling, information, and explanation of legal procedures for criminal cases. Support and education.

Children's Assessment Center www.cachouston.org **713-986-3300**
2500 Bolsover, Houston 77005
Multi-agency approach for prevention, investigation, and treatment for child victims of sexual abuse. One stop center reduces trauma to child, coordinates services and court preparation in a child friendly environment. Police,CPS, District Attorneys, agencies, and volunteers provide a team approach to assist victims and families. Specially trained doctors examine child victims of abuse. If a police report has been filed, law enforcement will pay for exam.

Chinese Community Center http://www.ccchouston.org **713-271-6100**
9800 Town Park Drive, Houston 77036
After-school tutorial, individual, and group counseling, Child Development Program, field trips/recreation, youth program, summer camp, ages 6-18. Focus is to deter gang activity/delinquency. Monthly parenting workshops. Focus on cultural awareness and adjusting to new environment. Adult ESL, job training, & senior program. Gym membership available to anyone in community.

CHIP (TexCare) http://www.chipmedicaid.org **Tel: 800-647-6558**
Children's health insurance for families and prenatal and pregnant women whose income is too high for Medicaid, but can't afford private insurance.

CHOSEN Clinic - UT Department of Pediatrics 713-500-5656;
Appointments: 832-325-7111
PO Box 20708, Houston 77225
UT Physicians Professional Building 6410 Fannin #510, 77030
Comprehensive care for children with chronic illnesses and disabilities. Provides a medical home, medical care, family support services, coordination with community based services.

Community Family Center http://www.communityfamilycenters.org **713-923-2316**
7524 Ave. E, Houston 77012
ESL classes, GED testing, Food Pantry, Summer/ after school program for children and adolescents.

Consumer Credit Counseling and Money Management International 713-923-2227
9007 W. Loop South, Houston 77096
http://www.moneymanagement.org
Financial education: free counseling services over debt management, housing related issues, and bankruptcy. Additional services include help in areas related to unemployment and education for first time home buyers (lower interest rates and monthly payments).

DAYA http://www.dayahouston.org **Helpline: 713-981-7645**
P.O. Box 571774, Houston 77257
Free services to South Asian survivors of domestic violence, sexual & emotional abuse. Counseling, advocacy, legal clinic, ESL & computer classes, translation & interpretation, outreach/education, transitional home and limited financial assistance for rent, utilities, child care, legal fees, transportation and education/job training.

Dispute Resolution Centers http://www.drchcuston.org **Administration: 713-755-8274**
49 San Jacinto #220, Houston 77002
Alternative resolution to disputes without costly court proceedings. Landlord/tenant, student/teacher, employer/employee, malicious mischief, neighborhood conflict, etc. Use trained volunteers. Juvenile cases accepted.

Food Stamp Offices: Texas Department of Human Services Information: 211
Clients will be issued a Lone Star Card to electronically access their benefits. Client will be given information on which office they are assigned to for DHS Self Support Services.

Fort Bend County Women's Center 24 hr Hotline: 888-427-3650
PO Box 183, Richmond, Texas 77406-0183 http://www.fortbendwomescenter.org
Administration: 281-344-5730 M-F,
Services to survivors of domestic violence, sexual assault, and/or incest. Services include emergency shelter, crisis hotline, volunteer accompaniment program, outreach, and counseling and referral programs.

Harris County Health Centers and WIC Sites http://www.hcphes.org/
Information: 713-439-6100
Main Office: 2223 W. Loop South, Houston 77027
Preventive health care services include dental services for children, EP/STD, family planning, immunizations for children, HIV testing and counseling, and various screenings. Small fees can be waived if patient is indigent. All services by appointment only.

Harris County Hospital District **713-757-0572**
5230 Griggs Rd, Houston 77021 **Appointments: 713-526-4243**
Must have Harris County Hospital District gold card. Must have referral from primary care physician. Extractions and treatment of dental and special oral surgical problems.