Refugee Health Education:  
“Learn to Succeed. Together We Build Our Community.”  

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INTRODUCTION

Resettled refugees in the United States (US) face challenges in health care, resulting in poor health outcomes. The consequences of being a refugee include short- and long-term physical and psychological suffering, including chronic medical conditions, depression and post-traumatic stress reaction (RHEMA, 2014). The US has resettled approximately 70 thousand refugees in 2015 across the various contiguous states. The Office of Refugee Resettlement (ORR) offers assistance through the Refugee Resettlement Program (RRP) for a short period of time, 8 months or less, with a lack of resources to advance the goal of self-sufficiency. After the RRP support, resettled refugees continue to experience disparities in health knowledge and a gap in socio-cultural awareness, which contribute to poor health outcomes.

PROBLEM STATEMENT

The risk of poor health outcomes among resettled refugees post-RRP from the date of arrival in the resettlement area is indicated by increased utilization of emergency room services, poor medical compliance, and lack of preventive health. Exacerbated by a lack of resettlement support and a lack of comprehensive culturally sensitive community health education program.

PURPOSE

To develop, implement, and evaluate the impact of a comprehensive culturally sensitive health education program in addressing resettled refugees’ identified health needs resulting from a lack of support after the Refugee Resettlement Program period ends.

METHODS

- 28 publications were selected.
- Utilized the result of the community needs assessment conducted by the author, fall of 2015, to develop the culturally sensitive health education program.
- Collaboration with community stakeholders.

THEORETICAL FRAMEWORK

Albert Bandura’s Social Cognitive Theory (SCT) posits that:
- Learning occurs through observation, imitation and modeling.
- Behavior modification relies on self-regulation, self-efficacy and positive reinforcement (Grusec, 1992; Horn, Jarrett, Anesetti-Rothermel, Tompkins, & Dino, 2014).
- Important theoretical framework in health education (Whitehead, 2001).

RESULTS

Demographics:
- 15 enrolled participants
- 85% is the program completion rate
- From Somalia, Congo and Angola

Quantitative Data:
I. Knowledge About General Health
   Improvement noted in understanding:
   - access to emergency care services: 38% vs. 54%
   - medication utilization: 69% vs. 91%
   - use of antibiotics: 31% vs. 64%

II. Knowledge About General Nutrition
   Increased comprehension noted in:
   - healthy food choices: 38% vs. 64%
   - understanding labels: 85% vs. 100%

III. Knowledge About Childcare
   Improvement in understanding:
   - importance of immunization: 77% vs. 91%
   - role of care providers on children’s education: 60% vs. 64%

IV. Health Education Skills
   Improvement of 9% in managing simple cough using household remedies

Qualitative Data:
- Identifying signs of stroke: 0% vs. 38%
- First aid skills for handling bleeding: 0% vs. 53%

Narratives post health education:
What is important to me: Learning about health and living healthy lifestyle
I like the program: Motivational, teaching me to take care of myself

CONCLUSIONS

- The Community Needs Assessment conducted fall 2015 provide the background and pillars of the health education program curriculum.
- Knowledge and skills learned in the program improved:
  - Self-worth,
  - Motivation to improve healthy living,
  - Influenced healthy living in the present and in the future within self, family and the community through role modeling.
- Community participation in program development.
- Increased partnership with community stakeholders and site agency.
- Site agency received grant money from Rhode Island Foundation to replicate the program.

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REFERENCES


