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Validating Visibility and Voice: A Community-Based Participatory Research Study to Address the Health Access of Cambodian Americans

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Jack J. Lu, Ph.D.
University of Connecticut, 2016

ABSTRACT

Since 1975, Cambodians have sought survival in the United States by escaping from extreme forms of violence, torture, and other traumas from the Khmer Rouge genocide and refugee camps. Although some have lived within the United States for several decades, many Cambodian Americans continue to experience inadequate access to health that results in ongoing poor health outcomes, such as physical suffering, psychological distress, and premature death. Rooted in social determinants (e.g., social economic status, education, stress), these poor health outcomes have led to disproportionate rates of illness (i.e. health disparities) when compared to the general population. Improving health access, defined as having the available resources to address key social determinants, may improve health outcomes.

This study explored Cambodian Americans’ experience of health access from the perspective of Cambodian community health workers (CHWs). This community-based participatory research employed qualitative methodology to understand health access from a public health lens and critical pedagogical framework. Findings suggest that although Cambodian Americans are survivors of historical trauma, the silence and invisibility they have experienced continues within the United States today through cultural invasion. Additionally, cultural synthesis and healing may occur when interventions address the social, cultural, economic, and political marginalization of Cambodian Americans. Although their lived
experiences may be unique, many other communities share the process of cultural invasion and the resulting effects on health. Public health social work is ideally suited to advance knowledge regarding health access; highlight the unique roles of CHWs; and challenge social, economic, and political injustice for Cambodian Americans and other communities that experience similar effects of marginalization on health.

*Keywords:* Cambodian Americans, community-based participatory research, health access, community health work, public health social work
Validating Visibility and Voice:
A Community-Based Participatory Research Study to
Address the Health Access of Cambodian Americans

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Doctor of Philosophy Dissertation

Validating Visibility and Voice: A Community-Based Participatory Research Study to Address the Health Access of Cambodian Americans

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A familiar proverb states, “It takes a village to raise a child.” From my experience with this study, I truly believe that no dissertation is completed in isolation; instead, they may only be nourished and birthed from the support of and collaboration with many mentors, colleagues, friends, and family.

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- ☮️ ♥️ 😊 ▲ Cheers to peace, love, happiness, and social change!
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Introduction

Since 1975, Cambodians have sought survival in the United States and other countries from the Khmer Rouge genocide. Many Cambodians who came to the United States since 1979 arrived with refugee status and currently live as lawful permanent residents or United States (U.S.) citizens. Although now free from extreme forms of torture and other atrocities experienced during the Khmer Rouge regime, Cambodian Americans continue to face adversity in the United States. Cambodian Americans experience disproportionate rates of poor health (i.e. health disparities) when compared to the general population and other Asian groups (Marshall, Schell, Elliott, Berthold, & Chun, 2005; Marshall et al., 2016; Wong et al., 2011). Health disparities translate to devastating health outcomes, such as premature death and suffering (Grigg-Saito, Och, Liang, Toof, & Silka, 2008), which also incurs exorbitant cost to the U.S. health care system (Chen, Cheng, Bennett, & Hibbert, 2015). These critical issues may be alleviated by improving Cambodian Americans’ access to health through essential community resources, which include Cambodian community health workers (Fedder, Chang, Curry, & Nichols, 2003; Grigg et al., 2008; Grigg et al., 2010, Whitley, Everhart, & Wright, 2006).

This qualitative dissertation employs a public health framework and critical pedagogy theory to explore Cambodian Americans’ experience of health access through the unique perspective of Cambodian community health workers (CHWs). Often sharing the historical experiences of their community, Cambodian CHWs successfully navigate both their Cambodian American communities and U.S. institutions to improve the health access and outcomes of Cambodian Americans. To explore the knowledge and experience of Cambodian CHWs, this community-based participatory research (CBPR) study promotes the integration of academic and community knowledge. For this CBPR dissertation, Khmer Health Advocates (KHA) is a
Cambodian community-based organization that serves as the community partner agency. Co-developed with KHA staff, this study has five research questions:

1. From the perspective of Cambodian CHWs, what does health mean to the Cambodian Americans who are served by CHWs?
2. What do Cambodian CHWs understand about the experience Cambodian Americans have with health access in the United States?
3. According to Cambodian CHWs, what are the top three barriers to health access for Cambodian Americans?
4. How do Cambodian CHWs negotiate conflicts between Cambodian Americans and Western health care providers to improve health access?
5. What action steps may address the health access needs of Cambodian Americans?

The first chapter contextualizes what Cambodians have experienced since 1970, along with the experience of Cambodians Americans in the United States. I employ a public health framework to define health disparities, the model of multiple causation, the concept of health access, and the role of CHWs in the United States. Three relevant concepts (cultural invasion, cultural synthesis, and critical consciousness) from critical pedagogy theory aide in the conceptualization of Cambodian Americans’ experience of health access in the United States. Finally, a discussion of this study’s significance highlights this dissertation’s relevance for the field of social work.

In chapter two, I delve into the CBPR approach and qualitative methodology used for this study. Chapter three analyzes and integrates the findings utilizing two overarching themes, silence & invisibility in two cultures and a holistic approach to healing. In the fourth chapter of this dissertation, I discuss implications for public health social work, limitations of this study, and
implications for theory and future research, which align structural violence with historical trauma and critical consciousness with liminality. Finally, my conclusive remarks for this dissertation summarize the findings, the value of community partnerships in addressing health access, and social work’s commitment to addressing the health disparities that Cambodian Americans experience on a daily basis.
Chapter 1: Background, Relevant Context, and Significance

Cambodia, Cambodian Refugees, and Cambodian Americans

The Khmer people are the largest ethnic group of Cambodia; Khmer also refers to the language and culture. In the 1970s, the Khmer Rouge regime, the Communist Party of Kampuchea, targeted the killing of people who were affluent, educated, professional, soldiers, mixed-race Chinese Cambodians, past and present government officials, and urban Cambodians that supported the previous government led by Lon Nol. These individuals, who may have typically provided leadership and guidance to the general populous, were identified as a reactionary force that needed to be targeted and eliminated (Sary, 1976/1998). To instill a culture of homogeneity through an extreme form of Maoism, the Khmer Rouge regime rejected practices of the Khmer culture associated with social elites, such as royalty, government, religious authority, higher socioeconomic classes, and Americans (Das, 2007; Ong, 1995). These cultural practices were antithetical to the Khmer Rouge regime’s goal - an agrarian utopia.

In the face of torture and genocide, silence became a survival mechanism for Cambodians during the Khmer Rouge regime. Speaking out or showing emotion often led to being murdered (Ly, 2015). Reinforced by this trauma, many of those who survived continue to live in silence (Tucci, 2015). Approximately seven million people lived in Cambodia in 1970 and more than half of this population are estimated to have been killed by “war, rebellion, man-made famine, genocide, politicide, and mass murder” (Rummel, 1998, para. 1). The National Cambodian American Health Initiative (NCAHI) (2012) estimated that “Cambodians lost 1/3 of their people” and over 90% of their educated populous during the Khmer Rouge regime in “one decade [1970s] of war, torture and genocide” (p. 2). Between the years of 1975 and 1979 alone, nearly two million Cambodians were killed (Cambodian Genocide Project, 2010; Needham &
Quintiliani, 2007). The refugees that survived were primarily poor, limited in formal education, from rural areas, non-professional, and mostly female single parent families with young children (Cambodian Genocide Project, 2010; Das, 2007; NCAHI, 2012). Even after surviving genocide, Cambodian refugees experienced trauma and abuses during their time in refugee camps, such as murder, rape, robbery, disease, and starvation (Chan, 2004; Mollica et al., 1993).

Between the years of 1975 and 1990, approximately 195,000 Cambodians resettled to the United States with at least 95% of these individuals having survived the Khmer Rouge regime (NCAHI, 2007). By 2012, the U.S. Census Bureau estimated over 310,000 Cambodians living in the United States with the two largest U.S. state concentrations of Cambodian Americans in California and Massachusetts. Long Beach, California is home to the single largest urban concentration with a population of over 22,000 (United States Census Bureau, 2010a), while Lowell, Massachusetts has the second highest concentration with over 14,000 residents (United States Census Bureau, 2010b). Cambodians also live in many other states, such as Connecticut, Rhode Island, Illinois, Minnesota, Oregon, Pennsylvania, Washington, Texas, and Florida, and research has found similar trends of health characteristics across geographies (NCAHI, 2007; NCAHI, 2012).

Descriptive data from a random community sample in Long Beach of adults (35 to 75 years-old) who “lived during some portion of the Khmer Rouge regime” highlights the following: 99% of Cambodians experienced near-death starvation, 90% witnessed the murder of at least one family member or friend, and 96% reported forced labor (Marshall et al., 2005, p. 572). During the time of this study (2003 – 2005), 69% had household incomes of less than 100% of federal poverty level (Marshall et al., 2005). Although these refugees no longer face genocide, their access to safety and health faced many adversities (Das, 2007). Cambodians
continued to experience violence and more traumas, such as witnessing “a dead body in their neighborhood,” being robbed, and threatened by a weapon with intent of serious injury or death (Marshall et al., 2005, p. 575). Cambodian Americans’ health outcomes may improve as researchers explicate the strength and resiliency of Cambodians from these devastating experiences (Cambodian Genocide Project, 2010; McGinnis, 2009).

**Cambodian Americans across three generations.** Current literature describes Cambodian Americans across three generations. The first generation consists of those who survived the Khmer Rouge genocide and are 60+ years of age, often referred to as “elders” (Knodel, Kim, Zimmer, & Puch, 2005). These elders primarily arrived through refugee camps in Southeast Asia. Those who are second generation Cambodian Americans also survived the Khmer Rouge genocide and are typically between the ages of 35 and 60 (Koch-Weser et al., 2012). The third or younger generation of Cambodian Americans are those primarily raised within the United States and primarily have not lived through the Khmer Rouge (Sangalang & Gee, 2015; Wallitt, 2008).

Similarities and differences in health status exist between each generation (Berthold et al., 2014; Grigg-Saito et al., 2008; Koch-Weser et al., 2012; Marshall et al., 2005; Marshall et al., 2016; Sangalang & Gee, 2015; Wallitt, 2008). For example, the elder generation often suffers from many comorbid chronic health conditions, which include cancer, cardiovascular disease, asthma, diabetes, high blood pressure, obesity, hypertension, depression, post-traumatic stress, anxiety, and addictions (Knodel et al., 2005). The middle generation of Cambodian Americans are showing signs of health issues that parallel the elders; however, they typically exhibit more pro-health behaviors (e.g., physical activity, non-smoking, nutritious diet) when they have higher education, income, and acculturation to the United States (Koch-Weser et al., 2012). The
younger generations of Cambodian Americans often show signs of social isolation and depression and are at significant risk of developing poorer health over time (Sangalang & Gee, 2015). Wallitt (2008) describes the experience of Cambodian American youth who live within two cultures (i.e. the mainstream U.S. and Cambodia cultures) and do not fit in either, thereby losing access to the resources of each. Despite generational differences, high risks of poor health remain across all generations.

**Community-based organizations.** Cambodian Mutual Assistance Associations (CMAAs) were founded by the federal government to improve self-sufficiency and acculturation in the 1980s (NCAHI, 2007). These organizations helped Cambodian refugees face the ongoing hardships experienced in the United States. CMAAs functioned as community-based organizations with Cambodian staff members at all levels, from frontline worker to board member. These organizations offered services and/or assistance with health/mental health, interpretation/translation, advocacy, asset building (e.g., first-time home buying, financing education), family support, youth mentorship, social services (e.g., SSI, food stamps), violence prevention, and education regarding immigration, English as a second language, and citizenship (CMAA Lowell, 2014; NCAHI, n.d.).

By the early 1990s, the number of CMAAs grew to approximately 150 organizations across the United States (NCAHI, 2007). This promising step toward rebuilding the Cambodian American communities met severe adversity. Changes to federal policies, such as the Welfare Reform Bill and the Immigration Act of 1996, decreased individual access to federal aid and immigrant communities were often hit the hardest (Borjas, 2002). This had a significant and negative longitudinal impact on Cambodian American families and their ability to improve their socioeconomic conditions through individual prosocial behaviors, such as seeking educational
opportunities (Quintiliani, 2014). These experiences increased complexities for organizations that were committed to addressing the needs of marginalized communities, including non-profits like CMAAs (NCAHI, 2007; Reisch & Sommerfield, 2003).

At the turn of the millennium, almost 50% of the Cambodians CMAAs closed due to significant decrease in funding and resources (NCAHI, 2007). NCAHI’s national study in 2006 found only “35 functioning Cambodian MAAs that have budgets greater than $25,000, serving an estimated 300,000 Cambodians in 50 states” (NCAHI, 2007, p. 3). As of February 4th, 2016, there are only seven estimated in existence (Mary Scully, personal communication). This severe reduction of community resources coupled with pervasive poor health access exacerbates the ongoing poorer health outcomes and health disparities for Cambodian Americans (Berthold et al., 2014; Wong et al., 2006).

**Confronting the legacy of silence and invisibility.** Cambodians continue to experience silence and invisibility in both Cambodia and the United States. Tucci (2015) describes these phenomena in Cambodia:

Although the Khmer Rouge regime ended 30 years ago, there have been no sound efforts of reconciliation, and its legacy continues to affect Cambodia today. Talking about the Khmer Rouge has been widely taboo in Cambodia since the end of the war. It can be accepted that Cambodia only learned to breathe again at the expense of silence and the will to forget, which has in turn had detrimental effects on the rebuilding of its society in the aftermath of war. (para. 7-8)

This legacy has reinforced the intergenerational transmission of trauma within Cambodian families (Pennington, 2008), which also continues in the United States (Choau, 2013). In the United States, institutional settings reinforce the Cambodian American experience of silence and
invisibility. For example, Cambodian American youth are often confronted with two barriers in the U.S. education system that reinforce silence and invisibility: (1) the model minority myth that categorizes Cambodian Americans as “Asian” and (2) the historical and often present-day lack of resources to address what they lost during the Khmer Rouge genocide and as refugees (Nhek, 2014; Wallitt, 2008). This legacy of silence and invisibility negatively affects the health status of Cambodian Americans and their ability to confront the social, economic, cultural, and political barriers to improve their health conditions within the United States.

**Theoretical Frame**

**Public Health: A Structural Framework**

The World Health Organization (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (2003b, para. 1). A public health framework assessment of health examines the social determinants that include “the conditions of daily life in which people are born, grow, live, work and age, which are shaped by the [unequal] distribution of money, power and resources at global, national and local levels” (WHO, 2012, para. 2). Therefore, improving the health of any population requires structural solutions and approaches that respond to the unique social, economic, and political experiences for each community.

In “The Solid Facts” report, the WHO (2003a) outlined examples of social determinants of health: the social gradient (i.e. socioeconomic status), stress, early life, social exclusion, work conditions, unemployment, low education levels, social support, addiction(s), access to food, and access to transportation (WHO, 2003a). Furthermore, Lurie and Dubowitz (2007) demonstrated that racial and ethnic minorities who have a higher likelihood of being poor and/or have lower educational levels are at disproportionately greater risk for “ill health” compared to
“nonminority, nonpoor, [and] better educated peers” (p. 1118). So although Cambodian Americans may seek access to biomedical interventions (e.g., medications) to treat illnesses (e.g., cardiovascular disease, diabetes, and PTSD), positive health outcomes (e.g., decreased rates of disease, increased social functioning) may best be improved by eliminating the systemic barriers to the social determinants of health (Wagner et al., 2013).

The barriers to the social determinants of health create disproportionate rates of illness between communities – health disparities. A community-based health promotion model emphasizing dimensions of “empowerment, participation, multidisciplinary collaboration, capacity building, equity, and sustainable development” may best remove these systemic barriers (Judd, Frankish, & Moulton, 2001, p. 367). Community-based health promotion models align with the WHO’s argument that the fundamental human right to health is “not only to timely and appropriate health care, but also to the underlying determinants of health” (WHO, 2014, para. 2).

From a public health framework, it is clear that Cambodian Americans experience obstacles in quality access to many social determinants of health. Cambodian Americans who lived under the Khmer Rouge regime suffered many horrific forms of trauma, before, during, and after the genocide. Others who were born after 1979 had experienced other serious forms of trauma in their early lives at refugee camps (Mollica et al., 1993) or in the United States (Berthold, 1999, 2000). Therefore, the ongoing stress they face with social exclusion, poverty, and barriers to social support and transportation create a complex problem for health outcomes (Chan, 2004; Koch-Weser, Liang, Grigg-Saito, & Toof, 2012; Peterman et al., 2010; Quintiliani, 2009; Wong et al., 2006; Wong et al., 2011).

Lack of quality access to health care has been pervasive for Cambodian Americans as a significant social determinant. In Marshall and colleagues’ (2006) study, Cambodian Americans
that met criteria for diagnosable mental health disorders in Long Beach often sought medical care (70%) and mental health care (46%) treatment. Many of these respondents struggled with poverty, unemployment, limited English-speaking proficiency, limited U.S. education, and public health insurance (Marshall et al., 2006). Additionally, the barriers that Cambodian Americans face include the cost of health care and need for interpretative services (Wagner et al., 2013). Furthermore, Wagner and colleagues (2013) identified that 95% of Cambodian Americans had “worries about the degree of understanding between the doctor and patient” (p. 1070). Berthold et al. (2014) had similar findings with most Cambodian American participants reporting barriers in transportation and language interpretation despite having long-term primary care physicians. The NCAHI (2007) estimated that approximately “65% of Cambodian American survivors require medical interpreters and support services to access health” (p. 4).

Beyond access to health care, Cambodian Americans struggle with unstable employment status and work conditions. Maintaining stable employment is out of reach for many due to pervasively poor health (Wong et al., 2011). Other social determinants of health, such as addictions and food insecurity, are key issues for subgroups within this community. For example, food insecurity is a grave concern for early female, widowed refugees who arrived during the 1980s (Peterman et al., 2010; Peterman, Wilde, Silka, Bermudez, & Rogers, 2013) and alcohol addictions disproportionately affect Cambodian men (Koch-Weser et al., 2012). A public health framework suggests that a community-centered health promotion model is well suited to examine and design interventions to improve the social determinants of health that pervasively affect Cambodian Americans. This type of health promotion model is valuable because it brings attention to the interactions among social, economic, and political factors (Judd et al., 2001).
Health and health disparities. Cambodian refugees have a distinctive profile of health (i.e. chronic co-morbid physical and mental health issues) due to their experience of years of starvation and forced labor. Additionally, there is limited evidence to suggest that Cambodian Americans will follow the health trajectory of other refugee or immigrant groups who may have an inverse correlation between acculturation and poor health outcomes. Known as the “Healthy Migrant Effect,” migrants that arrive from low-income countries to first world nations, like the United States, become less healthy over time (Delavari, Sonderlund, Swinburn, Mellor, & Renzaho, 2013, p. 1). Cambodian Americans differ from this phenomenon because they arrive primarily with poor health and poor health remains over their life course (Marshall et al., 2005; Marshall et al., 2016). Limited funding for research (National Cambodian American Health Initiative, 2007; Shaddox, 2011) and the primary focus on urban areas has hampered understanding Cambodian Americans’ health status in the United States. Despite these limitations, the available data are devastating.

Cambodian survivors in the United States continue to suffer many hardships, including high rates of mental health issues and comorbid physical illnesses (Berthold et al., 2014; Grigg-Saito et al., 2008; Marshall et al., 2005). Marshall and colleagues (2005) found rates of post-traumatic stress and depressive disorders affected 62% (weighted) and 51% (weighted) of Cambodian survivors, respectively. These conditions co-occurred 42% (weighted) of the time (Marshall et al., 2005). Severe chronic physical illnesses include cardiovascular disease (e.g., stroke, coronary heart disease, and tachycardia), diabetes, and hypertension (Berthold et al., 2014; Grigg-Saito et al., 2008; Marshall et al., 2016; Shaddox, 2011; Wagner, 2013). More frequently than not, these conditions are co-occurring, which compounds the poor health
outcomes and suffering that Cambodian Americans experience (Berthold et al., 2014; Marshall et al., 2016).

The ongoing severe and chronic health conditions reflect significant health disparities for Cambodian Americans. Grigg-Saito and colleagues (2008), in a sample of Cambodian Americans in Massachusetts, found that “a disproportionate share of adult deaths (age > 45 years) are attributed to stroke (15.9%) and diabetes (13.4%), when compared with all Massachusetts adults older than 45 years (6.5% and 2.5%, respectively)” (p. 416). When matched to the general U.S. population by age and gender, Cambodian refugees in Long Beach, California had significantly higher rates of diabetes, hypertension, and hyperlipidemia (Marshall et al., 2016). Between Asian American and Pacific Islander groups, Wong et al. (2011) found that 89% of Cambodian survivors self-reported their general health status as either fair or poor, which was approximately twice as high when compared to other Asian immigrant groups. In the same study, nearly 70% of Cambodian survivors met screening criteria for probable disability due to a mental health condition, which was compared to 26% of other Asian immigrants matched by “gender, age, income, and urbanicity” (p. 876). The magnitude of these health disparities is a strong indicator of the ongoing premature death and suffering that Cambodian Americans experience.

**Multiple causation.** The structural factors that affect the Cambodian Americans’ experience of poor health outcomes and disparities may best be understood through a multiple causation model that examines the social, economic, and political environment. This model promotes differentiation between epidemiological components that include examining the relationship between external agents (i.e. environmental causes) and the risk factors (e.g., genetic, behavioral) that increase the rates of illness. The multiple causation model thereby
creates two potential layers of interventions to health problems: a primary and secondary prevention approach. Primary prevention focuses on root causes of identified health problems (e.g., ensuring access to healthy foods to prevent diabetes), while secondary prevention addresses the consequences of these health problems as early as possible (e.g., prediabetes screening, changes in diet).

Cambodian Americans seek access to the biomedical interventions within the U.S. health care system for their physical and mental well-being (Berthold et al., 2007). Typically, biomedical interventions focus on tertiary prevention, such as medications that aid in managing biological symptoms and/or disease (e.g. diabetes, depression) or conventional talk therapies for mental health diagnoses. These biomedical interventions are insufficient to address the nature of the health problems that Cambodian Americans experience. Therefore, a focus on primary prevention may decrease the social determinants that perpetuate the health disparities faced by Cambodian Americans. Intervention at this level addresses health issues in the Cambodian community (i.e. decreasing health disparities by increasing health access), so that biomedical interventions may be more effective through tertiary prevention (i.e. health care).

**Health access.** Health access is a complex, multi-faceted concept. While access to quality health care is essential to health, it alone is insufficient to create or improve the social determinants of health. In this study, I define health access as having the available resources to improve the social determinants of health for an identified community. The seminal work of Penchansky and Thomas (1981) operationalized five dimensions of access “in health policy and health services research,” which include availability, accessibility, accommodation, affordability, and acceptability (p. 127). Although the contemporary study of these dimensions focus on health care access (Fogarty & Cronin, 2008; Gulzar, 1999; McFall & Yoder, 2012; Norris & Aiken,
2006), addressing these five dimensions with a framework that is broader than health care may not only improve health access, but also serve to focus attention to primary and secondary prevention strategies for Cambodian Americans in the United States (Sanchez & Mosque, 2012).

Sanchez and Mosque (2012) categorically distinguished these five dimensions by tangible (e.g., availability, accessibility, and affordability) and less tangible (e.g., accommodation and acceptability) resources. By concretizing these dimensions to resources within the community, identifiable steps for immediate action may improve health access that is practically relevant for a community in need (McIntyre & Mooney, 2007; Sanchez & Mosque, 2012). Therefore, increasing health access is broader than improving any complications that arise within the U.S. health care system, but to include changing any social, cultural, economic, and/or public policies that negatively affect a community (McIntyre & Mooney, 2007; Mooney, 2009). When tangible and less tangible community resources are available, more support is available for Cambodian Americans to navigate conflicts in cultural dimensions that are rooted in the political and historical events (i.e. structural factors) that have shaped their lived experience. Specific to Cambodian Americans, two types of less tangible conflicts include trust of those with authority (e.g., doctors) and the limited accommodations made to how U.S. health care systems provide services to this community.

Strengthening the relationships between these five health access dimensions from a community perspective remains salient to improving health access. In other words, when services are affordable (i.e. a tangible resource), “the relationship of clients’ attitudes about personal and practice characteristics of providers to the actual characteristics of existing providers, as well as to provider attitudes about acceptable personal characteristics of clients” may also serve to decrease a less tangible resource, acceptability (Penchansky & Thomas, 1981,
The personal and practice characteristics go beyond health behaviors; they encompass beliefs about social identity, such as gender, age, socioeconomic status, sexuality, and religious affiliation (Penchansky & Thomas, 1981). Therefore, to best increase health access, these categorized dimensions must be addressed holistically and from a community-engaged model.

**Community health workers and Cambodian Americans.** Since the 1960s, CHWs have been cornerstones to a strong foundation of public health through roles of advocacy and representation for marginalized communities (Ingram, Sabo, Rotbers, Wennerstrom, & Guernsey de Zapien, 2008; Landers & Stover, 2011). In 1989, the WHO defined CHWs as members of the community in which they work who are selected by and accountable to these communities; CHWs typically support health care systems, but usually do not work for them. By 2010, Rosenthal et al. argued that the United States’ public valuation of CHWs came into existence through the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (ACA) in the creation of a Standard Occupational Classification that far expanded the 1989 CHW definition by the WHO (U.S. Department of Labor, 2010). Though broad and not exhaustive, the ACA definition systematically recognizes CHWs in the United States, which reinforces the vital skills that CHWs offer to improve health in three dimensions: access, care, and outcomes.

CHWs may provide a broad spectrum of services, from improving the functions of health care delivery (e.g., interpretative services, increasing health knowledge and service utilization) on an individual level to community advocacy in confronting the disproportionate levels of illness by challenging the “structural underpinnings of health disparities” (Cherrington et al., 2010; Ingram et al., 2008, p. 417). This wide range of work serves to enhance health outcomes for marginalized populations experiencing health disparities. Furthermore, CHWs are often
community leaders who share the language, cultural and ethnic ties, socioeconomic status, and life experiences of the communities served (Appleford, 2013; Ingram et al., 2008). Therefore, CHWs typically have high intrinsic motivation based from personal interest and goal coherence with communities (Appleford, 2013; Dickin, Dollahite, & Habicht, 2010). High intrinsic motivation correlates with autonomy, competence, relationship with the community, the ability to influence community decisions, the self-perception of leadership within the community, and strong networks with stakeholders and decision-makers (Appleford, 2013; Dickin et al., 2010; Ingram et al., 2008).

Ample research highlights CHWs’ contribution to both improved health outcomes for patients and significant health care savings (e.g., net savings of $2.6 million dollars in Arkansas over three years) for patients, providers, and the entire U.S. health care system (Felix et al., 2011; Johnson et al., 2012; Zahn, Matos, Findley, & Hicks, 2012). This is particularly relevant for Cambodian survivors who experience high amounts of chronic disease and have an average health care cost equating to approximately 23 times that of an average U.S. citizen, totaling approximately three billion dollars per year (NCAHI, 2012). Therefore, not only do CHWs improve long-term positive health outcomes for vulnerable and marginalized patients, they also increase equitable access to publicly funded community care and reduce Medicaid claims and payments (Felix et al., 2011; Johnson et al., 2012; Zahn et al., 2012).

Although limited, research on Cambodian CHWs have found similar outcomes with regard to improved health outcomes for Cambodian Americans. This has come in the form of increasing breast and cervical cancer screening and awareness, health literacy and knowledge of diabetes, and hepatitis B education and interventions (Nguyen, Tanjasiri, Kagawa-Singer, Tran, & Foo, 2008; Renfrew et al., 2013; Taylor et al., 2013a; Taylor et al., 2013b). Despite these
studies, limited knowledge exists of how Cambodian CHWs facilitate health access in addition to how they are a transformational resource for Cambodian Americans and health care provision.

**Critical Pedagogy Theory and Community-Based Participatory Research**

Poor health access is not only a public health problem, but also a social justice and human rights issue (Hunt & Backman, 2008). To understand this phenomenon, a structural approach must be used to analyze how Cambodian Americans are marginalized. Critical pedagogy is a theory that may improve understanding to how and why these health disparities endure for Cambodian Americans after more than 30 years of inhabitance within the United States. Furthermore, CBPR can be employed to study how the concepts of critical pedagogy may be applied to examine the health access needs of Cambodian Americans.

**Critical pedagogy.** Paolo Freire (1990) critically examined the process in which dominant and non-dominant cultures interact through knowledge generation and education. This process may exist not only within conventional or formal academic settings (i.e. universities, schools), but also as part of progressive or popular education, which is knowledge developed within the community through practice, experience, and participation (Wallerstein & Duran, 2003). From a Marxist lens, Freire (2004) argued that the theory of critical pedagogy reflected a process and continual commitment to learn, reflect, unlearn, and critique conventional knowledge within social, historical, and political contexts. Though it may occur within a classroom, critical pedagogy is visible beyond the formal classroom – including non-academic settings, which may include interactive moments when adequate support (e.g., CHWs) exists for Cambodian Americans to navigate the U.S. health care system, as well as in the broader environment where Cambodians live. Finally, critical pedagogy empowers indigenous knowledge among those from non-dominant cultures that face oppression. To understand this
theory’s application within this dissertation, three concepts are pertinent: cultural invasion, cultural synthesis, and critical consciousness.

**Cultural invasion and cultural synthesis.** Cultural invasion is the process in which oppression of non-dominant cultures through colonization moves beyond geography to encompass practice, values, beliefs, knowledge, and ideology (Freire, 1990). The devaluation of indigenous knowledge by widely accepted, conventional knowledge is precisely what Freire (1990) would argue is “cultural invasion” (p. 150). Freire argued that cultural invasion might be a natural occurrence between dominant and non-dominant systems that does not require malice or intent, but simply the structural forces that reinforce dominance (e.g., public policy, social influences, and economic factors). For example, there may exist expectations from U.S. health care providers that Cambodian Americans can understand and successfully navigate the U.S. health care system (e.g., making appointments, taking medications as prescribed, completing paperwork, seeing medical specialists). Recognizing the significant barriers that exist for many Cambodian Americans (e.g., cultural expectations and health literacy of Western medicine, lower education levels, lower literacy rates, non-English speaking), this expectation by U.S. health care providers may serve as one example of how cultural invasion can exist. Recognizing these barriers, U.S. health care providers can establish methods to engage Cambodian Americans to navigate these barriers. A holistic, expansive, and in-depth understanding of how Cambodian Americans conceptualize health and what may improve their ability to achieve health (i.e. removing the barriers to health access) must be prioritized to challenge cultural invasion.

The concept of cultural synthesis is oppositional to cultural invasion. Freire (1990) argued that cultural synthesis is a reciprocal exchange between the cultures of systems with varied levels of dominance (e.g., Cambodian American communities, U.S. health care system).
In cultural synthesis—and only in cultural synthesis—it is possible to resolve the contradiction between the world view of the leaders and that of the people, to the enrichment of both. Cultural synthesis does not deny the differences between the two views; indeed, it is based on these differences. It *does* deny the invasion of one by the other, but affirms the undeniable support each gives to the other. (Freire, 1990, p. 183)

Therefore, knowledge generation in this dissertation from Cambodian CHWs may serve to promote the concept of cultural synthesis of health-related knowledge and practice between Cambodian American communities and the U.S. society. A CBPR approach is the guiding framework in this study and I employ a qualitative methodology to elicit indigenous knowledge of Cambodian CHWs. CBPR allows the researcher to take a facilitative role by promoting community members involvement in the explication of the community’s needs, desires, and goals (i.e. to improve health outcomes of Cambodian Americans with regard to this study’s focus – health access). For this study, staff from a community partner agency, Khmer Health Advocates, collaborated as equal partners throughout each stage of the dissertation.

**Critical consciousness, CBPR, and critical pedagogy.** Critical consciousness (i.e. conscientization), a concept from critical pedagogy, is the underlying change agent that combats cultural invasion and builds cultural synthesis. Freire (1990) conceptualized conscientization as a process in which individuals and communities from both dominant and non-dominant systems develop a comprehensive interpretation of the world that is social, historical, and political in nature. This comprehensive interpretation facilitates action against oppressive structures and values indigenous knowledge (Foucault, 1980). Popular education (i.e. participatory education that creates an environment for teachers and students to be co-learners) and the conscientization of oppression are central concepts through the reciprocal exchange between multiple cultural
systems, non-dominant and dominant alike (Freire, 1990). Conversely, formal education in classroom settings is often apart from the lived realities of politics oppression, and social action. Therefore, popular education within marginalized communities is vital and mirrors CBPR, best defined as an “action-oriented research method that involves a team approach inclusive of all participants” (Olschansky, 2012, p. 306).

The balance between action and research in CBPR supports improving the health status of vulnerable and disadvantaged populations that serve as research participants (Berge, Mendenhall, & Doherty, 2009; Kelly, 2009; Olschansky, 2012). I employ a CBPR approach to study the knowledge, perspective, and experience of Cambodian CHWs and promote an opportunity for CHWs to articulate their own definition of health, along with how best to achieve positive health outcomes that respects the needs of Cambodian Americans. Through this community-driven process, critical consciousness may bring awareness to innovative methods that may decrease the barriers to health access. Ultimately, the participants may not only be empowered by their involvement, but the explication of a community voice that reflects and brings attention to those within their communities who experience significant marginalization.

Two vital tenets of CBPR promote raising critical consciousness: first, direct community control of decision-making in the research and second, involvement of the community in the iterative and cyclical process of the research (Hick, 1997; Kemmis & McTaggart, 2005; Olschansky, 2012; Padgett, 2008). Additionally, essential features to maintaining the values of CBPR and changing social structures are a critical understanding of oppression and the hegemonic structure of dominant forces in society (Freire, 1990; Hick, 1997; Kemmis & McTaggart, 2005; Olschansky, 2012; Wallerstein & Duran, 2003). This critical awareness must be developed and shared between the researcher and participants, which translates into co-
constructed concrete action steps as the research progresses. Therefore, the concept of critical consciousness and the methodological framework of CBPR are interwoven, and I aim to address the poor health access of the Cambodian American community through the process of the research and the future actions steps are formalized. This process may ultimately support the foundation for cultural synthesis as theorized by Freire in critical pedagogy.

**Significance, Rationale, and Justification**

The Cambodian Americans’ experience of poor health access in the United States is a complex, multi-faceted problem. The health disparities that Cambodian Americans face in the United States remain immense and there does not appear to be an end in sight. Long-term solutions remain elusive due to the lack of resources for sustained community-involvement in developing effective and practical solutions. Further, any solutions derived without community-involvement may either be ineffective or inadvertently reinforce the problems that exist. This study shows promise for contributing to the knowledge that may improve health outcomes for Cambodian Americans from a community-based approach by including the voice and knowledge of CHWs who remain uniquely positioned to understand the barriers to poor health. The perspective of CHWs as frontline workers has largely been excluded from the literature and the health care planning process. Social work’s commitment to social justice, human rights, dignity and worth of the person, and cultural competence demands attention to and steps toward changing these dimensions (Lundy, 2011; NASW, 2008).

From a critical pedagogical lens, conventional research methodologies may not adequately capture the struggle that Cambodian Americans have with health access. Indigenous knowledge derived from research that is community-based and participatory in design may highlight innovate methods to improve health for this population. The process of this research,
therefore, empowers the participants to not only critically explore their lived experience, but also illuminates new understanding regarding the concept of health access. The CBPR approach utilized in this study shows promise for being an important part of the process toward achieving improved health access for Cambodian Americans. Finally, the methods employed within this dissertation may outline steps that help to align social work research, practice, values, and standards with the indigenous wisdom of communities who experience marginalization in the United States.
Chapter 2: Methodology

Research Design

This exploratory study integrates a community-based participatory research (CBPR) approach with qualitative methodology. I partnered with Khmer Health Advocates (KHA) staff, a community-based organization, on this study. One of the practice priorities of KHA is to address the poor health status of Cambodian Americans. Although there is no simple solution to improving the poor health of this population, KHA staff identified the vital work that Cambodian community health workers (CHWs) accomplish in improving health access and outcomes. There is a lack knowledge in how Cambodian Americans experience health access and how Cambodian CHWs effectively address the barriers to health access. To address these knowledge gaps, I explored the concept of health access through the perspective of Cambodian CHWs. Further, I examined how CHWs’ efforts decrease the barriers that Cambodian Americans face with health access. This chapter outlines the CBPR qualitative approach used in this study.

Community-Based Participatory Research

Research methodologies exist within paradigms that shape the nature of knowledge generation. Lincoln, Lyndham, and Guba (2011) argue that of these paradigms, the participatory paradigm values the primacy of practical and local (i.e. indigenous) knowledge. When utilized from a participatory paradigm, indigenous knowledge can shape how data are gathered and what information is relevant for the research findings and implications. For this dissertation, I employed a CBPR approach that reflects the participatory paradigm to engage the indigenous knowledge of Cambodian CHWs about their work within their community.

CBPR exists along a continuum, from study initiation by the researcher that includes community involvement to community-ownership of the research with facilitative support from
committed investigators (Lincoln et al., 2011). Israel, Schulz, Parker, Becker, Allen, and Guzman (2008) posit nine core principles that often comprise CBPR approaches. These principles state that CBPR:

1. Recognizes the community as a unit of identity;
2. Builds upon strengths and resources within the community;
3. Facilitates collaborative, equitable partnership in all phases of research;
4. Promotes co-learning and capacity building among all partners;
5. Integrates and achieves a balance of research and action for the mutual benefit of all partners;
6. Emphasizes local relevance of public health problems and ecological perspectives that recognize and attend to the multiple determinants of health and disease;
7. Involves systems development through a cyclical and iterative process;
8. Disseminates findings and knowledge gained to all partners and involves all partners in the dissemination process; and
9. Involves long-term process and commitment. (pp. 49-52)

When applying these principles to this dissertation, I negotiated with KHA staff how I could maintain consistency with each principle during the different phases of this research, which includes the pre-dissertation community engagement, the three phases of this dissertation research, and post-dissertation research (see Appendix A).

**A path to the work.** In early 2013, I began my pre-dissertation Cambodian community engagement in the city of Lowell, Massachusetts, which hosts the second highest concentration of Cambodians in the United States and houses significant concentrations of other refugee communities. In Lowell, I sought access to understanding a holistic approach to health care with
Cambodian Americans through the Metta Health Center, a department within the Lowell Community Health Center. The Metta Health Center integrates culturally responsive health care approaches that target wellness in both the mind and body with Cambodians and other Asian and refugee communities. I visited the Metta Health Center and learned about community health work in Lowell. I met most of the staff of whom approximately 70% were of Cambodian descent and more than 95% people of color (S. Peou, personal communication, May 23, 2013). Their work targets multiple determinants of health (e.g., social exclusion, transportation) and the community need for such services remain high in demand. The services that the Metta Health Center provides to their community are not a common experience of health care for Cambodians across the United States. Furthermore, the Metta Health Center staff acknowledge that work to address the pervasive health access barriers (e.g., level of education, linguistic, cultural, economic) experienced by Cambodian Americans requires an ongoing, longitudinal effort that involves community-driven solutions and interventions (Grigg-Saito et al., 2010).

From hearing about these challenges experienced by the Metta Health Center, I decided to broaden my pre-dissertation outreach to understand health access from various community perspectives. To accomplish this, I consulted with experts from different organizations (e.g., Alameda Health System in California; Boston Center for Refugee Health & Human Rights; and Khmer Health Advocates in Connecticut) committed to health work with Cambodians and other immigrant and refugee communities. These conversations shaped my understanding of the similarities and differences (e.g., amount of community engagement, level of organizational involvement, access to funding) in Cambodian Americans’ experience of health access across different geographic locations, along with the availability and variability of community health
work that often was dependent on several factors: population density, financial resources, and targeted interventions.

Over several months of outreach, I recognized that the interventions to ameliorate the health problems that Cambodian Americans experience in different areas of the United States might be contextualized by the access to and type of community resources. Therefore, I sought access to a national sample of Cambodian community health workers to better understand Cambodian Americans’ lived experience of health access. To gain access to a national sample from diverse Cambodian American communities, I invited KHA to be a partner in this research effort.

**A community partner agency.** KHA served as the community partner agency for this study. Located in West Hartford, Connecticut, KHA is a recognized leader in advocating for Cambodian Americans since 1984 (NCAHI, 2007, 2013). Due to their expertise in community health work, KHA staff aided me in explicating Cambodians’ experience of health access in the United States through the voice of Cambodian CHWs. I initiated outreach and a relationship with staff at KHA in January, 2014 with the support of two community researchers that are trusted in the Cambodian American community and who serve on this dissertation committee.

KHA’s advocacy efforts address social, economic, and political inequities for Cambodian Americans, as well as promote indigenous knowledge formation and cultural restoration. Since the early 1980s, KHA has provided direct care to Cambodians in Connecticut, Rhode Island, and Western Massachusetts. KHA also leads the National Cambodian American Health Initiative that includes all Cambodian American non-profit service agencies in the United States. Although small in staff, KHA has partnerships with many organizations both locally and
nationally. Therefore, KHA was a viable organization as a community partner to promote research of health access for Cambodian Americans.

Through initial meetings, staff at KHA agreed to my request for partnership and worked with me to determine a focus for this research. We identified Cambodian CHWs as repositories of indigenous knowledge for the intersection between Cambodian American communities and the U.S. society. Cambodians who practice community health work remain a vital resource and strength in addressing the health needs within their community (Taylor et al., 2013a; Taylor et al., 2013b). KHA served as a bridge to earn the trust of Cambodian CHWs to participate in this study.

Although I met with several individuals who work within KHA, my collaboration for this dissertation primarily included two individuals who work at KHA: Theanvy Kuoch and Mary Scully. Kuoch is the executive director and co-founder of KHA. She arrived to the United States in 1981 as a Cambodian refugee who worked as a health worker in border camps. Scully is the programs director at KHA, co-founder of KHA, and an advanced practicing nurse who served in the refugee camps. Since KHA’s inception, both Kuoch and Scully have been involved in numerous research studies and practice efforts to improve the health of Cambodian Americans. After several planning meetings and discussions on how best to conduct this research, Kuoch and Scully helped me gain access to a national sample of Cambodian CHWs through many introductions and correspondences. Since Kuoch and Scully were representing KHA, I will refer to my collaboration with them as my collaboration with KHA staff.

**Qualitative Research**

Studies have quantitatively examined the cost-effectiveness and impact of CHWs across several states and types of organizations: community-based programs in Arkansas (Felix et al.,
2011), Medicaid managed care in New Mexico (Johnson et al., 2012), and New York health home agencies (Zahn et al., 2012). Although these studies support evidence that CHWs are valuable to communities and U.S. health care systems, less remains known about what CHWs perceive as the health access barriers that plague their communities. For this dissertation, I chose qualitative methods to explore the vital perspectives of Cambodian CHWs regarding Cambodian American communities’ lived experience of poor health access and interventions to improve health access.

To contextualize this study’s qualitative findings from a community standpoint, I developed an egalitarian partnership with Kuoch and Scully. This partnership consisted of active engagement by both KHA staff and myself at each stage of the research that include:

- Constructing the multi-phase research design;
- Development of the research questions;
- Identification of a suitable population for study;
- Participant recruitment;
- Peer debriefing of the research findings; and
- Dissemination of findings.

The co-development at these stages highlights strengths that we each brought to this project: Kuoch and Scully’s vast experience with Cambodian American communities and my experience in public health social work. This partnership strengthened my opportunity to study the concept of health access from an indigenous standpoint.

**Multi-phased research design.** I employed three phases for this dissertation. The first two phases consisted of data collection, while the third included the development of the action steps. Throughout this research, I had multiple meetings and communications with Kuoch and
Scully at KHA, the dissertation committee for this study, University of Connecticut (UConn) Institutional Review Board (IRB), and the study participants. The following describes an overview of each phase.

**Phase one.** This first data collection stage consisted of a focus group that defined relevant concepts, such as a culturally tailored definition of a community health worker for Cambodians, and generated ideas that were constructed into questions that were used in the Phase Two semi-structured interview guide. I applied a public health framework (e.g., multiple causation model, social determinants of health) when facilitating the focus group to broadly understand important concepts (e.g., health, the Cambodian CHW’s role, and the Cambodian Americans’ experience with health access) from the participants’ perspectives. Afterward, I constructed a focus group guide by utilizing the research questions as topic areas and probes to facilitate discussion (see Appendix B). Held at KHA, the focus group occurred during a time and day convenient to those who participated.

**Phase two.** This second data collection stage consisted of sixteen in-depth, one-on-one interviews with a national sample of Cambodian CHWs. Participants from Phase One were excluded from these interviews. I conducted the semi-structured interviews at convenient times and locations for participants through Skype, by phone, or in-person. The mode of conversation was determined by balancing what participants requested (e.g., in-person, phone) and my ability to meet their request. For example, I met with any participant that requested in-person interviews from areas that I could travel to by car from my location in West Hartford, CT, which resulted in a travel radius of approximately 150 miles. If I was unable to reach the participant by car, I arranged for a Skype video or phone interview that reflected what was most comfortable for participants. This phase constituted the majority of the primary data used for the qualitative
analysis and findings. The interview guide for this phase was constructed from the results of the Phase One focus group (see Appendix C).

**Phase three.** Upon completion of the Phase Two interviews, data analysis of the interviews and reanalysis of the focus group was completed to constitute the results of this study. Once these findings were completed, I met with Kuoch and Scully to discuss the findings and develop a plan for future areas of collaboration and research.

**Research with Cambodian CHWs**

In early meetings with Kuoch and Scully at KHA, they conveyed to me that members of the Cambodian American community, similar to members of other marginalized communities, have had poor experience in some previous research studies. They often reported that participants did not experience mutual respect between themselves and the researchers. Additionally, Cambodian Americans have experienced research as a formal process without the beneficial commitment from researchers to improve their communities’ hardships and plight. In alignment to the CBPR approach, I developed a process with Kuoch and Scully to address these concerns. Once I established rapport with the KHA staff, we agreed to the research protocols outlined in this methodology. To reflect this protocol, the UConn IRB Form-1 was completed and approved prior to any data collection.

There were several important decisions made prior to conducting this study. Although study participants are fluent in Khmer, I used English for any verbal or written communication with participants in this study. As anticipated by Kuoch, Scully, and experts on the dissertation committee, the Cambodians CHWs’ English fluency and literacy was not likely to be a barrier for participants due to the nature of their work in U.S. health care settings. Additionally, meaningful recognition of the participants’ time and effort was essential for mutual trust and
respect between the participants, Kuoch and Scully at KHA, and me. Further, the leadership at KHA and I agreed to several process commitments: consistent respect in approaching participants, dissemination of this study’s findings to increase public awareness of the Cambodian Americans’ poor health, and development of an ongoing research agenda to improve health access for Cambodian Americans. Prior to any data collection, all participants signed an informed consent form affirming voluntary participation and the understanding of the study’s protocols and goals (see Appendix D).

During data collection, I worked to ensure a safe, comfortable environment for the focus group and interviews. I attended to the environment by creating a space that would be sensitive to participants’ experience of culture, language, and their emotional, physical, and social well-being. During the focus group, KHA served as a comfortable and familiar location. Throughout the interviews, when possible, I traveled to a desired location identified by participants. When a face-to-face interview was not possible, I ensured that the time of the interview would best serve each participant and their ability to access a space they felt comfortable and allowed them access to either a phone or computer. Several participants experienced some emotional reactivity when being invited to participate in this study and/or during active participation. For example, some participants were initially uncertain about the purpose of this study due to previous experiences with research studies. In those circumstances, I took great care and time to explain the study and answer any questions over multiple points of contact. These multiple points of contact allowed me to establish some trust and rapport. Additionally, I offered participants breaks and shifts in topic when content was emotionally sensitive to previous experiences during the Khmer Rouge genocide and/or their lived experience as refugees. Although I reminded participants that their involvement was voluntary, all who participated chose to remain in the study. Finally,
participants appeared to speak candidly and expressed appreciation of the opportunity to be involved in this study.

Once data were digital audio recorded and transcribed verbatim into MS Word, I removed participant names and used participant numbers to ensure confidentiality. Electronic data were stored in a password-protected laptop and kept within my locked office. In addition to the initial UConn IRB approval, three amendments were completed and approved to reflect changes in the semi-structured interview guide and informed consent forms for the interviews.

**Sampling**

For this design, I employed two sampling stages. Phase One consisted of a purposive sample identified by Kuoch and Scully at KHA. In Phase Two, I employed both a purposive and snowball sample, which were identified by Kuoch and Scully at KHA, participants who completed the focus group or an interview, and my dissertation committee members who have extensive research experience with Cambodian Americans. The inclusion criteria for both stages included: (1) Cambodian and/or combination of Cambodian and another ethnic/racial identity, (2) at least 18 years of age, (3) self-identification in practice of community health worker with at least one year of experience, and (4) fluency in English and Khmer as assessed by Kuoch and Scully at KHA and this researcher.

**Phase one – focus group.** KHA and I chose a purposive group of seven potential participants due to their diverse experience with health access in various settings, work with Cambodian Americans in many different geographical settings, and national knowledge of health care provision to Cambodian Americans. Additionally, they were involved in Racial and Ethnic Approaches to Community Health (REACH) 2010, a multi-year project funded by the Centers
for Disease Control and Prevention. This project funded work between KHA and Cambodian leaders throughout the nation on issues pertinent to community health work.

Of the seven that I outreached, five participants participated in the focus group. I was unable to reach one participant and the other participant was unable to participate due to schedule conflicts. During the focus group, four of the participants were present and the fifth participated by speakerphone. This stage was essential to gain access to indigenous knowledge about health access barriers in Cambodian American communities. Additionally, the focus group also allowed me to gain an insider perspective of Cambodian CHWs. This information was used to construct a semi-structured interview guide for the Phase Two interviews.

**Phase two – interviews.** Upon completion of the semi-structured interview guide, Kuoch and Scully at KHA, participants who completed the focus group or an interview, and my dissertation committee members provided referrals to 21 potential interview participants. From these referrals, I was able to recruit 16 Cambodian CHWs from six states in the United States to participate in semi-structured interviews. Of the five individuals who did not participate: two were unable to be reached by phone or email; two agreed to participate, but never followed through post initial contact; and one person asked for additional information about the study, but did not respond to additional contacts to participate. Of the sixteen interviews, three were in person, one by Skype video calling, and 11 by Skype phone calling. I employed both purposive and snowball sampling during this phase. Snowball sampling is a technique to access a hard to reach population through a referral process that promotes trust between researcher and participant, which also aligns to CBPR. This interviewee sample did not include any participants from the focus group.
Demographics. In total, I outreached to 28 individuals (seven for the focus group and twenty-one for interviews), of which 21 participated, and there was no attrition. Participants lived across seven states: California, Connecticut, Louisiana, Massachusetts, Minnesota, Oregon, and Rhode Island. There were more participants from both California and Massachusetts due to the higher concentrations of Cambodian Americans and the amount of predissertation outreach. I intentionally capped the number of semi-structured interview participants to three from any one specific geographical town/city and one place of employment. This promoted consistency with the purpose of this study: exploring the Cambodian CHWs’ perception of health access for Cambodian Americans across the United States.

Ninety-five percent of participants (n = 20) completed and returned the demographic survey. All participants were foreign-born and the majority of the participants were female. The average age of participants was 48.7 years and the ages ranged from 26 to 69 years (see Figure 1). All participants were fluent in Khmer and English. The majority of participants: had health insurance (95%), had at least an associate’s degree (85%), reported their health as “good” or better (80%), worked full-time in various jobs (78.9%), were female (67%), spent an equal amount of time speaking Khmer and English in their work (60%), and were married (52.6%).
There was a wide variance in household income and size, ranging from living in poverty (~$12,000/year) to having a middle-class income (~$60,000/year) and from one to eight member households. This variance was often dependent on available funding for their community health work and whether or not the participant’s household had additional income from a partner or other household members. The average length of participant experience in the field of community health work was 13.1 years. Of the 20 participants who responded to the demographic survey, this study encompassed a total of 262 years of community health work experience.

* Differences between the focus group and interview participants. Although data from all participants were included in the final qualitative findings, some demographic differences exist between the participants in the focus group and participants (see Table 1). When compared to Table 1.

<table>
<thead>
<tr>
<th>Sample</th>
<th>n</th>
<th>Age M (Mdn)</th>
<th>Years in the United States M (Mdn)</th>
<th>Female M (Mdn)</th>
<th>Years of CHW practice M (Mdn)</th>
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</thead>
<tbody>
<tr>
<td>Focus Group</td>
<td>5</td>
<td>53.6 (61)</td>
<td>33.4 (33)</td>
<td>100%</td>
<td>18.6 (17)</td>
</tr>
<tr>
<td>Interview</td>
<td>15*</td>
<td>47 (47)</td>
<td>27.1 (31)</td>
<td>56.3%</td>
<td>11.3 (9)</td>
</tr>
</tbody>
</table>

*Note: Although there were 16 participants interviewed, one did not return the demographic survey.

Interview participants, the individuals in the focus group were older and worked as CHWs longer. Although everyone in the focus group was female, the potential participant who could not participate due to scheduling conflicts was male. Despite these differences, other demographic dimensions (e.g., health insurance status, years of education, health status, level of employment, income, and members living in the household) remained consistent between the focus group and interview participants.
Role of the Researcher

Although both Kuoch and Scully from KHA were involved in each step of the research activities, I focused my role as the investigator by conducting each research phase within definable academic standards. To ensure academic rigor, I maintained auditable records of the data that I collected and analyzed. Furthermore, since staff at KHA did not collect the data or conduct the analyses themselves, their expertise in peer debriefing of the findings strengthened this study’s trustworthiness and credibility in each data collection phase. Essential to this process was my practice of reflexivity to balance my roles as an academic researcher and partner with the KHA staff.

Positionality and reflexivity. As an outsider to the Cambodian American community, I actively sought methods to ensure that my role as the researcher was reflexive and sensitive to biases that arose during this dissertation. This reflexive stance is paramount in qualitative methodology, which assumes that researcher bias is natural and warrants systematic self-reflection that is continuous and ongoing (Padgett, 2008). To support my reflexivity as a researcher, I maintained detailed field notes before, during, and after the focus group and interviews. Through these notes, I reflected upon how my social, economic, and/or political orientation affected what I understood from participants. Additionally, I utilized memos to reflect upon analytic decision-making processes and for opportunities to enhance the utility of peer debriefing or member checking.

During the course of this study, several personal social identity dimensions became salient to my role as the researcher: a foreign-born Chinese-Taiwanese male who was primarily educated in the United States and raised in poverty, a clinical social worker, and the son of a father who was an undocumented Chinese refugee and a mother who was orphaned at 13 in
Taiwan. Although participants recognized my Asian heritage, I did not discuss my identity unless they asked me to share information about myself. Participants shared some positive reflections about their work and gratitude in sharing their experiences in this study. Overwhelmingly, participants verbally appreciated my intentions and approach to this research project. Their praise and trust in my role as a researcher was possible due to my partnership with KHA staff and expert guidance from my dissertation committee.

My personal social identity dimensions increased my understanding of what participants shared; however, this also developed into personal biases when my personal expectations differed from participant lived experiences. One example of a personal bias is how my positionality and lived experienced in the United States reinforced my anticipation of harsher participant criticisms of the U.S. health care system. Contrary to what I anticipated, participants typically praised the positive aspects of the U.S. health care system and often discussed interventions to improve it without diminishing what this system has to offer (e.g., deconstructing cultural and structural barriers, changing U.S. policies). While employing a reflexive stance, I became aware that my anticipation of this criticism stemmed from my personal experience of someone who: was primarily raised and educated in the United States, grew up in poverty; and had poorer health care access. Through peer debriefing with my dissertation committee, Kuoch and Scully at KHA, and trusted colleagues, I employed several techniques to strengthen my accuracy in understanding participant experiences: open-ended and balanced interview questions; probes during interviews to access a deeper understanding; analytic memos and field notes to track my interpretation; and member checks and debriefing with peers for verification purposes.
Data Collection

Prior to any data collection, I gave all participants information about the study and asked for written consent to voluntary participation. This process took place in one of the following venues: in-person, by mail, or through email. Each form had an assigned participant number that served as a unique identifier. I used this identifier to maintain confidentiality of the participants’ identity and as a record to keep track of participants through each stage of data management: informed consent, demographic survey, digital record of focus group and interviews, verbatim transcriptions, and field notes.

In alignment with the two-staged sampling procedure, the methods of data collection include demographic sheets (See Appendix E), focus group, interviews, and participant screening guides (See Appendix F). The demographic survey was completed in-person, by mail, or by email. Held at KHA’s office, the focus group was at a mutually beneficial time and date for all participants. The focus group met for approximately 73 minutes and I digitally recorded the dialogue for verbatim transcription. The interviews ranged from approximately 35 to 67 minutes in length. In-person interviews were audio recorded by the LiveScribe Smartpen and a back-up digital recorder. I used the Skype application to conduct both phone and video interviews and electronically recorded the audio of these interviews with the Amolto Call Recorder for Skype program. The participant screening guide was used for the focus group and interviews to ensure that inclusion criteria for this study was met.

Each participant agreed to electronic recording during the consent process. Upon completion of any electronic recording, I uploaded data onto a password-protected laptop that was stored in my locked office. After the focus group and each interview was completed, I
logged field notes on any additional information about the process and content of the experience, including observations, reflections, and considerations for data analysis.

**Data Sources**

**Primary data.** The verbatim transcriptions of the focus group and interviews served as the primary data used for qualitative analysis in this study. I purposely selected these sources for analysis so that I could access indigenous knowledge from the participants’ narrative voice. Any additional data that I gathered served as contextual data.

**Contextual data.** The field notes and memos that I collected over the course of this study became contextual data. In addition to my pre-dissertation work in 2013, I also included observations from my attendance at a health outreach fair at a local Cambodian temple where a Cambodian CHW interacted with her community, a community forum organized by KHA staff for the Southeast Asian American community health and wellness, and a visit to the Cambodian Mutual Assistance Association of Lowell, MA. This data helped inform my analysis of the primary data.

**Data Analysis**

For this dissertation, I inductively coded and organized the transcriptions of the focus group and interviews within NVivo version 10. The use of qualitative data analysis software facilitated my ability to employ several coding methods and catalog memos as an audit trail for the decisions made during the analysis. As a whole, this methodical process and trail supports transparency, trustworthiness, and transferability – vital components to any rigorous, credible qualitative study (Padgett, 2008).
Coding Structure and Thematic Analysis

I employed several coding methods in a sequential fashion to promote a holistic strategy for the qualitative analyses in this study. I categorized these coding approaches into first and second cycle methods to strengthen credibility and trustworthiness of the findings. Saldaña (2013) distinguishes these methods by defining first cycle methods as initial coding structures that aid in early stages of categorization, while second cycle methods are “more challenging because they require such analytic skills as classifying, prioritizing, integrating, synthesizing, abstracting, conceptualizing, and theory building” (p. 58). The coding methods chosen reflect several components of this study: (1) the exploratory purpose; (2) the format of the semi-structured interviews; (3) the nature of the research questions; and (4) how the codes informed the different phases within the study.

First cycle. I employed first cycle coding methods at two time points within this study. First, after I completed the Phase One focus group, I used an exploratory method (e.g., holistic codes) to develop preliminary ways to observe patterns and potential themes. As a result, there were 31 holistic codes that generated ideas and topic areas, which I used to develop the semi-structured interview guide (See Appendix G).

Separate from these holistic codes and upon completion of the Phase Two interviews, I coded the interviews and later recoded the focus group using more complex first cycle coding structures. This included four coding methods that are defined with two types of coding structures: elemental (structural, descriptive, and process coding) and literary/language (narrative coding). Each of the coding methods chosen highlight different aspects of the data.

The elemental methods allowed me to capture specific concepts (i.e. structural), important topics (i.e. descriptive), and the sequencing of events (i.e. process). For example,
participants often discussed the impact of the Khmer Rouge genocide on Cambodian survivors and their ability to navigate the U.S. health care system. The structural codes captured how specific topics/events (e.g., Khmer Rouge genocide, French colonization) shapes the concept of health care access. The process codes helped me to formulate the series of events and consequences between surviving the Khmer Rouge genocide and navigating the U.S. health care system. Furthermore, I included narrative coding because I found that participants often shared stories and metaphors to explain their thoughts and experiences. Narrative coding allowed me to apply an interpretative analysis that deepened the texture of the other coding structures.

Using these four coding methods, I devised a list of 121 first cycle codes to organize the data for the second cycle method. To ensure integrity of each coding process, I piloted these four coding methods individually and sequentially to seven randomly selected transcripts. After developing familiarity from coding these transcripts, I found simultaneous coding of these four methods to be more holistic and natural.

**Second cycle.** Upon completion of both first cycle coding steps, I used NVivo to organize the codes within a map that contained relevant domains and sub-domains (See Appendix H). This organization of the code mapping helped distinguish emerging concepts and possible themes between domains and sub-domains, which facilitated my second cycle method, pattern coding. Pattern coding was particularly relevant for this dissertation to explore emerging themes by examining consonant or harmonious codes across participant responses from different geographic locations. This resulted in four domains and one sub-domain for the first cycle codes that I used to develop the semi-structured interview guide. The second cycle codes for the interviews and recoded focus group resulted in four domains and eighteen sub-domains that I used to organize and explicate the dissertation findings (See Appendix H).
Thematic analysis. The pattern codes developed into emergent themes and concepts. I attributed meaning to these themes through the application of several lens: primary and contextual data, field notes, literature review, peer debriefing, and member checking. This resulted in two overarching themes that I discuss in Chapter 3.

Scientific Rigor and Trustworthiness

Analytic quality and trustworthiness promote strong scientific rigor in qualitative research. These standards were achievable through the application of auditability, consistency, truthfulness, and credibility (Padgett, 2008). To ensure the application of these four principles, I meticulously documented procedures and steps that I took so that the progression of this study would be traceable, logical, and replicable.

An audit trail of field and analytic memos strengthens the auditability of this study. Memos are detailed notes that a researcher uses to clarify and articulate methodology, enhance reflexivity, strengthen rigor, improve analytic quality, and contextualize findings (Birks, Chapman, & Francis, 2008). I kept detailed notes that helped me reflect upon ideas generated after meetings, data collection, and any observations in the field. For example, in the early stages of data collection during the Phase Two interviews, I noticed a positive and linear association between Cambodian Americans’ ability to navigate the U.S. health care system and desire to know more about their health (i.e. the higher ability to navigate the U.S. health care system, the higher individual desire to know about their health). Over time, however, I gained deeper awareness by utilizing analytic memos to reflect upon forces (e.g., fear, disempowerment, CHWs) that moderate this association. In sum, this process resulted in 32 unique field notes that ranged from one-half page to up to four pages of typed, single-spaced MS Word documents. Several of these documents originated from handwritten notes that I transferred into electronic
format to enhance organization of relevant information. Additionally, I developed 20 analytic
memos during the process of data analysis to guide my analytic and decision-making process.

Trustworthiness and credibility are essential to strengthen the rigor of data collection and
persuasiveness of the analyzed findings. I employed peer debriefing and member checking
strategies to strengthen these trustworthiness and credibility (Padgett, 2008). Peer debriefing
occurred with KHA staff and two experts on Cambodian CHWs after the completion of the
Phase One focus group and the construction of the semi-structured interview guide questions.
Upon completion of the analysis of the Phase Two interviews, I again peer debriefed my findings
with the KHA staff to promote truthfulness and confirmability. Additionally, member checking
promotes credibility between collected data and reported results. All participants confirmed their
willingness to be contacted for any follow-up after I collected data in either Phase One or Two.
During the process of data collection of the focus group and interviews, I member checked with
participants to verify accuracy and confirm findings when I experienced uncertainty in content or
interpretation of what participants discussed.

Summary

For this study, I employed a CBPR approach to explore Cambodian community health
workers’ perspective of health access for Cambodians in the United States. Qualitative methods
were used to explore this study’s research questions. In partnership with KHA, a multi-phased
research design was developed and used to collect data from a focus group of Cambodian CHW
key informants, semi-structured interviews with Cambodian CHWs from several states, and field
observations. The CBPR approach was ideal to gain insider perspectives from Cambodian
American communities and explicating indigenous knowledge culminating in the development
of a plan for several actions that could be taken to improve Cambodian Americans’ access to health.
Chapter 3: Findings

This study’s aims include: (1) gain a deeper understanding of Cambodian Americans’ health status and their experience of health access from the perspective of Cambodian CHWs; (2) build knowledge and critical analyses of the interactions between Cambodian Americans and the U.S. health care system; and (3) identify action steps to improve health access for Cambodian Americans. Expanding upon the themes of Cambodian silence and invisibility from previous studies (Nhek, 2014; Tucci, 2015; Wallitt, 2008), the findings of this dissertation illuminate how silence and invisibility remains prominent in the present day lives of survivors of the Khmer Rouge genocide. These experiences are further reinforced within the United States by institutional systems (e.g., health care, education) and their dominant cultural values (e.g., individualism), along with poor access to resources (e.g., stable employment). Furthermore, healing from the experiences of the Cambodian genocide may require a synthesis between Cambodian and the mainstream culture in the United States that span social, economic, cultural, and political dimensions.

In this chapter, I present the findings of the semi-structured interviews and focus group related to the five research questions through the lens of two themes that emerged from the data: silence and invisibility in two cultures and a holistic approach to healing. These themes allow the reader to delve into the Cambodian Americans’ experience of health access in the United States from the perspective of Cambodian CHWs who participated in this study. Subthemes within each overarching theme explicate the dimensions that constitute the lived experience of Cambodian Americans regarding their health and experience of health access.
Silence & Invisibility in Two Cultures

Cambodian Americans live within two points of reference: life in Cambodia and living in the United States. Although common for many who migrate to the United States from another country, this lived experience has unique meaning for Cambodian Americans and their access to health. Participants in this study attributed their community’s poor health status to the silence and invisibility they experienced during the time that the Khmer Rouge came into power and the subsequent decades of broken bonds to their ethnic roots, culture, and indigenous resources. Participants identified how silence and invisibility has longitudinal impacts and continues to affect multiple generations of Cambodian Americans, including current youth. There are similarities and differences in how Cambodian Americans experience silence and invisibility across generations. Participants spoke about their experience of this phenomenon and the lasting effects that silence and invisibility have had on the health trajectories of Cambodian Americans in the United States.

A context of Cambodian culture and health. The Cambodian culture is rich with customs and practices that reinforce healthier living through familial and community relationships. Many participants described how they and others strengthen the health of their community through Khmer dance, music, and food. These activities often celebrate events (e.g., the Cambodian New Year) and promote bonds within a community. These Khmer practices are salient to a culture that values community solidarity. One participant described how she organizes communal events that improve community solidarity, which in turn strengthens individual health and self-worth:

We get together, you feel proud and you tend to try to take good care of yourself when you make each other happy. We’re going to take good care of ourselves. When we meet
each other, we laugh, we eat, we dress up very nice, we dance, we get together and do potluck….It’s the way of showing off our talent and what we can do, and that adds to our self-esteem also.

From this viewpoint, health is a reciprocal relationship between individuals and their community. In other words, the communal bond is a conduit through which individuals commit to their self-care and care for others. Another participant highlighted this interdependent experience of health, “Helping you is helping me. Both sides benefit.” Further, participants often shared how this interdependent experience is antithetical to the social isolation many Cambodian Americans experience in the United States.

The roots of these cultural practices stem from generations that pre-date the Khmer Rouge regime. A participant described her childhood in Cambodia with deep fondness as a time when people cared for each other and could trust one another:

The culture that I grew up with is really very kind. Everybody care[s] and [is] involved with each other. And we don’t have to know [a] person, but when at meal time, you sat and ate; the person who pass by, you say, “Hello.” If they say, “hello,” then they are your friends already. So, you come [and] eat. It doesn’t matter [if] we have meal or not [for them], we share [and] we eat together. We’re very caring and giving people. And, [I] remember that time [in] 1960, I was less than 10 years old. Eleven at night, I went to the movies all by myself. It was very, very safe. We looked out for each other.

Her experience was common for other participants raised in Cambodia prior to the late 1960s. When she spoke of her childhood and experiences in the 1970s, her narrative and voice moved from fondness to coldness. Her exemplification of a familiar adage transformed into an experience that held far less compassion, “It takes a village to raise a child, really. And that’s
my [childhood] and then things changed a lot…A lot of trust before the Khmer Rouge.” During the 1970s, the experience of collective health came up against a more basic health need: survival.

**Cambodia, the Khmer Rouge, and a path toward survival.** The effects of the Vietnam War, the civil war in Cambodia, and the Khmer Rouge genocide on Cambodians are many and severe. Participants spoke of how these longstanding effects impact the health of Cambodian American communities today. A second generation male participant shared his experience in working with elders, “They’ve [elders] been through the war, starvations, the camps…they are not in good health…and so, they have some chronic disease like diabetes, cholesterol, [and] high blood pressure.” In addition to severe health conditions, these historical events reinforced fear, mistrust, and shame. During the interviews and focus group, many participants identified these feelings as common reactions of Cambodian refugees. One participant who arrived to the United States as a female refugee in her late-twenties described what she witnessed during the 1980s:

> When [the] first time someone came in the first ten years [to the United States], when I came, we [Cambodians] don’t think [we’re] close. We kind of isolated ourselves. We didn’t want to contact anybody because of the depression of what we’ve been through, we didn’t have trust amongst each other.

In a different part of the United States, another female participant who arrived in the 1980s as a refugee in her early thirties shared something similar:

> [The] majority of the community [have] been through the Khmer Rouge and [are] always having problems.…they don’t want to join or participate in any meetings and they don’t tell the truth, they don’t speak up, they [are] kind of hiding their problems.
One female elder participant described how the historical trauma that she experienced continues to affect her today:

They still have it [referring to trauma and depression from the genocide], even if it’s thirty years [later]. I still have it. I feel like, I’m doing well, I have a good job and I have my community support, but what happen[ed] to me a long time ago, it never go[es] away. I can cope, I go on with my life, but the feelings [are] still there. Once in a while, I feel bad [in reference to trauma]. Every time on the [triggering] events, the atmosphere, the sense, especially winter, or when it’s raining. You go back to what you went through at that time. It’s still scary. And my brother, too, who came here. He’s a very successful man, very educated, he still have [trauma] once in a while. It’s there.

Contrary to the indigenous value of strong relational bonds within Khmer culture, many Cambodians survived through silence and invisibility during the height of the Khmer Rouge regime. These experiences continue to affect Cambodians who lived during this time.

Of the many survival mechanisms that Cambodians employed during the 1970s, silence and invisibility became not only essential, but also a uniquely devastating phenomenon for Cambodian Americans and their health. An elder participant who survived these times and lived in the United States for over thirty years shared her reflections on how this phenomenon affects the experience of health access for Cambodian Americans:

Cambodian[s] have been brainwashed during the Khmer Rouge…they have been in the concentration camp[s] for three years, eight months, and 24 days. And during that time, the Khmer Rouge had said to keep you is no gains, to lose you is no loss….In order to survive, you can’t say anything at all. If you say, you die. So, when they came to this country, it was totally the opposite. One, they lost resources overnight…the Cambodians
lost their own resources. Second, besides [the fact that] they cannot speak the language [English]… the brainwash continues in their mind. They cannot, they won’t talk. [During the Khmer Rouge genocide] if they talk[ed], they die[d]. In the United States, if you don’t talk, you die.

The “brainwashing” described refers to the cognitive, behavioral, and emotional reinforcement by the regime, aimed at dissolving relational ties to life in Cambodia before the Khmer Rouge came into power. The Khmer Rouge used a faceless concept known as “Ankar” to embody a uniform political identity for allegiance and relational ties between all Cambodians and the regime (Form, 2009; Ly, 2015; Schmetzer, 1998). Individuals who were found to oppose Ankar were “declared an ‘enemy’ opponent of the revolution” and were often “interrogated and tortured,” and eventually killed (Form, 2009, p. 892).

When Cambodians fled from the Khmer Rouge, their path to survival in border refugee camps and the United States was filled with hardship and danger. Many families who already experienced separation continued to experience fragmentation, and bonds to their country of origin were broken. One survivor described this experience:

Trust has been broken during the Khmer Rouge because [of] what they said, you no longer belong to your clan or anybody, and then when you came to the [refugee] camp [and] with immigration, that’s another fear, distrust with immigration. Because they [United States] treated the Cambodians like the aliens and they didn’t give them no respect and they give another trauma that Cambodians went through.

Another participant recounted her story of fleeing Cambodia and how family separation was a common experience for many in her community who survived during this time:
My second son that was separated [from me occurred] when he was two years old. [When] fleeing to the border camps, I had to leave him behind with my niece and we [the participant and her daughters] need[ed] to move on to the border camps and we [the participant and her son] got separated. Until he become 12 years old is when we got him back, to here in the United States.

One essential survival mechanism for many Cambodian refugees came in the form of remaining silent and invisible to anyone with power. In the United States, however, these same survival mechanisms reinforce high levels of social isolation and increase barriers to health access.

**In the United States.** According to the perspectives of the Cambodian CHWs who participated in this study, Cambodian Americans’ experience of silence and invisibility affects their health access in several ways. First, the dominant U.S. cultural values of individualism often overshadow the indigenous communal values of the Cambodian culture and its practices. When this occurs, Cambodian American communities become more segregated and invisible. Second, the impacts of the Khmer Rouge genocide and subsequent survival through refugee camps and migration to the United States on health and health access remains insufficiently understood by many in the mainstream U.S. society. Third, U.S. health care systems are often ill equipped to address the unique needs of Cambodian Americans. Each of these subthemes contribute to Cambodian Americans’ poor health access and sustain longitudinal poor health outcomes.

**A people divided.** One male Cambodian CHW described the experience of Cambodians when they enter the United States and its culture, “Moving from Cambodia to here, you’re being taught to serve yourself mostly, and I’m not saying that that’s a bad thing, but looking into helping the community and helping the people that you’re here with [is not common].” From the
perception of participants, this experience of the U.S. culture reinforces the isolation and mistrust that Cambodians experienced during the Khmer Rouge genocide and drives deeper wedges between Cambodians and their indigenous communal roots. Participants described how this wedge further segregates Cambodian Americans from each other and the Khmer cultural value of the communal bonds that reinforce healthier living. Participants described their complex experience in working with Cambodian Americans who desired to remain invisible within the United States. Despite differences in education and employment status, participants also identified a common thread of mistrust for Cambodian Americans who experience isolation:

[The United States] want[s] to take control of me, that’s why they [U.S. Census Bureau] want the [demographic] information. That’s from the uneducated one. From the one that live[s] in [west coast city], like a frog live in the pit in the well, it sees the opening, sees the sky and the world as big as the opening of the well, because they live in so deep in that darkness and if I spoke with the well-educated one, the one that work, that get [the] paycheck, but they don’t want to participate. They said, “The government just take money from my paycheck, you know? I file tax[es], I pay tax[es] every year, I work to death to make ends meet, and yet, they take all my money, and use that kind of money to do such thing that [do] not benefit me; don’t give any benefit back to the taxpayer. Try to help someone that the state live on government assistance and they do something that not benefit to us that work to death, trying to get a paycheck to live from paycheck to paycheck.”…They still don’t understand, so I cannot make them believe….But as a Cambodian, we need not only live your life, but yet you need to make a difference in our community, we need to help those in need.
The division between Cambodian Americans reinforces social exclusion, a key social determinant to health (WHO, 2003a).

*The legacy of the Khmer Rouge.* Cambodian Americans who are survivors of the Khmer Rouge genocide continue to experience the effects of trauma today to varying degrees. One participant shared what he often hears from community members, “Oh, I worry a lot. I don’t sleep a lot. I think a lot. I keep dreaming about my cousin or dreaming about my mom or dad that passed away.” This traumatic experience is also true for those Cambodian CHWs that have lived through the Khmer Rouge genocide. Another participant described how her survival experience parallels the experiences of others in her community:

My experience...[the] PTSD that I have, it’s hard for me...I live in that life for so long, until almost 2003 or 2002, when I stopped having that nightmare...that I have that fear inside of me, because all [of] that is very miserable. For a mother that left and separated from her two-year-old son, it’s not that easy [to] manage. And plus, I dunno [sic] which way I should do, because I need to live the way it is, because I cannot leave my three daughters over here [United States] and go back to Cambodia for that one [son]. That [is the] way I need[ed] to struggle to live the life that it is, take care of the three over here, and keep working to get my green card so that way I can petition him [two-year-old son], by sending money for them [family remaining in Southeast Asia]...another reflection for me, like I see myself, my problems is a mirror as well as the community that also have some similar problem[s]. I always think, “Hey, [it’s] not only me who [is] facing this...that on the mirror, [I] put my problem in the mirror and see that problem. But that mirror is also facing the community I live in, which is the Cambodian community.” Then I can see [that] other people have the same problem.
Another participant described her survival experience that strengthens her unique perspective of her community’s history and the legacy of trauma that affects her health and struggles:

I have diabetes for 15 years or 20 years and…my husband got killed, my family [were killed]. Forty-seven members [of my family] get killed in Cambodia and my son is kept away, nobody was able to talk with him, but I have such PTSD.

From a different generational perspective, a younger participant shared his experience in working with Cambodian Americans as someone who was some distance from the direct effects of the genocide:

I’m not born during Khmer Rouge, I didn’t know anything about my people. I know about my people, but I don’t know their real lives….Until I have been through work for two-and-a-half years for [a Cambodian community-based health organization], I go see [them] and I felt really sad….You have to be patient…some people that you call, they don’t even want to see you. They feel like, they don’t want to tell you the truth. They feel embarrassed to tell you what is going on in their lives.

The ongoing shame that many Cambodian Americans endured and continue to experience reinforces their invisibility and silence in the United States, which compounds their experience of social exclusion.

*Experience of the U.S. health care system.* Several participants described how some Cambodian Americans’ view of Western medicine stems from experiences with French colonization and health care systems within urban areas that often treated individuals with wealth and public status in Cambodia. “Modern medicine” is typically viewed as highly valuable, but often out of reach for the common Cambodian survivor. One participant described the historical experience of Cambodians:
Cambodia was under French colony for over 83 years [1860s – 1950s]. And during those times, we believe in the foreign kind of medical care system, because [of the] French [colonization, they] introduce[d] the French medical system into Cambodia, so the French medicines and everything influenced Cambodian[s] centuries ago. People believe in those kind of medicines because it helps them treat their sickness so quickly and efficiently and effectively. From then on [and] even now in Cambodia, [when] we treat medicine with French writing, they think [it] is the best!...They trust the French medical system.

The same participant continued to explain how this experience shapes Cambodian Americans’ view of the U.S. health care system:

That’s why when they [Cambodians] come to the United States, they also believe in this kind of foreign medical system, because they learn about heart transplant, they watch TV and they knew their friends who got kidney transplant and heart transplant, or inner organ transplant, and things like that, and they’re still alive for some certain years. This kind of thing never happened in Cambodia, because if you [have] problems with your heart and you went to see the doctor, you’d die just a few months after. They knew that a lot of people live longer, even if you got cancer. So, the information about better treatments from TV, newspaper, and also community events about this modern health care really make them believe [in the] foreign kind of medical health care. Influence is from the French colony and also the French medicine in, in Cambodia back in 1800….So it’s those two experiences, the colonization experience they had from France and now, when they see specific interventions like surgical procedures or organ transplants, things that seem very magical or very powerful, they think of that as Western health medicine.
These experiences shape expectations and assumptions about the U.S. health care system (e.g., the power of Western medicine), which adds complexity to Cambodian Americans’ perception of their access to health (e.g., Western medicine should be able to successfully treat any ailments to the body) and strengthens the perceived authority that U.S. health care providers possess in health care settings. This perceived authority may fortify the power differential between U.S. health care providers and Cambodian Americans as patients.

Consistent with how the U.S. health care system systematizes treatment of one’s physical health, several participants share the difficulties in applying Western models of mental health treatment to Cambodian Americans. One participant shared her experience as a community health worker employing Cognitive Behavioral Therapy (CBT) approaches at her workplace:

My challenges...sometime, I say with clients, “You need to come every week so we can do, you know CBT...and it’s twelve sessions or whatever.” It hasn’t really worked that way (laughs). That’s my challenge, but I think that I need to let go some of that, and be where the client is and support them and provide them with what they need, and what they feel that they come in for. That’s their [Cambodians] goals and our [the agency] goals might be a little different. [And if I have to choose,] I need to go with their goals. This mismatch between goals and interventions may strengthen the barriers to health care access through the dimensions of accessibility, acceptability, and accommodation (Penchansky & Thomas, 1981). Another participant described her personal experience in receiving mental health treatment:

I came to a counselor too. I went, but it didn’t help. It’s an American counselor, but it doesn’t mean that he doesn’t know anything or [what to] ask, it’s just we [Cambodians] have [a] different mentality, [a] different culture. I wouldn’t tell him whatever happened
to me secretly, you know? We [Cambodians] never tell them [Western mental health providers] anything. Maybe he asked me certain questions, I just cry, but the more I cry, the better I feel. But I didn’t go, I didn’t go see him more than three or four times, then I quit and I came back to start to help myself because I feel that if I don’t help myself, then nobody can [help me].

In addition to psychotherapeutic services, one participant described the role of psychiatric medication compared with cultural approaches to healing:

[If] you want to treat someone who has nightmares every night and then you would just prescribe some medicine, [but] the medicine itself doesn’t really help us, you need to understand the cultural aspect of their [Cambodian] tradition and then you also need to really balance that all together, right?…So the way you treat me, should also be tailored to understanding my tradition and culture, otherwise, you would not really treat me properly. Appreciation of our culture and tradition, alongside the modern medicine would be very effective and helpful.

Due to the high comorbidity between physical and mental health issues, many participants described conflicts for Cambodian Americans between affordability, acceptability, and treatment adherence. A female participant with over 20 years of experience in community health work shared what she witnessed of these three factors in health care settings:

They [Cambodian Americans] feel like every time they go see a doctor, they get more medicine to take on top of whatever they are taking. Honestly, they probably [are] not taking everything they were prescribed, especially the physical health medication and their mental health medication, so they have to choose and pick which one is most important.
These health care access barriers between Cambodian Americans and Western mental health care treatment create distance between Cambodian Americans and mental health providers, which may lead to and reinforce mistrust.

One participant described why trust is essential and how she initiates trust through an engagement strategy (e.g., giving compliments) central to traditional Khmer culture:

And when they trust you, they feel better. And they feel, “I’m not alone.” So that’s how I do [my work] when people have emotional issues, you cannot distance yourself from them to the counselor, it’s just not work[ing] for them. It didn’t work with me….My first effective strategy is to give people compliment[s]. Before you get into anything, it helps me a lot, but it helps most of the time, 99% of my case[s].

A male participant with just over two years of experience highlighted a link between trust and shame derived primarily from the historical trauma of the Khmer Rouge genocide:

You have to be patient….They [Cambodian Americans] don’t want to tell you the truth. They feel embarrassed to tell you what is going on in their lives. You gotta build a lot of trust, trust is very, very important to this community, because [of] what they’ve been through….I’m sad to say that Cambodian people don’t want to say they are Cambodian [because of the Khmer Rouge]. That’s how sad it is.

The combination of historical trauma and difficulties in navigating the U.S. health care system perpetuate poor health and barriers to health access. Many participants described how this process culminates into a lived experience enveloped by fear.

Participants often explained how fear compounds feelings of helplessness in addressing health concerns. Several shared how some of their own family members and community members avoid going to seeing health care providers in fear of being told something negative
about their health. One participant explained his knowledge about these experiences from a personal standpoint:

He [participant’s father] has never even gone to a hospital for medical checkup for 40 years in a row, never even once because if he goes to the hospital, he’s sure that the doctor will find a lot [of] health concerns in him. So to him, knowing that he’s sick [is] more serious than not knowing it. No news is good news to him.…That kind of sentiment is well shared among a lot of Cambodians.

This same participant further elaborated on how medical exams and procedures further decrease community members’ motivation to follow through with recommendations due to the complexity of Western health care. This complexity is further compounded by concerns of financial cost.

So, people don’t want to go [to medical appointments] at all and the moment you hear the words from the doctor, the moment you never have a good sleep anymore, because you say, “Oh my goodness, if I am sick, what happen if I don’t get it treated?” But you don’t really have money to get it treated. That’s why people ignore this.

Another participant shared how fear may often remain hidden unless it is uncovered over time and through community health work:

For example, you’re talking to a lady about taking her medication, and…she gets home, she’s not doing it. When she comes in front of you, she will say she’s doing it, but it takes a lot of time to find out, “Oh, I’m afraid of this, I’m afraid of that.”

The many factors that reinforce the experience of silence and invisibility for Cambodian Americans contribute to their current health status and barriers to health access. Participants described that successful efforts to address these factors require a multi-dimensional approach that honors a process of healing and synthesizes the Khmer and U.S. mainstream culture.
A Holistic Approach to Healing

The Cambodian CHWs who participated in this study confront these complex dynamics identified above by integrating their knowledge of Cambodian culture and history with strategies to navigate U.S. institutions. Further, participants discussed strategies that targeted the social, economic, political, cultural, and historical factors that affect the health of Cambodian Americans. Addressing these factors contribute to a holistic approach that improves health and wellness.

The Khmer concept of health. Participants frequently spoke of health as a reciprocal relationship between individual and community wellness, which includes one’s family. The Khmer concept of health expands beyond identifying and treating disease and illness. They defined health with the following words: “mind-body-spirit,” “holistic,” “financial,” and “emotional.” One participant described the Khmer concept of health in the following words, “I think health to Cambodians is a very comprehensive idea. I think everything is involved with health: your spiritual health, your mental health, and your body…[it] is not separated.” Another participant shared her thoughts, “I don’t think many people [in the United States] make the connection between the physical health and mental health.”

Participants also defined health through activities of daily living and social connections that include relationships, employment, daily tasks, community participation, physical activity, and family relationships. One middle generation, male CHW described his understanding of these factors that contribute to health, “Health right [now] is the most important [thing] in our communities. So when you’re healthy, you can work [and] you can make money. You can support your families.” A female, middle generation participant confirmed this viewpoint, “To them [Cambodian Americans], the majority of them, I think as long as they can get up and go to
work and their physical activity is normal, to them, that’s healthy.” The social connections capture the reciprocal relationship of health between community members, including CHWs:

I’m glad that I’m take part of my community’s [health work]...I’ve never dreamed of [doing this work] in the past, I’ve always think, “Okay, I’m not going to work with my community, I want to isolate myself.” But now, for these 14 or 17 years, I love my communities.

Another participant described the meaningfulness of this reciprocal healing experience by stating, “To heal you is to heal me. When I help, I give support [to my community] that makes me feel good, like I did something good to the society and [my help is] not wasted.”

**Current health status.** Participants distinguished similarities and differences with Cambodian Americans’ health status within three generations of Cambodian Americans (elder, middle, and younger) that aligns with descriptions found in current literature. According to participants, many social determinants reinforce the poor health status of Cambodian Americans across each of these generations, including economic hardship, culture and language conflicts, stress, social exclusion, lower levels of education, unemployment or underemployment, poor access to health foods, and poor transportation access.

The Cambodian CHWs reported that they often witness current and future generations of Cambodian Americans experiencing a reciprocal cycle between the consistent difficulty in improving the determinants to their health and the longitudinal effects of poor health. One community health worker highlighted how he saw these long-term effects on Cambodian youth, “If more programs or research can [be] put into the elementary level…[because] at that early age, you can also witness some problems that can grow to be bigger over time.” This participant continued to share how he views the value of early childhood interventions and the potential
longitudinal impacts to healthier outcomes by improving success in early educational settings that strengthens access to employment opportunities as these youth develop into adulthood. Participants described a multitude of programs (e.g., health promotion and education, culturally tailored parenting in the United States, environmental awareness) that aim to improve health through interventions at the community level. In these examples, participants delineated many barriers to health access.

**Barriers to health access.** In addition to individual dimensions (e.g., citizenship status, level of education, language, gender), health conditions are exacerbated by a long host of determinants that range from social experiences (e.g., isolation, violence within homes or in the community), economic conditions (e.g., poverty, unemployment, unstable housing, need for fuel assistance), and physical aspects of the environment (e.g., pollution, poor access to fresh and healthy foods). Of these, the three most frequently discussed barriers to health access that participants identified include lower levels of education, poorer economic conditions, and difficulty with health care navigation (e.g., language, education, transportation).

**Education.** Education remains a significant health access barrier for Cambodian Americans. Participants often commented on how most Cambodian elders who survived the Khmer Rouge had less formal education. A participant in her mid-forties described how education plays a significant role for both health access and status:

Let’s just talk about my parents’ generation first. So they lived through the killing fields, and the educations are very limited. The majority of them did not graduate from high school, so literacy is a problem. So I think that health status is a lot worse than my generation [middle generation].
Another participant described how lower levels of education impact health care decisions for middle generations of Cambodian Americans.

To [get them to] take their regular medication, some of them are lacking education and understanding. Let’s just say you have a mom who brought a child who is sick and then the doctors say, “Here is some antibiotic. You should have the child take it for 10 days. You should take it for 10 days.” But if they [U.S. health care providers] don’t provide them [Cambodian Americans] enough education about the 10 days [of] medication, the mom may stop [when the medication] work[s], “My child is feeling better, why should I keep giving him or her the medication?” So they may stop. So I think education is very important at different levels.

Finally, a participant reflected about what he witnessed among Cambodian American youth and their challenges within the U.S. education system:

I think sometimes when we wonder why our [Cambodian American] students are not focusing or paying attention in class...not doing their homework, I think a lot of the [U.S.] teachers that we have now don’t understand that [the experience of Cambodian American youth] clearly enough. I think of all the things on the child’s mind and I think that everything that upsets them, their mental health and well-being...we don’t see it enough.

This participant discussed in detail the reality that many Cambodian American youth face in their homes and communities (e.g., poverty, violence, trauma, stress) that often remain invisible to U.S. educators. This invisibility compounds the challenges that Cambodian American youth face within the education setting, which translates longitudinally into poor access to both healthier living conditions and improved economic conditions.
**Economic conditions.** Cambodian Americans continue to face significant economic hardships. One participant estimated their experience of this economic hardship in Long Beach, California:

At least 45% of the Cambodian population in Long Beach that [are] facing the housing problem and having problem access [health] care and also get some support for food, to live healthy life by having enough food, enough money to spend for food or otherwise they need to use...just to pay rent.

Participants described how poor economic conditions and challenges to stable employment affect Cambodian Americans’ ability to navigate how best to meet their basic needs. A participant shared such an example:

A few weeks ago, I saw a woman that I help. She became unemployed, she couldn’t get a job, [and] she have young children….She came for help, to really help her about fuel assistance, not getting unemployment, needing to look for job, she didn’t have enough money for her housing or her gas and heat. So I help her understanding the paperwork, understanding to get the fuel assistance, you have to fill out, you have to have the proof of income, the proof of when she becomes unemployed, how much, money she have and how many children she have.

Cambodian CHWs easily understand the relationship between health and economic conditions. Another participant reflected across many years of experience in working with Cambodian Americans:

Speaking of the clients that I’ve worked with, including youth and adults, I think that one thing that I see a lot is that health in terms of physical, financial, [and] emotional. A lot of the stressors that they have or the things that cause them to [have] a lack of financial
stability and just having a decent amount of support, or the families struggle to find a job, or jobs that are stable, this contributes to not working in [a] healthy environment and not working in a healthy lifestyle.

Stable and adequate employment is difficult for many Cambodian Americans across different generations. Another participant described what she viewed as common for both older and younger generations of Cambodian Americans:

[There are those] who are having a hard time to get a job or it’s taking a lot [of] time to get a GED. And the job here is getting less....So, if you don’t have the job and the commercial insurance, the way your health might be different, because people who came to the [urban city in the Northeast] area, or even the [another urban city in the Northeast], it was that they were able to get jobs and even though the[y] [were] manufacturing jobs, they [Cambodian Americans] were able to support themselves or support their family. In the past ten years, I have been having a lot of elders who come to me because they are looking for job because they cannot get a job.

From this experience, stable employment affects not only their health access, but also overall health status.

Many participants described how employment serves several functions: economic stability, ability to afford health care, physical activity, sense of self-worth, and a role within the family and community. One participant described the importance of employment from a cultural standpoint, “When they [are] working, they feel like they are productive, and able to provide for the family.” With ongoing economic hardships, Cambodian Americans are particularly vulnerable to poor access to health and worse health outcomes.
Health care navigation. Many Cambodian Americans experience difficulty navigating the U.S. health care system. This difficulty is compounded by many determinants (e.g., language barriers, cultural conflicts, poverty, and transportation issues) that affect their ability to access health care. Participants contextualized the complexities for Cambodian Americans in navigating the U.S. health care system. An elder participant described her experience with health care navigation in the northeast:

With any limited English-speaking communities and even folks who do understand English…our [the United States’] health care system is very complex. So just from start to finish, just making that appointment, going to that appointment, understanding what’s need[ed] as follow-up, then following up, then the transportation, going from A to Z is a barrier for a lot of our community members who are sick or older.

Another participant explained some of the complexities of health care navigation in more detail:

They [Cambodian Americans] need translation or interpreting to understand the health system, to understand you have to book appointment[s], you have to get health insurance, there are certain medical conditions that is helped by the primary care doctors, but if there are other health conditions that might need to be helped by specialist[s] or requesting [a] primary care doctor to refer to specialists.

A younger generation participant described his experience in another U.S. state:

There is not proper transportation and they [elders] rely on their children to transport them to the hospital, but [the] children are busy, they cannot go and wait for you for [a] few hours, until you got your medical checkup done.

The complexity of the U.S. health care system is an important component that underscores a larger phenomenon for Cambodian Americans: the relationship between trust and healing.
To highlight this relationship, participants described several aspects about how Cambodian Americans experience the U.S. health care system. First, participants described how older Cambodian generations grew up with poor access to affordable modern health care systems and “are not accustomed to health care, prevention, or any of the health care system that is being offered here in the U.S.” Due to this lack of access, Cambodian Americans typically sought health interventions only when they experience debilitating symptoms, which one participant’s quote exemplified of what their community members often say, “If I have no symptom of any kind of illness, why do I need to see anybody?” Second, they utilize traditional medicines, often containing natural and/or herbal remedies, due to familiarity, trust, and access. Third, although Cambodian Americans may hold high opinions of modern medicine, they experience more fear with the U.S. health care system than traditional healing practices due to less familiarity and their perceived lack of control in being able to change health problems identified by doctors. One participant shared her knowledge about this phenomenon:

[What is] different is that we [Cambodians] don’t have preventive care from our culture standpoint, we only go to see a doctor when we are sick….From my experience working in the community, we [CHWs] have to find out what’s wrong with us [Cambodians] because we [Cambodians] believe that if you don’t find out anything about your illness, then you [would] be better off, because if you find out about your illness [and don’t know what to do], then you will be scared. And that anxiety will even hurt you more because of what you know about your health.

This phenomenon brings a unique perspective to the euphemism, “ignorance is bliss.” Many participants described that their community members have a strong desire to know and learn more about their health when they are less afraid, trust the source, and have the ability to change
any identified problems. Instead, many community members often desire to know less about their health because they experience so much helplessness in navigating the U.S. health care system.

**Cambodian community health work.** The participants in this study shared many examples of their efforts to address the current health status of their communities and the barriers they experience with health access. Their work illustrates how they address their communities’ experience of poor health status and health access. The common foundational elements that emerged across the various examples of community health work include cooperation, flexibility, creativity, commitment, patience, and trust. One participant described her work:

> It takes a lot of explanation and education and outreach to the community to sort of keep doing the same thing for years and years and then sooner or later you will get some kind of result. But don’t expect a result within one or two years during your educational effort[s] or strategies or activities, because it takes a long time because the community is less literate than any other community, there’s a lot of mistrust, toward…outsiders.

From one participant standpoint, trust is an essential concept that “breaks or makes our people in the community.”

Although the participants of this study shared many identity dimensions with their Cambodian communities and would often consider themselves as insiders to their community, they were also careful to acknowledge that their status as CHWs required constant negotiation and efforts to build trust. One middle generation, male participant shared how he views his role as a CHW:

> You have to have a person who is committed to having their heart inside the community and be willing to take in a lot of extra work and extra emotional feelings that come with it.
as well. So it’s a lot of services, projects, programs, and everything else that are sort of in a box of a community health worker.

A male participant who has worked within his community for a couple of years noted, “I think it took some time to get to know the population and community that I was working with, I think it takes some time to build trust…and respect their space.”

Cambodian American communities benefit significantly from community health work. A middle generation female participant highlighted how communities could benefit from access to CHWs:

I think each community should have maybe a health care or a community health worker representing their community full time, and be able to pick up a patient and accompany them to their visit…hire a familiar face, somebody who understands their culture.

Cambodian CHWs remain effective by working in a range of settings to best address the diverse needs of their community members. One participant described how she sees her work with Cambodian Americans:

Navigating the health care system, the health insurance system, the social services system. It’s pretty much [the] essential[s] of life, because you need the shelter, you need your income, you need your food, [and] you need your good health. So when they come with that and because they are refugee[s] or immigrant[s], how do they get their naturalization or their U.S. citizenship? So they will come asking for help at different stages at their acculturation or integration in society. And, I think when we talking about community health worker, for myself that [is] the portion that I do.
Cambodian CHWs create dramatic positive changes for both Cambodian Americans and the U.S. society. One participant shared an example of how both Cambodian Americans and the U.S. health care system may benefit:

There was a woman who gave me feedback a couple of years later, “All of things you teach me, that you told me about what I am eating or why I need to take the medications that I didn’t follow through with [in the past], I [used to] end up in the emergency room so many times...but now, I am making some changes so I am not in the emergency room anymore.”

This example highlights how Cambodian Americans may experience better health while reducing the burden of cost and service on the U.S. health care system. Participants shared several factors that they perceived to be essential to be successful in their role as CHWs: skills essential to community health work, coalitions among various stakeholders, sustainable resources and funding for Cambodian community-based organizations, and policies that support Cambodian Americans.

**Cambodian CHWs and the skills they employ.** Participants in this study shared an orthogonal cultural identity that aided their work with Cambodian Americans. Successful features of CHWs include three components: first, their identity as Cambodian CHWs; second, their ability to negotiate conflicts between U.S. institutions and Cambodian Americans; and third, their awareness of the structural barriers that affect Cambodian Americans and their health. The amalgam of these three components are perceived by the participants to create a foundation of trust between the CHWs and Cambodian American community members that supports effective communication within health care settings and leads to improved health care access and healthier outcomes over time.
The Cambodian CHWs that participated in this study often self-identified with both the Khmer and mainstream culture in the United States. Several participants explicated how they understand their orthogonal cultural identity. One middle generation, female participant stated:

I would say I’m a mix. My culture is both Cambodian and American culture, and so we’re trying to combine the two [cultures] together, so we still like to carry on the Cambodian culture, but at the same time, learn about the American or implement the American culture as well….That’s two different cultures [Khmer and American]…it’s [my cultural identity] dependent on [the setting, whether or not] it [is] professionally or personally [applied]? I think personally I’m more of the Cambodian culture, professionally I would say I do a mix.

A male participant who is also from the same generation described a similar lived experience:

Since I was born in Cambodia, I’m a Cambodian. I’m more in between, but I’m more inclined to work toward the Cambodian cultures, basically the traditional Cambodian cultures more than the American culture, though I’m a little bit acculturated as well.

Participants also shared how their orthogonal cultural identity may differ from the cultural sacrifices that different generations of Cambodian Americans experience within their communities. A middle generation male participant explained how he understands what is happening in his community:

Just like any other community, the culture changes based on the new generation. While the older generation is basically holding on to what they brought here or to what they have in them. It’s hard for them [elders] to get a hang on to a new culture, and at the same time trying to hold on and cherish what they have; while at the same time the new generation is basically acculturated faster just because they live here, they speak the
language, they know a lot of the stuff, and so it’s a lot of back and forth, but being able to hang onto the culture is one of the prides within the Cambodian community. And you will see that if you come into the city, the store names, the plaques, the sculptures and what not [are written in Cambodian], so there’s a lot of leaning toward preserving the culture.

An elder generation, female participant expounded her perceptions on the cultural dimensions of Cambodian Americans in her community:

When the parents came from Cambodia, they don’t know this culture, they don’t go out...they [are] uneducated. They cannot read or write; they depend on the children. And the children, they grow up here as an American. It’s not that an American [culture] is a bad culture, it’s just their [the children’s] culture…they become individually [focused]. And our [Khmer] culture, we’re family oriented and that’s culture too…

When helping you [Cambodian parents to their children]...you don’t give your kids freedom or [the ability to] speak out and do things. You don’t let your children explore. So, when the kids go to school, they learn the American way. To express their view[s] and stuff, and the parents kind of [have] helpless feeling[s]. They [parents] feel bad and…they feel like they’re failures [or that] nobody cares about them, even their own kids.

These impacts expand to health care settings. One participant shared how a lack of awareness of traditional family roles from the Khmer culture may come into conflict with U.S. health care protocols when necessary services (e.g., medical interpreters who understand Khmer culture) are unavailable:
When they live[d] in Cambodia, the father was the head of the household. After they’ve been here [and] because they don’t speak the [English] language, sometimes they have the children [interpret], they [children] learn quick about the [English] language. When they [parents] head for their appointment, they have to take the children to translate for them as the interpreter. And sometimes the question was not good to let the children know, for example, when I was working very close with the psychiatrist and the psychiatric nurse, when they ask the parents for example that, “Do you feel like you want to hurt yourself or something?” And for the children to translate for the parent is very difficult…to ask the parent for that question. But when we have an interpreter, they don’t use the children anymore. Sometimes they [parents] go with the children to the clinic and they [the parents] have to ask them [the children] if we [the clinic] have an interpreter to translate for the parents. And this is very important that the families should not use the children to translate for them.

Another middle generation, female CHW shared her impressions of the divide between older Cambodian generations and what is required to be effective in the U.S. health care setting:

[In traditional Khmer culture,] children are not supposed to speak up. You [children] are supposed to agree with whatever your parents tell you to do. So, coming here, trying to navigate through the health system here, you [Cambodian Americans] have to pass that barrier, “This is what I need to do.” You have to be aggressive to get what you need. And that’s what many of the elders, many of the communities don’t have. Unless, the children can pass through that gate.

Although U.S. health care providers and their services intend to be beneficial, providers may lack cultural sensitivity to the Khmer culture, and therefore may not realize the impact they may
have on Cambodian American families. Another participant shared her experience in working with U.S. doctors to enhance their cultural competence in working with Cambodian Americans, “And not all places [U.S. healthcare settings] are really receptive of you [Cambodian CHWs]. I went to another place and this guy was a doctor, he said, ‘Hey, why doesn’t your community learn about American culture?’” This same participant recognized that while some U.S. health care settings and providers are more apt to practice cultural competence and/or cultural humility with Cambodian Americans, others might be far less receptive. This inconsistency across U.S. health care settings reinforces mistrust between Cambodian Americans and U.S. health care systems.

Due to these potential conflicts, Cambodian CHWs work to bridge the Khmer and U.S. culture for the mutual benefit of both. Participants frequently described how their role as CHWs fit this process, “Community health worker, they’re at the core of the community. First of all, they are family members, they’re resources, [and] they’re advocacy for the community” and “[Cambodian CHWs are] not only the resources for their own [Cambodian] community, but also for the general [U.S.] community as well….So they [Cambodian CHWs] are pulled in-between the two [Cambodian Americans and U.S. society].” Participants recognized this bicultural awareness as a unique opportunity to address gaps in health care access.

In addition to improving health care access, Cambodian CHWs’ may uniquely understand differences between how Cambodian Americans and the mainstream society in the United States understand health. This understanding offers opportunities for Cambodian CHWs to integrate concepts of health that are meaningful to their orthogonal cultural identity. One 55-year-old, female participant explained the importance of distinguishing culture from language:
The scope of community health work, it’s work that [includes] someone that can understand both our [Khmer] culture and the language….If you just have someone that just understand[s] the language and doesn’t understand the culture, it doesn’t help, because both work hand-in-hand. We have a lot of younger generation[s] that may be able to understand the language, but they don’t understand the culture. Therefore, their work might not be successful, because they didn’t have the cultural background to understand the whole concept.

Younger Cambodian CHWs that participated in this study accentuated this by sharing their experiential distance with the historical trauma that elders experienced. One 30-year-old male participant raised in Cambodia shared:

I’m glad I got to tell you about my experience…in working with the Cambodian people…I major[ed] in Math and I had no idea about [the historical trauma]...I’m not born during Khmer Rouge, I didn’t know anything about my people. I know about my people, but I don’t know [what] their real lives is, you know?

A 45-year-old male CHW further elaborated on what he believed to be a different cultural perspective between older Cambodian Americans and the mainstream society in the United States:

And I know community preventive care is not a concept for our [Cambodian] community, from where we came from, and physical activity or exercising is not a concept for us. Also, if we’re working, running around working eight to ten hours a day, that is our physical activity.

Central to older generations of Cambodian Americans and their cultural identity, traditional Khmer healing remedies remain in use and an important component to healing. Many
participants acknowledged how this is particularly true for the elders who may also experience economic hardships and/or mistrust with the U.S. health care providers.

The CHWs in this study often recognized the importance of traditional Khmer healing remedies because it signifies a valuable belief system from the perspective of a Cambodian American and a method to improve patient-provider collaboration. Further, participants also identified potential complications with regard to U.S. medical treatment and prognosis. One participant described the importance:

You just have to respect the community’s traditional remedies and also you need to understand that if the patient is using herbal medication, they [U.S. doctors] should allow the patient to use it. And to try to understand that this is what they believe. For example, if I believe that I’m not feeling [well] and if I go for coining [and] I feel better. Then that should allow me to have that opportunity to do that. Instead of just saying, “That’s not going to help you, you have to do this.” Because what you believe is powerful treatment for me, if I believe something that is most likely going to help me, then I feel better.

This example demonstrates how different cultural interpretations may exist between U.S. health care providers and Cambodian Americans about Khmer traditional healing practices (e.g., coining, herbal remedies). For U.S. health care providers, such Khmer traditional healing practices may exist as placebos; however, for Cambodian Americans and their healers, these traditional practices may represent interventions that aim to heal the body and the mind. The mind-body connection is exemplified by one participant’s description of her work, “I think key roles of community health workers [is that] they really understand that holistic definition of health.”
In addition to cultural factors, U.S. health care providers may also lack an understanding of how structural barriers to health access affect Cambodian Americans. One participant shared how a historic structural barrier for Cambodian elders continues today:

I remember going to the temple and providing educational material about diabetes, because diabetes is such a high prevalence in the Cambodian community. And to be able to talk to them about their diet, you have to understand where they come from and what their diet involves. So we know that the Cambodian community eats rice, white rice, three or four times a day, and then to educate them about their diet, you have to understand that they live[d] through the Khmer Rouge and where food was very limited, to nothing, for them.

U.S. health care providers are aware that diets high in white rice exacerbates diabetes and worsens one’s health, therefore, providers may approach removal of white rice from a patient’s dietary as a relatively simple, straightforward matter. Cambodian American elders who lived during the Khmer Rouge genocide experienced extreme forms of starvation and white rice served as one of a very few survival mechanisms. Reinforced by structural factors (e.g., Khmer Rouge governance of Cambodia, near-death starvation, poverty), the bond between Cambodians elders and white rice is not easily understood by many U.S. health care providers. Due to these types of structural barriers, Cambodian Americans often experience deeper struggles with their health and health care access.

At times, cultural and structural barriers within health care settings may present in similar ways. For example, familiar to all participants is that Cambodian Americans may not be comfortable advocating for any concerns about their health with U.S. health care providers. Ideally, this type of scenario requires providers to assess whether barriers to communication exist
within the dimensions of culture, structure, or both. Excerpts from participants described and expounded the possible dynamics at play with this type of scenario. One participant discussed the history of the Khmer Rouge genocide as a structural factor that contributes to why Cambodian Americans do not speak for themselves within a health care setting:

We [Cambodian CHWs] teach them how to speak up, because none of them [are] speaking up because they are scared….It’s survival from Pol Pot, because the people who speak up got killed. The people that if you speak up, they will kill you. Back then, so they kill you, so everything for them is just “Fine, fine, fine,” even though they are really sick, like they [are] not whining.

Another participant acknowledged how cultural and structural factors had a deep influence on how Cambodians were raised prior to coming to the United States:

Even if you can speak the language, but going through the system yourself, if you’re not aggressive enough, you don’t get what you need and many of us, many of our community, are not that aggressive, [that’s] the way we are brought up [e.g., communal Khmer values, living during the civil war and Khmer Rouge, and migration to the United States].

Accurate assessment of the cultural and structural barriers that affect health care interactions highlight steps to improve health care navigation. When U.S. health care providers navigate cultural and structural barriers successfully, Cambodian Americans experience improved access to health care.

Community collaboration and coalition building. The health access barriers that Cambodian Americans experience go beyond U.S. health care settings. To ameliorate these barriers, Cambodian CHWs often employ a diverse range of community practice skills.
Participants often describe how they build community collaborations and coalitions amongst diverse communities with shared experiences. These efforts help to address the shared challenges that Cambodian communities face in the United States by bringing greater public awareness through collective action and resource-sharing to address common goals and sustain change efforts.

One participant described how a portion of his community health work is devoted to sustaining a collaborative community effort between his Cambodian community, the local health center where he works, and a local elementary school. This community collaboration addresses the health and education needs of Cambodian American youth through changes at a local elementary school curriculum. On a weekly basis, Cambodian youth learn and experience activities about Khmer culture and successful strategies to stay both mentally and physically healthy. The participant described how this work was successful with youth, and how their family and community experienced positive effects.

I think there’s a lot of change [in] their [i.e. youth] emotional state changes. When they come to the program, they are very happy, they are excited to learn. They go home and they introduce to their parents the Khmer words that they’ve learned in class. They [youth] go back, they share all these things that their parents never see them do, and so we introduce the [Khmer] culture, a language that they might not have been taught….I think that’s what is being helped with the elders….I think the elders and grandchildren [are] disconnected, when the grandchildren go home and share what they learn at school in the program, it provides some connection [between elders and youth]. I think it gives grandparents hope too, that the language and culture has not been lost at this day, at this time in the United States. I think that when we bring the language and culture to the
elementary students, we hope it inspires them, to motivate them to [do] more and more [with their culture of origin], to work the way they can, and to know where they came from.

This example highlights an opportunity to improve health access through the reciprocal exchange of Khmer culture between Cambodian youth and elders that occurs both at the local elementary school setting and within the home. This participant described how such efforts are only possible through the collaboration of invested community stakeholders.

Beyond community collaborations, participants also identified efforts to develop coalitions that focus on changing the structures of U.S. institutions and policies. Gamble and Weil (2010) identify two efforts essential for coalition formulation: community organizing and community building. They recognize that the former include strategies to effect social change through power and the later “implies building relationships among all the diverse sectors of the community” (Gamble & Weil, p. 327). One participant described the complexity inherent to coalition work with multiple partners and organizations as stakeholders.

And people have their own agendas [when it comes to improving one’s community]. It’s hard to find out if they’re doing it [community work] because they have these personal agendas or are they doing it really or sincerely feel that it’s the best for the community. And then, having to work and develop these private and public partnerships, there’s people that can [help] in the public realm, public officials that may be very attached or feeling like they need to give or do something because some private person have given them something that may have benefitted them in the past. So, I come across a lot of these little things in the work that I do and sometimes you’re like, “Oh, that doesn’t look like [a good thing], that looks like a landmine, like a minefield and you
don’t want to step into all of that!” But it sucks, because those people have the power to
change things, so you have to think creative ways that may take a little bit longer to make
things happen.

This same participant described how he attempts to circumvent personal agendas to aid the needs
of the individuals and communities that he serves. One example involved his work in
developing community gardens within public housing settings:

For [public] housing, making connections between [communities and elected officials], if
I have the power or if I was the mayor to address the issues within public housing over
here [a lot more would get done]. [Due to personal agendas] you wouldn’t [directly] talk
to the mayor or the housing authority or something, but another creative approach is: how
do we couple community gardens with this need within the housing authority of the
renters? Thinking sort of outside the box or thinking creatively. That has been part of
my success. Just making those connections happen where people didn’t see those things
happening.

From this perspective, this participant envisioned many possible benefits of community gardens
within public housing that serve to increase health access, which include: increasing community
access to healthy foods; fulfilling monthly community service quotas to maintain residence with
public housing; developing skills that public housing residents may transfer to employment
opportunities; and expanding the built public space to be a healthier environment.

Community collaboration and coalition building require the navigation of diverse
political forums. One participant described how he viewed his role in these forums as a bridge to
his community:
You have to be able to hear about things and sit and have a voice on different boards, so that you can be a voice for the people. The underserved community that I report to [and] serve and want to represent within the community. Otherwise they wouldn’t have a shot of getting anything.

Without these vital community practice skills, the sustained efforts of CHWs and their communities would remain fragmented and unsuccessful in making longitudinal changes to the Cambodian American experience of health access.

**Funding community health work.** Cambodian CHWs often work countless hours with limited financial resources and support. Although their work is highly valuable, participants often experience pervasive difficulties in locating or sustaining financial resources to support their efforts. Participants recognize two key factors that contribute to poor financial support for their work: conventional funding structures and the lack of public policies that fund community health work. One participant identified grants as one primary, but unsustainable source of funding for community health work:

Community health workers are often funded through grants, and once the program ends, so does the role of the community health workers. But then you’ll see in introductions that a lot of community health workers or peers here are still working as volunteers. Due to a lack of funding, an elder CHW from the northeast described how she continues their community health work on a voluntary basis:

As soon as I got laid off in 2012, I still [work] with the Cambodian family, and still go out there and help them and call them, things like the doctor, if they need anything, I help them with things like prescriptions, on Saturdays and Sunday. I call the doctors to get the
prescriptions refilled. If [they need people to] buy food for them, I can do that. I still do things. Even without money, I love my people. Whatever they need, I do it.

A 55-year-old participant explained how she is able to sustain her community health work on the west coast:

I already have a job and I’m doing this community work on a pro bono [basis], so I would assume those who don’t have a regular job wouldn’t be able to do this pro bono [work] because they need to support their families. Therefore, here in [city in west coast state], we don’t have a [paid]…community worker that is helping out the communities, because we just don’t have a non-profit agency in Khmer that have funding to support that work.

These participants highlighted the significant intrinsic motivation that CHWs experience with their work. Though admirable, these efforts are unsustainable and add burden to CHWs, their communities, and the U.S. health care system.

One participant described a recurring pattern that she witnessed when funding ends for community health work programs:

Some of the responses [from the community] are: “When is the next time that this is going to happen?” or “I miss those walks.” It’s just so sadness [sic]. For some of them, they enjoy [our work], they look forward to the different programs, because sometimes it’s their only way of meeting other people as well, getting out of the house, meeting other people. So you definitely feel some emptiness with that.

To address these issues, several participants shared what may benefit their work. A 34-year-old female participant who has no funding for community health work stated:
Medicaid reimbursement for the work would be helpful. I think there is some work around that, but there is no clear direction in terms of how to get there. They should be reimbursed like any other health care provider.

Another female participant who is close in age, but has funding stated something similar:

I think the most positive thing that could happen with the policy changes in the United States would be to increase funds with community health workers to be able to be here in the health care setting[s], because they are definitely needed and they are the people who bridge the gap for any culture. They are the ones who understand and speak the language…and read the language. And they are able to communicate with their community.

Limited funding affects community health work across many states. The CHWs who participated in this study commonly recognize these funding issues and its impact on their communities.

**Public policy provision.** Although Cambodian CHWs spend most of their time in direct care settings, they have a general understanding of how federal, state, and local policies affect their work and the communities they serve. Most participants spoke about two federal policies that affect their communities: the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (ACA) and the Title VI of the Civil Rights Act of 1964 (i.e. Title VI). Participants described a single theme about these two policies: although they are a step in the right direction, they are not enough.

A female participant working in the northeast described her experience with the ACA and its impact on her community:
The Affordable Care Act has some of the help, but you need people to understand the policy and it takes time for them [Cambodian Americans] to understand the policy.

A male participant shared his experience with the ACA:

Affordable Care Act is somehow affordable, but it’s not really affordable…you need to pay a lot still. It should be free…, because [the] Cambodian community have low-income. So to make them stay healthy and go to see doctor, we have to make the…Affordable Care Act amended so that they could really have more coverage and for cheaper price.

Although many participants recognized the role of the ACA to improve health care access by increasing access to health insurance, few participants were familiar with potential funding opportunities for community health work.

In addition to the ACA, participants recognized Title VI, which “prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance” (U.S. Department of Justice, 2016, para. 1). This is particularly pertinent for many Cambodian Americans who seek medical services from organizations and agencies that receive federal funding, such as community health centers. One female CHW noted her perception of Title VI:

Title VI is a law, but it’s not enforced. Most agencies don’t comply to it, so there has to be some work around that.

Further, another participant who has over 35 years of community health experience shared her observations of U.S. health care policy:

There’s services that are being used for mental health, but they restored the medical for the dental program, but it’s still limited. For example, a patient with Medicare and
Medicaid [may] have a toothache and they go to a dentist, but they can’t get that particular tooth fixed because of the [federal] regulations, therefore, they have to extract everything so that they can get dentures, which is a sad thing, it’s just not sensitive to patient’s needs. There’s been regulations that you can only fix certain teeth. How can you [U.S. policy decision makers] come to that conclusion and make that rule?

Cambodian Americans consistently experience silence and invisibility with regard to U.S. public policies. To improve health access for Cambodian Americans, participants strongly urged deeper commitments from U.S. policy makers to understand the plight of their communities and the effects of public policy at the community level.

**Summary**

Cambodian Americans’ experience of health access is complex and shaped by the historical trauma they experienced during the Khmer Rouge genocide and their journey into the United States as refugees. During the 1970s, silence and invisibility became primary survival mechanisms in Cambodia and participants spoke of the lasting effects of these mechanisms on their community today. In the United States, the cultural and structural barriers that Cambodian Americans experience in social, economic, and political dimensions shapes and reinforces another form of silence and invisibility that decreases health access.

Despite the cultural and structural adversities that Cambodian Americans face, participants described efforts that reflect a synthesis between the values indigenous to the Khmer concept of health and the successful navigation of U.S. institutions through health care systems, community collaborations and coalitions, and public policy. These efforts frame a holistic approach to healing and ameliorate the barriers that Cambodian Americans experience across social, economic, and political dimensions. When viewed in unison, participant voices,
experiences, and recommendations serve as a roadmap to improving health access for Cambodian Americans.
Chapter 4: Discussion

Cambodian Americans experience many barriers to health access. This study supports findings in the literature that every generation of Cambodian Americans continue to struggle with poor health. This chapter covers several areas that emerged from this research: implications for social work practice and research; study limitations; theoretical contributions from the study findings and future research; and concluding remarks.

Implications for Social Work

A natural alignment exists between the field of social work and the efforts of Cambodian CHWs to ameliorate the plight of Cambodian Americans’ health status and health access. Implications of this dissertation identify areas for social work involvement. These areas target the field of public health social work in the following dimensions: integrated health care teams, cultural and structural competence in U.S. health care, health policy advocacy, and the role of CBPR to integrate practice and research.

Public health social work. The social work profession’s investment in the field of public health dates back to the 19th century settlement house movement through work in containing infectious diseases and improving the health and well-being of mothers and their children (Bloom, 1995; Carlton, 1988; Dhooper, 1997; Popple & Leighninger, 2002). Social work’s foundational commitment to social justice remains in alignment to efforts within the public health field to address the structural inequalities that exacerbate health conditions (Ashcroft, 2014). The integration of public health and social work has occurred in diverse settings, which encompass practice, education, and research (Addy, Browne, Blake, & Bailey, 2015; Kerson & McCoyd, 2013; Ruth, Marshall, Velásquez, & Bachman, 2015). Although these areas of integration may decrease the structural barriers to health and health care in the United
States, the field of public health social work remains underdeveloped and less resourced when compared to other social work endeavors (Addy et al., 2015; Keefe, 2010; Marshall et al., 2011).

The field of public health social work requires significant investment and advancement to confront the social, economic, and political injustices that negatively affect the health of individuals and their communities (Jackson, 2015). Clear evidence highlights the significant health disparities that Cambodian Americans experience when compared to the general U.S. populace and other Asian American communities (Grigg-Saito et al., 2008; Marshall et al., 2016; Wong et al., 2011). Although this evidence may not be surprising due to the historical trauma that many Cambodians have experienced, this dissertation highlights ongoing health access barriers that unfairly perpetuate the significant disparities that exist. Further, public health social workers may work to integrate a human rights-based approach to health to ameliorate the health disparities that Cambodian Americans face in the United States.

Public health social work represents an integration of two disciplines that are committed to addressing health disparities and the inequalities that marginalized communities, such as Cambodian Americans, experience in society (Keefe, 2010; Jackson, 2015). The social work profession may evolve in both micro and macro dimensions to better address the health access barriers faced by Cambodian Americans. The dimensions in social work include: enhancing direct service provision within U.S. health care (e.g., cultural and structural competence; integrated health care teams) and improving health policy to increase resource investment (e.g., funding CHWs through community-based organizations) into Cambodian American communities.

**Distinguishing cultural and structural competence.** The cultural and structural factors that perpetuate the poor health status of Cambodian Americans and the barriers to health access
are highlighted throughout this study. Social workers that practice in health care settings must be educated and trained in how to assess, differentiate, and address the cultural and structural factors that affect Cambodian Americans, along with other communities that experience similar marginalization. Social workers who develop both cultural and structural competencies may better ameliorate the health care access barriers for Cambodian Americans and other marginalized communities.

Since the seminal work of Cross, Bazron, Dennis, and Isaacs (1989), many definitions of cultural competence have emerged for health care settings. The definition of cultural competence in health care developed by Betancourt, Green, and Carrillo (2002) “describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs” (p. v.). Metzl and Hansen (2014) differentiate structural competence with the following definition for health care providers:

[As] the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases…represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even the very definitions of illness and health. (p. 128)

This definition recognizes the social, economic, political, and historical factors that may cause and/or reinforce one’s health status and health trajectory.

In 2001, the National Association of Social Workers (NASW) standardized the role of cultural competence for social workers, which remains relevant to current practice (Nadan, 2014). Despite the professional embrace of cultural competence by NASW, formalization of
structural competence would strengthen public health social work’s intervention of the structural causes to poor health and barriers to health access. Curriculum and training in developing both culturally and structurally competent skills may help social workers in U.S. health care settings holistically conceptualize the health issues that Cambodian Americans face and tailor interventions that accurately address the cultural and/or structural problems. Additionally, when practitioners employ these skills in tandem, joint efforts between the public health and social work disciplines may strengthen and improve health care access for Cambodian Americans, which may translate into longitudinally healthier outcomes.

**Integrated health care and a team approach.** Since the 1960s, multidisciplinary approaches between physical and behavioral health care have improved the health outcomes and decreased barriers to health care access for many individuals and communities (Vogel, Kirkpatrick, Collings, Cederna-Meko, & Grey, 2012). The evolution of multidisciplinary approaches have sparked many types of collaborations: universal screening, coordinated care, co-located care, health homes, and system-level integration of care (Kaiser Commission on Medicaid and the Uninsured, 2014). These approaches continue to evolve as a paradigmatic shift within U.S. health care, known as integrated health care.

The Hogg Foundation for Mental Health (2008) defines integrated health care as “the systematic coordination of physical and behavioral health care” (p. 7). The fundamental belief that undergirds the integrated health care movement is that “physical and behavioral health problems often occur at the same time” and the integration of services lead to better outcomes for both providers and patients (Hogg Foundation for Mental Health, 2008, p. 7). One promising model of integrated health care are integrated care teams that consist of a “team of professionals
with complementary skills who work together to care for a population of patients” (University of
Washington AIMS Center, 2016b, para. 1).

Integrated care teams consist of patients and professionals across diverse health
disciplines (e.g., primary care, psychiatry, psychology, social work). These teams may be led by
care coordinators or “managers” (University of Washington AIMS Center, 2016a), which is
ideally suited for social workers (University of Washington AIMS Center, 2016a; United States
Department of Health and Human Services, 2007). Beyond the efforts of care coordinators
within health care settings, an additional gap between the community (i.e. patients) and U.S.
health care systems (i.e. integrated care teams) remains, which may be ideally addressed by
CHWs (United States Department of Health and Human Services, 2007).

Models of care that include robust roles for CHWs “improve the quality and cultural
competence of service delivery” and CHWs are critical partners for social workers (APHA,
2015, para. 2). CHWs often provide invaluable resources to improve the tangible (e.g.,
transportation, interpretation) and less tangible (e.g., empathy, concern) resources that enhance
health access. For example, Cambodian Americans may experience less social exclusion when
transportation needs and community engagement are prioritized through the efforts of CHWs.
Previous research suggests that CHWs’ effectiveness may be enhanced when working within a
“model of care” (United States Department of Health and Human Services, 2007, p. vii) that
include social workers as lead providers of U.S. health care systems. To best lead these U.S.
health care teams and enhance practice with marginalized communities (e.g., Cambodian
Americans), social workers must better understand CHWs and their role within their
communities.
Collaborations between social workers and CHWs may develop into community-partnered integrated care teams. Although not yet developed, these teams may include a co-led integrated care model that includes social workers at the helm of U.S. health care systems and CHWs as the community leaders who are able to explicate the needs of their community. Therefore, employing CHWs as the frontline public health workers may help to facilitate community needs (e.g., trust, language and cultural interpretation), while allowing social workers to negotiate the complexities within U.S. health care systems (e.g., interdisciplinary collaborations). Furthermore, this co-led team approach may not only improve health care access for Cambodian Americans, but also further strengthen how the U.S. society recognizes the contribution and leadership of CHWs by formalizing their leadership roles within the community.

**Health policy and resource investment for community health work.** Beyond advancing direct service provision (e.g., cultural and structural competency; integrated care teams), public policy shapes whether or not opportunities exist to address the health access barriers that Cambodian Americans face. In 2010, the U.S. government expanded access to health care through the passage of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, commonly referred as the ACA. The U.S. Department of Health & Human Services (n.d.) argues that this legislation expands areas of innovation for health care reform by increasing health care access, improving the quality and lowering the cost of health care, and instilling new consumer protections. Through a human rights-based approach to health, social workers can play a pivotal role as advocates and policy makers to enhance legislation for the betterment of Cambodian Americans.
The cost of health care in the United States. The rise in health care expenditures for people in the United States have sparked national awareness and dialogue regarding cost-effective health care (Girod, Weltz, & Hart, 2015). By 2013, the United States spent 17.1% of its gross domestic product (GDP) on public and private health expenditures (The World Bank, 2015a). The United States ranked second internationally in GDP spending on health care, which outspent other comparable nations (e.g., the Netherlands, Japan, Russia, Mexico, China) by approximately 200 to 300% (The World Bank, 2015a). Unfortunately, these health care expenditures did not translate to improved proportional health outcomes across many dimensions, including life expectancy, infant mortality, and diabetes (Central Intelligence Agency, n.d.; Health Intelligence, 2011; The World Bank, 2015a; The World Bank, 2015b).

Current policy provision for community health work. Recognizing the exorbitant cost of health care without substantial returns on investment, U.S. health care systems must work toward expanding beyond their conventional modes of delivery. Community health work remains one key element to improving health outcomes and significant health care savings for patients, providers, and the entire health care system (Felix, Mays, Stewart, Cottoms, & Olson, 2011; United States Department of Health and Human Services, 2007; Zahn et al., 2012). Unfortunately, community health work often lacks sustainable funding. Currently, the ACA may help to ensure the viability of community health work through state innovation model (SIM) awards, which may be used to fund the enhancement and study of health care delivery systems that support sustainable funding structures for CHWs (Kishbaugh, McEvoy, Moran, Pryor, Trevino, & Wilson, 2016). The executive branch of state governments allocate and distribute SIM awards for innovation in health and health care. Social workers can broker relationships between state governments and community-based organizations committed to serving the rights
of Cambodian Americans (e.g., KHA) by enhancing public awareness of the value of community health work. Beyond this current legislation, social workers play a vital role in confronting the economic and social costs of the U.S. health care system by bridging public policies with a framework that recognizes the human right to health.

*Integrating a human rights framework into public policy.* The Office of the United Nations High Commissioner for Human Rights (2008) define the right to health as “a fundamental part of our human rights and of our understanding of a life in dignity” (p. 1). They align this definition to the World Health Organization’s (WHO) constitution adopted in 1946, which states the following: “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (2006, p. 1). The WHO (2006) further outlines principles and standards that integrate a human rights-based approach to health, which include the following: non-discrimination, availability, accessibility, acceptability, quality, accountability, and universality. These principles and standards align and expand upon the 1981 definition of health access by Penchansky and Thomas. Social work’s commitment to marginalized communities, such as Cambodian Americans, and social justice calls our profession to examine current U.S. public policies with a human rights-based approach and interventions to uphold the principles and standards outlined by the WHO.

Participants recognized the importance of current public policies (e.g., ACA, Title VI) that confront the social and economic barriers that Cambodian Americans face in the United States. Though these public policies ameliorate some of the barriers (e.g., no health insurance, need for medical interpretation), there remains much need for advancement and progress. Social workers are ideally suited to promote public awareness to the gaps in current policy provision by
integrating a human rights framework into future legislation. For example, participants stated that although the ACA increases access to health insurance, it is still too costly and too complex for their communities to navigate. From a human rights framework, social workers may advocate for future legislation to establish a single-payer source that provides universal health coverage. Additionally, this legislation may have stronger accountability and non-discrimination standards than current legislation, such as Title VI and the ACA. When drafted in concert with the human rights-based approach to health, U.S. policies may uphold the WHO (2015) principles and standards and improve health access for Cambodian Americans. Further, health care costs may decrease as U.S. policy makers reduce the structural barriers to health.

Promoting organizations that sustain community health work. The social determinants of health reinforce how barriers to health access exist, such as the disparities that Cambodian Americans experience in income and education. The organization of community participation and resources that may secure one need (e.g., transportation for health care appointments) may be transferable for another (e.g., transportation for employment). Lehmann and Sanders (2007) found many examples of “small-scale programmes initiated within and by communities, often with assistance from an NGO [non-governmental organization] or a church group” in culturally diverse communities that aligned with the work of empowered communities to address the social determinants of health (p. 22). When adequately funded, community-based programs and organizations that recognize the rights of Cambodian Americans can decrease health disparities.

For CHWs to be successful, promoting agencies with organizational policies that support effective community health work is essential. One example includes social enterprises or entrepreneurship, which aim to improve the health of communities exist within the United States and internationally (Lysaght, Jakobsen, & Granhaug, 2012; McAusland, 2006; Penfold, 2012).
Initially introduced within the United States during the 1980s (Ferguson, 2012), social enterprises are for-profit businesses that generate profits to further the social aims of organizations committed to improving social, economic, and political justice for communities who experience marginalization (McAusland, 2006). They may not only aim to reduce health disparities by improving health access for Cambodian Americans and other similar communities, but also integrate an economic development approach to strengthen community resources (Krupa, Lagarde, & Carmichael, 2003).

Social enterprises that employ CHWs may benefit from SIM awards to enhance the sustainability of conventional funding streams, such as Medicare, Medicaid, private health insurance reimbursements, and public or foundation grants (Ferguson, 2012). Social workers may aid these enterprises by working to strengthen relationships between state governments and these type of organizations. Models of social enterprise may exist as the Cambodian Mutual Assistance Associations that emerged in the 1980s. Securing resources within Cambodian American communities would build access to social and economic supports, which may further enhance collaborative opportunities between Cambodian Americans and those serving within U.S. institutional settings (e.g., health care, education). Additionally, these collaborative opportunities may serve as a foundation for Cambodian Americans to address their experience of social isolation and improve successful navigation of U.S. institutions (Sanchez & Mosque, 2012).

**Summary.** Public health social workers serve vital roles for Cambodian Americans. To ensure the success of these roles, future areas of development include the training of social workers in differentiating cultural and structural competence. Additionally, public health social workers may ideally serve as co-leaders with CHWs of integrated care teams. Further, social
workers may strengthen health-related policies from a human rights-based approach. Finally, public health social workers may aid in bridging the relationships between U.S. policy makers and leaders of organizations who are committed to serving Cambodian Americans.

These implications may ameliorate health access barriers for Cambodian Americans and create opportunities to improve health outcomes and decrease the health disparities experienced by this population. To ensure such opportunities, public health social workers must examine the ACA and future U.S. health policies to ensure that resources invested into the community not only address health care, but also the structural factors that contribute to poor health and barriers to health access.

Limitations

In addition to the contributions of this exploratory study, there are several limitations worth noting. These limitations reflect several factors: resource restrictions; sampling methodology; and balancing academic and practice standards when employing CBPR within a dissertation. Although each factor may have inhibited several dimensions of this study, each factor shaped the practical decisions that reflect the goals of a CBPR dissertation.

Consistent with any self-funded study, resource limitations directly affect decisions made during the research. Due to the national scope of this study, resource limitations had a direct impact whether or not in-person interviews were possible during the Phase Two data collection. Face-to-face contact builds trust and rapport, which is highly salient for Cambodian Americans. Although I offered the Skype video interview format, only one person elected to use this format. Furthermore, no participant who expressed interest in participating dropped out due to this limitation; however, this may have affected what they chose to share during the interviews.
I designed the purposive and snowball sampling methodology to access different Cambodian American communities across the United States. Despite multiple outreach attempts (Kuoch and Scully from KHA, researcher-initiated, and participant word-of-mouth), this methodology was less successful in accessing pockets of Cambodian Americans communities that are smaller and have less resources for community health work. My difficulty in accessing these communities may have strengthened sampling bias and may have limited some of the exploratory findings within this study.

One final limitation worth considering is how I employed CBPR within this study. CBPR exists along a spectrum of research design, from community involvement through research activities (e.g., goal formulation, needs assessment) to community-led research methods (e.g., community members formulate research questions, conduct data collection/analysis, and report findings). For this dissertation, I chose to balance several vital goals: the identified community needs through partnership with KHA staff, feasibility for a study of this magnitude, and demonstration of scientific rigor and scholastic aptitude within this dissertation (e.g., integration of public health and social work; qualitative data analysis). In balancing these goals, the level of community participation for this dissertation in the areas of data collection, data analysis, and dissemination of the findings was limited. Future studies may incorporate different methodological protocols (e.g., CHWs as co-researchers) when employing a CBPR approach with Cambodian Americans and other marginalized communities.

Implications for Theory & Future Research

Two overarching themes emerged from the data in this study: silence and invisibility in two cultures and a holistic path to healing. These themes provide context for future
developments in theory and research. I present additional theories and concepts to spark areas of inquiry and further investigation beyond this dissertation.

**Silence & invisibility in two cultures.** Marred by torture and/or other forms of trauma, Cambodian genocide survivors have experienced silence and invisibility that continue today. Although their silence served as a protective factor during the Khmer Rouge genocide, many Cambodian survivors’ experience of silence may serve as a risk factor that exacerbates ongoing health concerns. These health risks exist not only for the survivors of the Khmer Rouge, but also for current generations of Cambodian American youth.

The relationship between two phenomena may help to contextualize Cambodian Americans’ experience of health access: historical trauma and structural violence. Their experience of silence, invisibility, and poor health access remains due to several factors: the dominant U.S. cultural value of individualism, a lack of awareness into how historical trauma continues to affect the health of Cambodian Americans, and the limitations of the U.S. health care system to address the cultural and structural barriers that reinforce poor health access. Intentional efforts to build foundations of healing must occur to stop the ongoing silence and invisibility that many Cambodian Americans experience.

**Historical trauma & structural violence.** Cambodian Americans experience historical trauma that is consistent with other communities (e.g., Indigenous tribes of Northern America, Holocaust survivors, African Americans) who have survived “complex and collective trauma experienced over time and across generations” (Mohatt, Thompson, Thai, & Tebes, 2014, p. 128). Each community that has survived historical trauma “share[s] an identity, affiliation, or circumstance” (Mohatt et al., 2014, p. 128). Although many conceptualizations of historical trauma exist, Hartmann and Gone (2014) outline four key concepts:
1. Colonial injury to Indigenous people as a consequence of experiences with conquest, subjugation, and dispossession by European and Euro-American settlers is the basis of the concept;
2. Collective experience of these injuries by entire Indigenous communities or collectivities whose identities, ideals, and social lives were impaired as a result is highlighted;
3. Cumulative effects of these injuries from continued oppression that have accumulated or “snowballed” over time through extended histories of harm by dominant settler-colonial society is accentuated; and
4. Cross-generational impacts result from these injuries as they are transmitted to subsequent generations in unremitting fashion in the form of legacies of risk and vulnerability to BH [behavioral health] problems until healing has occurred. (p. 275)

These concepts are present for Cambodians due to their survival of the following: French colonization; U.S. military campaigns in Southeast Asia; and the Khmer Rouge (Heder, 1997; Holocaust Memorial Day Trust, 2013). Currently, the practice of dominant colonial ideologies silence Cambodian Americans. When not held accountable, the dominant mainstream society in the United States may inadvertently reinforce the colonization of Cambodian Americans.

Generations of Cambodian Americans may continue to experience the effects of historic cataclysmic events (e.g., Khmer Rouge genocide) regardless of whether or not they have lived through them. Kirmayer, Gone, and Moses (2014) argue that structural violence and inequality that any community experiences in their current residence moderate the impact of these cataclysmic events on health. Developed from the work of Johan Galtung in the 1960s, Farmer, Nizuye, Stulac, and Keshavjee (2006) posit that structural violence “describes social structures—
economic, political, legal, religious, and cultural—that stop individuals, groups, and societies from reaching their full potential” (p. 1686). For Cambodian Americans, the structural factors that moderate their lived violence are embedded within the impoverished geographic environments (e.g., poor access to fresh and healthy foods, pollution) in which they reside and the U.S. institutions (e.g., education, health care) that serve them. These U.S. institutions silence Cambodian Americans through dominant cultural ideology (e.g., individualism) and expectations (e.g., one size fits all). Finally, inadequate or unenforced public policy (e.g., Title VI) reinforces Cambodian Americans’ silence and invisibility.

Future research into restoring the bonds that heal. The early life experiences of many Cambodians that survived the Khmer Rouge regime and refugee camps often remain invisible within the United States. Further study may determine how these life experiences may have been transferred across generations and may continue to affect Cambodian Americans who have not lived during that time. Additionally, research may explore how contemporary experiences with structural violence may reinforce Cambodian Americans’ historical trauma. The effects across generations may present as ongoing social isolation and exclusion, which are significant barriers to health access. Furthermore, the impact of the relationship between these barriers and the existence of dominant “mainstream” cultural values (e.g., self-advocacy, individualism) on Cambodian Americans may be longitudinally studied. As more Cambodian survivors of the Khmer Rouge die in the coming years, opportunities to heal historic and intergenerational wound may be decreasing. To address these areas, future research may study how holistic and relational healing approaches that are consistent with Cambodian cultural values and integrated into U.S. health care systems may improve the health outcomes of Cambodian Americans.
A holistic approach to healing. Health is conceptually constructed, defined, and measured by the dominant healing models that exist in any given culture and timeframe. Within the United States, the biomedical model, which arose from the formation of the American Medical Association in 1848 by allopathic physicians, defines how we understand health. By 1910, the Flexner Report advanced the biomedical model and professionalization of biomedicine through the scientific paradigm of empiricism with measurable changes in biology, which at the same time discredited any healing approach not based from this framework. Therefore, biomedicine has positioned itself as the “mainstream” health care and other approaches to healing remain marginalized as alternative forms of medicine.

The effects of the dominance of the biomedical model (i.e. biomedicine) in the United States constrains Cambodian Americans’ ability to heal from historical trauma. Although Cambodian CHWs bridge some of the gaps between the U.S. health care system and Cambodian Americans, the gulf between the two remains monumental. To narrow this chasm, I will discuss concepts from critical pedagogy theory (e.g., cultural invasion, cultural synthesis, and critical consciousness) and the concept of liminality. When applied, these theoretical concepts ignite further inquiry into Cambodian Americans’ health status, experience of health access, and role of CHWs for the future.

Conceptualizing health through a critical pedagogical framework. I employed three concepts (e.g., cultural invasion, cultural synthesis, and critical consciousness) from critical pedagogy theory to understand Cambodian Americans’ experience of health access in the United States. This study’s findings contextualize how Cambodian Americans may experience cultural invasion through ongoing silence and invisibility. Essential topics of inquiry with regard to health remain:
1. How may cultural synthesis occur between Cambodian Americans and the health care systems that serve them?

2. What roles may Cambodian CHWs take on that may help to promote cultural synthesis?

3. What consequences exist for both Cambodian Americans and the health care systems that serve them if cultural synthesis remains unachieved?

These questions are also applicable to other marginalized communities (e.g., Indigenous tribes of Northern America, African Americans) who experience historical trauma, continue to have poor health, and live with poor health access in the United States.

Cambodian CHWs who participated in this study displayed critical awareness to the social, economic, and political oppressions that constrain Cambodian Americans’ health status. This critical consciousness reinforces a commitment from participants to confront these oppressions. Freire (1990) posited that critical consciousness is a cyclical process that occurs when individuals or communities: (1) actively reflect upon their experiences of social, economic, and political oppression, and (2) take action to change the oppressive structures that maintain their marginalization. When reflecting upon their lived experiences and community health work, participants described the cyclical process of critical consciousness.

Freire (1990) argued that critical consciousness is the potential change agent between cultural invasion and synthesis, the former reinforcing systems of oppression and the latter being true liberation. When contextualized to health, the liberation that Cambodian Americans may experience with cultural synthesis may evolve into healing from the experience of social, economic, and political oppression (e.g., historical trauma), not merely the absence of biological diseases, such as diabetes or hypertension. This may be visible when the social, economic, and
political rights of Cambodian Americans are systematically upheld. For example, increased political accountability may involve stronger efforts to enforce Title VI and steps to improve justice for when Cambodian Americans experience discrimination in U.S. health care settings.

Cultural synthesis is an evolving process that may not exist as a static outcome. Although participants described critical consciousness in their role as CHWs, sustainable efforts to achieve cultural synthesis as an outcome remain elusive as evidenced by the systemic experience of ongoing social, economic, and political hardships that Cambodian Americans experience across the United States. As these hardships continue to affect current and future generations of Cambodian Americans, greater concerns arise:

- How might cultural invasion affect the developing field of community health work when resources are not allocated to maintaining their community-based identity?
- What consequences may arise if the field of community health work is ultimately absorbed into the current dominant biomedical structure that constitutes the U.S. health care system?

These questions beg inquiry into how Cambodian CHWs develop and maintain critical consciousness. The concept of liminality aids in understanding the unique experience of Cambodian CHWs.

_Navigating two worlds and liminality_. Participants describe their identity as a relationship between their lived experiences and their work that bridges cultures of Cambodia and the United States. To be successful in their community health work, participants balance an orthogonal cultural identity by maintaining a bond to their Khmer roots and integrating values native to the mainstream culture in the United States. This balance may exist when participants employ community health work to help their communities navigate U.S. institutions (e.g., health
care, education, and legal systems). In reflecting upon their work, participants often describe how their personal experiences in facing systemic oppression within U.S. institutions is shared by many in their community. Through this active reflection, participants successfully navigate U.S. institutions by integrating their identities as Cambodians and Americans.

Beyond this personal cultural identity, the role that CHWs currently exist may represent another unique identity. The U.S. Department of Labor (2010) has only recently defined the occupation classification of CHWs, which includes a broad range of activities. Much remains to evolve within the field of community health work and no national organization currently exists to accredit the professionalized status of CHWs. In recognizing both personal and professional identities, Cambodian CHWs’ critical consciousness may arise from an experience of liminality.

Liminality is a concept that defines a transitory phase of existence. Derived from Arnold van Gennep’s work in the early 1900s, Victor Turner initially developed the concept of liminality in 1964 to describe the ambiguous space between rites of passage in African culture (Babcock, 2002). When referencing individuals and their relationships to social structures, liminality may be conceptualized as phase when “a person is in between two identity constructions: when they are neither one thing nor the other” (Beech, 2011, p. 286). This concept of liminality has been applied to individuals within work place settings (Beech, 2011; Howard-Grenville, Golden-Biddle, Irwin, & Mao, 2011) and other Asian communities, such as Chinese immigrants who employ cultural practices (e.g., dance) within the United States (Wilcox, 2011). For most of the participants in this study, successful navigation within their community health work requires a transitory (i.e. liminal) space in which they identify with both their Khmer culture of origin and the U.S. culture.
**Future research with CHWs.** Further study with CHWs may expand how liminality may exist. Investigation into potential ritualistic practices (e.g., building trust between health care providers and community members through collective negotiation) of CHWs may help to define the elements that support or hinder the relationship between liminality and critical consciousness. This investigation may spark further inquiry into what factors (e.g., level of education, bond to culture of origin, level of acculturation, socioeconomic status, professionalized status) strengthen or weaken these liminal roles and how this may impact the CHWs’ ability to be successful in their roles for their communities and U.S. society.

In addition to studying the concepts of liminality and critical consciousness, future study of CHWs and their work across other marginalized communities may aid in the development of comprehensive models of community health work, which may improve health access and address health disparities. Once developed, these models may quantitatively evaluate the meaningful impacts that CHWs achieve through two public health statistics for health care interventions: incremental cost-effectiveness ratios (ICERs) and quality-adjusted life years (QALYs). ICERs and QALYs contribute to the Institute for Healthcare Improvement’s triple aim: improving the quality and satisfaction of health care, improving population health, and reducing health care costs (Institute for Healthcare Improvement, 2016).

In addition to studying these models, the CBPR elements of this dissertation may expand by integrating CHWs as researchers. Once properly engaged and trained, CHWs may serve as ideal research collaborators who may conduct specific research activities, such as interviewing their community members as participants. By deepening the integration of CHWs within research activities, investigators may gain even deeper understanding of health access and
interventions to decrease the barriers. Furthermore, the distance between academic researchers as outsiders and marginalized communities as insiders lessen by such methods.

**Conclusion**

Cambodian Americans experience many barriers to health access in the United States. These barriers stem from historical trauma (e.g., Khmer Rouge), structural factors (e.g., poverty, less formal education), and cultural and linguistic differences between the mainstream society in the United States and Khmer culture. Although the details of these barriers may be unique, many communities in the United States share the experience of poor health access and status. Further, these barriers will remain persistent until community-defined solutions, such as community health work, are prioritized and maintained.

This study incorporates a community-based participatory approach to understanding and changing how Cambodian Americans experience health access in the United States. The community partnership established to complete this dissertation reflects an effort toward cultural synthesis. Without community partnerships, the dominant values of the United States reinforce the cultural invasion of Cambodian Americans through silence and invisibility. For Cambodian Americans and other marginalized communities, silence and invisibility are the hallmarks of subjugation. Bilingual Cambodian CHWs who identify with an orthogonal culture aid in challenging the oppressive structures that reinforce subjugation.

Social work practice values the dignity of and justice for all marginalized communities. Community-based participatory research is a process-oriented commitment to practicing these values. Social work’s commitment to social justice and human rights requires both an active stance that confronts marginalization and equitable community partnerships to defend against
cultural invasion. For Cambodian Americans, a path to healing requires a sustained commitment from those who have better access to health in the United States.
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Appendix A

CBPR Core Principles

<table>
<thead>
<tr>
<th>CBPR Core Principle</th>
<th>Target Population</th>
<th>Research Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Community as a unit of identity</td>
<td>Cambodian American communities</td>
<td>Pre-dissertation community engagement; All Phases</td>
</tr>
<tr>
<td>2. Builds upon strengths and resources within the community</td>
<td>Cambodian community health workers; Khmer Health Advocates organization</td>
<td>All Phases</td>
</tr>
<tr>
<td>3. Collaborative, equitable partnership in all phases of research</td>
<td>Khmer Health Advocates staff</td>
<td>All Phases</td>
</tr>
<tr>
<td>4. Promotes co-learning and capacity building among all partners</td>
<td>Khmer Health Advocates staff; Participants</td>
<td>All Phases; Phase 3</td>
</tr>
<tr>
<td>5. Balance of research and action for the mutual benefit of all partners</td>
<td>Khmer Health Advocates staff</td>
<td>All Phases</td>
</tr>
<tr>
<td>6. Emphasizes local relevance of public health problems and ecological perspectives that recognize and attend to the multiple determinants of health and disease</td>
<td>Participants</td>
<td>Pre-dissertation community engagement, Phase 1 and 2</td>
</tr>
<tr>
<td>7. Involves systems development through a cyclical and iterative process</td>
<td>Khmer Health Advocates staff</td>
<td>All Phases</td>
</tr>
<tr>
<td>8. Disseminates findings and knowledge gained to all partners and involves all partners in the dissemination process</td>
<td>Khmer Health Advocates staff; Participants; Cambodian American communities</td>
<td>Phase 3</td>
</tr>
<tr>
<td>9. Involves long-term process and commitment</td>
<td>Cambodian American communities</td>
<td>Pre-dissertation community engagement; All Phases; post-dissertation research</td>
</tr>
</tbody>
</table>

Adapted from Israel et al. (2008)
Appendix B

Focus Group Discussion Guide

Facilitator’s role

1. IRB Informed Consent
2. Review purpose:
   a. To gain essential knowledge and understanding from Cambodian community health workers about relevant concepts with regard to: defining health from the Cambodian American community, the CHW role for Cambodian Americans, and the Cambodian’s experience with health access
   b. To develop a culturally appropriate semi-structured interview guide to be used for interviews of community health workers about health access
3. Introductions and use of Participant numbers

Topic Guide

Research Questions

Question 1: From the perspective of Cambodian CHWs, what does health mean to Cambodians that are served by CHWs?

Question 2: What do Cambodian CHWs understand about the experience Cambodian Americans have with health access in the U.S.?

Question 3: According to Cambodian CHWs, what are the top three barriers to health access for Cambodian Americans?

Question 4: How do Cambodian community health workers negotiate conflicts between Cambodian Americans and western health care providers to improve health access?

Question 5: What action steps may address the health access needs of Cambodian Americans?

Additional Goals of Focus Group

1. Define health from the perspective of Cambodian Americans
   a. Identify key concepts/components to health
2. Define “community health worker”
3. Understanding how CHWs can be helpful in facilitating health access for Cambodian Americans
Appendix C

Semi-Structured Interview Guide

1. What community(ies) do/did you serve?
   a. How would you define your community?
   b. How would you describe your culture?
      i. How would you describe the culture of your community?
      ii. From your cultural standpoint, what does health and health care mean to you?
      iii. From your community’s cultural standpoint, what does health and health care mean to them?
      iv. What is similar and/or different to the U.S.’ culture of health and health care?
      v. How has your community’s relationship with their culture of origin changed over time (e.g., strengthened or weakened)? How does this impact your communities’ health?
   c. What is the current health status of your community?
      i. How does your community address their current health status?
      ii. How do individuals in your community address their current health status?
      iii. What does your community need to improve health outcomes?
      iv. What do individuals in your community need to improve health outcomes?

2. How would you define community health work?
   a. How would you define the scope of community health work?
   b. What does being a community health worker mean to you?
   c. How did you start practicing community health work?
   d. Please tell me about why you practice community health work.
   e. How long have you practiced community health work?
   f. Has your community health work changed over this time?
      i. If so, how?
   g. What challenges, if any, have you faced in maintaining your role as a community health worker?

3. How do you know when you are successful in your role as a community health worker?
a. What helps you be successful as a community health worker?
   i. May you share a story about when you felt most successful? (Both on individually and community levels)

b. Outside of your Cambodian community, who counts on you to help in your role as a community health worker?

4. How do you know when you are LEAST successful in your role as a community health worker? (Tell a story)

5. What do Cambodians experience with western medicine?
   a. What works well? What doesn’t work well? (Ask for a story)
   b. What do Cambodians feel that western doctors do really well? (Ask for a story)
   c. How does western medicine differ from traditional Cambodian healing practice of Kru Khmer?
   d. If Cambodians could let their western doctors know anything, what might it be? (Ask for a story)

6. How do you work to integrate your community’s health needs into the U.S. society? (Ask for stories)
   a. Does gathering more data about your community and their health needs help?
      i. If so, in what way?
   b. How do current public policies (e.g., Affordable Care Act, Title VI) impact your work?
   c. What policy changes would you suggest to better support the health of your community?

7. What other strategies do you use to improve health outcomes for Cambodian communities?

8. Is there anything else you would like to let me know?
Appendix D

Interview Consent

University of Connecticut
Consent Form for Participation in a Research Study

Principal Researcher: Nina Heller, PhD
Student Researcher: Jack Lu, LCSW, MSW
Study Title: A Community Based Participatory Approach to Address the Health Access of Cambodian Americans

Introduction

You are invited to participate in a research study to gain a deeper understanding of health access for Cambodian Americans. This study will explore the experiences, knowledge, and perspective of Cambodian community health workers (CHWs) to best understand how to improve health outcomes for Cambodian Americans. Cambodian CHWs are a vital resource to improving Cambodian Americans' health in the United States.

Why is this study being done?

Although Cambodian refugees have come to the U.S. since 1975, many Cambodians continue to experience inadequate access to health that results in ongoing poor health outcomes. Inadequate health access may lead to poor health outcomes, such as physical suffering, psychological distress, and premature death. The purpose of this research is to advance the knowledge regarding health access for Cambodian Americans; highlight the unique roles of CHWs; and challenge injustice that Cambodian Americans face.

What are the study procedures? What will I be asked to do?

You are asked to participate in a one-to-one interview. A mutually defined time will be agreed upon for the interviews to be conducted through Skype, phone, or in person. Interviews will be audio recorded through Skype Auto Recorder or by an electronic smart pen and tape recorder, dependent on format of interview. You will be asked to select a location that is comfortable and private for you to speak over Skype, by phone, or in person.

What are the risks or inconveniences of the study?

An inconvenience to this study may be your time. Although you have committed countless hours to help improve Cambodian Americans' health in the U.S., this study will ask you to invest between one to two hours of your time to complete an informed consent and participate in the interview. Additionally, you may be contacted in a follow-up to clarify what was shared during the interview. This may take an additional thirty minutes.
What are the benefits of the study?

Direct anticipated benefits may come in several ways:
1. Provide opportunities for critical reflection of the work that CHWs accomplish
2. Dissemination of findings to participants and KHA may offer some strategies to improving the work of CHWs from different regions
3. Recommendation of action step(s) to improve health access for Cambodian Americans by the conclusion of this study

Will I receive payment for participation? Are there costs to participate?

There are no costs and you will not be paid to be in this study.

How will my personal information be protected?

All participants will be assigned a unique identifier once you have agreed to participate and signed the informed consent form. Your unique identifier will be used to protect your confidentiality, which only the student researcher will have access to. All data that is collected will be stored in a locked cabinet in a locked office that only the researchers for this project will have access to. The digital recordings of the interviews and the transcriptions of these recordings will be stored as electronic data. Any electronic data will also be stored on a password protected laptop and password protected flashdrive. Upon the completion of this study, all digital recordings will be destroyed. Please note, that electronic correspondence is not the most secure transfer of information. If you are concerned about sharing the demographic survey and/or informed consent by email, I may send you an addressed envelope for the forms to be submitted.

You should also know that the UConn Institutional Review Board (IRB) and the Office of Research Compliance may inspect study records as part of its auditing program, but these reviews will only focus on the researchers and not on your responses or involvement. The IRB is a group of people who review research studies to protect the rights and welfare of research participants.

Can I stop being in the study and what are my rights?

You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate.

Whom do I contact if I have questions about the study?

Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator (Nina Heller at 860-570-9174) or the student researcher (Jack Lu at 860-878-5648). If you have any questions concerning your rights as a research subject, you may contact the University of Connecticut Institutional Review Board (IRB) at 860-486-8802.
Appendix E

A Community Based Participatory Approach to
Address the Health Access of Cambodian Americans

Participant Demographic Information

Participant ID: __________________ Date: __________________

Thank you for agreeing to participate in this study. The primary objectives of this project are to: 1.) Understand the knowledge, perspective, and experience of Cambodian community health workers with Cambodian American health access; 2.) Identify ways to improve health access for Cambodian Americans; and 3.) Develop action step(s) to improve health access for Cambodian Americans.

Before we begin, I’d like to ask you a few questions in order to learn more about you. I want to remind you that all information that you share is stored by participant ID number only, not by name, and that all data is kept strictly confidential. I am the only person who will have a record of your ID number matched to your name and this record will be kept in a locked storage cabinet and destroyed at the end of the study. The results will be reported as a group and will not be linked back to any individual participant. If you have any questions about this survey, please do not hesitate to ask.

1. What is your race / ethnicity? (Please choose all that apply)
   - Asian
     - If you identify as Asian, are you...
       - Cambodian
       - Vietnamese
       - Laotian
       - Pilipino
       - Japanese
       - Chinese
       - Other Asian group: _______________________________________

     - Latino/Hispanic
     - Black or of African Descent
     - American Indian or Alaska Native
     - Native Hawaiian or Other Pacific Islander
     - White
     - Other ____________________________________________
     - Don’t know

2. What country were you born in? ______________
3. How many years have you lived in the United States? __________

4. What town/city and state do you currently live in? ______________________________________

5. What is your age in years? ______

6. How many people live in your household? ___________________

7. What is the highest level of school you’ve finished? These are in terms of U.S. standards. If these standards are not familiar to you, please ask for clarification. (Please choose one).
   - No schooling
   - Elementary School (grade 6 or less)
   - Middle School (grade 7 or grade 8)
   - Some High School (grades 9-12), no diploma
   - High School Grad or GED
   - Technical or Vocational School
   - Some college
   - Associates Degree
   - B.A. or B.S.
   - Graduate or Professional Degree
   - Other: Please specify:________________________________________
   - Don’t know

8. What is your gender?
   - Female
   - Male
   - Other:________________

9. What language do you speak most often in your role as a community health worker? (Please choose one).
   - English
   - Khmer
   - English and Khmer Equally
   - Other: Please specify:________________________________________

10. In general, would you say that your health is...? (Please choose one).
    - Excellent
    - Very Good
    - Good
    - Fair
11. **In terms of relationship status are you currently...? (Please choose one).**
- Single (never married, not living together)
- Married (not separated)
- Living together (not married)
- Separated
- Divorced
- Widowed
- Other: Please specify: ________________________________

12. **Which of the following best describes your current employment situation? (Please choose all that apply).**
- Not employed or laid off
- Working full-time
- Working, part-time
- Student
- Other: Please specify: ________________________________

13. **How much is your monthly household income? (Please choose one).**
- None
- Less than $500
- $500-$999
- $1000-$1,999
- $2,000-$3,999
- $4,000-$5,999
- $6,000 or more
- Other: Please specify: ________________________________
- Don’t know

14. **Do you have health insurance? (Please choose one).**
- Yes
- No (uninsured)
- Don’t know

**Before answering question 15, please refer to the following:**
A community health worker is defined by the U.S. Department of Labor (2010) as people who:
- Assist individuals and communities to adopt healthy behaviors.
- Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health.
• May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening.
• May collect data to help identify community health needs.
• Excludes “Health Educators” (21-1091). Illustrative examples: Peer Health Promoter, Lay Health Advocate

15. Are you or have you ever practiced as a community health worker?
☐ No  ☐ Yes

16. How many years have you practiced as a community health worker?

17. Please list in the space below the location(s) by state and time(s) by year(s) that you practiced community health work (e.g. Massachusetts - 1999, Texas - 2004-2005)?
Appendix F

Participant Screening Sheet

A Community Based Participatory Approach to Address the Health Access of Cambodian Americans

Name of Participant: ______________________
Contact information:
Mailing Address: ______________________
____________________________________
____________________________________
Phone Number: ______________________
Email Address: ______________________

1. Are you of Cambodian descent?
☐ No ☐ Yes

2. Are you at least 18 years of age?
☐ No ☐ Yes

A community health worker is defined by the U.S. Department of Labor (2010) as people who:

- Assist individuals and communities to adopt healthy behaviors.
- Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health.
- May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening.
- May collect data to help identify community health needs. Excludes “Health Educators” (21-1091).
- Illustrative examples: Peer Health Promoter, Lay Health Advocate

3. Are you or have you ever practiced as a community health worker?
☐ No ☐ Yes

4. Have you practiced community health worker for at least one year?
☐ No ☐ Yes

5. Are you currently practicing community health work?
☐ No ☐ Yes

6. Are you fluent and literate in both English and Khmer?
☐ No ☐ Yes
## Appendix G

**First Cycle Coding Map for Phase One Focus Group**

<table>
<thead>
<tr>
<th>Challenges</th>
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<tbody>
<tr>
<td>Culture conflict</td>
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<td>Displacement from home</td>
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<tr>
<td>Fear</td>
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<tr>
<td>Health care navigation</td>
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<tr>
<td>Immigration experience</td>
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<tr>
<td>Khmer Rouge Genocide</td>
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<tr>
<td>Language Fluency</td>
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<tr>
<td>Mistrust</td>
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<tr>
<td>Older adults</td>
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<tr>
<td>Resources</td>
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<tr>
<td>Education</td>
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<tr>
<td>Financial</td>
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<td>Health Insurance</td>
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<td>Transportation</td>
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<tr>
<td>Sexism</td>
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<tr>
<td>Social Exclusion</td>
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<td>Stereotyping and overgeneralization</td>
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<thead>
<tr>
<th>CHW</th>
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<tr>
<td>Role</td>
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<td>Health and Healing</td>
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<td>Biomedicine</td>
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<th>Strategies</th>
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<td>Community organization</td>
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<td>Data collection</td>
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Appendix H

Second Cycle Coding Map for

Phase Two Interviews and Phase One Focus Group

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<tr>
<th>Domain</th>
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<td>Action Steps</td>
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<tr>
<td>Bridging gap between U.S. leaders and the community</td>
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<tr>
<td>Developing Resources that are sustainable</td>
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<tr>
<td>Early child intervention through schools</td>
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<tr>
<td>Enforcement of current policies</td>
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<tr>
<td>Ongoing community education series</td>
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<td>Critical Pedagogy</td>
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<td>System support</td>
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<td>Cultural Invasion</td>
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<td>Cultural Synthesis</td>
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<td>Health</td>
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<td>Barriers that affect Health</td>
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<td>Citizenship status &amp; Uniting families</td>
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<td>Domestic and Community Violence</td>
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<td>Economic factors</td>
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<td>Crime</td>
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<td>Lack of resources</td>
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