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Improving the Health of Cambodian Americans: Grassroots Approaches and Root Causes

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Abstract

Background—Cambodian Americans experience great disparities in health compared to other Americans, yet may be underserved by conventional healthcare systems. CBPR is a means to engage underserved communities in health research and programming. We describe results of our efforts to engage the Cambodian grassroots members as well as formal leaders in Oakland, CA.

Objectives—In addition to a community advisory group, we convened a Community Work Group (CWG), composed of ten grassroots community women of varying ages and backgrounds. The project aimed to leverage the lived experiences of these women and their understandings of health and wellness in identifying specific health issues and developing culturally resonant strategies.

Methods—The CWG met weekly with staff facilitators using methods for collective analysis including theater, body mapping, and other expressive arts.

Results—The approach proved logistically challenging, but resulted in novel analyses and strategies. The group identified trauma, along with poor access to education, un- and under-employment, social isolation, and generation gap, together with community violence, as root causes of key behavioral health issues, i.e. alcohol abuse, gambling, prescription drug misuse, and domestic violence. Strategies proposed and implemented by the group and project staff were a community garden, Cambodian New Year's celebrations, and a museum exhibit on the Cambodian refugee experiences.

Conclusions—Grassroots community engagement can support projects in identifying social determinants of health and developing the capacities of community members to conduct research and actions to improve health.

Background

Many years after the genocidal Khmer Rouge period, Cambodian Americans and their children continue to experience poor health (1–4), evidenced by high rates of post-traumatic stress disorder (PTSD), depression, anxiety, and substance misuse (5–11). Community-Based Participatory Research (CBPR) may aid in identifying new ways to address such persistent health conditions (12–14). Our project utilized CBPR to improve the behavioral health of Cambodian Americans in Oakland, CA. We focused on building the capacities of grassroots Cambodian American women to identify behavioral health issues and disparities, and develop ideas for interventions addressing those issues.

Objectives

Partnerships

The project was a collaboration between the Pacific Institute for Research and Evaluation (PIRE), a public health research agency, and Community Health for Asian Americans (CHAA), a community-based behavioral health and wellness provider, together with Cambodian Community Development, Inc. (CCDI), and Center for Empowering Refugees and Immigrants (CERI), two community-based organizations serving Oakland Cambodian Americans. These partners had worked together in various configurations for ten years prior to the project, including federally-funded research and intervention projects on the etiology of problematic substance use among U.S. Southeast Asians (15–17), and had a mutual interest in improving the health of Cambodian Americans through research and community engagement. Following these projects we conducted focus groups with key community leaders to assess unmet community behavioral health needs and consider new approaches to address these needs. During the project period a third community-based organization, Peralta Hacienda Historical Park (PHHP), was recruited as an event site and eventually came to act as a full collaborator. We obtained funding for a two-year pilot CBPR project in which the collaborators were to assemble a community advisory board and conduct primary research to identify a key health issue in a 6-month Phase 1, and then design, field, and evaluate a pilot intervention to address this health issue for a 18-month Phase 2.

“Community engagement” operationalized

In the U.S. there has been increasing interest in community-engaged research approaches (18, 19); however, it often unclear how “the community” should be represented (20). We chose to engage the Oakland Cambodian American community at the “formal leadership” level, i.e., Cambodians representing the community in a professional capacity, and at the the grassroots level, i.e., Cambodians who may not (yet) be in formal leadership roles. This decision derived from our understanding of CBPR as an approach to addressing persistent behavioral health issues for Cambodian Americans.

Although many Cambodians seek treatment, there is a limited behavioral health workforce with adequate training to address the unique needs of this population. Of equal importance, many Cambodians present behavioral health issues somatically (10, 21) and bring these issues to primary care rather than a behavioral health service. We speculated that engaging

the community only at the level of formal leadership—people already working within conventional behavioral health settings—might keep the project interventions within pre-established service modalities. In order to identify new and innovative approaches, we focused on utilizing CBPR to support grassroots community members to bring new information to light based in their own lived experiences of behavioral health issues, and to use this research to design a pilot intervention, at the same time developing the leadership capacity of grassroots community member. We focused on women since our community assessment had identified the key roles women play in family health and wellness.

Methods

Community representation

For this project CHAA hired a full-time Community Health Worker (CHW), a Cambodian American woman with deep ties to local Cambodian American residents as well as experience working with key organizations serving Cambodian Americans. The CHW's role was to support the work of the Community Work Group (the core group of grassroots co-researchers) by providing interpretation and translation in meetings, supporting CWG members to attend project activities, and also outreach to key community resources (e.g., Buddhist temples; community leaders). PIRE also hired a Cambodian American Research Assistant (RA), an Oakland native with a wide range of research skills, to support community research activities and assist in documenting the process. We organized a volunteer Community Advisory Committee (CAC), composed of 16 people who represented a variety of Cambodian-serving social service, educational and health organizations. The CAC's role was to support the project activities in all phases of the project with resources and guidance. In Phase 1, the CAC established the criteria for the CHW and for CWG membership and recruited candidates for these roles. In Phase 2, the CAC linked the project activities to on-going community initiatives and resources. CCDI and CERI were contracted to serve as "Community Hosts" to provide the project with culturally-appropriate resources including meeting spaces, translation of documents, outreach and support of research activities, and their executive staff served on the CAC. The authors of this article include staff from all four of the key collaborating agencies, including the project's CHW and RA.

Community Work Group/Cambodian Women's Group

At the core of the project was a Community Work Group (CWG), also referred to as the Cambodian Women's Group by our project team. Typically when community members are engaged in community-based research this involvement is limited to focus groups and key informant interviews conducted by a research expert who extracts information from participants on preselected topics. The results of this research may be analyzed and interpreted by the professional researchers, possibly with consultation from other professionals within the community, and utilized to improve outreach for health education, prevention programs, and other interventions. Dutta (22) refers to this type of approach as a *cultural sensitivity approach*, also referred to as *cultural tailoring* by Peterson (20) in contrast to a *culturally-centered approach* in which "alternative theories of health are generated by engaging in meaning-making with cultural participants." Our project aimed for a culturally-centered approach. The CWG participants were engaged as co-researchers, and the "data"

upon which our collaborative research was based would be derived from expertise based on their lived experiences and ways of understanding health and wellness (23).

Following the advice of the CAC that the CWG represent the diversity of the experiences of Cambodian Americans in Oakland, we recruited 10 women who ranged in age from 21 to 65 and included Cambodian-born refugees, American-born children of refugees, and recent immigrants from Cambodia. Additionally, the CWG included LGBTQ members as another feature of diversity. While all members were able to speak and understand some Khmer and some English, younger members were much more proficient in English, while older members and recent immigrants were much more proficient in Khmer. Some participants were able to read and write in English but not Khmer, some were proficient in written Khmer but had limited proficiency in written English, and some could not read or write in either language.

The CWG met once a week for two-hours per session. Each session was facilitated by project staff, which included two non-Cambodians with expertise in CBPR as well as the Cambodian American CHW, and recorded in detailed notes by the bilingual/bicultural Research Assistant. These staff members met weekly to plan each session, led by the CBPR expert in Popular Education methods. All project protocols were reviewed and approved by PIRE's Institutional Review Board. CWG participants received stipends of \$50 per session. Over the course of the project, three CWG members dropped out due to personal reasons.

Collective analysis methods

The high validity of analyses conducted in a grassroots approach to CBPR derives from the iterative cycles of action and reflection within which community members conduct research and/or intervention activities and then connect this work to their own lived experiences to contextualize the work and deepen their understandings of it (24). Working with the facilitation team, the CWG conducted collective analyses beginning with the domains of health, wellness, and community, and then expanding to include emergent topics such as family and generation gap, and on to specific issues that helped shape the components of a pilot intervention. These collective analyses formed the core of Phase 1 activities but continued throughout Phase 2. We utilized methods from Freirian Popular Education that use concrete, typically non-verbal, foci to generate reflection and dialogue by enabling participants “to ‘see’ their reality with new eyes and develop new ways of thinking and acting,” (25–27). The methods we used were:

Popular theater—This technique involved role playing, sometimes called applied theater, as well as Theater of the Oppressed (28). Working in pairs or small groups, the participants developed brief dramatic improvisations based on their lived experiences of focal issues. These pieces were presented to and discussed within the group. This method—combining theater with participatory learning (29–31)—was particularly effective for exploring and articulating complex relationships associated with community health issues such as alcohol use and misuse, domestic violence, and the generation gap within families.

Body mapping—In our project the method of body mapping (32–35) was used to establish a foundation of co-learning as well as identify recurring and/or complementary

themes across the experiences of the diverse group of CWG participants. This method facilitated discussions of life experiences and how they are connected to the physical and socio-cultural environment and historical context. By the end of the exercise, the CWG members were able to articulate these connections in their own lives.

Interpretive art making—At various stages in the collective analysis the participants sculpted items and images from play-dough as ways to depict and contextualize themes that emerged, such as food or self-image. The group collaboratively generated murals to conceptualize possible futures for Cambodian Americans, including detailed depictions of their proposed intervention components described below (Figure 1, drafted for the CWG by co-author TS, illustrates linkages between root cause analyses and the community garden component of the intervention design).

Analysis and interpretation

The analytic process consisted of small group discussions, supported by the facilitation team. These conversations were summarized and presented to the larger group. Analyses and interpretation across small groups were summarized as bullet points on large pieces of paper posted at the end of the session. When decisions were made within the group—notably, selection of a focal health issue and pilot intervention components—the decision-making process was by vote.

All discussions were conducted with interpretation in English and Khmer. Notes were generally summarized in English. The small and whole group discussions were recorded in English by the project Research Assistant and combined as session notes. These weekly session notes were uploaded to a database accessible to all staff members. The facilitation team also met weekly to debrief on the sessions, consider the results, and plan for the following sessions. These debrief and planning meetings were also documented in written notes.

Weekly session summaries prepared by the project Research Assistant were sent to all CAC members. In quarterly meetings, the results of the CWG sessions were presented to the CAC for review, consideration, and feedback.

Results

Health issues and root causes

The CWG identified a constellation of interrelated behavioral health issues that shared common roots. Four issues they identified are familiar within the lexicon of behavioral health issues addressed in treatment and prevention programs: alcohol misuse; problem gambling; prescription drug misuse; and domestic violence. Other issues are less directly recognizable as “health issues” *per se* although some are increasingly recognized as social determinants of health. These were: generation gap; lack of education; un/underemployment; community violence; social isolation; and trauma. Trauma included both the Khmer Rouge and refugee experiences as well as new traumas and re-traumatization due to community- and gang-related violence, poverty, and discrimination in the U.S.

Practical solutions: Centering the community

The practical solutions that the CWG proposed aimed to address root causes of behavioral health issues for Cambodian Americans living in Oakland. The group's original proposal was to develop a Cambodian community center: a space where Cambodians could socialize in positive ways, providing alternatives to parties that featured or included gambling and drinking, which the CWG identified as the main ways Cambodians socialize. A center could be a place where people could find company and comfort while reducing their social and cultural isolation. A community center could provide services such as tutoring and mentoring to support educational aspirations and cultural preservation goals. Finally, such a center could provide a space for both older and younger Oakland Cambodians to meet within activities and programs (e.g., Khmer language or music classes; all-ages social events) that could help bridge the generation gap.

Given that our federal funding and two-year timeline precluded establishing such a facility, the group instead considered what might be key features of a Cambodian community center that could constitute doable projects. The group came up with a list of possible and doable projects and voted on these. This process resulted in the identification of three core components of our pilot intervention: *Cambodian Community Gardens*, with an initial demonstration garden followed by two more gardens; *Cambodian Community New Year's Celebrations*, organized in 2011 and 2012 by the project and in 2013, 2014, and 2015 by community leaders; and a *Cambodian Cultural Exhibit*, featuring the life stories of CWG and other community members and Cambodian cultural practices (e.g., music, dance) and social change. The intervention components, the root causes they aimed to address, and their community impacts are summarized in Table 1.

The project timeline did not allow us to evaluate intervention outcomes. However, process evaluation indicated that the CWG accurately assessed and addressed areas of unmet need. Process evaluation for the intervention consisted of surveys or attendance rolls to record participation in and responses to the intervention activities by the broader Oakland Cambodian American community. Of attendees at the 2011 New Year's event, 171 took a survey addressing key Cambodian American community concerns including the root causes identified by the CWG as well as health and social issues. The survey was conducted in both English and Khmer. Respondents ranged in age from 18 to 84, with the median age of 32 (standard deviation 16). Of these participants, many reported a good deal of social isolation: only 26% reported ever going to Buddhist temples, and there was a lack of activity outside the home for older adults. The majority (55%) reported that the best thing about the event was seeing other Cambodian Americans. Since the end of our project, Cambodian American community activists working with Peralta Hacienda Historical Park have taken on leadership of this event and have continued to host it with the same essential structure (36). The community garden intervention, in which 129 Cambodian American community members participated, has likewise been adopted by two of the collaborating organizations (CHAA and CERI).

Of the 108 people who took the community survey at the 2012 Cambodian New Year celebration, 54% (58 people) reported that they saw the cultural exhibit. Most of these who saw the exhibit reported that the best thing about it was "pride in my culture." Peralta

Hacienda Historical Park and collaborating community leaders, including one of our project staff and two CAC members, have obtained funds from local traditional arts councils to develop and expand the cultural exhibit (37, 38) by developing the supplemental audios into a larger oral history project.

Such efforts to institutionalize these project components reflect the success of these intervention activities in meeting the community's goals and needs. The CWG members have continued to show leadership in these and other related activities. Additionally, these activities have provided opportunities for new leaders, both older people of the refugee generation and younger Cambodian Americans, to step up, take ownership and responsibility for these activities, and develop their leadership capacities.

Conclusions

Research shows that personal choices and behaviors influence only part of what determines an individual's health status, but that social determinants of health—economic and social conditions—influence the health of people and communities as a whole (39–41). Many of the unfavorable conditions that arise in communities—particularly in low-income and communities of color—are due to the circumstances in which people live, work, age, socialize, and form relationships, and the gaps in the systems aiming to regulate and ameliorate negative impacts of these social circumstances. Our research methods supported our interest in better understanding and addressing the underlying social determinants of health in the Cambodian American community from the community's direct, lived experiences. This project may be also seen as contributing to the emerging “Trauma-Informed Care” discourse which places individuals' and communities' experience at the center and pulls the frame of health problems out to a larger and more holistic system of interconnected, recursive and self-amplifying issues (42). Accordingly, the Cambodian Women's Group members did not focus on one isolated health problem but developed an in-depth examination of inter-related contexts and root causes of multiple interconnected health and social problems in their community. The grassroots approach allowed us to not only identify root causes but also propose novel and community-centered responses to address social determinants of poor health.

Our process challenges underscore why culturally-tailored approaches to community engagement may be more common than culturally-centered approaches. Peterson notes that community members may be limited in their ability to participate in community engagement processes because of material and opportunity costs (43). For our group, younger community participants, and sometimes staff, were already stretched thin across work (multiple part-time jobs for some) and school as well as taking care of children, older parents, and other family members. Childcare needs prevented some members from participating in project events scheduled outside of sessions—as yet, federal grant funds do not allow for childcare reimbursement.

Language proved to be a core challenge. Even as the diversity within the group proved to be a great strength and asset for the project and participants, working simultaneously in two languages was difficult. Staff and participants had to learn to pause frequently during

speeches and conversations to allow for interpretation. When interpretation was delayed or shortened, participants and staff members expressed frustration at feeling they were missing vital ideas, or concerned that their own words were not being communicated adequately. However, this bilingual work process was critical to the project's ability to encompass the lived experiences of a wide range of Cambodian Americans. The pauses needed for interpretation also provided opportunities for reflection that may have been missed if the group proceeded at full speed.

While our research methods were well-suited to a group which included members with limited literacy, these methods required skills in facilitation and implementation that might prove challenging to mainstream researchers and health and social service settings. Nonverbal methods also helped to bridge age and experiential gaps that could get in the way of sharing and communications, as well as to provide movement-based therapeutic outlets for those suffering from the effects of trauma and PTSD (e.g., 44). However, the intensive staff structure entailed substantial investments in labor and time for the partner agencies.

Finally, in refugee and immigrant communities, bridging generational gaps may be challenging for program design, but ultimately rewarding both for results and community capacity building. Like many societies, Cambodian diasporic society places a high value on children and on the well-being of future generations. This feeling may be particularly poignant for survivors of genocide. At the same time, youth are taught to honor and show respect by not challenging or contradicting elders, and may feel inhibited speaking at all in the presence of elders. Our program bridged the tension between these positions by deliberately constructing a setting within which elders and youth were encouraged to participate as equals with valid experiences and perspectives. The facilitators and bilingual bicultural staff (the RA and CHW, who themselves represented the younger and older generation) "held" this space in key ways. The staff helped the group establish guidelines and agreements that supported mutual respect; for example, an agreement to take turns in talking circles and yield the floor to whoever was holding a toy donut—symbolizing both equality and the donut-making small businesses by which many U.S. Cambodian families make a living. The staff planned group discussions and activities with sensitivity to generation gap issues; for example, soliciting opinions from both youth and elders in group discussions and ensuring that break-out discussion groups included members of both generations. The staff also invited the CWG members to directly address the generation gap by scripting and enacting brief performances about it, as a way to have fun, safely raise difficult and sensitive generation gap issues, and analyze these issues as a group. As a result, the participants gained valuable experiences in bridging the generation gap and developed a greater awareness of both the challenges faced by each generation as well as the assets each brings to the work of community building. Moreover, the resulting interventions benefit from reflecting the perspectives and serving interests of both younger and older community members.

In conclusion, we encourage researchers to consider engaging grassroots community members directly in community-partnered research. Grassroots engagement has great potential to deepen the investigation of the social determinants of health and move intervention strategies into innovative modalities and structures, perhaps with high risks but

also with potential for high rewards, to address seemingly-intractable health issues. Grassroots engagement may support community ownership and institutionalization of intervention strategies, and develop new leadership capacities to improve community well-being.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Figure 1.

Table 1**Pilot Intervention Components**

Intervention Component	Actualization	Roots Causes Addressed	Activities Included	C
Cambodian Community Gardens	<ul style="list-style-type: none"> Demonstration garden connected to local food bank CWG directed garden work 	<ul style="list-style-type: none"> Social Isolation Generation Gap Trauma Underemployment 	<ul style="list-style-type: none"> Collective efforts (breaking ground, planting, tending, harvesting) Multigenerational work Restful setting Linked with food bank 	
Cambodian New Year Celebrations	<ul style="list-style-type: none"> Oakland Cambodian New Year 2011 Oakland Cambodian New Year 2012 CWG planned and implemented 	<ul style="list-style-type: none"> Social Isolation Generation Gap Alcohol Abuse Community Violence 	<ul style="list-style-type: none"> All-day celebrations with live traditional music, dancing, games, food and tabling by CBOs and service providers, police safety training Alcohol-free Multigenerational 	
Cambodian Cultural Exhibit	<ul style="list-style-type: none"> Rhythm of the Refugees: Museum display on Oakland Cambodians, with Cambodian music as organizing theme 	<ul style="list-style-type: none"> Generation Gap Lack of Education Discrimination Social Isolation 	<ul style="list-style-type: none"> Co-curation by CWG, CCDI, and PHHP Exhibit featured life histories, images, material culture objects, and audio accompaniment 	