

## Practice Notes

# Community-Led Health Promotion Groups in a Bhutanese–Nepali Refugee Community

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*This practice note reports on the work of the Namaste Community Health Partnership, an academic-community partnership established to address health disparities in a metro-area Bhutanese–Nepali refugee community in the western United States. Partners worked together to develop, implement, and evaluate a culturally-tailored health promotion program where Bhutanese–Nepali individuals led weekly walking groups and shared health promotion information and behavior change tools with community participants. The program was implemented with approximately 70 community members across two metro-area neighborhoods and two adult day care centers serving elders. Evaluation strategies included documenting walk attendance, tracking engagement with health promotion goals, and focus group discussions with program participants. Once enrolled, most participants consistently attended walks and achieved weekly goals—some even increased walking frequency beyond program requirements. Participants provided positive feedback about having a community leader and reported learning new information and enjoying participating with other community members. Challenges and lessons learned included difficulties engaging younger adults from the*

*community, concerns about signing research consent forms, cultural norms discouraging the distribution of individual research participation incentives, variability across groups in preferences for program activities, and barriers to administering survey-based evaluation instruments. This academic–community partnership built capacity in the local Bhutanese–Nepali community, produced culturally relevant health programming, and trained and employed community members as health educators and physical activity leaders. The program resulting from this work has the potential to improve health knowledge and chronic disease prevention practices and ultimately reduce health disparities in an underserved refugee community.*

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## ► ASSESSMENT OF NEED

With the goal of addressing health disparities in a metro-area Bhutanese–Nepali refugee community, we established an academic–community partnership comprised of a public health researcher, an expert in health programming for refugee communities, and a group of community representatives. Our group, which identified itself as the “Namaste Community Health Partnership (NCHP),” received two grants to support partnership development and program design activities, including (a) conversations with community members about priority health needs, (b) development and pilot testing of a community-led health promotion program, and (c) capacity-building opportunities supporting community partners as health professionals and researchers.

Partners used a conversation guide developed by the NCHP to engage fellow community members, including elders attending a day care center program and adults in family, friend, and neighbor networks, in discussions about priority health issues and needs. Concerns largely aligned with existing information about refugee health, in general, and among Bhutanese–Nepali refugees, specifically (Elwell et al., 2014; U.S. Department of Health and Human Services, 2014). They included difficulties accessing healthy organic food; maintaining a healthy weight; managing hypertension, heart disease, and diabetes; and struggles with isolation, anxiety, and depression. Partners shared that physical activity was traditionally obtained through farming, other work activities, or tasks like walking to obtain water or food, rather than something people engaged in as an end in itself. In addition, many community members lack information about chronic disease prevention and management, are accustomed to using the health care system only for illness or emergencies, and are reluctant to ask questions or seek health information from providers in traditional medical settings.

## ► PROGRAM DEVELOPMENT AND IMPLEMENTATION

These observations led us to focus on the promotion of health education and physical activity in the community. We designed a program that integrated community-led walking groups with health education and support

for improving chronic disease prevention practices. Six bilingual Bhutanese–Nepali community members (most of whom were NCHP members) were hired as walking group leaders. They were trained by the Walk2Connect Cooperative (<https://www.walk2connect.com/>) in walk leadership skills, including safety practices and basic first aid procedures, group management, and strategies for prompting health-related discussions among walkers. Group leaders participated in the design of an 8-week walking group series aimed at improving physical activity knowledge, attitudes, self-efficacy, and behaviors. During weekly walks, leaders shared information about (a) the health benefits of activity and risks of inactivity, (b) who should be active, (c) recommended activity levels, (d) establishing a regular activity routine, (e) developing a buddy system, (f) overcoming barriers, (g) foot health, (h) fall prevention, (i) warm-up and cool-down exercises, and (j) assembling a physical activity toolkit (National Institute on Aging, 2020; Rixt Zijlstra et al., 2009). Leaders began and ended each weekly walk with warm-up and cool-down activities; demonstrated endurance, strength, or balance exercises that participants could do at home (and distributed corresponding pictures); used prompts to motivate participant discussions and share-outs; and set a weekly steps goal (35,000) that could be tracked with pedometers provided to participants.

We established walking groups in two neighborhood sites where many Bhutanese–Nepali individuals live and at two adult day care centers that serve community elders. Centers were recruited through conversations with leadership. All the approximately 30 clients served by each center were invited to participate. Seven participants were recruited for one neighborhood walking group and five for the other. NCHP leadership mapped walking routes at each site and met with participants to (a) explain the nature and purpose of the program, (b) review study consent forms, and (c) describe evaluation activities. Participants were offered small individual (neighborhood sites) or group (day care sites) cash incentives for completing evaluation activities. All study procedures were reviewed and approved by the Colorado Multiple Institutional Review Board (COMIRB).

## ► EVALUATION

Weekly walk attendance and completion of physical activity goals were tracked in both neighborhood groups (it was not possible to do this at adult day care sites). In one neighborhood group, 100% of participants attended all eight walks and achieved/surpassed each weekly steps goal. In the other neighborhood group, attendance ranged from 30% to 100% over the 8 weeks, and 50% of

participants achieved/surpassed each weekly steps goal. Postprogram focus groups were also conducted with participants from one neighborhood group and one adult day care center site (see Table 1 for findings).

### ► **SUCCESSSES, CHALLENGES, AND LESSONS LEARNED**

The successes and challenges we experienced during the pilot implementation of this program, along with lessons learned about how to successfully implement and evaluate a peer-led health promotion program aimed at reducing health disparities in an undeserved ethnic refugee community, are described in Table 1.

We were more successful in recruiting elder participants than younger adults who had child care responsibilities and work obligations that spread across daytime and evening schedules. To broaden participation across the community in the future, it will be imperative to work with community leaders to promote the program in multiple forums (e.g., cultural festivals, housing complexes, language centers, parenting groups) that reach different sectors of the community. It will also be critical to learn more about the needs, interests, and participation barriers of younger and older community members so that walking groups can be established to meet individual needs and program activities and content can be tailored accordingly. This will also be useful as our pilot experience revealed that groups evolved organically to prefer some activities over others (e.g., stretches and strength exercises vs. walking; walking exclusively vs. walking combined with health education). To add flexibility, the program would ideally provide a menu of options that would allow each group to select the activities and content they find most useful and engaging.

The use of bilingual community members as walking group leaders was a key to the success of the program. They played a critical role in securing community participation and in delivering program content and activities in a culturally appropriate and engaging way. However, it proved difficult to recruit walking group leaders for a position that was neither full time nor permanent. In the future, it would be ideal to embed the walking groups in an existing program or organization (e.g., at local health care centers, community centers, libraries, adult day care centers) that is accessible to community members and that can offer continuous employment to walk leaders.

Regarding research and evaluation, we were only successful in recruiting community members to participate in data collection activities after obtaining a waiver of signed informed consent from the IRB that had oversight for this project. This was due to widespread fears

in the community about signing an unfamiliar document. It underscored the need to partner with trusted community leaders to lend credibility to the program and associated evaluation activities. It also demonstrated the importance of working closely with IRBs to creatively address community concerns about research participation.

Finally, we obtained important qualitative feedback about program engagement and effectiveness from focus group discussions with participants (see Table 1). We were less successful in obtaining quantitative evaluation data from pre- and postprogram surveys because we lacked the resources necessary to develop culturally and contextually appropriate measurement tools, and have them administered by trained bilingual interviewers. Such work will, however, be imperative to future efforts to establish the effectiveness of this community-engaged health promotion program.

### ► **NEXT STEPS AND IMPLICATIONS FOR PRACTICE**

Based on our experience during the pilot period, we have adapted the program to increase flexibility and sustainability. To address variability in activity preferences, we introduced a menu of options, including walking, yoga/stretching, and strength and balance exercises. We developed additional health content (e.g., preventive health care guidelines) and integrated supplemental activities tailored to seniors, such as brief English-language lessons and games and puzzles for cognitive stimulation. We are working with leadership from adult day care centers and a metro-area community program to incorporate these groups into their programming, using community members as leaders. We are in the process of developing alternative metrics and methods by which effectiveness can be measured, including a translated and pretested survey instrument that can be administered to individual participants by third-party interpreters.

The results of our pilot work demonstrated that participants were highly engaged in program activities. They learned new information, adopted new behaviors, and enjoyed participating with fellow community members. The academic–community partnership built capacity in the local Bhutanese–Nepali community, produced culturally relevant health programming, and trained and employed community members as health educators and physical activity leaders. The program resulting from this work has the potential to improve health knowledge and chronic disease prevention practices, and reduce health disparities in an underserved refugee community.

**TABLE 1**  
**Successes, Challenges, and Lessons Learned During Pilot Implementation of Community-Led Health Promotion Walking Groups for a Bhutanese-Nepali Refugee Community**

<i>Operational issue</i>	<i>Successes</i>	<i>Challenges</i>	<i>Lessons learned</i>
Participant recruitment	<ul style="list-style-type: none"> <li>Ease of recruiting older adults</li> </ul>	<ul style="list-style-type: none"> <li>Difficulty recruiting younger adults because of family and work obligations</li> </ul>	<ul style="list-style-type: none"> <li>Work with community leaders to raise awareness about the program via multiple community forums and venues (e.g., cultural festivals, housing complexes, language centers)</li> <li>Tailor program activities/content to align with the needs of younger and older participants</li> <li>Provide child care and flexible session scheduling to reduce participation barriers for younger community members</li> </ul>
Program implementation	<ul style="list-style-type: none"> <li>Once enrolled, most participants consistently attended walks and achieved weekly goals</li> <li>One neighborhood group increased their walks from once a week to two times per day</li> </ul>	<ul style="list-style-type: none"> <li>Groups evolved organically to prefer some activities over others (e.g., stretches and strength exercises vs. walking; walking exclusively vs. walking combined with health education)</li> </ul>	<ul style="list-style-type: none"> <li>Provide a menu of program options that allow individual groups to choose/prioritize preferred activities, including walking, other forms of physical activity, health education, group discussions, and paired discussions</li> </ul>
Community members as walking group leaders	<ul style="list-style-type: none"> <li>Community walk leaders facilitated participant recruitment and ensured that health information and group activities were culturally relevant and engaging</li> </ul>	<ul style="list-style-type: none"> <li>Difficulty recruiting bilingual community members to serve as walk leaders because the position was neither full time nor permanent</li> </ul>	<ul style="list-style-type: none"> <li>Embed walking groups into existing programs already available to community members (e.g., at local health care centers, community centers, libraries, adult day care centers) so that leaders have continuous employment</li> </ul>
Research participation	<ul style="list-style-type: none"> <li>Obtained a waiver of written consent to participate in research activities from Institutional Review Board (IRB)</li> </ul>	<ul style="list-style-type: none"> <li>Widespread community resistance to participate in research because of fears about signing an unfamiliar consent form (rooted in historical experiences with deceptive practices prior to resettlement)</li> </ul>	<ul style="list-style-type: none"> <li>Engage trusted community leaders to lend credibility to program and evaluation activities</li> <li>Work closely with IRBs to address community concerns about participating in research</li> </ul>

(continued)

TABLE 1 (CONTINUED)

<i>Operational issue</i>	<i>Successes</i>	<i>Challenges</i>	<i>Lessons learned</i>
IRB approvals	<ul style="list-style-type: none"> <li>Obtained IRB approval to disburse either individual or group incentives for research participation, depending on implementation context</li> </ul>	<ul style="list-style-type: none"> <li>Disbursing individual incentives for research participation was not possible in the adult day care sites because it did not align with cultural norms about collective benefit</li> </ul>	<ul style="list-style-type: none"> <li>Work closely with IRBs to tailor research protocols to be responsive to community preferences and cultural norms</li> </ul>
Evaluation	<ul style="list-style-type: none"> <li>Participants easily provided program feedback in focus groups</li> <li>Participants reported in focus group discussions that they (a) appreciated having “a teacher” from their own community, (b) learned new health information, (c) achieved a better understanding of the benefits of physical activity, (d) were motivated to increase their physical activity by the steps goals, and (e) enjoyed the program because it brought them together with other community members and created opportunities to be outside</li> <li>More than half of the participants from one adult day care center reported that they were still doing the exercises taught during the program, and nearly all said they would participate again</li> </ul>	<ul style="list-style-type: none"> <li>Collection of quantitative evaluation data (e.g., pre- and postprogram surveys) was limited by a lack of culturally appropriate measurement tools and the expense of individual interviewer-administered assessments</li> </ul>	<ul style="list-style-type: none"> <li>There is a need for translation and extensive pretesting of existing measurement tools to ensure cultural appropriateness and understandability of evaluation tools</li> <li>Build in resources for trained, neutral interpreters to administer survey instruments in individual, private settings</li> <li>Develop alternative metrics for program engagement and effectiveness</li> </ul>

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## REFERENCES

Elwell, D., Junker, S., Sillau, S., & Aagaard, E. (2014). Refugees in Denver and their perceptions of their health and health care. *Journal of Health Care for the Poor and Underserved*, 25(1), 128–141. <https://doi.org/10.1353/hpu.2014.0032>

National Institute on Aging. (2020). *Exercise and physical activity*. <https://www.nia.nih.gov/health/exercise-physical-activity>

Rixt Zijlstra, G. A., van Haastregt, J. C. M., Ambergen, T., van Rossum, E., van Eijk, J. T. M., Tennstedt, S. L., & Kempen, G. I. J. M. (2009). Effects of a multicomponent cognitive behavioral group intervention on fear of falling and activity avoidance in community-dwelling older adults: Results of a randomized controlled trial. *Journal of the American Geriatrics Society*, 57(11), 2020–2028. <https://doi.org/10.1111/j.1532-5415.2009.02489.x>

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases, Division of Global Migration and Quarantine. (2014). *Bhutanese refugee health profile*. <https://www.cdc.gov/immigrantrefugeehealth/pdf/bhutanese-health-profile.pdf>