J Community Health (2016) 41:509–517
DOI 10.1007/s10900-015-0124-z

CrossMark

ORIGINAL PAPER

Building Social Capital Through a Peer-Led Community Health Workshop: A Pilot with the Bhutanese Refugee Community

Hyojin Im[1] · **Rachel Rosenberg**[1]

Published online: 14 November 2015
© Springer Science+Business Media New York 2015

Abstract Despite the high health and mental health care needs, resettled refugees often face cultural and linguistic challenges that hinder the access to appropriate and timely interventions and services. Additionally, such concepts as preventive health or mental health treatment are foreign to this population, which creates additional burdens to the refugee community that already have difficulty navigating a complex health care system in the U.S. To address multiple and complex gaps in health and mental health support for the refugee community, requested is an innovative approach that can convey culturally responsive and effective interventions for health promotion, such as peer-based health education. Few studies have been conducted on the effectiveness of peer-led community health interventions with refugee populations in the U.S. resettlement context. However, peer-led interventions have been shown to be effective when working with cultural minorities and interventions in an international context. Adopting a social capital framework, the current study conducted qualitative evaluation on the impact of a pilot peer-led community health workshop (CHW) in the Bhutanese refugee community. A hybrid thematic analysis of focus group discussion data revealed the improvement in health promotion outcomes and health practice, as well as perceived emotional health. The results also showed that the peer-led CHW provided a platform of community building and participation, while increasing a sense of community, sense of belonging and unity. The findings posit that a peer-led intervention model provides culturally responsive and effective tools for building social capital and promoting community health in the refugee community.

Keywords Peer-led intervention · Community health workshop · Bhutanese refugee · Social capital · Qualitative Evaluation

✉ Hyojin Im
him@vcu.edu

[1] School of Social Work, Virginia Commonwealth University, 1000 Floyd Ave. Academic Learning Commons Rm# 3207, Richmond, VA 23284, USA

Introduction

Access to health and mental health services are among the numerous needs that refugee communities have throughout migration and the resettlement process. Adversities leading to forced migration, such as war, social conflicts and various forms of violence, tend to devastate the health and mental health status of refugees. Furthermore, migration to a new cultural environment plays as a risk factor for additional health problems, including diabetes [1–3], obesity [4, 5], acculturative stress [6], somatic pains [7], and common mental health disorders such as depression, posttraumatic stress disorder (PTSD) and other anxiety disorders [8, 9]. Despite the high needs of health and mental care, resettled refugees often face another set of challenges that obstruct appropriate and timely interventions and services. In addition to the alien concepts of preventative health and mental health treatment [10], refugees often experience a lack of culturally and linguistically competent providers in various settings, which tends to create additional burdens to the refugee community that already have difficulty navigating a complex healthcare system in the U.S [11, 12]. To address such multiple and complex gaps in health and mental health support for the refugee community, requested is an innovative approach that can convey culturally responsive and effective interventions for health

promotion. Among others, a peer-led or peer-based intervention model is known to be an effective tool for culturally competent, evidence-based care [13–15].

A peer-led intervention utilizes people who share a common belief, ethnicity, religion, or other common factors to change health behaviors and increase positive health outcomes among members of their own community [16]. Health knowledge and behavior among peers translates to other peers through interaction and creating new social norms within the group. Due to the commonality among peers, peer-led interventions have shown effectiveness with not only high-risk and hard-to-reach populations but also cultural minority populations [16]. The *Promotora* (health promoter) program, for example, is well documented as an effective peer-based model with Latino communities in addressing various common health problems encountered commonly by the immigrant community in the U.S. [17–19].

The peer-led intervention model has been used and proven effective in a diverse range of health issues, including heart health [20], diabetes [18], bipolar disorder [21], schizophrenia [22], substance abuse and loss and bereavement [23, 24], sexual behaviors [25], and cancer [26]. In addition to desired health outcomes, a peer-based approach is also likely to create additional positive outcomes, such as increasing participant involvement, creating a bond and support between the peer facilitator and the participant, empowering the group and enhancing social inclusion [1, 16]. Such benefits are often as salient as the direct health outcomes and critical to further improvement and changes in health behaviors [13, 27–29]. In particular, social capital, along with social support, has been identified as one of the significant elements and outcomes of peer-based interventions [30, 31]. Social capital, defined by the amount of resources available within a social structure [32], is essential in bringing members of a community together around common agendas and establishing the group toward collective goals [33]. In the meantime, social capital can also be promoted by group participation and activities through peer-based interventions, and functions as a vehicle to fostering connectedness among the group and achieving physical and psychological wellbeing of group members [34, 35]. In this regard, a peer-based intervention model, by its characteristics, not only requires forms of social capital but also can generate and promote social capital in the group and broader community.

Despite the relevance and potentials of peer-based health promotion interventions to the refugee community, few studies have been conducted with refugee populations in the U.S. resettlement context. The current study explores the impact of a peer-led intervention for health promotion with the Bhutanese refugee community as a pilot while adopting a social capital framework to assess the effect of a peer-led model on various forms of social capital in peers.

Methods

The current study is a part of a community-based participatory research (CBPR) project to promote refugee wellness and healthy adaptation during resettlement. The overall project was comprised of community wellness partnership building, competency-based training of refugee leaders and service providers, and a subsequent community health intervention fostering a peer-to-peer model. The project was piloted with the Bhutanese community since Bhutanese refugees were identified as one of the most vulnerable to health and mental health issues upon resettlement (as shown in the suicide study by CDC [36]) and yet the most organized group in the research setting (i.e., the Greater Richmond area of Virginia). In close collaboration with community stakeholders, including mental health service providers and refugee community leaders, the first author developed and provided a four-day training on mental health and psychosocial support to community leaders and active members from the Bhutanese refugee community. Six out of nine trainees, three males and three females, volunteered to provide community-based health workshops to their peer refugees after additional training on health education and group facilitation skills. The Community Health Workshop (CHW) curriculum was based on the psychoeducation modules by the first author [37], adopting nutrition and healthy eating part of the Nutrition Outreach Toolkit by USCRI [38]. For a culturally sensitive and effective intervention, the trained refugee leaders were actively involved in the development and adaptation process by providing inputs and feedback on the topics and the contents and adding culturally relevant examples and activities to the curriculum (ex. Bhutanese proverbs regarding health, chanting for opening and closure, etc.). Since the curriculum was developed in English and yet delivered in the native language of the Bhutanese refugees (i.e., Nepali), key terms of the intervention topics, such as stress, acculturation, mental health, nutrition, healthy lifestyle, and community, were examined as a team in both languages and the peer facilitators had additional meetings prior to each session to go over the contents in Nepali. The CHW intervention consisted of eight sessions relating to healthy eating and nutrition, daily stressors of resettlement, healthy coping, common psychological distress and mental health issues facing the refugee community.

Participants and Data Collection

The peer facilitators identified twenty-seven community members from the Bhutanese community, who were in need of health education and had difficulties accessing

health care as well as social services due to low educational levels and language barriers. All have lived in the U.S. between one and 6 years and hold permanent residency status. Twenty-two participants, consisting of 4 males and 18 females, completed all eight sessions of the CHW over the 2 month period and provided feedback on both the process and the effects of the intervention during and after each session. Due to low literacy levels and unfamiliarity to a structured survey format (e.g., Likert scale), no quantitative questionnaire was administered. Instead, the study designed a series of focus group discussions (FGDs) embedded in the CHW meetings in order to minimize interruption of the session flow and intervention activities. Each session, except for the first one, started with a check-in that includes questions related to the lessons from the previous session contents. All eight sessions ended with a set of reflective questions, such as main lessons, learned knowledge and skills, challenges and gaps, future suggestions including cultural topics and examples. The last session included a closure ceremony followed by a post-intervention evaluation that includes questions on the overall impact of the CHW as well as the group process. Since all FGDs were conducted in Nepali, the data was interpreted into English by peer facilitators and recorded and transcribed verbatim in English by two research assistants who were present during the CHW. IRB approval was granted before the project started and the refugee peer facilitators obtained informed consent from the participants during recruitment.

Data Analysis

All FGD data were compiled for a hybrid thematic analysis, which enabled both inductive and deductive approaches to the data [39]. This approach was particularly suitable for this study since the inductive part was useful for coding the unstructured discussion and interrupted conversation from focus group interviews [40], while the deductive thematization allowed applying theory-driven concepts (i.e., social capital) to the emerging codes. The FGD data was analyzed stepwise by the two authors independently. After a comprehensive review of the transcribed data, numerous raw codes were created for initial coding. The data-driven codes were analyzed for thematic coding, to which the theoretical framework of social capital was applied. The authors adopted differentiation between structural and cognitive social capital in order to reveal distinctive and yet interrelated impacts of the intervention [41]. According to this framework,

> The structural component includes extent and intensity of associational links or activity, and the cognitive component covers perceptions of support, reciprocity, sharing and trust. At the simplest level, these two components can be respectively characterized as what people'do' and what people 'feel' in terms of social relation (p. 106, [41]).

More specifically, structural social capital contains concepts regarding participation in a group or community, collective action, links to groups with resources and parallel groups. Cognitive social capital is rather psychological resources, such as general, emotional, and instrumental social support, trust, sense of belonging and community, perceived fairness and responsibility, reciprocity and cooperation and social harmony [41]. This provides guidance to the thematization of the codes related to social and group aspects of the health promotion factors. A series of reconciliation meetings between two coders enabled the final themes.

Results

The thematic analysis generated two grand themes with multiple subthemes that reveal the effectiveness of the peer-led CHW (see Table 1). The first theme, named "improvement in health promotion", depicted a major impact of the intervention, which corresponds to the direct objectives of the CHW curriculum. The second domain, "building social capital", focuses on a broader context of healthy living and conditions for health promotion.

Domain 1: Improvement in Health Promotion

Positive change was reported in three thematic areas: (1) improvement in health promotion outcomes, such as health knowledge and competency in access to proper health resources; (2) improved health practice, including change in health behaviors and coping; and (3) enhancement of health expressed as a change in perceived or subjective health. The three themes were all interrelated but presented different stages of health promotion.

Health promotion outcomes consist of personal means of improving health, such as awareness, knowledge, skills, efficacy, and competency. The participants reported an increase in health knowledge and competence in coping with both physical and psychological health concerns. The codes around the improved health promotion outcomes include information gained around healthy eating, nutrition facts, appropriate portion of a daily meal, multiple ways to cope with stress, and understanding of the impacts of trauma on a human body and mind, and mental health counselling. Nutrition and healthy diet was one of the most frequently discussed health topics where most participants reported knowledge increase.

Table 1 Themes emerging from CHW focus group discussions

Themes and subthemes	Concepts
Health promotion	
Health promotion outcomes (knowledge, skills, competency)	Increased knowledge in healthy eating (knowing healthy and unhealthy foods)
	Knowledge in nutrition facts
	Awareness of appropriate portion of daily meal
	Multiple ways to cope with stress
	Learning about mental health (Impacts of trauma on body and mind, understanding what mental health counseling is about)
	Learning self-help skills
Health practice (behavioral change)	Change in diet
	Change in stress coping
	Change in exercise
	Teaching family new healthy habits
Perceived health	Psychological/emotional wellness
	Subjective health (both physical and psychological)
	Addressing loneliness
	Growing hope
Social capital	
Structural social capital	Gathering together as a community
	Expanding social network in the community
	Building support system
	Reinforcing group/family for collective coping
	Building community capacity (Training leaders)
	Community leadership (peer mentorship)
	Participation in group (CHW)
	Participation in solving community issues
Cognitive social capital	Mutual respect
	Sense of community
	Safety
	Connectedness
	Unity

> After that [the session on nutrition and healthy eating] my family learned about different kinds of foods that we need to eat to be healthy. We learned about the nutrients, different amounts of nutrients, and balancing diets. We also learned about medicine, if we take more than needed it turns to poison.

A majority of workshop topics were new to the participants, although some were to reinforce their existing health beliefs and knowledge, such as the importance of regular exercise and outdoor activities. The CHW also offered an opportunity for the participants to openly discuss both commonly-shared health concerns and sensitive topics, such as mental health issues in the community. Refugee trauma and psychological distress that the community has experienced and forced migration and resettlement to a new culture had rarely been expressed as a group and yet deeply affected each and every individual in the community. After a session on stress coping, a senior community member stood up and shared as following:

> Our refugees settle in 50 different states and we always hear about people committing suicide. So in order to avoid that, we have to focus on stress and trauma. If you are able to share [our lessons] with friends and family, that can relieve stress and build a better community.

In fact, prevalent mental health issues and high suicide incidences in the Bhutanese community tend to increase the level of overall health and mental health burdens across the refugee community [36, 42]. Mental health therapy and related concepts, however, are not familiar to the refugee participants, especially those who are elderly or less educated. The CWH allowed the participants to open up to the tabooed topic and acknowledge mental health problems existing in the community, while encouraging and promoting the intention to seek help and help others in spite of high stigma around mental health in the Bhutanese culture.

Participants also reported that the gained health knowledge led to actual change in health behaviors and practice as well. Eating habits and diets were some of the most prominent and immediate change reported in the group.

> I found lots of changes in me, including my diet and my food.

> Now I try to use less salt. I know my husband will look for salt and ask me to bring it, so I go hide it. It is good for him and my family in the end.

Some of these positive changes were expected to trickle down to improvement in health outcomes, although the CHW was not intended to directly assess participants' health status and its changes in this pilot study. Some subjective or psychological impact, however, was consistently reported by the participants and these themes were congruous with the main subjects of overall CHW curriculum. The influence of CHW was so powerful to affect the overall perception of their health and wellness after the intervention. A female elderly participant commented after the fifth session:

> Taking these classes, my hopes opened. I don't know how many classes you will have but I have started feeling good. I have started seeing some good signs.

It was not always clear whether 'feeling good' refers to physical health or psychological wellness. However, it was stressed throughout the CHW that both physical and psychological health are interconnected and a healthy body is linked to a healthy mind and vice versa. Such lessons as body-mind linkage and interconnectivity of health issues were repeatedly discussed as an important theme and the pattern of healthy living in the Bhutanese community. This holistic view was also consistently found in the participant's view of self and community. Health was not treated as a solely individual issue but as a communal goal and direction for the Bhutanese refugees.

> Angry people always look for issues to fight on. They always try to get help from alcohol and smoking to calm the self down. They involve in vandalism like breaking things around and fighting and hitting family members like kids or wives.

Linking lessons on mental health to the common community issues, such as domestic violence and substance abuse, reoccurred throughout FGDs. It demonstrates the collectivistic aspect of the Bhutanese culture and their strong interest in building community to cope with the communal issues that the refugee community encounters with upon resettlement to a new cultural environment.

Domain 2: Building Social Capital for Health Promotion

Another grand theme of the CHW's impact was building and strengthening social capital as the basis of healthy living. Multiple codes related to this secondary impact of health education were arranged under two subthemes that are strongly interrelated and yet distinctive: structural and cognitive social capital. This distinction was useful in understanding the distinction between building social conditions for healthy living and the psychological influences that systems had on the participants.

The first category, structural social capital, incorporates the concepts cohesive to community building and participation, including: building support systems, building community capacity, and participating in the group and the community action. The CHW provided a platform of regular gatherings and socializing opportunities, which the community had been missing after living in the U.S.

> There is definitely some change in me. First thing, I have not met all of these people before. [……] We are all busy after living in the US. I have not spoken in a group of more than two people, and this is a big group to me. We have grown to know one another.

The gatherings for the CHW, in itself, enhanced the opportunity for the participants to engage with other community members and expand their social network within the community. It was particularly important to the Bhutanese culture since the community was perceived as an inseparable agent of health promotion and well-being. Even when the interview question was on an individual-level or family-level change or lesson, discussions on coping and healthy life style repeatedly coincided with a broader context of community life. Some of the examples include: gaining the health knowledge to help other community members, group/community support to refine the skills needed for a healthy lifestyle, relieving isolation through group participation, and helping each other for healthy community. As the participants gain skills and improve practice for health promotion the common belief was that the individual change begin to translate into not only their family but also the overall community.

> If we become healthy, then we can help our families become healthy, then our communities become healthy, and then the society becomes healthy.

Another participant chimed in, saying:

> If you think or behave in a way that we are taught here, there will be a change in our community.

The CHW was able to bring community members together by increasing access to potential resources and information, while motivating people to rebuild and strengthen the Bhutanese community. During the CHW many participants acknowledged the importance of an organized group and showed the confidence and relationships they developed through participation in the CHW.

> What I've learned most is that the first day I felt alone. I felt bad. [Over the sessions] the rest of us worked together to help each other and found our group, and it makes me feel like we missed a group of our own. And we really need a group to live.

As the group is formed and the sense of community developed, self-help emerged among the participants. The importance of mutual help and community participation became highlighted and the comfort level of seeking help and open discussion about problems increased through the CHW. One participant shared how sharing a concern and asking for advice from peers changed the course of a day when he struggled with a medical bill:

> As he [one of the peer facilitators] showed me the direction, I went to four different screenings [……]. I had something like $2800 bills, and after the screening, I only had $250 to pay. This was a relief of stress. That is why we cannot always keep problems to ourselves. We have to ask for direction and they [peers] can help us relieve our stress.

As seen in this anecdote, structural social capital built through the CHW among peers turned into an informational and instrumental social support that brought actual improvement in life. There were a few other examples shared among the participants regarding how the peer group helped their daily coping of stress and increased emotional wellness.

Another essential component of social capital was development of leadership and community's capacity. As participants gained confidence and familiarity with the group, leadership skills began to excel. Participation in the group activities and discussions led to acknowledging the importance of having community leadership and taking pride in the training provided by peer facilitators. A participant who is one of the religious leaders commented the importance of leadership in the Bhutanese community during the last CHW session as:

> I want to expand leadership roles in the community and to train volunteers and help families adjust and learn basic tasks in the community.

Most importantly, these community building efforts were linked to a sense of connectedness and belonging, which led to strong unity among the participants. To the participants unity involved both helping each other inside their community and getting involved with other communities, including the host society. Making connections outside of the refuge community was discussed among participants at various levels: expanding English classes for elders, addressing transportation issues to explore other neighborhoods, and gaining more information on available services and resources outside the Bhutanese community. If was demonstrated through the CHW that connectedness to the larger community is key to the refugee community's acculturation process and participants emphasized the importance of additional resources that could be provided through a stronger connection with the larger community.

Discussion

The peer-led community health workshop had a wide range of impacts on the Bhutanese refugee community. First, the peer-based model turned out as an effective approach to establish an initial phase for health promotion in the refugee community. The Bhutanese community members in the CHW reported a meaningful increase in knowledge, awareness, and skills relating to dietary and behavioral health practice and emotional coping. In addition to such health promotion outcomes, the participants presented actual changes in health behaviors along with a positive effect on perceived, subjective health. Although the current pilot study is for a rather preventive and educational purpose and not aimed for addressing specific health concerns, subjective psychological wellness was one significant improvement repeatedly reported during and after the CHW.

While meeting the initial objectives around health-related outcomes, the peer-based model also showed significant development in various forms of social capital: expanded social networks and opportunities for participation in the community; a growing sense of community and unity; building community capacity and leadership; and an increase in connectedness and access to instrumental help. The development of social capital facilitated refugee participants' awareness and efforts for healthy living through the support from peers. This result corroborates the inseparable relationship between social capital and health promotion in the refugee community and its implications for healthy integration and participation to the new culture [43]. In fact, social capital built through the CHW gatherings provided a basis for extended community initiatives and further capacity for cultural integration. At the end of the CHW, a respected elderly participant expressed gratitude to the peer facilitators:

> From my perspective, people have been doing a great job conducting classes like this. People like you, the educated members in society, can provide more free classes in the Nepali language; it would be very helpful for our community.

After the CHW pilot, the peer mentors and participants voluntarily continued their regular gatherings to offer citizenship classes, which is another important topic to the community. Although it was beyond the scope of this study, it showed the potential of the peer-based model for community empowerment and sustainability of community action.

Furthermore, the findings of this study support the cultural sensitivity and relevance of the peer-based model with the refugee community. The same cultural values and language shared among peers allowed the intervention to be accepted and highly regarded, while fostering effective learning and group process. Offering the CHW by peers in the same mother tongue, unlike most classes or interventions that refugees can access to during early resettlement phases (ex. English classes and driving lessons), had a number of benefits. One of the well-known hindrance of forming social capital and appropriate health resources is a language barrier [44–47]. Refugees often do not speak the same language as the dominant culture and this tends to result in isolation and marginalization after resettlement. Without understanding of the host culture and social systems it is difficult to form a support system across the community, which can lead to a loss of formal support, low access to resources, and segregation or exclusion from the

society [45]. The peer-based approach addressed such language concerns and allowed cultural competency and adaptation of the CHW intervention by accommodating shared cultural knowledge and practice. It also helped cultivate balanced acculturation by promoting new health knowledge and skills needed for refugees' cross-cultural experiences in the U.S., while reinforcing the cultural wisdoms and values of the refugee community. Furthermore, the peer-based approach validates the cultural norms and values of collectivity, mutual-help and communal living that most refugee communities cherish and want to continue to promote. Empowering such collective coping and community-centered problem-solving is both valued and necessary for working with the refugee populations facing the common social and cultural challenges during resettlement.

In this study, a CBPR approach also took a significant role. The peer-led intervention embedded to a CBPR approach allowed adopting cultural insights and wisdom from peer facilitators and members and it meaningfully improved cultural competency of the intervention curriculum and activities. Both peer group participants and facilitators were encouraged to suggest cultural examples and subjects to the curriculum for future groups and the project team received meaningful inputs and feedback. For example, during a session on healthy living, a new topic, sanitation (i.e., keeping oneself clean and keeping house clean), emerged as an important health topic and was added to the CHW curriculum. Sanitation not only means physical hygiene but also has an important cultural and religious meaning in the Bhutanese culture and thus had been stressed during the pastoral life in Bhutan and in refugee camps in Nepal. This kind of constructive feedback and inputs were possible not only due to the close bonding and lack of language barriers between the facilitators and the participants but also because of the community-centered approach of this project. In addition, community-based partnership building through training of the trainer for peer refugees contributed to community's capacity and leadership and provided a channel for further collective efforts for solving refugee resettlement and acculturation challenges across the community. This approach enabled the community to take charge in the process of community building and change, and to speak out for what refugees are doing well and what they still need.

The peer-led CHW brought various positive effects to the participants and the Bhutanese community but the project was not without challenges and limitations. First, some challenges were identified by both peer facilitators and participants regarding logistical issues: securing and maintaining a communal space for community workshops, keeping punctuality, and finding optimal time for gatherings. Securing a venue for the CHW to be held was difficult for many reasons. There is often a lack of communal space that is proximal to refugees' neighborhood. Refugee community members tend to have limited transportation options, so the CHW had to be held somewhere they can walk or use public transit to access. Time management was not a simple task to peer facilitators, although it showed significant improvement over time as facilitators' familiarity to the group and leadership skills grew. Several challenges specific to the evaluation also exist. The focus group approach was inevitable not only due to the limited time availability among participants and peer mentors, but also because of its minimized intrusion of the intervention, while gaining fresh memories of each session. However, this format was not suitable to track individual's progress in health promotion outcomes and change over time. The self-report based on qualitative evaluation questions may need to be vetted by follow-ups in the future. Also, there was a sense of social desirability among the participants due to the Bhutanese culture. The research team took precaution and set protocols to avoid influencing the responses. For example, focus group discussions were run by peers who did not facilitate the pertinent session and the third person interpreted and translated evaluation data.

Despite the limitations, this study has important implications for future interventions and research with the refugee community. By effectively creating and promoting social capital, the peer-based intervention established a foundation to community health and further initiatives in the refugee community. This intervention model can be applied to various community issues beyond health problems, and used to address specific needs, such as domestic violence, youth delinquency and cultural bereavement, that many refugee communities commonly face. The peer model can also be embedded to other programs, such as cultural orientation and resettlement services, so that it can produce synergic outcomes. Building and rebuilding community's support systems through peer activities and group participation will be critical to addressing many other resettlement challenges. In the future, a peer-based intervention can be extended to building social capital beyond the refugee community and help expand the community's network and accessible resources (i.e., bridging social capital) by incorporating direct interaction with service providers and the host community. Trained peers and peer mentors will take a critical role in linking the refugee community to others, being a cultural broker or navigator. In the future research around peer-led interventions with the refugee community, an innovative evaluation method will be beneficial, especially an evaluation study with refugee groups with low literacy or education level. Using photo voices or other visual images will be considerable for nonintrusive and yet effective evaluation research.

Acknowledgments The current study was possible thanks to the funding support from the Virginia Department of Behavioral Health and Developmental Services (DBHDS) Office of Cultural and Linguistic Competence (OCLC). Also, we are indebted to the healing partnership network, the Greater Richmond Refugee Mental Health Council (GRRMHC) and the devoted refugee community leaders of the Bhutanese Community of the Greater Richmond (BCGR). We would like to thank all the participants who joined the project and shared their valuable opinions with the research team.

References

1. Petosa, R., & Smith, L. H. (2014). Peer mentoring for health behavior change: A systematic review. *American Journal of Health Education, 45*(6), 351–357. doi:10.1080/19325037.2014.945670.
2. Wang, F., Stewart, M., McDermott, S., et al. (2012). Migration and diabetes in British Columbia and Quebec: Prevalence and health service utilization. *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique*, *103*(1), 59–64.
3. Kinzie, J. D., Riley, C., McFarland, B., et al. (2008). High prevalence rates of diabetes and hypertension among refugee psychiatric patients. *The Journal of Nervous and Mental Disease, 196*(2), 108–112. doi:10.1097/NMD.0b013e318162aa51.
4. Palinkas, L. A., & Pickwell, S. M. (1995). Acculturation as a risk factor for chronic disease among Cambodian refugees in the United States. *Social Science and Medicine, 40*(12), 1643–1653. doi:10.1016/0277-9536(94)00344-S.
5. Yun, K., Hebrank, K., Graber, L. K., Sullivan, M.-C., Chen, I., & Gupta, J. (2012). High prevalence of chronic non-communicable conditions among adult refugees: Implications for practice and policy. *Journal of Community Health, 37*(5), 1110–1118. doi:10.1007/s10900-012-9552-1.
6. Hovey, J. D. (2000). Acculturative stress, depression, and suicidal ideation among Central American immigrants. *Suicide and Life-Threatening Behavior, 30*(2), 125–139. doi:10.1111/j.1943-278X.2000.tb01071.x.
7. Hinton, D. E., & Otto, M. W. (2006). Symptom presentation and symptom meaning among traumatized Cambodian refugees: Relevance to a somatically focused cognitive-behavior therapy. *Cognitive and Behavioral Practice, 13*(4), 249–260. doi:10.1016/j.cbpra.2006.04.006.
8. Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review. *The Lancet, 365*(9467), 1309–1314. doi:10.1016/S0140-6736(05)61027-6.
9. Marshall, G. N., Schell, T. L., Elliott, M. N., Berthold, S. M., & Chun, C.-A. (2005). Mental health of Cambodian refugees 2 decades after resettlement in the United States. *Journal of the American Medical Association, 294*(5), 571–579. doi:10.1001/jama.294.5.571.
10. Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O, 2nd. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*(4), 293.
11. Kirmayer, L. J., Narasiah, L., Munoz, M., et al. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *Canadian Medical Association Journal, 183*(12), E959–E967. doi:10.1503/cmaj.090292.
12. Pumariega, A. J., Rothe, E., & Pumariega, J. B. (2005). Mental health of immigrants and refugees. *Community Mental Health Journal, 41*(5), 581–597. doi:10.1007/s10597-005-6363-1.
13. Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, J. K. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice, 6*(2), 165–187. doi:10.1093/clipsy.6.2.165.
14. Henderson, S., Kendall, E., & See, L. (2011). The effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically diverse communities: A systematic literature review. *Health and Social Care in the Community, 19*(3), 225–249. doi:10.1111/j.1365-2524.2010.00972.x.
15. Turner, G., & Shepherd, J. (1999). A method in search of a theory: Peer education and health promotion. *Health Education Research, 14*(2), 235–247. doi:10.1093/her/14.2.235.
16. Webel, A. R., Okonsky, J., Trompeta, J., & Holzemer, W. L. (2010). A systematic review of the effectiveness of peer-based interventions on health-related behaviors in adults. *American Journal of Public Health, 100*(2), 247. doi:10.2105/AJPH.2008.149419.
17. Boothroyd, R. I., & Fisher, E. B. (2010). Peers for progress: Promoting peer support for health around the world. *Family Practice, 27*(suppl 1), i62–i68. doi:10.1093/fampra/cmq017.
18. Perez, L. G., Arredondo, E. M., Elder, J. P., Barquera, S., Nagle, B., & Holub, C. K. (2013). Evidence-based obesity treatment interventions for Latino adults in the us: A systematic review. *American Journal of Preventive Medicine, 44*(5), 550–560. doi:10.1016/j.amepre.2013.01.016.
19. Philis-Tsimikas, A., Fortmann, A., Lleva-Ocana, L., Walker, C., & Gallo, L. C. (2011). Peer-led diabetes education programs in high-risk mexican americans improve glycemic control compared with standard approaches a project dulce promotora randomized trial. *Diabetes Care, 34*(9), 1926–1931. doi:10.1016/j.amepre.2013.01.016.
20. Willock, R. J., Mayberry, R. M., Yan, F., & Daniels, P. (2015). Peer training of community health workers to improve heart health among African American women. *Health Promotion Practice, 16*(1), 63–71. doi:10.1177/1524839914535775.
21. Proudfoot, J. G., Jayawant, A., Whitton, A. E., et al. (2012). Mechanisms underpinning effective peer support: A qualitative analysis of interactions between expert peers and patients newly-diagnosed with bipolar disorder. *BMC Psychiatry, 12*(1), 196. doi:10.1186/1471-244X-12-196.
22. Ahmed, A. O., Doane, N. J., Mabe, P. A., Buckley, P. F., Birgenheir, D., & Goodrum, N. M. (2012). Peers and peer-led interventions for people with schizophrenia. *Psychiatric Clinics of North America, 35*(3), 699–715. doi:10.1016/j.psc.2012.06.009.
23. Kyrouz, E., Humphreys, K., & Loomis, C. (2002). *A review of research on the effectiveness of self help mutual aid groups; expanded and updated. American Self-Help Clearinghouse Self-Help Group Sourcebook (7e)*. New Jersey: American Self-Help Clearinghouse.
24. White, W. L. (2000). The history of recovered people as wounded healers: I. From native America to the rise of the modern alcoholism movement. *Alcoholism Treatment Quarterly, 18*(1), 1–23. doi:10.1300/J020v18n01_01.
25. Cupples, J. B., Zukoski, A. P., & Dierwechter, T. (2010). Reaching young men: Lessons learned in the recruitment, training, and utilization of male peer sexual health educators. *Health Promotion Practice, 11*(3 suppl), 19S–25S. doi:10.1177/1524839909358847.
26. Koumi, I., & Tsiantis, J. (2001). Smoking trends in adolescence: Report on a greek school-based, peer-led intervention aimed at prevention. *Health Promotion International, 16*(1), 65–72. doi:10.1093/heapro/16.1.65.
27. Corrigan, P. W. (2006). Impact of consumer-operated services on empowerment and recovery of people with psychiatric disabilities. *Psychiatric Services, 57*(10), 1493–1496.

28. Dumont, J., & Jones, K. (2002). Findings from a consumer/survivor defined alternative to psychiatric hospitalization. *Outlook, 3*, 4–6.
29. Resnick, S. G., & Rosenheck, R. A. (2008). Integrating peer-provided services: A quasi-experimental study of recovery orientation, confidence, and empowerment. *Psychiatric Services, 59*(11), 1307–1314.
30. Hoey, L. M., Ieropoli, S. C., White, V. M., & Jefford, M. (2008). Systematic review of peer-support programs for people with cancer. *Patient Education and Counseling, 70*(3), 315–337. doi:10.1016/j.pec.2007.11.016.
31. Hogan, B. E., Linden, W., & Najarian, B. (2002). Social support interventions: Do they work? *Clinical Psychology Review, 22*(3), 381–440. doi:10.1016/S0272-7358(01)00102-7.
32. Coleman, J. S. (1988). Social capital in the creation of human capital. *American Journal of Sociology*, *94*, S95–S120.
33. Broadhead, R. S., Heckathorn, D. D., Altice, F. L., et al. (2002). Increasing drug users' adherence to HIV treatment: Results of a peer-driven intervention feasibility study. *Social Science and Medicine, 55*(2), 235–246. doi:10.1016/S0277-9536(01)00167-8.
34. Berkman, L. F., & Glass, T. (2000). Social integration, social networks, social support, and health. *Social Epidemiology, 1*, 137–173.
35. Kawachi, I., & Berkman, L. F. (2001). Social ties and mental health. *Journal of Urban Health, 78*(3), 458–467. doi:10.1093/jurban/78.3.458.
36. Ao, T., Taylor, E., Lankau, E., et al. (2012). An investigation into suicides among Bhutanese refugees in the us 2009–2012 stakeholders report. *Center for Disease Control and Prevention.* Available at http://www.azdhs.gov/phs/edc/odis/refugee/documents/bhutanese-suicide-stakeholder-report-oct12.pdf.
37. Im, H. (2014). *Trauma-informed cross-cultural psychoeducation: refugee mental health training for community leaders*. Richmond, VA: Virginia Commonwealth University (VCU) & Virginia Department of Behavioral Health and Developmental Services (DBHDS).
38. Cottrell, B. W. (2010). Healthy eating, healthy living in the United States: A nutrition education flip chart. US Committee for Refugees and Immigrants. Available at http://www.refugees.org/resources/for-refugeesimmigrants/health/nutrition/refugee-nutrition-outreach.html.
39. Fereday, J., & Muir-Cochrane, E. (2008). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods, 5*(1), 80–92.
40. Polit, D. F., & Beck, C. T. (2013). *Essentials of nursing research: Appraising evidence for nursing practice*. Philadelphia: Lippincott Williams & Wilkins.
41. Harpham, T., Grant, E., & Thomas, E. (2002). Measuring social capital within health surveys: Key issues. *Health Policy and Planning, 17*(1), 106–111. doi:10.1093/heapol/17.1.106.
42. Van Ommeren, M., Sharma, B., Sharma, G. K., Komproe, I., Cardeña, E., & de Jong, J. T. (2002). The relationship between somatic and PTSD symptoms among Bhutanese refugee torture survivors: Examination of comorbidity with anxiety and depression. *Journal of Traumatic Stress, 15*(5), 415–421. doi:10.1023/A:1020141510005.
43. Deuchar, R. (2011). 'People look at us, the way we dress, and they think we're gangsters': Bonds, bridges, gangs and refugees: A qualitative study of inter-cultural social capital in glasgow. *Journal of Refugee Studies, 24*(4), 672–689. doi:10.1093/jrs/fer032.
44. Allen, R. P. (2007). *"Sometimes it's hard here to call someone to ask for help": Social capital in a refugee community in Portland, Maine (Doctoral dissertation)*. MA: Massachusetts Institute of Technology.
45. Nawyn, S. J., Gjokaj, L., Agbényiga, D. L., & Grace, B. (2012). Linguistic isolation, social capital, and immigrant belonging. *Journal of Contemporary Ethnography, 41*(3), 255–282. doi:10.1177/0891241611433623.
46. Warriner, D. S. (2007). Language learning and the politics of belonging: Sudanese women refugees becoming and being "American". *Anthropology & Education Quarterly, 38*(4), 343–359. doi:10.1525/aeq.2007.38.4.343.
47. Rumbaut, R. G. (2005). Sites of belonging: Acculturation, discrimination, and ethnic identity among children of immigrants. In T. S. Weiner (Ed.), *Discovering successful pathways in children's development: Mixed methods in the study of childhood and family life* (pp. 111–164). Chicago: University of Chicago Press. Available at SSRN: http://ssrn.com/abstract=1882684.