A PROGRAM EVALUATION OF HEALTHY GIRLS CIRCLE-YOUTH AND ELDERS SHARING

by

Amy E. Brown

B.A., Gustavus Adolphus College, 2007

Submitted to the Graduate Faculty of

Graduate School of Public Health in partial fulfillment

of the requirements for the degree of

Master of Public Health

University of Pittsburgh

2011

UNIVERSITY OF PITTSBURGH

Graduate School of Public Health

This thesis was presented

by

Amy E. Brown

It was defended on

May 18th, 2011

and approved by

Thesis Chair:
Beth A.D. Nolan, PhD
Assistant Professor
Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

Committee Member:
Martha Ann Terry, PhD
Assistant Professor
Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

Committee Member:
Sara Goodkind, PhD
Assistant Professor
School of Social Work
University of Pittsburgh

Beth A.D. Nolan, PhD

A PROGRAM EVALUATION OF HEALTHY GIRLS CIRCLE-YOUTH AND ELDERS SHARING

Amy E. Brown, M.P.H

University of Pittsburgh, 2011

There is an urgent need for culturally appropriate strategies to promote the health of the refugee population and facilitate its successful adaptation in the United States. Without this adaptation, refugees in the United States being at risk of developing and maintaining high levels of negative health outcomes, which creates a significant public health problem. Healthy Girls Circle- Youth and Elders Sharing" (HGC-YES) program aims to 1) educate Somali Bantu female refugees who now reside in Pittsburgh on health related topics such as reproductive health, exercise, and nutrition, and 2) train the participants as lay health educators so they can disseminate the health related information to members of the Bantu community, specifically elder females. Process and outcome measures were used to gain a better understanding of program effectiveness and its ability to fulfill its objectives. Evaluation measures indicated that participants experienced a consistent increase in knowledge of health related topics, but participants failed to document their dissemination of information into the Bantu community. Additionally, varying attendance rates due to scheduling conflicts and miscommunication between HGC-YES staff and participants contributed to the programs difficulty in achieving its objectives. Since the HGC-YES supervisor has developed a trusting relationship with the Bantu community over several years, there are opportunities for change. The HGC-YES program holds a great deal of potential in promoting the health of the refugee population and facilitating its successful adaptation in the United States.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

PREFACE

First of all, thank you to the participants of the HGC-YES program. Without your hospitality and insight, this project would not have been possible. Also, thank you to the program supervisor of HGC-YES, Ebony Hughes, for your mentorship and for allowing me to be a part of this remarkable program. Thank you to my thesis committee for guiding and mentoring my academic growth. A great deal of thanks to my very supportive friends and family, especially my parents. Finally, thank you to Jessica. Your unwavering support and encouragement have been invaluable throughout this process. Even more so than coffee ☺

1.0 INTRODUCTION

1.1 PROBLEM STATEMENT

Health is defined in the World Health Organization's (WHO) constitution of 1948 as a state of complete physical, social, and mental well-being, and not merely the absence of disease or infirmity (World Health Organization, 1948). Health is regarded by WHO as a fundamental human right; therefore, all individuals should have access to basic resources to attain and maintain a healthy lifestyle. WHO states that health can be expressed in functional terms as a resource that permits people to lead an individually, socially, and economically productive lives (Nutbeam, 1998).

Health equity has served as a crucial objective for a variety of health organizations, such as WHO, and has provided a basis for developing goals and interventions. The United States (U.S.) has also been striving to create health initiatives to ensure health equity for all citizens. In order to better achieve this goal, the U.S. Department of Health and Human Services (DHHS) developed the Healthy People program. This program provides comprehensive nationwide health promotion and disease prevention objectives to improve the quality of health through the entire U.S.

According to the U.S. DHHS (2000), *Healthy People 2020* creates success in healthcare by utilizing scientific advances that have occurred in the past 20 years in preventative medicine,

disease surveillance, vaccine and therapeutic development, and information technology. Additionally, the Healthy People agenda addresses future health concerns such as the growing diversity of the nation. The Healthy People agenda recognizes a more diversified nation, with regard to ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location, which contributes to an individual's ability to achieve quality health. It is crucial to acknowledge the substantial impact that social determinants have on health outcomes of specific populations (DHHS, 2000).

Although the U.S. prides itself on its health initiatives to care for the general population, there are numerous disenfranchised populations that have minimal access to health services. Two particular populations that are subject to a variety of health disparities and inequalities are immigrants and refugees who have come to the U.S.

Leading health indicators show the behavioral patterns of immigrants are different from the U.S.-born population, which can have both positive and negative effects on their health. For instance, immigrants are initially less obese than a majority of U.S. -born citizens but an increase in obesity among immigrants occurs as they acculturate to the U.S. (Kandula et al., 2004).

In addition to varying behavioral patterns, starkly different cultural experiences and background among the immigrant and refugee populations present a unique challenge to the U.S. healthcare system. Refugee experiences of healthcare in their native country or refugee camps differs greatly from those in the U.S, which presents healthcare providers with challenges in serving the refugee population (Herrel et al., 2004). For example, due to cultural practices in Somalia, it is estimated that only two percent of all birth deliveries take place in a health facility or are attended by a skilled professional. As a result, the overall risk of women dying due to related complications related to birth is one in seven (Herrel et al., 2004). Additionally, in

reference to the varying background and experiences of refugee populations, a significant number of refugees have experienced a history of trauma and/or torture. In a study that explored the mental health of Somali adolescent refugees, results indicated high overall trauma and torture exposure, and associated physical, social and psychological problems (Robertson et al., 2006). Another study indicated that many young Somali and Oromo immigrants to the U.S. experience life problems associated with war trauma and torture (Halcon et al., 2004).

These examples reinforce the need for age and culturally appropriate strategies to promote the health of the refugee population and facilitate their successful adaptation in the U.S. (Halcon et al., 2004). One means of facilitating successful adaptation following immigration can be accomplished through implementation of programs and interventions that focus on the health education of immigrants (Halcon et al., 2004). This paper focuses on the evaluation of a public health program that was designed to improve the health and well-being of the Somali Bantu refugee population in Pittsburgh, Pennsylvania.

1.2 TARGET POPULATION

Currently, one of the fastest growing sub-groups in the U.S. is refugees. One group immigrating to the U.S. at an increasing rate is Somali immigrants (UNHCR, 2006b). This particular population is primarily from northern Kenya where, due to a civil war in Somalia, most have lived a large portion of their lives in refugee camps. Despite efforts to provide them with a safe and humane place for people seeking asylum, these places of harbor are often a place of repeated human rights violations. Refugee camps, specifically in northern Kenya, have a well-known history of various forms of torture, violence, trauma, and inadequate living conditions

(Ljubinkovic, 2005). These conditions result in a plethora of severe psychological and physical ailments among the refugee population. Some examples of oppressive treatment encountered by Somali refugees include rape, beatings, torture by electricity, mutilation by knife and fire, unjustified detention, bombings, and being forced to watch friends or family members shot to death (Ljubinkovic, 2005).

Although both men and women experienced inhumane treatment, women in particular were subjected to violent acts inflicted upon them by members of their own family and community (Crisp, 1999). Domestic, physical, and sexual abuse can be a daily reality for women and girls who arrive unaccompanied, or as minors, to the refugee camps (Crisp, 1999).

As a direct result of having lived in refugee camps, Somali refugee women have been denied the chance to develop skills to rebuild their lives and those of their families. Given their history in refugee camps, these women have experienced a range of health problems and a lack of preventative education and health measures. Thus, before programs can offer aid as these women adjust to life in the U.S., it is crucial to investigate and determine how to accommodate cultural differences in attempts to overcome health barriers (Ljubinkovic, 2005).

1.3 LOCAL SOMALI COMMUNITY IN PITTSBURGH

The city of Pittsburgh is part of a government resettlement project to help place Somali Bantus from refugee camps in northern Kenya (Kalson, 2004). The settlement of immigrants in the U.S. benefits cities by replenishing neighborhoods, filling labor shortages, and increasing ethnic diversity (Alba & Reynolds, 2002). Currently the main groups of refugees relocated in the

western Pennsylvania region are the Somali Bantu from Northern Kenya, the Muscasian Turks from Russia, and Uzbekistanis from Romania (UNHCR, December 2010).

Several refugee populations have experienced similar appalling conditions prior to immigrating to the U.S. For instance, refugees have relied on relief aid from the United Nations, have lived in inhabitable housing conditions, and face language and cultural barriers upon arrival in the U.S. (UNHCR, December 2010). However, these groups have a greater likelihood of attending school and pursuing a career of choice than the Bantu. Already a minority group in their own country, this Somalian tribe faces barriers to proper integration in the U.S. (Kalson, 2004). Somali Bantu have higher levels of illiteracy than any other refugee population because they were barred from formal education in their home country (Kalson, 2004; Van Lehman & Eno, 2002). Due to their lack of education and poor proficiency in the English language, the Somali Bantu have tremendous difficulty finding employment, are poor, and have minimal access to adequate health services. Lastly, similar to several other refugee populations, the Somali Bantu have experienced difficulty gaining acceptance into the communities where they reside, which makes integration into Pittsburgh particularly difficult.

1.4 AIM

Since a majority of Somali women arriving in the U.S. have spent most of their lives in refugee camps, they have a history of receiving minimal or no education. Poor education contributed to the lack of knowledge on health related topics. Additionally, culture and religious practices among the Somali Bantu prohibit most women from receiving adequate education (Owens,

2003). This lack of education reinforces the need to educate Somali women on the importance of preventative and maternal health care.

The target population for this study is the Somali Bantu refugees who now reside in Pittsburgh enrolled in "Healthy Girls Circle- Youth and Elders Sharing," (HGC-YES), a program implemented by Magee-Womencare International. The objectives of the Healthy Girls Circle-Youth and Elders Sharing program are: 1) to enhance Somali high school girls' preparation for studies and careers in the healthcare or other fields through leadership building, health advocacy, health promotion, and project development; 2) to encourage Somali high school girls to share information with elder women in their community who cannot be effectively reached due to language and cultural barriers; and 3) to strengthen the healthcare/self-care awareness and practice among the Somali high school girls to make informed choices that will support each individual to reach her potential after high school and promote a healthy lifestyle.

The purpose of this study is to evaluate HGC-YES, in order to assess the program's implementation process and determine the program's ability to attain its objectives. The findings can be used to secure funding for future interventions, educate healthcare workers on the needs of this particular population, and design additional programs that target this particular population.

2.0 BACKGROUND: LITERATURE REVIEW

2.1 HISTORY OF REFUGEE STATUS

2.1.1 Refugees on a Global Scale

In 1950, the United Nations General Assembly established the United Nations High Commissioner for Refugees (UNHCR) with a mandate to help resettle European refugees from World War II within three years (UNHCR, December 2010). Throughout the 1950s and early 1960s, UNHCR expanded its support of refugees from Europe and other parts of the globe. In 1967, a new *Protocol Relating to the Status of Refugees* was drafted to redefine the definition of a refugee. With the adoption of the new protocol, the international definition of a refugee became any person who

> owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political option, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country… (UNHCR, 2006a).

UNHCR is responsible for protecting refugees as soon as they flee their home country, while also ensuring refugees long-term security and settlement. In order to accomplish this, UNHCR aids refugees in pursuing one of the three 'durable' solutions: voluntary repatriation; integration into the country of first asylum; or resettlement in a third country (UNHCR, 2010).

Each of the options is considered durable because it aims to bring an end to the refugees' suffering and their dependence on the international system (UNHCR, 2006c).

2.2 REFUGEES IN SOMALIA

In 1991, eighteen months after a civil war had broken out in southern Somalia, food production ground to a halt, creating a famine that affected the entire country. Though exact numbers are unknown, there are estimates that about 200,000 individuals died as a result of the famine and famine-related diseases during this time (de Waal, 1997). Over the next 15 years, an estimated 285,000 Somalis fled into northern Kenya to escape the devastation, while several hundred thousands of Somalis also left for Ethiopia and Djibouti (Loescher, 2001). It is estimated that as of December 2006 almost 400,000 Somali refugees remained in camps run by the UNHCR (UNHCR, 2006).

Many southern Somalis fled to Liboi, which is located on the equator of Kenya, near a town named Dadaab, about ten miles west of the Kenya-Somali border. UNHCR established three additional camps in the Dadaab area in the Northwestern Province in Kenya when the Liboi camp grew to over 40,000 refugees (Van Lehman & Eno, 2002). Although the refugees had fled violence in Somalia, they were not entirely safe in the Dadaab camps, because the area was often frequented by Somali and Kenyan *shiftas*, or bandits. Discrimination by other Somali (non-Bantu) refugees forced the Bantus to settle on the outskirts of camps, thus making them more vulnerable to attacks by the *shiftas* (Van Lehman & Eno, 2002). Bantu females were especially vulnerable while collecting firewood outside of the camps, where they were often raped by *shiftas* or ethnic Somalis from the camps (Van Lehman & Eno, 2002).

2.3 RESETTLEMENT IN THE U.S.

2.3.1 Concerns with Resettlement

In 2000, the U.S. agreed to resettle 12,000 Somali Bantu men and women, who had spent 15 years in refugee camps. The first group arrived in Pittsburgh in the spring of 2004 (Kalson, 2004). Although the UNHCR and the International Organization for Migration (IOM) facilitated the resettlement process, this was still an extremely challenging and psychologically draining process for the Somali Bantus (Kalson, 2004).

The Bantu refugees had a significant history of marginalization and years of oppression, which have had a considerable impact on their self-esteem (Van Lehman & Eno, 2003). During the Bantu resettlement period into the U.S., the IOM raised concerns about trauma-related issues, including hopelessness and depression as a result of their history of oppression . As a result, social agencies in the U.S. were forewarned about the effects of violence-related trauma, as well as the culture of oppression and inferiority in which the Bantu had been living (Van Lehman & Eno, 2002).

2.3.2 Acculturation and Assimilation

The process of transition can be challenging for refugees. It is common for refugee populations to experience a general lack of sensitivity by indigenous residents towards their culture, history, and traditions. Cultural assimilation is a process whereby a minority group gradually adapts to the customs and attitudes of the prevailing culture and customs (Alba & Nee, 1997). Although the concept of assimilation is often portrayed as a simple and routine practice among immigrants,

it is often much more complex. Not all immigrants undergo the same process or path to incorporation; they are neither uniformly assimilated, nor equally incorporated (Alba & Reynolds, 2002). Successful incorporation is the result of appropriate acclimation upon arrival. Factors that promote acclimation include the following: mode of entry and reception upon arrival; social and economic context of the host society; port of entry, and eventual place of settlement (Portes & Zhou, 1999).

Acculturation refers to a cultural modification of an individual, or group of people by adapting to or borrowing traits from another culture (Merriam-Webster Dictionary, 2011). It is important to note that, according to this definition, each group keeps characteristics from their own culture, while adapting to the foreign culture in other ways. Eventually, this may result in cohabitation of cultures.

In regard to public health, acculturation and assimilation can be used to determine an immigrant population's utilization of health services (Alba & Nee, 1997). Understanding the acculturation process of various immigrant groups can assist in identifying culturally appropriate strategies to introduce them to existing programs or in designing interventions that best suit their needs (Goodman, 200l). There are a variety of barriers that interfere with the resettlement of the immigrant population, thus negatively impacting their acculturation process. For instance, the acculturation process in the Pittsburgh Bantu female population is hindered by their cultural beliefs that the males must be the community liaisons and the females are generally isolated. As a result, thus they are not as likely as other immigrant populations to learn about the health services available to them as women (Owens, 2003).

2.3.3 Barriers to ensuring Positive Health Outcomes in The U.S.

Although refugees face a variety of barriers while resettling in another country, two of the fundamental barriers to ensuring positive health outcomes include citizenship and language.

A common barrier to accessing health services for refugee populations is language. Citizenship and language, in English speaking countries, contribute significantly to disparities in health coverage, access, and quality of services received by racial and ethnic minorities. Minority immigrants have a higher likelihood of being uninsured than native minority populations (Ku & Waidman, 2003). According to the Welfare Reform Act, immigrants who enter the U.S. (legally) after 1996 cannot receive assistance, except for emergencies, during the first five years they live in the country (UNHCR, 2010.) As a result, immigrants have few options for medical coverage, the ramifications of which include high medical costs and limited access to affordable or consistent medical care.

A lack of proficiency in English appears to result in decreased access to health care services (Davies, 2001). In addition to coverage, non-English speaking women reported that inadequate communication with healthcare workers was a primary concern in seeking healthcare information (Davies, 2001). Translation services were rarely provided in healthcare settings, making it difficult for immigrants to receive adequate and reliable care (Davies, 2001). Often times, interpreting services were made available only when the patient's health had deteriorated, clearly creating a discrepancy among non-English speaking patients who received preventative services and/or care in a timely manner (Davies, 2001).

Additionally, the multilayered organizational healthcare structure is often viewed as intimidating to those who are unfamiliar with its intricacies. Somali women reported that understanding the different services that are available to them was a challenge, thus they avoid or

delay receiving care (Davies, 2001). Obstacles such as lack of proficiency in the local language need to be recognized and addressed by healthcare providers in order for refugee populations to receive sufficient and timely care.

2.4 LACK OF CULTURALLY APPROPRIATE SERVICES

2.4.1 Somali Focused Interventions at Magee Womens Hospital

Since 2004, Pittsburgh has become home to over 200 Somali Bantu refugees. In 2007, Magee Womencare International received funding from the Jewish Women's Foundation to work with Somali Bantu high school girls through an intervention designed to explore and educate them on topics of interest within their community. In order to better gauge the topics of interest and importance within the community, a total of ten Healthy Girls/Healthy Family (HGHF) sessions were held.

Although Magee Womencare International thought this time frame would be appropriate, program implementers and participants were challenged by the limited time in which to cover the critical themes identified by the girls. In spite of limited time, Magee Womencare International was able to successfully present initial information on a variety of topics, which ranged from reproductive health to nutrition. According to program evaluations in 2007, the HGHF program gave the girls a sense of control, empowerment, and freedom. The girls also expressed interest in exploring additional topics and identified a new topic of importance to them: planning for

post-secondary school. The program's success served as a testament for the need and demand for culturally appropriate educational interventions for the Somali population.

In 2009, Magee Womencare International received funding from the FISA Foundation to build on the HGHF program by creating a new program, titled Healthy Girls Circle (HGC). The HGC program focused on wellness and post-secondary school options with peer support in a structured group setting.

2.5 HGC-YES PROGRAM OBJECTIVES

Additionally, the program objectives of HGC-YES, as outlined in the original grant proposal, included:

1. Enhancing girls' preparation for studies and careers in healthcare and other fields through lay health educator training, leadership building, health advocacy, health promotion, and project development.
2. Encouraging girls to share health information with elder women in their community who cannot be effectively reached due to language and cultural barriers.
3. Strengthening health care/self-care awareness and practice of HGC-YES participants and elder women in the Bantu community to make informed choices that will support each individual to reach her potential after high school and promote a healthy lifestyle.

2.5.1 HGC-YES Logic Model

Figures 1 and 2 depict a logic model of the HGC-YES program, including the problem and priorities, the inputs for the program, a detail of the activities, the outputs produced from these activities, and the resulting outcomes, from short to long-term.

Figure 1: Logic Model: Situation and Priorities

Inputs	Activities	Outputs	Outcomes -- Impact: Short	Outcomes -- Impact: Medium	Outcomes -- Impact: Long
Staff: Ebony Hughes, Stefanie Vigil, Amy Brown **Time**: 25-30 hours per week (8-10 hours/staff member) **Finances**: Grant from Jewish Women's Foundation ($9,000) & FISA ($5,000) **Materials/resources**: training sites; transportation; incentives for participants; teaching materials; 2 computers; office supplies **Partners**: Somali community partnership, Magee Women-care International, Jewish Women's Foundation, FISA Foundation.	1 session on community mapping and identification of information gaps and priorities within the Somali community 10-15Training Sessions for HG on the following topics* : 1) Lay Health Education 2) Reproductive Health 3) Menstruation 4) Exercise and Nutrition 5) Healthy relationships 6) General Health The 10-15 training sessions will also be used to: 1) Debrief and review previous training topics 2) Discuss challenges and successes in presenting information to community members 3) Develop strategies to reach and teach other Somali women and their peers 10-15 education sessions between HG and female member(s) of their community.	Target population: Adolescent Somali girls (Healthy Girls: HG's) 20 HG attend sessions and identify important health topics in their community and women that they can teach as indicated in attendance sheets. 20 HG attend training sessions and demonstrate knowledge acquisition on the following topics as indicated in pre/post tests. 20 HG educate members of the Somali community on the previous topics as indicated in the "Teaching Experience" tracking forms. 20 HG attend sessions to review training topics; discuss challenges and successes; develop strategies to reach and teach other Somali women and their peers, as indicated in attendance sheets and evaluation forms. 20 HG develop a reference and information folder (from handouts provided in the trainings) as indicated in evaluation forms.	Increase in awareness and discussions of important health topics within the Somali community, as indicated in attendance sheets. Increase in knowledge acquisition on previously mentioned health topics, as indicated in pre/post tests. Increase in health related conversations with elder women in the Somali community, as indicated in "Teaching Experience" tracking forms. Increased confidence in teaching abilities and increased desire to share learned information with members of the Somali community, as indicated in evaluation forms.	Improved ability to teach Somali community members on health related topics, as indicated in pre/post tests and evaluation sheets Improved communications between Somali youth and elders, as indicated in "Teaching Experience" tracking forms. Increased leadership and self-efficacy among HG's, as indicated in evaluation forms	Increase in HG's knowledge acquisition of leadership, project development, and health advocacy Increased preparation for HG's studies and careers Increased healthcare/self-care awareness among HG's and elder Somali women

Figure 2: Logic Model: Inputs, Activities, Outputs, and Outcomes

2.6 RECRUITMENT

Through HGHF and HGC, Magee Womencare International has established a sense of trust with the Somali Bantu refugees in Pittsburgh. This trust has allowed for exploration and better understanding of this population's needs, challenges, and desires. An established rapport has also ensured that the HGC programs can recruit from a large pool of perspective participants. Participants in previous programs have recruited friends and siblings to participate in current and

future Magee Womencare International interventions. The positive reputation of Magee Womencare International within the Somali community, along with the networking among Bantu community members, ensured a steady recruitment process for HGC-YES.

To recruit for the 2010 HGC-YES program, Magee Womencare International sent out flyers and invitations to all previous participants in Healthy Girl programs. Additionally, the program supervisor attempted to make contact with all previous participants via telephone. Previous participants were encouraged to bring their female siblings and friends to the introductory session on March 31, 2010.

3.0 METHODS

3.1 PURPOSE: TO EVALUATE HGC

The objective of this study is to conduct a program evaluation of HGC-YES in order to determine the program's ability to attain its objectives. Since the 1950s, program evaluation has become a common component of public health interventions (Rossi, Lipsey, & Freeman, 2004). Systematic evaluations assist in determining whether a program is meeting its goals and objectives, as well as to help generate future hypotheses for research and contribute to the knowledge of effective program designs (Rossi, Lipsey, & Freeman, 2004).

Program evaluation can include one or a variety of evaluation methods, ranging from needs assessments, accreditation, cost/benefit analysis, effectiveness, efficiency, formative, summative, goal-based, process, and outcomes based evaluation (Rossi, Lipsey, & Freeman, 2004). For purposes of this project, data were collected through process and short-term outcomes evaluations.

Process evaluations are designed to assess the fidelity and effectiveness of a program's implementation, by evaluating the activities and operations of the program through ongoing program monitoring. A process evaluation documents and analyzes the early development and actual implementation of the strategy or program, assessing whether strategies were implemented as planned and whether expected outcomes were produced (Rossi, Lipsey, & Freeman, 2004).

An outcome evaluation is defined as the systematic collection of information to assess the impact of a program, present conclusions about the merit or worth of a program, and make recommendations about future program direction or improvement Rossi, Lipsey, & Freeman, 2004).

Outcome evaluations assess progress on the sequence of outcomes that the program is to address. Programs often describe this sequence using terms like short-term, intermediate, and long-term outcomes, or proximal or distal (DHHS, 2000). For purposes of this project, a short-term outcome evaluation was conducted due to the scope of this 12 month program. Depending on the stage of development of the program and the purpose of the evaluation, outcome evaluations may measure: 1) changes in people's attitudes and beliefs, 2) changes in risk or protective behaviors, 3) changes in the environment, including public and private policies, formal and informal, 4) enforcement of regulations, and influence of social norms and other societal forces, and 5) changes in trends in morbidity and mortality (DHHS, 2000).

3.1.1 Questions to be answered

Ongoing meetings with the HGC-YES Program Supervisor offered essential direction, input, and feedback for this project. In the initial meetings with the Program Supervisor, a variety of questions were formulated. The program evaluation of HGC-YES aims to answer these questions to gain a better understanding of the effectiveness of the program. These questions include

1) To what extent is the program meeting its objectives?
2) Are unanticipated events occurring as a result of the program?
3) Are the program objectives appropriate given the resources available?

4) Are the program costs reasonable given the benefits received?
5) How well is the program managed?
6) How effective is the intervention in changing behavior (or meeting other objectives?)

3.2 PARTICIPANTS

Participants included 18 Somali Bantu adolescent females who range from 14 to 23 years old. Prior to immigrating to America, all of the participants spent time or lived in refugee camps in Kenya after the civil war in Somali began. Most of the participants began their immigration to the U.S. in 2004. After immigrating to the U.S., all of the participants enrolled in school. All participants completed middle school and junior high. Due to age limits enforced by the education system, one participant had to withdraw from school after completing ninth grade. Four participants are high school graduates and, of these participants, two are enrolled in post-secondary education courses. Prior to the start of the program, three participants were married. Throughout the HGC-YES program, two participants got married. Both of these participants moved out of Pennsylvania during the program, leaving a total of 16 to complete the program. Six of the 18 participants already had children when the program began.

3.3 MEASURES

Both qualitative and quantitative methods were used to conduct a comprehensive evaluation, which assesses the program effectiveness on several levels. Additionally, process and outcome measures were utilized to gain a better understanding of the program effectiveness and ability to fulfill its objectives.

3.3.1 Attendance

Participant attendance was monitored and utilized as a process measure in the evaluation. Participant attendance was taken at each HGC-YES session to determine if any trends were present. An attendance sheet and a pen were passed around, so each participant could sign in. The program supervisor passed around the attendance sheet 15 minutes after each session began, in order to ensure that all participants had arrived and were settled. The attendance sheet listed the topic and date of each session. For any participant who was not present, the group was asked if they knew the reason for the absence. This reason was, for most absences, also tracked.

3.3.2 Feedback Forms

Feedback Forms were distributed and collected at the end of the following sessions: March 31, 2010, April 24, 2010, May 15, 2010, June 5, 2010, June 26, 2010, July 17, 2010, October 16, 2010, November 6, 2010, November 20, 2010, and December 4, 2010. The collected data were tracked as an outcome measure in the evaluation. Feedback Forms utilized both qualitative and quantitative methods to assess the participants' perceptions of and satisfaction with the program,

containing both open-ended and multiple choice answers. The Feedback Forms were in paper format and consisted of eight questions, which were reviewed and piloted for clarity by program staff prior to administration. Participants were asked to indicate which option best represented their opinion on each quantitative item. The options were similar to a Lykert scale and included: Strongly Agree, Agree, Disagree, and Strongly Disagree.

The questions were divided into three different categories: 1) content of the session, to represent the participants' views of the material presented in each session; 2) instructor presentation, to represent the participants' perceptions of the instructor's abilities to present the material and facilitate each session; and 3) confidence to disseminate information to represent the participants' confidence to disseminate health related information.

The qualitative section of each Feedback Form consisted of several open ended questions. The qualitative questions were created to gain an increased depth and breadth of participants' assessment of the sessions. Eight of the ten evaluation forms contained three qualitative questions. Two of the ten evaluation forms contained five qualitative questions, due to the discusssion based nature of the session. The program supervisor distributed a Feedback Form and a pen to each participant. Participants were instructed to pass their completed forms to the program supervisor. Feedback Forms from each session can be viewed in Appendix A.

3.3.3 Pre and Post-Tests

Pre and post-post tests were administered and collected, and then the collected data were used as an evaluation measure. Pre and post-tests were distributed and collected at the following sessions: March 31, 2010, April 24, 2010, June 5, 2010, July 17, 2010, October 16, 2010, November 6, 2010, November 20, 2010, and December 4, 2010. At each of the training

sessions, pre-tests were given to determine prior knowledge, and post-tests were administered to determine participants' knowledge acquisition on the designated health topic. Tests consisted of five questions, and were reviewed and piloted for clarity with program staff prior to administration. The program supervisor distributed a pen and a pre-test to each participant 15 minutes after the start of each session, to ensure that all participants had arrived and were settled. Participants were instructed to pass their completed pre-tests to the program supervisor upon completion. The program supervisor distributed a pen and a post-test to each participant at the end of each session. Participants were instructed to pass their completed post-test to the program supervisor upon completion. Pre-test and post-tests from each session can be viewed in Appendix C.

3.3.4 Teaching Experience Tracking Forms

Teaching experience tracking forms (TETF) were kept by participants to monitor an increase or decrease in health related conversations between HG participants and other members of the Somali community. The forms were similar to an experience diary kept by participants, which encouraged them to keep track of how many Bantu women they taught. Participants were asked to record six items: 1) Name of student and relationship 2) Date of lesson and subject taught 3) Was this teaching session helpful to the student? How did you know? 4) Did you feel prepared to teach this subject? 5) How can you improve your teaching skills? 6) Will you continue to teach? Teaching experience tracking forms (TETF) were distributed and discussed at the first training session on March 31, 2010. Participants were asked to bring their completed forms to the final session, which was held on December 11th, 2010. Data from the TETF forms were collected and then used as an outcome measure in the evaluation. Full TETF can be viewed in Appendix D.

3.4 ANALYSIS

A descriptive analysis was performed on all quantitative responses. Qualitative answers from the Feedback Forms and the teaching experience tracking forms were transcribed and examined for themes.

4.0 RESULTS

4.1 ATTENDANCE

Table 1 presents the data collected from using attendance forms for all HGC-YES sessions. Session attendance varied considerably throughout the one year HGC-YES program. Number of attendees per session ranged from 15 to one. The mean number of attendees per session was 7.76, with a standard deviation of 3.42. How often each participant attended also varied, from one of the 17 sessions (6% of the sessions) to 14 of the 17 sessions (82% of the sessions). The mean percentage of sessions participants attended was 44%, or 7.5 of the sessions, with a standard deviation of 21%.

Table: 1 Participant attendance for each HGC-YES session from March 20 through Dec 18th

ID #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	%
1		X	X	X		X			X				X	X			X	47%
2	X	X	X	X	X		X	X	X			X				X	X	65%
3	X	X	X		X			X	X							X	X	47%
4	X			X	X		X										X	45%
5	X	X	X	X	X	X	X	X	X			X	X	X		X	X	82%
6	X	X	X		X	X	X	X				X	X	X	X	X	X	76%
7	X	X	X				X	X				X	X				X	47%
8	X	X							X				X				X	29%
9	X	X					X	X	X			X			X		X	47%
10				X	X	X	X	X	X	X	X	X	X	X	X		X	76%
11													X	X	X	X	X	29%
12		X	X	X		X			X				X	X			X	47%
13		X		X	X	X								X				29%
14			X				X	X	X				X			X		35%
15		X	X				X	X	X			X		X			X	47%
16							X			X		X					X	24%
17													X				X	12%
18													X					6%
# at each class	8	11	9	7	7	6	10	9	10	2	1	8	11	8	4	6	15	

Figure 3 shows the relationship between the attendance rates and session topics. The session with the highest number of participants in attendance (15) was held on December 18, 2010, when the activity was ice-skating. The session with the lowest number of participants in attendance (one) was held on September 25, 2010, when the topic was "Healthy vs. Unhealthy Relationships and Legal Rights," which was presented by the Women's Center and Shelter of Greater Pittsburgh.

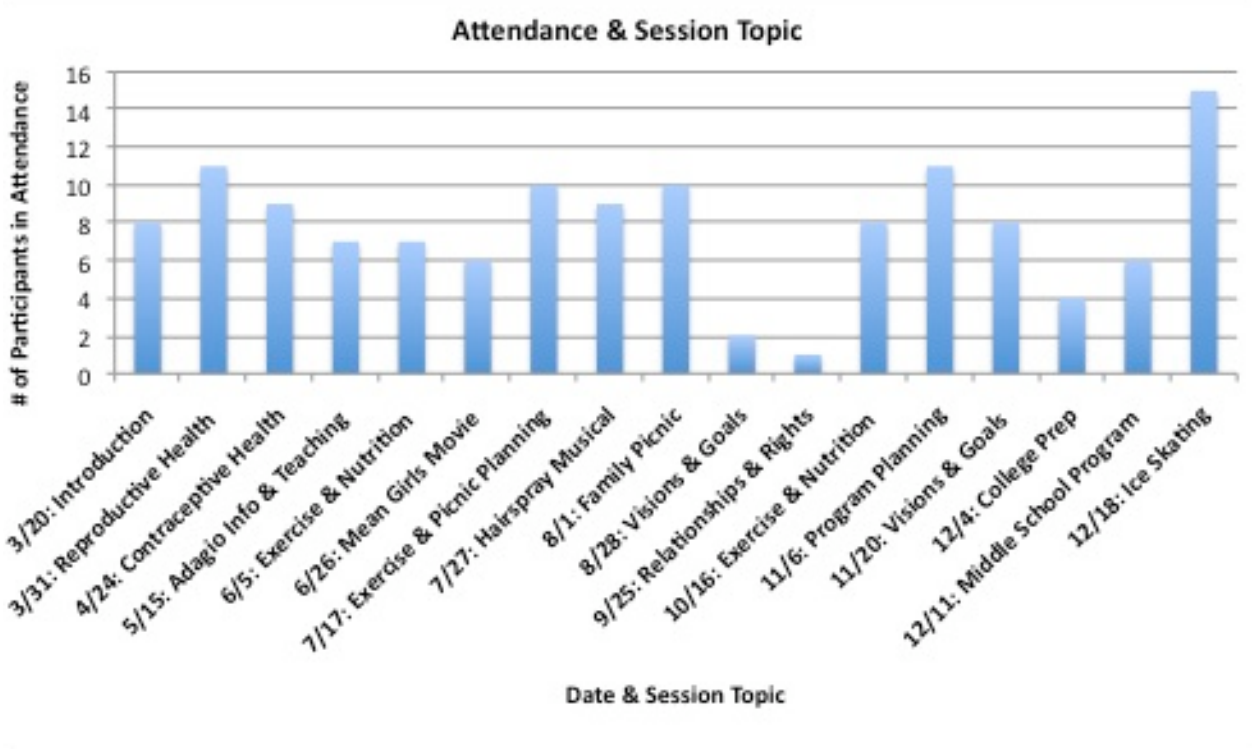

Figure 3: Participant attendance and topic of each HGC-YES session.

4.2 FEEDBACK FORMS

4.2.1 Feedback Form Results from all 10 Sessions

Figure 4 presents responses on the Feedback Form that reflected participants' assessment of the session's content. Fifty one percent (40/79) and 41% (32/79) of respondents strongly agreed and agreed, repectively, that the session was well-organized. The remaining 8% (7/79 respondents) disagreed that the session was organized well.

In regards to clarity of the presentation, 46% (36/78) and 40% (31/78) of respondents strongly agreed and agreed, repectively, that the presentation of material was clear. The

remaining 13% (7/79) disagreed that the presentation of material was clear. Only one respondent strongly disagreed that the presentation of material was clear.

In regards to usefulness of handouts, 35% (26/74), and 60% (44/74) of respondents strongly agreed and agreed, repectively, that the handouts were useful. The remaining 5% (4/74) of respondents reported that they disagreed that the handouts were useful.

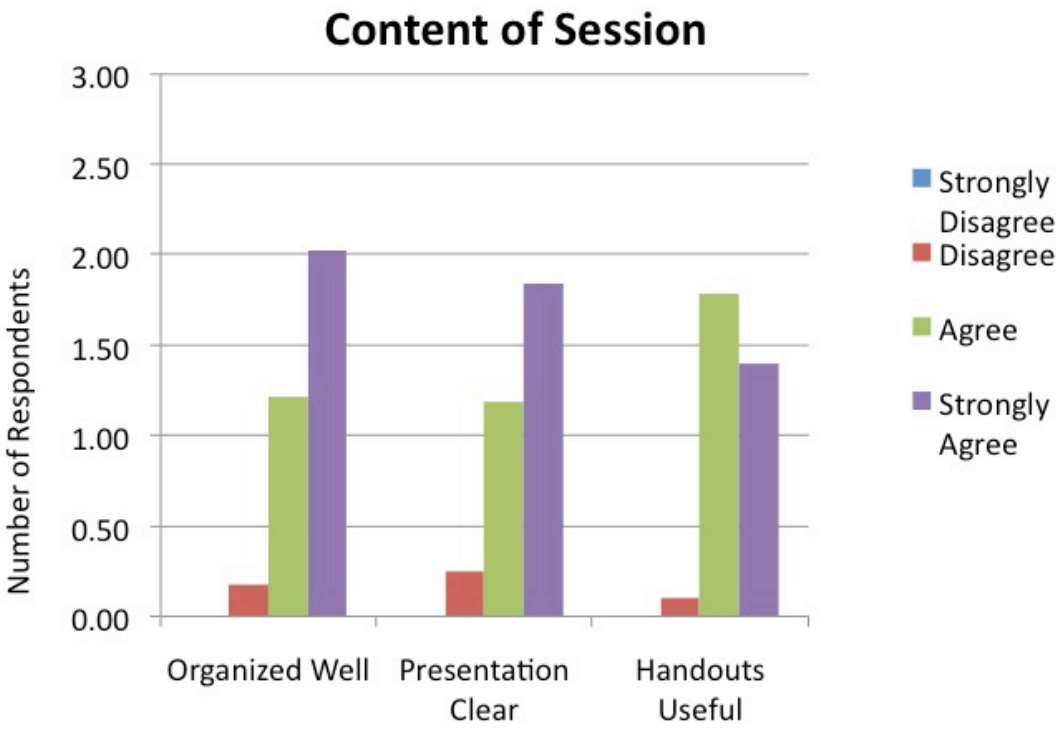

Figure 4: Content of the Session

Figure 5 presents the responses on the Feedback Form that reflected participants' assessment of the instructor's presentation. Fifty-four percent (43/80) and 40% (32/80) of respondents strongly agreed or agreed, respectively, that the instructor was well prepared. The remaining 6% (5/80) of respondents disagreed that the instructor was well prepared.

In regards to participants being comfortable asking questions, 39% (31/80) and 49% (39/80) of respondents strongly agreed or agreed, respectively, that they felt comfortable asking questions. Ten percent (8/80) of respondents disagreed that they felt comfortable asking questions. The remaining 2% (2/80) of respondents strongly disagreed that they felt comfortable asking questions.

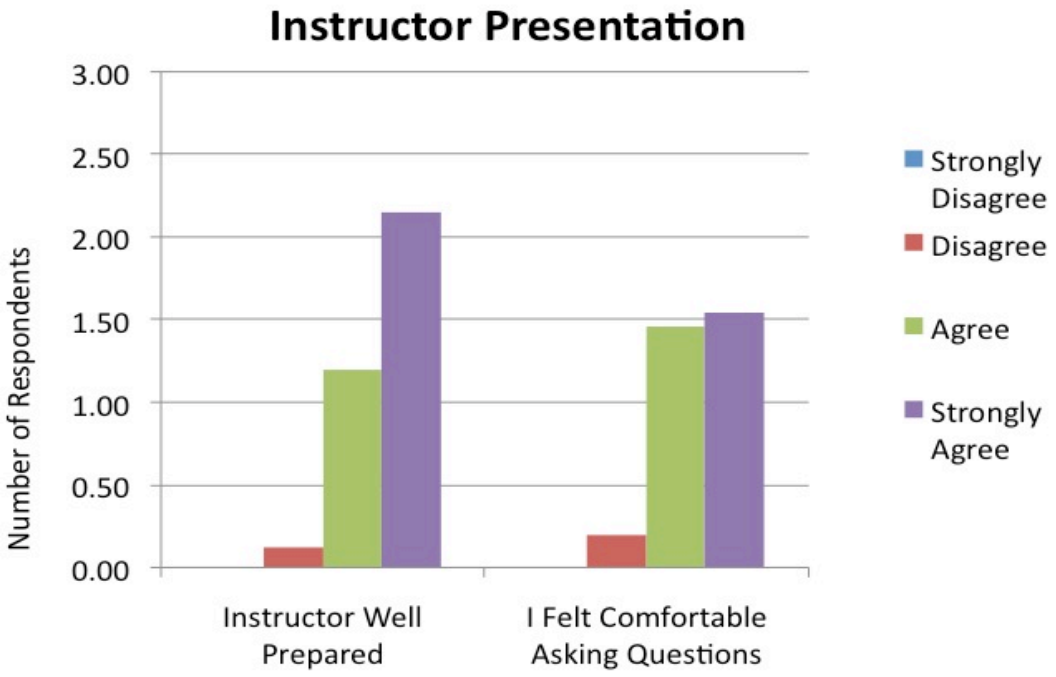

Figure 5: Instructor Presentation Over all 10 Sessions

Figure 6 illustrates the responses on the Feedback Form that reflected participants' assessment of session's ability to improve confidence to disseminate information. Thirty-four percent (26/77) and 47% (36/77) of respondents strongly agreed and agreed, respectively, that the session increased their confidence to teach elders. Eighteen percent (14/77) of respondents disagreed that the session increased their confidence to teach elders. Only one respondent (1/77) strongly disagreed that the session increased her confidence to teach elders.

In regards to confidence in teaching peers, 39% (31/79) and 56% (44/79) of respondents strongly agreed and agreed, respectively, that the session increased their confidence to teach their peers. The remaining 5% (4/79) of participants disagreed that the session increased their confidence to teach their peers.

In regards to level of comfort in talking about the health topic taught during the session, 34% (27/80) and 60% (48/80) of respondents strongly agreed and agreed, respectively, that the session increased their level of comfort in talking about the health topic. The remaining 6% (5/80) of respondents disagreed that the session had increased their level of comfort in talking about the health topic.

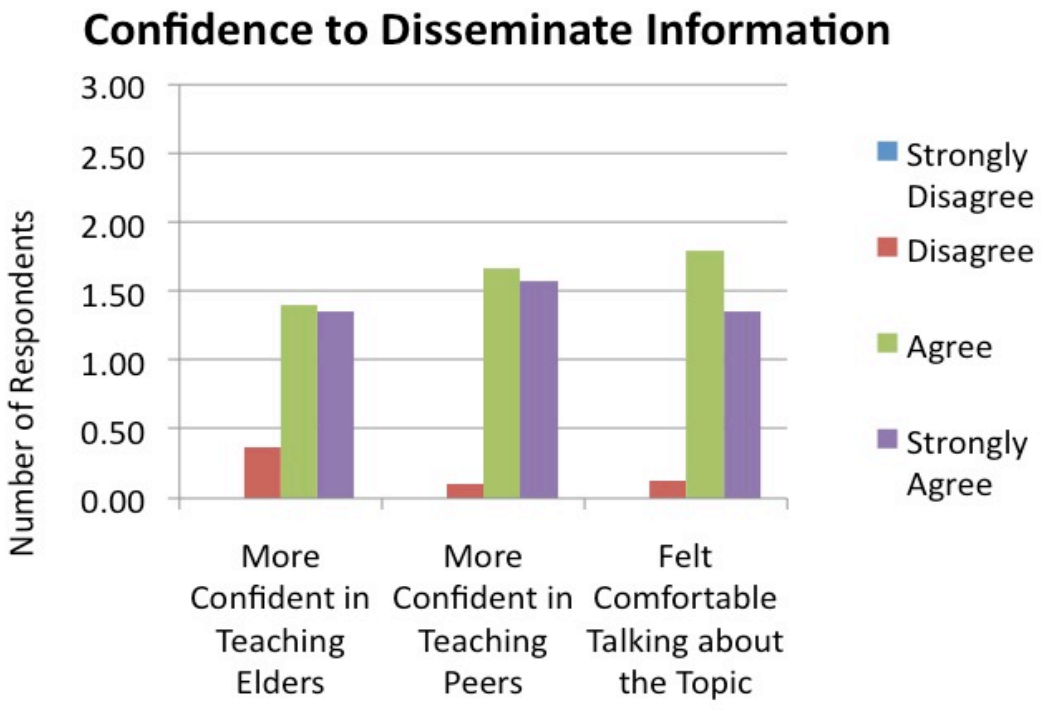

Figure 6: Confidence to Disseminate Information

In the qualitative response portion of the Feedback Forms, a majority of participants did not report any other topics in which they were interested. A select few participants reported they would be interested in fun activities, such as going to Kennywood, having more fun and activities, and more food. Participants expressed gratitude for the sessions and did not provide any critical feedback. The qualitative response portion of Feedback Forms from all sessions can be found in Appendix B.

4.3 PRE AND POST TEST RESULTS

4.3.1 Pre-Tests and Post-Tests Group Mean Results for Each Session

Figure 7 illustrates the mean score of all participants, at each session, on each pre-test and post-test. The reproductive health pre-test mean score was 1.9 out of a possible 5, and increased to a mean of 3.2 out of 5 at the post-test.. The contraceptive health pre-test mean score was 3.0 out of 5 and the post-test score was 3.4 out of 5. The exercise and nutrition pre-test mean score was 1.6 out of 5 and the post-test score was 2.6 out of 5. The exercise pre-test mean score was 1.4 out of 5 and the post-test score was 3.0 out of 5. The exercise and nutrition pre-test mean score was 2.5 out of 5 and the post-test score was 3.1 out of 5. The program planning pre-test mean score was 1.5 out of 5 and the post-test score was 2.3 out of 5. The visions and dreams pre-test mean score was 4.0 out of 5 and the post-test score was 4.8 out of 5. Finally, the college preparatory pre-test mean score was 1.5 out of 5 and the post-test score was 3.1 out of 5.

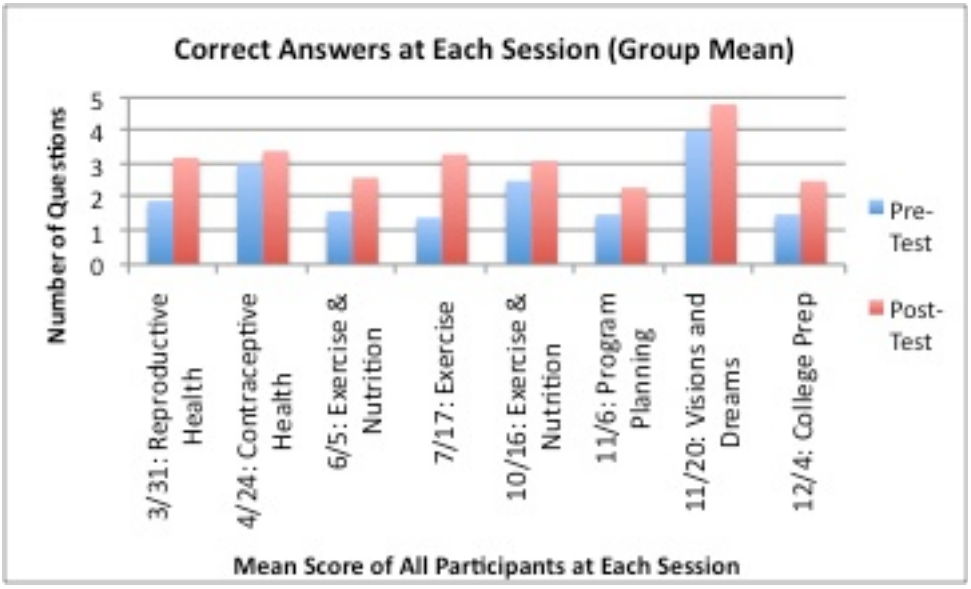

Figure 7: Pre-Test and Post-Test Group Mean Results for Each Session

4.4 TEACHING EXPERIENCE TRACKING FORMS

Three participants tracked their teaching encounters using the TETF and submitted their completed form at the final session on December 11, 2010 (see Table 2). These three participants tracked five separate teaching experiences, which resulted in five community members receiving a lesson from HGC-YES participants. One participant noted that she taught two individuals at the same time, so she named both participants in the same "Name of student and Relationship" category. The other two participants documented two separate teaching experiences. All participants responded, "Yes" in the "Will you continue to teach?" category. Additionally, in the "Was this teaching session helpful to the student?" category, participants responded that students felt the teaching session was helpful.

Table 2: Teaching Experience Tracking Form

Participant ID #	Name of Student and Relationship *	Date of Lesson & Subject Taught	Was this teaching session helpful to the student? How did you know?	Did you feel prepared to teach this subject?	How can you improve your teaching skills?	Will you continue to teach?
1	Kimberly & Ms. Moore	Exercising and Diabetes	It was helpful because once I tell them they just follow it.	Yes.	I think I don't need to improve my skill because I was prepared.	Yes.
2	Ashley	-	How to stay healthy. Yea they were happy to learn something new.	I was shy a little bit but okay.	By learning more and teaching to others.	Yes
2	Betsy	-	How to stay healthy. Yes they were happy to learn something new.	Shy but okay.	Learn more and teach to parents.	Yes
3	Anne	A month ago- November	I teach her to eat healthy food because she has diabetes that's why.	Well kind of.	By asking them questions and giving them information	Yes
3	Jessica	11/28/10	I teach her to eat healthy food because she had high blood pressure.	It help her a lot.	By asking questions if they want to ask.	Yes

*** Names have been changed to ensure privacy of participant and student**

5.0 DISCUSSION

The objectives of the HGC-YES program were to, as stated above, enhance girls' preparation for studies and careers, encourage girls to share health information with elder women in their community, and strengthen the health care/self-care awareness and practice of HGC-YES participants and elder women in the Bantu community. The purpose of the program evaluation was to gain a better understanding of the program's effectiveness and ability to fulfill its objectives. Overall, the program participants experienced a consistent increase in knowledge of health related topics, but participants failed to document their dissemination of information into the Bantu community. Additionally, varying attendance rates due to scheduling conflicts and miscommunication between HGC-YES staff and participants contributed to the programs difficulty achieving all of its objectives. This section provides a more detailed description of 1) the evaluation measures and observations made about the execution of the program, 2) the evaluation findings based on the overall program objectives, 3) study limitations, and 4) future program directions.

5.1 DISCUSSION OF EVALUATION MEASURES AND PROGRAM OBSERVATIONS

5.1.1 Attendance

A significant issue that impacted the program was the participants' getting married and shortly thereafter planning to have children. A number of the participants were planning to marry men who were living outside of the Pittsburgh vicinity, including Las Vegas, Buffalo, and Minneapolis. It is commonly accepted in the Bantu culture that women relocate to live with their new husband's family. The fact that two participants were married during the duration of the program also affected participant attendance. Two of the participants moved away from Pittsburgh, which resulted in them dropping out of the program.

Another participant, who was married shortly before the beginning of the program, experienced her own set of barriers in attending HGC-YES sessions. Since HGC-YES recruited and included only female participants, this participant's new husband felt a sense of uneasiness about not being involved in the program. The supervisor attempted to alleviate some of this anxiety by planning a family picnic on August 1, 2010, to which all family members were invited to attend and learn more about the HGC-YES program and objectives. Although the inclusive picnic was only a couple of weeks away, the husband forbade his new wife from attending any further HGC-YES sessions. In an effort to avoid similar predicaments in future programs, HGC-YES staff discussed the possibility of hosting an introductory session for all interested community members. At the introductory session, program objectives would be outlined in an effort to maintain a sense of transparency for community members who are not familiar with the HGC-YES program.

An additional challenge, which impacted HGC-YES's ability to meet its objectives, was the multiple scheduling conflicts throughout the duration of the program. One recurring conflict was finding reliable childcare. According to the participants, in the Bantu culture, it is solely the woman's responsibility to care for the children, which means all of the participants with children had to arrange for childcare for every session. This was a difficult task, as their other female family members of friends had their own children to care for. As a result, participants with children would often miss sessions.

Additionally, even participants who did not have children were more prone to miss sessions due to needing to care for their younger siblings. Since several of the participants were related, this created a burden in finding reliable childcare for participants' children and/or younger siblings. Participants reported having to take turns with one another to determine who could attend HGC-YES sessions. As a result, this caused a decrease in participant attendance throughout the duration of the program.

Various cultural traditions and community events also influenced participant attendance. For instance, prior to scheduling an event during Ramadan, the program supervisor asked participants if this session would create a scheduling conflict. Participants reassured the supervisor that they would attend the session, regardless if it were scheduled during Ramadan. So, a HGC-YES session was scheduled for August 28, 2010, and only two participants showed up to the session. When the program supervisor asked participants why the other participants had not attended, they replied that their families did not want them attending HGC-YES sessions while celebrating Ramadan. Due to low participant attendance, the session was canceled. This served as a learning experience for the HGC-YES supervisor and staff members. The supervisor

recognized that religious events clearly take precedence over extracurricular activities, so she concluded that she would refrain from scheduling sessions during religious events in the future.

Events within the Bantu community also influenced participant attendance at HGC-YES sessions. For instance, unbeknownst to the program supervisor, a member of the Bantu community was to be married on September 25, 2010, the same day as a HGC-YES session. Since the Bantu community is so close-knit, it is expected that all members of the community will attend weddings, or will make a significant effort to attend. Moreover, HGC-YES staff discovered that a funeral was also being held on the same day. Although a funeral is unanticipated, it is similar to a wedding in the respect that all that members of the Bantu community are expected to attend funerals. Given these expectations, on the day of the HGC-YES session, only one participant showed up. The HGC-YES staff also marked this experience as a learning opportunity, and noted that there were be an increased effort to avoid scheduling sessions on the same day as anticipated community events.

5.1.2 Discomfort with Teaching Elders

An additional issue that presented a challenge to carrying out the HGC-YES objectives was the participants' level of comfort in teaching elder women in their community. In the Bantu culture, age strongly influences the hierarchical structure. Elder Bantu receive a great deal of respect in their community, particularly from youth. These power dynamics had a significant impact on the HGC-YES participants' comfort level in delivering health messages to elder Bantu women.

Although participants had previously identified reproductive and sexual health as priority knowledge gaps within the Bantu community, the participants were now expressing reservations. Participants revealed concerns in private conversations with the program supervisor. According

to the program supervisor, the girls were apprehensive in delivering reproductive and sexual health information to elder women. Participants reassured the program supervisor that they were comfortable discussing health topics other than reproductive and sexual health (e.g. nutrition and exercise) with elder women. Given these findings, the program supervisor revised the HGC-YES curriculum to accommodate the participants' expressed concerns and comfort level.

5.1.3 English Proficiency

Language also presented a barrier to achieving the HGC-YES objectives. Since translators were not necessary in previous "Healthy Girls" programs, due to participants proficiency in English, it was assumed that most, if not all, HGC-YES participants would be proficient in English. However, there were a select few participants who presented as having limited knowledge of the English language. Given this language barrier, it was apparent that these participants were not able to understand a significant amount of material presented during sessions. If participants were not able to thoroughly understand the presented material, they would be less likely to disseminate the material to elder women in their community. In an effort to include all participants, there was discussion among HGC-YES staff of ensuring that a translator is available for future "Healthy Girls" programs.

5.2 INTERPRETATION OF RESULTS FOR EACH PROGRAM OBJECTIVE

The first objective of the HGC-YES Program was to enhance girls' preparation for studies and careers in health care and other fields through lay health educator training, leadership building, health advocacy, health promotion, and project development. The second objective of the HGC-YES Program was to encourage girls to share health information with elder women in their community who cannot be reached effectively due to language and cultural barriers. The third objective of the HGC-YES program was to strengthen the healthcare/self-care awareness and practice of young women among the Somali high school girls to make informed choices that will support each individual to reach her potential after high school and promote a healthy lifestyle. All three objectives were measured using attendance monitoring sheets, Feedback Forms, and the change in health knowledge acquisition, as indicated in the pre-tests and post-tests. In addition to using the previously mentioned measurement tools, the second objective was also measured using the TETFs.

There was considerable variation in attendance throughout the HGC-YES program. Low attendance was greatly affected by scheduling conflicts and miscommunication between HGC participants and staff members. The only limitation to a completely conclusive statement of this objective has been met is the attendance.

Feedback Forms results indicated that most participants expressed gratitude for the program and did not provide any critical feedback. Also, most participants did not report any other topics in which they were interested. Given the ceiling effect that was seen in the Feedback Form data, this author hypothesizes that the participants may simply have enjoyed the program and were grateful for the information, and failed to critically evaluate it. The lack of critical

feedback may have also been attributed to power differentials between the HGC-YES participants and staff. That being said, the overall results were positive.

The pre and post-tests demonstrated a clear increase in the participants' knowledge of health related material presented during HGC-YES sessions. There was a slight increase in participants' knowledge on the topics of college preparation, goal setting, program planning, nutrition, exercise and contraceptive health. There was a more substantial increase in participants' knowledge on the topics reproductive health. The collective increase in knowledge across all health topics indicated a positive result for corresponding objectives.

Only three participants tracked their teaching encounters using the TETFs. These three participants tracked five separate teaching experiences, which resulted in six community members receiving a health related lesson from HGC-YES participants. The low number of participants who documented their teaching experiences on the TETF presents a challenge in determining the program's ability to achieve its objective disseminating health related information into the Bantu community via HGC-YES participants. Thus, lack of data collected using the TETF and underuse of the form proved to be a limitation to a completely conclusive statement of the second objective.

5.3 STUDY LIMITATIONS

A variety of other issues were barriers in conducting a thorough program evaluation. One specific example is ensuring that high quality data are collected using Feedback Forms.

The overwhelming positive results in the quantitative and qualitative sections of the Feedback Forms could be interpreted in one of three ways: 1) the participants enjoyed the topics

and the content completely and nothing should change in regards to content; 2) their level of gratitude as expressed in the comments outweighed their desire to give any critical feedback in any manner. In other words, it is possible that the participants "liked us" so much that they did not want to be critical of us; 3) the participants didn't feel comfortable being critical of the program. This could have been attributed to the power dynamics that exist in the Bantu culture. For instance, the younger Bantu generation is viewed as subordinate to their elders. Also, the younger Bantu generation is not expected or allowed to give critical feedback.

Future HGC-YES staff members may need to provide coaching to participants at the initial session, in which Feedback Forms are handed out, in such a manner that describes the purpose of the Feedback Forms and how to provide critical statements. Furthermore, it is essential to assure participants that even though they may not be accustomed to providing critical feedback, that the HCG-YES program is a safe space in which to make these recommendations.

An additional barrier to collecting quality data was participants' rushing to complete Feedback Forms at the end of each session. Although participants were encouraged to spend adequate time completing the Feedback Forms, they often hurried to complete the forms, in order to have more time to socialize. As a result, HGC-YES staff distributed the forms with at least 10 minutes left in the session. Although some participants did spend this extra time completing the Feedback Forms, there were still several participants who completed the forms in a hurried manner. This dilemma impacted the quality of the data collected after each HGC-YES session. In future "Healthy Girls" programs, participants should be coached at the initial session to take their time in filling out evaluation materials, which will ensure higher quality data is collected.

An additional barrier was the lack of qualitative responses from participants in the qualitative portion of the Feedback Form. In an effort to increase participants' qualitative

responses, the HGC-YES supervisor suggested modifying the qualitative questions due to the discussion based nature of a select few sessions.

During these two sessions, more of an emphasis was put on discussing, reflecting, and teaching learned material. For instance, the session held on June 26, 2010, consisted of watching "Mean Girls," the movie, then holding a discussion session afterwards. Additionally, the session held on October 16, 2010 included reviewing previously learned material on exercise and nutrition, then discussing and practicing how to present this material when teaching elder Bantu women. Given the structure of these sessions, the HGC-YES supervisor viewed this as an opportunity to gather a greater depth and breadth of data. As a result, these particular Feedback Forms were modified to contain five qualitative questions, rather than the standard three questions found on all other Feedback Forms. This tactic proved useful in gathering more qualitative data on the Feedback Forms. In future "Healthy Girls" programs, it may be useful to include more discussion orientated sessions and to modify qualitative section of the Feedback Forms.

Participant attrition also affected the program evaluation. As previously mentioned, participants' marrying during the program and moving away from Pittsburgh had a substantial impact on the evaluation. Since these participants were not able to continue the program, TEFT data was not collected. The lack of TETF data impacted the ability to draw conclusions on the program's effectiveness in influencing participants to disseminate health-related information to members of the Bantu community.

The method of distribution and collection of the TEFT could be modified. For instance, TETF were distributed during one of the first HGC-YES sessions and were not collected until the final session. Since participants were not required to bring in their completed forms on a

regular basis throughout the duration of the program, there was a lack of follow through in checking-up on whether participants were teaching and documenting their experiences on the TETFs. Participants reassured the HGC-YES supervisor that they had disseminated health information to elder women in the Bantu community throughout the duration of the program. However, at the final session, only three participants had filled out the TETF and had documented teaching interactions with a total of five elders.

The lack of TETF data collection presented an obstacle in determining the program's effectiveness for disseminating health related information into the Bantu community via HGC-YES participants. Given this experience, it may be useful to create periodic check-ins throughout the program for participants to report their teaching experiences. For instance, participants could be expected to report their teaching experiences, or lack thereof, at every session. Moreover, in order to avoid the dilemma of participants forgetting their TETF at home, the program supervisor could distribute a new TETF at each session, give participants time to complete the forms, then collect the forms before participants leave the building. Making these simple modifications to distribution and collection methods will provide program staff with better data about the number of teaching experiences participants are engaging in, thus allowing staff to properly gauge the program's effectiveness in attaining some of it's objectives.

5.4 FUTURE DIRECTIONS FOR THE HGC-YES PROGRAM

In addition to suggestions mentioned throughout the paper, the program could be improved, based on observations. First, increase attendance by providing childcare. A second suggestion to improve the program is through stakeholder engagement. A final way to improve the program

would be to foster and engage in communication with the community to decrease scheduling conflicts.

One suggestion to increase attendance is to provide reliable childcare. The challenge of finding dependable childcare was a recurring dilemma for several participants. This predicament often resulted in participants missing multiple sessions. According to participants, it is solely the woman's responsibility to care for the children in the Bantu culture. This means that all of the participants with children or younger siblings had to arrange for childcare for each session.

Since Magee Womens Hospital provides various other health education classes for members of the community, it was surprising that childcare is not offered for all individuals who participate in health education programs. Similar to the HGC-YES program, childcare services could impact the attendance rates of other health education programs offered at Magee Womens Hospital.

An additional component of the HGC-YES program that shows room for improvement is engaging stakeholders. When the first HGC program was initiated, there was a tremendous effort to engage stakeholders of the Bantu community. According to HGC-YES staff, this heavy emphasis on stakeholder outreach was crucial in order to create a successful and sustainable program for the Bantu community. The HGC-YES program supervisor has worked with this population since the beginning of the HGC programs, which has resulted in a trusting relationship with members of the community. Although trust and rapport have been established, it is crucial to continue stakeholder outreach on an annual basis, as there are several new participants to the program each year. A technique that has proven successful in previous years was meeting with the Somali community partnership board. According to the program supervisor, these meetings were an opportunity to meet members of the community, gain trust

within the Bantu community and learn about the community's needs. Given the opportunity these meetings offer to garner support, reinstating a meeting with the Somali community partnership board prior to the start of future HGC programs may be worthwhile.

Prior to the start of HGC-YES, meetings with the Somali community partnership board could have significantly contributed to the planning and implementation of the program. For instance, conversations with community members could have resulted in the HGC-YES staff having a better understanding of the power structure and dynamics within the Bantu culture prior to the program's planning and implementation phases. More specifically, within the Bantu culture, young males and females are subordinate to their elder family members. This cultural dynamic was acknowledged early in the program, when participants expressed reservations about teaching elder women about health related information. Knowing this valuable information prior to the planning and implementation of the program, the HGC-YES staff members could have modified their objectives to be more culturally sensitive to the Bantu culture. A suggested modification, for future HGC programs, could include the participants being trained as lay health educators, and then sharing health related information with peers, instead of their elders.

An additional manner in which to gain stakeholder support is by hosting an introductory HGC session for all interested community members. HGC-YES staff introduced this idea in response to a participant's husband feeling excluded by the HGC-YES program. An introductory session would serve as an opportunity for members of the Bantu community to gain a thorough understanding of all HGC program objectives. An inclusive introductory session would allow family and community members to meet and learn more about HGC staff. From the HGC staff perspective, these meetings provide an opportunity to gain support for the upcoming program, which can improve attendance and sustainability of the intervention.

An additional area for improvement, already acknowledged by HGC-YES staff, is addressing scheduling conflicts. The lack of recognition of Bantu cultural events and holidays contributed significantly to the low attendance rates. For instance, one HGC-YES session scheduled during Ramadan, was canceled due to low attendance. Participants had assured the HGC-YES supervisor that they would be able to attend the scheduled session, despite the holiday, but only two participants attended the session. Additionally, another HGC-YES session was canceled due to a marriage and a funeral within the Bantu community, which was scheduled on the same day as HGC-YES session. Although the wedding was an anticipated event, and the funeral was an unanticipated event, all Bantu community members are expected to attend both events. Thus, on the day of the HGC-YES session, only one participant attended the session. Since the program supervisor was not aware of either of these events prior to scheduling a session, there was minimal opportunity to prevent conflicting schedules.

Anticipated scheduling conflicts can be decreased by not planning HGC-YES sessions on the same day as cultural events and holidays recognized within the Bantu community. Engaging in stakeholder outreach could prove as an opportunity to become familiar with the cultural events and holidays recognized by the Bantu community. Becoming familiar with the cultural events and holidays within the Bantu culture is also crucial in ensuring the cultural sensitivity of the HGC-YES program and it's staff. Reestablishing the practice of meeting with Somali community partnership board may prove useful in preventing anticipated scheduling conflicts, which will increase attendance rates and ensure a sense of cultural sensitivity towards the Bantu culture.

Although the HGC-YES staff has discussed and acknowledged a majority of these opportunities for change, it is crucial to note that poor communication has played a fundamental

role in the program limitations. Fortunately, a significant number of these dilemmas can be avoided through improved communication between HGC-YES staff and participants. One way to encourage open communication is by establishing an open relationship with and gaining trust of the participants early on in the program. Stakeholder meetings prior to the start of each new HGC program and an inclusive introductory session for all interested community members are methods to encourage open dialogue not only amongst community members, but also with HGC participants. Since the Bantu culture places a great deal of value on family input, establishing an open relationship with community members and gaining a better understanding of the community's health priorities is a crucial step in ensuring the success of future programs. Given the trusting relationship between HGC –YES staff and Bantu community members, these opportunities for change listed above can be easily executed. With these change, the HGC-YES program holds a great deal of potential at meeting its stated objectives.

6.0 CONCLUSIONS

Programs such as HGC-YES are a necessary tool for refugee populations to achieve what the WHO defines as health. Similar to the WHO, the HGC-YES program regards health as a fundamental human right, which means all individuals should have access to basic resources to attain and maintain a healthy lifestyle.

The public health significance and ramifications of failing to address the health related needs of this population are an increased risk of developing and maintaining high levels of negative health outcomes. Thus, there is an urgent need for culturally appropriate strategies to promote the health of the refugee population and facilitate their successful adaptation in the U.S.

One means of facilitating successful adaptation following immigration can be accomplished through implementation of programs and interventions that focus on the health education of immigrants. In response to the need for these programs, HGC-YES was designed to improve the health and well being of the Somali Bantu refugee population in Pittsburgh, Pennsylvania.

Conducting a program evaluation proved to be useful in evaluating the program's implementation process and determining the program's ability to attain its objectives. The evaluation measures indicated that when participants attended, they experienced a consistent increase in knowledge acquisition of health related topics, but participants failed to document their dissemination of information into the Bantu community. Additionally, a majority of

participants strongly agreed or agreed, respectively, with the clarity of the content in the sessions and the instructor's presentation of material. A majority of participants also strongly agreed or agreed that the sessions increased their confidence to disseminate information into the Bantu community.

Since the HGC-YES supervisor has worked with the Bantu community for several years, thus having built a trusting relationship, it is highly likely that improving communication and increasing stakeholder outreach could prevent anticipated scheduling conflicts, thereby increasing participant attendance. Additionally, improved communication and stakeholder outreach may prove useful in increasing the likelihood of disseminating of health information in the manner originally intended by the program. Lastly, an increase in communication and stakeholder outreach could assist in the planning and implementation of future HGC programs, which would contribute significantly to the program's success.

Given the program's multiple successes and manageable opportunities for change, the HGC-YES program holds a great deal of potential in promoting the health of the refugee population and facilitating their successful adaptation in the U.S.

APPENDIX A: FEEDBACK FORMS

A.1.1 Feedback Form: Session 3/31/10

Instructor: Damien and Maria (from Adagio Health) **Date:** 3/31/10

Please give us your opinion of the session. Your comments will help us improve future sessions.

Please **circle** the number that describes your level of agreement with each statement, with 1=strongly agree, 2=agree, 3=disagree, and 4=strongly disagree.

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. The class session was well organized	1	2	3	4
2. The class content was too easy	1	2	3	4
3. The presentation was clear and understandable	1	2	3	4
4. The instructors were well prepared	1	2	3	4
5. I felt comfortable asking questions	1	2	3	4
6. The handouts were useful	1	2	3	4
7. This session made me feel more confident in teaching elders	1	2	3	4
8. This session made me feel more confident in teaching my peers	1	2	3	4
9. I now feel comfortable talking about sexual health	1	2	3	4

Please comment:

Were there any topics you were interested in, that were not covered in this session?

How could this session have been better or more helpful?

Any other comments?

Thank you very much!

Please give your completed evaluation form to Ebony.

A.1.2 Feedback Form: Session 4/24/10

Instructor: Maria (from Adagio Health) **Date:** 4/24/10

Please give us your opinion of the session. Your comments will help us improve future sessions.

Please **circle** the number that describes your level of agreement with each statement, with 1=strongly agree, 2=agree, 3=disagree, and 4=strongly disagree.

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. The class session was well organized	1	2	3	4
2. The class content was too easy	1	2	3	4
3. The presentation was clear and understandable	1	2	3	4
4. The instructors were well prepared	1	2	3	4
5. I felt comfortable asking questions	1	2	3	4
6. The handouts were useful	1	2	3	4
7. This session made me feel more confident in teaching elders	1	2	3	4
8. This session made me feel more confident in teaching my peers	1	2	3	4
9. I now feel comfortable talking about sexual health	1	2	3	4

Please comment:

Are there any topics you are interested in, that were not covered in this session?

How could this session have been better or more helpful?

Any other comments?

Thank you very much!

Please give your evaluation forms to Ebony.

A.1.3 Feedback Form: Session 5/15/10

Class: Instructor:_____ **Date: 5/15/2010**

Please give us your opinion of the session. Your comments will help us improve future sessions.

Please **circle** the number that describes your level of agreement with each statement, with 1=strongly disagree, 2=disagree, 3=agree, and 4=strongly agree.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. The class material was too easy	1	2	3	4
2. The class session was clear and understandable	1	2	3	4
3. The instructors were well prepared	1	2	3	4
4. I felt comfortable asking questions	1	2	3	4
5. The handouts were useful	1	2	3	4
6. This session made me feel more confident in teaching elders	1	2	3	4
7. This session made me feel more confident in teaching my peers	1	2	3	4
8. I now feel comfortable talking about sexual health	1	2	3	4

Please comment:

Are there any other topics that you are interested in?

Any suggestions to improve future sessions?

Any other comments?

Thank you very much!

Please give your evaluation forms to Ebony.

A.1.4 Feedback Form: Session 6/5/10

Instructor:_____ **Date: 6/5/2010**

Please give us your opinion of the session. Your comments will help us improve future sessions.

Please **circle** the number that describes your level of agreement with each statement, with 1=strongly disagree, 2=disagree, 3=agree, and 4=strongly agree.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. The class material was too easy	1	2	3	4
2. The class session was clear and understandable	1	2	3	4
3. The instructors were well prepared	1	2	3	4
4. I felt comfortable asking questions	1	2	3	4
5. The handouts were useful	1	2	3	4
6. This session made me feel more confident in teaching elders	1	2	3	4
7. This session made me feel more confident in teaching my peers	1	2	3	4
8. I now feel comfortable talking about exercise and nutrition	1	2	3	4

Please comment:

Are there any other topics that you are interested in?

Any suggestions to improve future sessions?

Any other comments?

Thank you very much!

Please give your evaluation forms to Ebony.

A.1.5 Feedback Form: Session 6/26/10

Session topic:_____ **Date:** 6/26/2010

Please give us your opinion of the session. Your comments will help us improve future sessions.

Please **circle** the number that describes your level of agreement with each statement, with 1=strongly disagree, 2=disagree, 3=agree, and 4=strongly agree.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. The class material was too easy	1	2	3	4
2. The class session was clear and understandable	1	2	3	4
3. The instructors were well prepared	1	2	3	4
4. I felt comfortable asking questions	1	2	3	4
5. The handouts were useful	1	2	3	4
6. This session made me feel more confident in teaching elders	1	2	3	4
7. This session made me feel more confident in teaching my peers	1	2	3	4
8. I now feel comfortable talking about peer pressure	1	2	3	4

Please comment:

Name one thing you have learned today.

Has this session been helpful? Why or why not?

Are there any other topics that you are interested in?

Any suggestions to improve future sessions?

Any other comments?

Thank you very much! Please give your evaluation forms to Ebony.

A.1.6 Feedback Form: Section 7/17/10

Class Instructor:_____ **Date:** 7/17/2010

Please give us your opinion of the session. Your comments will help us improve future sessions.

Please **circle** the number that describes your level of agreement with each statement, with 1=strongly disagree, 2=disagree, 3=agree, and 4=strongly agree.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. The class material was too easy	1	2	3	4
2. The class session was clear and understandable	1	2	3	4
3. The instructors were well prepared	1	2	3	4
4. I felt comfortable asking questions	1	2	3	4
5. The handouts were useful	1	2	3	4
6. This session made me feel more confident in teaching elders	1	2	3	4
7. This session made me feel more confident in teaching my peers	1	2	3	4
8. I now feel comfortable talking about exercise	1	2	3	4

Please comment:

Are there any other topics that you are interested in?

Any suggestions to improve future sessions?

Any other comments?

Thank you very much!

Please give your evaluation forms to Ebony.

A.1.7 Feedback Forms: Session 10/16/10

Class Instructor:_____ **Date:** 10/16/2010

Please give us your opinion of the session. Your comments will help us improve future sessions.

Please **circle** the number that describes your level of agreement with each statement, with 1=strongly disagree, 2=disagree, 3=agree, and 4=strongly agree.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. The class material was too easy	1	2	3	4
2. The class session was clear and understandable	1	2	3	4
3. The instructors were well prepared	1	2	3	4
4. I felt comfortable asking questions	1	2	3	4
5. The handouts were useful	1	2	3	4
6. This session made me feel more confident in teaching elders	1	2	3	4
7. This session made me feel more confident in teaching my peers	1	2	3	4
8. I now feel more comfortable talking about exercise and nutrition	1	2	3	4

Please comment:

What did you like about this program?

Name one thing you learned.

What programs would you like to have in the future?

Any suggestions to improve future sessions?

Any other comments?

Thank you very much! Please give your completed evaluation forms to Ebony.

A.1.8 Feedback Form: Session 11/6/10

Class Instructor:_____ **Date:** 11/6/2010

Please give us your opinion of the session. Your comments will help us improve future sessions.

Please **circle** the number that describes your level of agreement with each statement, with 1=strongly disagree, 2=disagree, 3=agree, and 4=strongly agree.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. The class material was too easy	1	2	3	4
2. The class session was clear and understandable	1	2	3	4
3. The instructors were well prepared	1	2	3	4
4. I felt comfortable asking questions	1	2	3	4
5. The handouts were useful	1	2	3	4
6. This session made me feel more confident in teaching elders	1	2	3	4
7. This session made me feel more confident in teaching my peers	1	2	3	4
8. I now feel more comfortable talking about program planning	1	2	3	4

Please comment:

Are there any other topics that you are interested in?

Any suggestions to improve future sessions?

Any other comments?

Thank you very much! Please give your completed evaluation forms to Ebony.

A.1.9 Feedback Form: Session 11/20/10

Topic: "Visions of My Tomorrow: Goals and Dreams to live by"

Date: 11/20/2010

Please give us your opinion of the session. Your comments will help us improve future sessions.

Please **circle** the number that describes your level of agreement with each statement, with 1=strongly disagree, 2=disagree, 3=agree, and 4=strongly agree.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. The class material was too easy	1	2	3	4
2. The class session was clear and understandable	1	2	3	4
3. The instructors were well prepared	1	2	3	4
4. I felt comfortable asking questions	1	2	3	4
5. The handouts were useful	1	2	3	4
6. This session made me feel more confident in teaching elders	1	2	3	4
7. This session made me feel more confident in teaching my peers	1	2	3	4
8. I now feel comfortable talking about my future and my goals	1	2	3	4

Please comment:

Are there any other topics that you are interested in?

Any suggestions to improve future sessions?

Any other comments?

Thank you very much! Please give your evaluation forms to Ebony.

Class Instructor:_____ **Date:** 12/4/2010

Please give us your opinion of the session. Your comments will help us improve future sessions.

Please **circle** the number that describes your level of agreement with each statement, with 1=strongly disagree, 2=disagree, 3=agree, and 4=strongly agree.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. The class material was too easy	1	2	3	4
2. The class session was clear and understandable	1	2	3	4
3. The instructors were well prepared	1	2	3	4
4. I felt comfortable asking questions	1	2	3	4
5. The handouts were useful	1	2	3	4
6. This session made me feel more confident in teaching elders	1	2	3	4
7. This session made me feel more confident in teaching my peers	1	2	3	4
8. I now feel more comfortable talking about college preparation	1	2	3	4

Please comment:

Are there any other topics that you are interested in?

Any suggestions to improve future sessions?

Any other comments?

Thank you very much! Please give your completed evaluation forms to Ebony.

APPENDIX B: QUALITATIVE RESPONSES FROM FEEDBACK FORMS

B.1.1 Qualitative Responses on 3/31/10 Feedback Form

Are there any other topics that you are interested in?	Any suggestions to improve future sessions?	Any other comments?
No (x's 7)	No (x's 4)	Thank you.
No, everything is good.	This class was good.	It's a great time.
		No (x's 3)

B.1.2 Qualitative Questions on 4/24/10 Feedback Form

Are there any topics you are interested in, that were not covered in this class?	How could this session have been better or more helpful?	Any other comments?
No (x's 4)	More activities.	I love it.
No. Everything went well.	The session was perfect.	Thank you. We are grateful.
Yes	No (x's 3)	No (x's 2)
		It's best.
		Thank you.

B.1.3 Qualitative Questions on 5/15/10 Feedback Form

Are there any other topics you are interested in?	Any suggestions to improve future sessions?	Any other comments?
No, they were cool.	No (x's 5)	I learned a lot.
No (x's 3)	I learn a lot.	No (x's 2)
When we were making the necklaces with the beads.		I love it. I love the class.
I love the topics. So, no.		Yes. It was fantastic and fun.

B.1.4 Qualitative Questions on 6/5/10 Feedback Form

Are there any other topics you are interested in?	Any suggestions to improve future sessions?	Any other comments?
No (x's 2)	No (x's 3)	No (x's 5)
		I like the program. It was fun.

B.1.5 Qualitative Questions on 6/26/10 Feedback Form

Name on thing you have learned today.	Has this session been helpful? Why or why not?	Are there any other topics you are interested in?	Any suggestions to improve future sessions?	Any other comments?
I learned many things about mean girls- how they are and how they act	This session has been helpful to me because there are a lot of things that I learned that will help me in the future.	No	No	I am learning a lot of things that I didn't know- and it will help me in the future

Don't try to be something you are not.	Yes- because it was fun and I really enjoyed it.	-	More movies and fun.	I love this program.
Girls saying mean things to each other	Yes- because saying mean things to other is not good.	No	No	No
Don't act upon rumors	Yes- because I used to act upon the things I heard.	-	The sessions are perfect the way they are.	-
[I learned] who the mean girls are. [They] made all the students fight in the school	The session been helpful- when the African girl say she wrote the book- even when she didn't do it.	-	-	-
I learned how being in a group effects your education at school and at home. Never listen to what people say about others	Yes-because I learned the difference between real friendships and bad ones.	Believing [in] yourself.	Yes	No

B.1.6 Qualitative Questions on 7/17/10 Feedback Form

Are there any other topics that you are interested in?	**Any suggestions to improve future sessions?**	**Any other comments?**
No (x's 3)	No (x's 4)	No (x's 5)
Yes	Yes	Hope we keep this program forever.
	Not sure now.	Thank you for healthy girls circle.

B.1.7 Qualitative Responses on Feedback Form

What did you like about the program?	Name one thing you learned.	What programs would you like to have in the future?	Any suggestions to improve future sessions?	Any other comments?
Musical Chairs	Talk to each other	It will help all my family.	I will tell other people what I have learned and they will learn from it and it will help them in the future.	It will help me when I have to do the same things.
Everything that we do and I learns new things everyday.	To exercise right. To eat healthy food.	A program that helps me how to take care of a baby.	Yes (x's 2)	Myself don't eat healthy. It can help me and my family.
I was happy decision many different things.	Eating healthy food.	None. Sad to leave the girls next year.	No (x's 3)	I think it will better my life.
Talking about exercise	Eating healthy food is important.	Talk about everything.	This information will help me in the future.	No (x's 2)
The way we communicate to each other	Musical Chairs	The same thing we have now.		
Everything	How many times do I exercise a week.	Anything.		
	I learned musical chairs.			

B.1.8 Qualitative Questions on 11/6/10 Feedback Form

Are there any other topics that you are interested in?	Any suggestions to improve future sessions?	Any other comments?
More activities.	No (x's 5)	I learn lots.
No (x's 3)	More food!	Thank you for healthy girls.
		No (x's 2)

B.1.9 Qualitative Questions on Feedback Form

Are there any other topics that you are interested in?	Any suggestions to improve future sessions?	Any other comments?
No (x's 5)	No (x's 4)	No (x's 4)
Healthy and fun.	There should be more [sessions].	I love this workshop. I learn new things.
The goals.	No. It is perfect.	Thank you for starting the program for us.
		I love healthy girls.

B.1.10 Qualitative Questions on Feedback Forms

Are there any other topics that you are interested in?	Any suggestions to improve future sessions?	Any other comments?
Yes. Make the necklace.	Kennywood!	Thank you.
No (x's 2)	No (x's 2)	No.

APPENDIX C: PRE AND POST TESTS

C.1.1 Pre/Post Test: Session 3/31/11

Name:_____ 3/31/10

Reproductive Health- Adagio Health

Pre/Post Test
Healthy Girls Circle-2010
Magee-Women's Hospital of UPMC

1) What is the name of the organ that holds an unborn baby?
   a. Uterus
   b. Fallopian Tube
   c. Vagina

2) What is menstruation?
   a. The shedding of a thickened uterus lining
   b. The body getting rid of damaged blood cells and other wastes
   c. A monthly cleaning of the uterus to keep it disease free

3) Which is the average length of the menstrual cycle?
   a. 14 days
   b. 28 days
   c. 45 days

4) At what stage in the menstrual cycle is a woman most likely to get pregnant?
   a. The day or two before her period
   b. During her period
   c. During mid-cycle, about two weeks before her period

5) If you want to use pads or tampons, how often should you change them?
   a. Every hour
   b. Every 14-16 hours
   c. Every 4-8 hours

C.1.2: Pre/Post Test: Session 4/24/10

Name:_____ 4/24/10

Birth Control- Adagio Health

Pre/Post Test
Healthy Girls Circle-2010
Magee-Women's Hospital of UPMC

1) Which is a barrier method of birth control?
    a. Birth Control Patch
    b. Female Condom
    c. Vaginal Ring

2) Which birth control method may not work well if you are taking an antibiotic medication like amoxicillin?
    a. Depo Provera
    b. IUD
    c. Birth Control Pills

3) If teen girls have unprotected sex, what are their chances of getting pregnant within one year's time?
    a. 10 %
    b. 60%
    c. 90%

4) True or False: Nothing can prevent a pregnancy after unprotected sex.
    a. True
    b. False

5) True or False: There's one method of birth control that is 100% effective against pregnancy or STI's.
    a. True
    b. False

C.1.3 Pre/Post Test: Session 6/5/10

Name:_____ 6/5/10

Exercise and Nutrition

Pre/Post Test
Healthy Girls Circle-2010
Magee-Women's Hospital of UPMC

1) How many servings of fruits and vegetables should you eat per day?
    a. Five-seven
    b. 15-20
    c. One or two

2) True or False: When planning your meal, it is important to have a variety of colors on your plate (like a rainbow).
    a. True
    b. False

3) How often should you exercise?
    a. Seven days per week, for two hours each time
    b. Once a month, for 15 minutes each time
    c. At least three times per week, for 30 minutes each time

4) What is NOT a form of exercise?
    a. Walking
    b. Watching TV
    c. Yoga

5) Which is a benefit of exercise?
    a. Increases self-esteem
    b. Strengthens your heart
    c. Relieves stress
    d. All of the above

C.1.4 Pre/Post Test: Session 7/17/10

Name:_____

Pre/Post Test Questions: Exercise
Healthy Girls Circle-2010
Magee-Women's Hospital of UPMC

1) Which of the following are benefits of exercise?
   a. Assists in lowering blood pressure
   b. Strengthens bones
   c. Weight loss
   d. All of the above

2) What is the recommended times per week someone should exercise?
   a. 1-2
   b. 2-3
   c. 5-6

3) What is the recommended time someone should exercise per day?
   a. 1 hour
   b. 3 hours
   c. 10 minutes
   d. 30 minutes

4) What does a pedometer measure?
   a. Body fat index
   b. Weight
   c. Number of steps

5) Which of the following are risk factor(s) for physical inactivity?
   a. High blood pressure
   b. Obesity
   c. Cardiovascular (heart) disease
   d. All of the above

C.1.5: Pre/Post Test: Session 10/16/10

Name:_____ 10/16/10

Exercise and Nutrition

Pre/Post Test
Healthy Girls Circle-2010
Magee-Women's Hospital of UPMC

1) True or False: Calcium is a mineral that keeps your bones strong and healthy.
   a. True
   b. False

2) Which food is the best source of calcium?
   a. Chicken
   b. Banana
   c. Yogurt
   d. Bread

3) How many glasses of water should you drink everyday?
   a. Three to four
   b. 15-20
   c. Eight to nine

4) One serving of meat is the size of _____.
   a. A deck of cards
   b. A magazine
   c. A pencil box

5) One bagel (one serving of grains) should be the size of _____.
   a. A softball (bigger)
   b. A baseball (smaller)
   c. A Frisbee

C.1.6 Pre/Post Test: Session 11/6/10

Name:_____ 10/16/10

Program Planning

Pre/Post Test
Healthy Girls Circle-2010
Magee-Women's Hospital of UPMC

1) True or False: When planning an event or a program, it is best to not let anyone else help and do all the planning on your own.

    a. True
    b. False

2) When planning an event or a program, what is the first thing you should do?

    a. Make a checklist of what needs to be done
    b. Start planning the food that you will have
    c. Start inviting people

3) True or False: All of the information presented at an event should be very very hard, so people feel like they learned something.

    a. True
    b. False

4) How many activities should an event have?

    a. There should be activities every second of the event, so people don't have time to sit down
    b. There should be some activities, so people have time to think and talk about what they learned
    c. There should be no activities

5) True or False: A planning committee is helpful in planning an event, so you can understand other people's ideas and opinions.

    a. True
    b. False

C.1.7 Pre/Post Test: Session 11/20/10

Name:_____ 11/20/10

"***Visions of My Tomorrow -- Goals and Dreams to Live By***."

Pre/Post Test
Healthy Girls Circle-2010
Magee-Women's Hospital of UPMC

1) What types of goals are best to set?

    a. One large over-arching goal

    b. Several small easily achievable goals

2) A vision board is a visual representation of your goals and dreams. True or False

3) Goals are better achieved if they are:

    a. Specific

    b. Vague

4) It is best to set difficult unrealistic goals. True or False

5) Once you set a goal, you can never change or modify it. True or False

C.1.8 Pre/Post Test: Session 12/4/10

Name:_____ 12/4/10

College and Career Preparation

Pre/Post Test
Healthy Girls Circle-2010
Magee-Women's Hospital of UPMC

1. What is the name of an exam most people take to get accepted into college?
    a. SAT
    b. ABC
    c. XYZ
2. When is it best to start applying for college?
    a. Freshman year
    b. Junior year
    c. After you graduate
3. All colleges require an interview to be accepted. True or False
4. It is helpful to create a resume for your college application. True or False.
5. Who usually writes a recommendation for your college application?
    a. Yourself
    b. A family member
    c. A teacher or job supervisor

APPENDIX D: TEACHING EXPERIENCE TRACKING FORM (TETF)

D.1.1 Teaching Experience Tracking Form Data Collected

Participant ID #	Name of Student and Relationship *	Date of Lesson & Subject Taught	Was this teaching session helpful to the student? How did you know?	Did you feel prepared to teach this subject?	How can you improve your teaching skills?	Will you continue to teach?
1	Kimberly & Ms. Moore	Exercising and Diabetes	It was helpful because once I tell them they just follow it.	Yes.	I think I don't need to improve my skill because I was prepared.	Yes.
2	Ashley	-	How to stay healthy. Yea they were happy to learn something new.	I was shy a little bit but okay.	By learning more and teaching to others.	Yes
2	Betsy	-	How to stay healthy. Yes they were happy to learn something new.	Shy but okay.	Learn more and teach to parents.	Yes
3	Anne	A month ago- November	I teach her to eat healthy food because she has diabetes that's why.	Well kind of.	By asking them questions and giving them information	Yes
3	Jessica	11/28/10	I teach her to eat healthy food because she had high blood pressure.	It help her a lot.	By asking questions if they want to ask.	Yes

*** Names have been changed to ensure privacy of participant and student**

BIBLIOGRAPHY

Alba, R., & Nee, V. (1997). *Rethinking Assimilation Theory for a New Era of Immigration.* The Centre for Migration Studies of New York, Inc., 826-874.

Alba, R., & Reynolds, F. (2002). The New Second Generation in the U.S. *International Migration Review, 36(3),* 669-701.

Crist, J. (UNHCR): 1999. A State of Insecurity: The Political Economy of Violence in Refugee Populated Areas of Kenya. Retrieved on January 23rd, 2011. http://www.unhcr.org/cgi-bin/texis/vtx/home/opendocPDFViewer.html?docid=3ae6a0c44.

Davies, M., & Bath, P. (2001). The maternity information concerns of Somali women in the United Kingdom. *Issue and Innovations in Nursing Practice, 36*(2), 237-245.

De Waal, A. (1997). *Famine Crimes: Politics and the Disaster Relief Industry in Africa.* Bloomington, IN: Indiana University Press.

Goodman, R. M. (2000). Bridging The Gap in Effective Program Implementation From Concept to Application. *Journal of Community Psychology*, 309-321.

Halcón L. L., Robertson, C., Savik, K., Johnson, D.R., Spring, M.A., Butcher, J.N., Westermeyer, J.J., Jaranson, J.M., (2004). Trauma and coping in Somali and Oromo refugee youth. *Journal of Adolescent Health,* 35(1), 17-25.

Herrel, N., Olevitch, L., DuBois, D. K., Terry, P., Thorp, D., Kind, E., & Said, A., (2004). Somali Refugee Women Speak Out About Their Needs for Care During Pregnancy and Delivery. *The Journal of Midwifery & Women's Health*, 49, 345–349.

Kalson, S. (2004). Somali Bantu Refugees Adjust to their New Lives in Pittsburgh. Pittsburgh Post Gazette. Retrieved February 3rd, 2011, http://www.post-gazette.com/pg/04139/317935-85.stm.

Kandula, N. R., Kersey, M., & Lurie, N. (2004). Assuring the Health of Immigrants: What the leading health indicators tell us. *Annual Review of Public Health, 25,* 357-76.

Ku, L., & Waidman, T. (2003). *How Race/Ethnicity, Immigration Status and Language Affect Health Insurance Coverage, Access to Quality Care Among Low Income Population.*

(Publication # 4132) Kaiser Commission on Medicaid and the Uninsured. Retrieved February 3rd, 2011, http://www.kff.org/uninsured/kcmu4132report.cfm.

Loescher, G. (2001). *The UNHCR and World Politics: A Perilous Path.* Oxford: Oxford University Press.

Ljubinkovic, A. (2005). Report of Field Research Conducted in Dadaab Refugee Camps. Retrieved February 3rd, 2011. http://www.humiliationstudies.org/documents/LjubinkovicReportonField%20ResearchinDadaab.pdf.

Nutbeam, D. (1998). Health promotion glossary. *Health Promotion International, 13*(4), 349-64.

Owens, C.W. (2003). Somali Bantu Refugees. *EthnoMed* 1-7. Retrieved on March 13th 2011. http://ethnomed.org/culture/somali-bantu.

Portes, A., & Zhou, M. (1993). The Second Generation: Segmented Assimilation and Its Variants. *The ANNALS of the American Academy of Political and Social Science 530* (1), 74-96.

World Health Organization. (1948). Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

Robertson, C., Halcón L. L., Savik, K., Johnson, D.R., Spring, M.A., Butcher, J.N., Westermeyer, J.J., Jaranson, J.M., (2006). Somali and Oromo refugee women: trauma and associated factors. *Journal of Advanced Nursing, 56*(6), 577-87.

Rossi, P. H., Lipsey, M. W., & Freeman, H. E. (2004). Evaluation: A systematic Approach, 7th Ed. Thousand Oaks, CA: Sage Publishing.

United Nations High Commissioner for Refugees. (December, 2010). Convention and Protocol Relating to the Status of Refugees. Retrieved January 9th, 2011 from http://www.unhcr.org/3b66c2aa10.html.

United Nations High Commissioner for Refugees. (2006a). *Somali Refugees in Neighbouring Countries: Djibouti, Ethiopia, Eritrea, Kenya, Uganda and Yemen.* Retrieved January 21st, 2011 from http://ochaonline.un.org/OchaLinkClick.aspx?link=ocha&docid=33857.

United Nations High Commissioner for Refugees. (2006b). *The State of the World's Refugees 2006: Human Displacement in the New Millennium,* Oxford: Oxford University Press. Retrieved January 11th, 2011 from http://www.unhcr.org/4a4dc1a89.html.

U.S Department of Health and Human Services. (2010). Healthy People 2020: Understanding and Improving Health. 2nd ed. Washington, DC: U.S. Government Printing Office. Retrieved from http://healthypeople.gov/2020/default.aspx.

Van Lehman, D., & Eno, O., (2002). *The Somali Bantu: Their History and Culture.* Washington DC: Center for Applied Linguistics. Retrieved on February 12th from http://www.cal.org/co/bantu/somali_bantu.pdf.