The Impact of Gender Roles and Cultural Dynamics in the Work of Global to Local’s Community Health Promoters (CHPs): An Exploration Paper

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Global WACh Capstone Project 2013
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Introduction

Global to Local builds on the expertise of Washington State’s global health institutions, bringing home strategies that have proved effective in addressing health disparities in developing countries (Global to Local, 2012). HealthPoint Community Health Clinics, Washington Global Health Alliance, Swedish Medical Center and King County Public Health partnered with the city of SeaTac and Tukwila to launch the Global to Local Initiative in May 2010 (King County Public Health, 2010). The non-profit organization currently serves residents of South King County who have limited health access to healthcare and is currently piloting approaches to improve individual and community health outcomes, lower health care costs, and empower economic development.

In the early development process of Global to Local, community cafes were held to initiate conversations with community members of SeaTac and Tukwila on the particular strategies the community would like to implement to target health disparity. One of the proposed approaches community members suggested was recruiting community health promoters (CHPs) for specific populations. Due to the diversity of the SeaTac and Tukwila region - with over 80 languages spoken in the area including Amharic, Nepalese, Burmese, Spanish, Tigrinya, and many others – community members felt CHPs could provide valuable assistance in providing health education that is culturally appropriate for their community. Now three years after the community’s proposal, five female CHPs are currently employed by Global to Local and are actively working with the following communities: Burmese, Latino, Eritrean, Somali and English-
Speaking community. The health topics CHPs are currently focusing on include diabetes prevention, nutrition/healthy cooking classes and fitness.

This paper will focus on the five CHPs and explore how culture and gender roles impact the CHPs’ programs and work with the community. Common themes were discovered during the analysis of the qualitative data and provides the following structure for this paper: 1) Methodology; 2) Literature Review- Community Health Workers: Benefits and Effectiveness for Minority Populations in the United States; 3) CHP Led Global to Local Programs; 4) Traditional Gender Roles: Women as the Caretaker of the Children and Home; 5) Cultural and Gender Dynamics of CHP-Led Programs; 5) Benefits of Impacting Women Participants; and 4) Discussion.

**Methodology**

This paper is based on qualitative research that explored the impact of culture and gender roles on the work of Global to Local’s CHPs. Qualitative research is a methodology that provides an “exploration of the quality of experience through the study of meanings and process” (McMichael, 2002, p. 174). I chose qualitative research as my main methodology to gather first-hand experience and knowledge from the CHPs. Interviews were conducted with each of the five CHPs, and in addition I decided to also interview the CHPs’ program supervisor in order to further understand the impact of culture and gender roles on the CHPs’ work from an observant standpoint.

The following were the goals of the qualitative research; 1) To explore how CHPs factor their community’s culture and gender roles in delivering nutrition, physical activity

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1 The health topics were chosen by community members involved in the community cafes during the initial stages of Global to Local.
and health education programs to their community and 2) To determine whether the participation of community members is impacted by the gender roles and cultural dynamics present in specific communities; specifically investigating whether this has an impact on the gender dynamics of participants.

Interviews were conducted during the month of May 2013 and prior to approaching the CHPs for interviews, I had to receive permission from the CHPs’ program supervisor. I worked with the program supervisor closely to refine the questions for the CHPs to ensure its appropriateness; my adviser and myself tailored questions for the program supervisor. Prior to the interviews, the CHPs and the program supervisor each received via email the questions to help them prep for the interview, and in addition a consent form with information regarding the research was also sent out.

Interviews were semi-structured and follow-up questions were adapted to each of the response. All interviews were recorded, stored in a secure space and transcribed. Each of the interviewee received a copy of their transcribed interview electronically and was provided the option to comment and edit their transcription if they wanted to. Any names of individuals provided during the interview have been omitted in both the transcription and this paper for confidentiality purposes. Raw data from each of the transcription were then analyzed and key relevant themes that appeared throughout all of the interviews were chosen for the focus topics of this paper.

It is also important to note that approaching the CHPs and the program supervisor for the interviews was fairly easy due to my academic and employment position with Global to Local; it is currently my advanced year practicum site for my MSW and in addition I am also a part-time employee with the organization. My prior relationship with
the CHPs and the program supervisor provided a comfortable conversational flow to the pace of the interviews I conducted. However, my conflicting position as a researcher, practicum student and part-time employee also provided minor challenges during the research process such as ensuring that I provide a clear disclaimer in the consent form stating that none of the information I gather from the interviews will be used for Global to Local programming decisions.

While the minor challenges provided a learning experience for my qualitative research process, the amount of knowledge I learned from each of the CHPs regarding the cultural and gender dynamics of their community surpassed what I anticipated. I learned not only the value of the CHPs work with the community in regards to health education, but also the delicate considerations they have to take into their work in regards to promoting nutrition, diabetes prevention and fitness in a culturally appropriate manner for their community. In addition, I also learned gender roles have a strong impact on the female participants that are predominantly attending the CHPs’ programs. Prior to interviewing the CHPs, I heard that mainly women were working with the CHPs but it was not until the interviews that I began to understand the cultural, social and economic impact gender roles have in determining this dynamic.

**Literature Review – Community Health Workers: Benefits and Effectiveness for Minority Populations in the United States**

While Global to Local uses the term community health promoters (CHPs), there are a variety of other synonyms used to title CHPs including promotoras, lay workers, auxiliary health workers, indigenous lay workers, community health aides and many
others (Andrews et al., 2004). A popular term that is currently used by the World Health Organization (WHO) and other health organizations is community health workers (CHWs). CHWs are defined as “community members who work almost exclusively in community settings and who serve as connectors between healthcare consumers and providers to promote health among groups that have traditionally lacked access to adequate care” (Hunter et al., 2004, p. 19).

Internationally CHWs have been used in developing countries to improve the health statuses of communities in developing countries and CHWs are thought to have derived from the concept of “barefoot doctors” implemented in China during the late 60’s to improve healthcare in rural settings by training paramedics to travel to the non-urban areas (Fedder, 2003; Zang and Unschuld, 2008). Nationally, CHWs were introduced in the United States during the 60’s as well and were initially trained to provide “general health education, parent education and patient advocacy” (Andrews et al., 2004, p. 358). However, the types of health topics CHWs currently focus on in the United States have greatly expanded and include diabetes management, breast and cervical cancer screening, prenatal care, smoking cessation, hypertension, HIV/AIDS, sexual education and many other relevant health topics prevalent within the target community (Andrews et al., 2004; Hunter, et al., 2004).

The use of CHWs in the United States primarily has been used to improve the health statuses of minority populations who suffer from inadequate access to healthcare. Ethnic communities who have benefited from CHWs include African Americans, Mexican-Americans, Asian Americans and also immigrant and refugee populations such

\[\text{All of the academic literature used for this paper’s literature review used the CHW term}\]
as Vietnamese, Somali, and other communities (Hunter et al., 2004). In addition, CHWs have also focused on improving more specific vulnerable groups such as ethnic minority women - Hispanic, Southeast Asian women and others – who suffer worse rates of health status, disability, mortality, access to healthcare and overall quality of life compared to Caucasian women (Andrews, 2004). A variety of health interventions led by CHWs for ethnic minority women have proven to be successful such as increasing breast and cervical cancer awareness among Cambodian women; increasing fitness activities among African-American women with Type 2 diabetes; and increasing preventative chronic illness exams among elder Mexican-American women living along the U.S.-Mexico Border (Andrews et al., 2004; Hunter et al., 2004; Mahloch et al., 1999). CHWs improve the health of vulnerable minority populations by delivering health education that is culturally appropriate for the target community through the recruitment of CHWs that are members of that community and culture (Andrews et al., 2004; Fedder, 2003).

The roles of CHWs essentially include the following seven core roles: “cultural mediation, informal counselling and social support, advocating for individual and community needs, assuring people get the services they need, building individual and communal capacity, and providing direct services” (Swider, 2002, p. 12). Community involvement is not only essential for the work of CHWs but essentially is the way in which CHWs “identify, intervene and evaluate” the health issues that are prevalent among community members (Andrews et al., 2004, p. 363). Additionally, by recruiting individuals who come from the same community and culture to act as CHWs, community building and advocacy also becomes an element of CHWs’ work as they become the voices for their underserved community.
Overall, the use of CHWs locally in the United States has provided positive results in improving the health statuses of minority communities. CHWs provide a participatory method of health intervention that encourages community members to actively take initiative regarding improving their health. Due to the diversity of community dynamics, evidence regarding CHWs processes of intervention is scarce, however, literature evidence indicates that CHWs are effective in increasing the access, knowledge and behavioural changes of minority communities (Andrews et al., 2004; add another source).

**CHP Led Global to Local Programs**

The five CHPs with Global to Local deliver health intervention programs that focus on nutrition, physical activity and health education, specifically diabetes prevention. The deliveries of each of the programs are tailored particularly to how the CHPs feel is appropriate for their community. Classes are typically run in the CHPs and communities’ primarily language: Tigrinya, Somali, Spanish, Burmese/Karen and English. The Global to Local model focuses on “behavioural changes, community advocacy and participant to participant motivational support” (Global to Local, 2013). Community leaders are also actively assisting the CHPs with programs and CHPs are partnering with local agencies such as the Tukwila Community Center, Truth Center\(^3\) and YMCA.

The specific programs CHPs are currently involved in cover topics related to basic nutrition, diabetes, hypertension, cholesterol and focusing on fitness as a prevention

\(^3\) Faith-based organization located in Tukwila
method for future chronic illnesses (Global to Local, 2013). Cooking Demonstration Classes focus on teaching community members how to cook healthily and CHPs team up with nutritionists and chefs to provide participants with culturally appropriate recipe demonstrations, as well as nutritional value information (Global to Local, 2013). Physical activity related programs include the Global to Local and Tukwila Community Center Women Only Fitness Class; a program that delivers an all women fitness environment once a week for three hours. Childcare is provided and TCC provides an enclosed and safe space for women to exercise, eliminating the barriers that hinder women from accessing other fitness facilities. In addition, another physical activity program is the Eight-Week Exercise Program, which provides strength and core exercise routines for participants. CHPs work with trainers by translating the routines and encourage participants to continue the exercises at their own home.

**Traditional Gender Roles: Women as the Caretaker of the Children and Home**

The World Health Organization Report On Community Health Workers indicates that 70 percent of the CHWs active in international community-based programs are females (WHO, 2007). Looking at Global to Local’s current CHPs and Program Supervisor, it is important to note that all of them are also women. Before beginning to analyse the way culture and gender roles influence the delivery of the CHPs’ work, the CHP being all women is important to discuss. When asked how the Program Supervisor (2013) viewed gender roles relating to Global to Local, she touched on the fact that predominantly women are employed by the organization,
I mean at the end of the day any kind of community work primarily is female focused just because they're the nurturing individuals in the home and you know a lot of the stuff that we're doing has to do with health education and social issues that just seem to be a lot more predominantly taken care of by women. I mean as an organization when you look at our structure and the people on management team and everything I mean it’s primarily female and I do think it has to do because we're dealing with health and social issues (Program Supervisor, 2013, p.1).

Health education and social issues is primarily a matter that women handle or an area that mainly attract women’s attention; women are at the forefront in tackling these issues and within community work, female professionals dominate the field. This gender dynamic is not only seen in the staffing of Global to Local but also in the participants that are attending the CHPs’ programs (Program Supervisor, 2013, p.1). Most of the interview participants discussed the fact that predominantly women are attending the CHPs’ programs. Women’s role as the caretaker of the children, the home and the whole family dominated the conversation of the interviews and the participants reflected on this factor as a large reasoning for the women’s attendance.

All of the CHPs mention that female traditional roles play a part in the gender dynamics of their programs, particularly for the predominantly women attendance in the nutrition-cooking demonstration classes. The Burmese CHP mentions, “From my culture the home-maker are the one of who takes care of the house chores, cooking, cleaning the house, are mostly women. So mostly women come to my class” (CHP #3, 2013, p.2). Similarly the Latina CHP says, “Most of the Latina women they are really into the
kitchen; they like to cook, to provide and nurture their family so I think that’s definitely a draw for them” (CHP #4, 2013, p.1). The Somali CHP also mentions how traditional gender roles impact her attitude towards her work, “My approach was to start with the women because they’re the ones that cook, they’re the ones that make a lot of decisions around cooking and at the house, they’re the ones that take care of the children” (CHP #5, 2013, p. 4). The Eritrean CHP similarly shared a comment regarding women’s drive for coming to Global to Local classes, “For example, when I talk with the women, we talk about health also but everybody wants to talk about their kids…women told me, if we want to come, we want to come for the kids” (CHP #2, 2013, p. 3). The English-Speaking CHP also mentions parallel comments to the other CHPs, “All of the women I work with they are always thinking about their husbands and their kids and everything…they are really concerned with other people” (CHP #1, 2013, p. 7).

Women are the decision-makers of the home: the primary caretakers of their children, the main cook of the household and the head nurturer of all other family members. It is interesting to note that throughout my discussion with all of the CHPs regarding predominantly women attending the classes, they all mention the women’s children as the factor that drive their female participants to want to learn how to cook healthily, to want to improve fitness and to want to learn about diabetes prevention. The Program Supervisor who has had over 25 plus years experience of community work with diverse populations mentions that she has seen this trend throughout her career. She referred to a specific example of a predominantly female presence in a focus group discussion she held in the past on hazardous material in the home, “For them (women) simply it was the fact that they are concerned about their children, they’re concerned
about the family, they’re concerned about the impact that it’s going to have on their health so they’re more likely to go to something to get educated because it’s going to protect their family” (Program Supervisor, 2013, p. 11).

**Cultural and Gender Dynamics of CHP-Led Programs**

For all of the CHPs, traditional female roles factor into the gender dynamics of the CHPs’ classes but it is also important to mention that there are also differences in this dynamic. The Latina and Somali CHPs mention that they are working with mostly women, while the Burmese, Eritrean and English-Speaking CHPs are working with more of a mixed group with men involved in classes alongside women or actively participating in particular programs. The Somali CHP mention religion, culture and traditional gender roles as intertwining with one another and impacting this separation for her community, “Culture I can't for me…I can't mix I mean I can but it’s just the way things are. I can't mix gender because for Somalis there is more of religion that defines what gender roles always does, so culture also follows. So it’s religion plus culture that says women and men are divided so the roles are different” (CHP #5, 2013, p. 1). Similarly the Latina CHP mentions the lack of male attendance in her programs as a mix of culture and traditional roles, specifically the men’s role as the breadwinner of the family; “I think there is a lot of cultural issues that come with that and I also think it’s the community’s behaviour, women take care of the household, men go out and they provide for the families so how they see their role as not taking care of themselves but taking care of the family (financially) and the woman is the one that takes care of the husband and kids” (CHP #4, 2013, p. 5).
The Latina and Somali CHP indicate that the community’s cultural beliefs regarding traditional gender roles strictly focus on women as the primary caretaker of the children and the home, meanwhile the husbands are the breadwinners of the family. This division of gender roles seem to be the primary impact on the outcome of mainly women participants. Both the CHPs also mention the fact that particular topics such as the cooking classes may not be attractive for men due to this division. The Latina CHP mention that out of all of the topics Global to Local focuses on, diabetes would be the most attractive to men, however, she also mentions, “Having men come or maybe even having the wives bring their husbands with them is…we have asked before in the past but like I said, they’re more drawn into working and the after works they’re too tired and so they just want to go home, eat and then relax” (CHP #4, 2013, p. 5). The Somali CHP also share a similar perspective to the Latina CHP and says the following in regarding to topics that would be more attractive for Somali men, “Diabetes education might not be a problem, fitness might not be a problem but cooking might because they usually don’t cook so it’s not something…they have a lot of things (to do) and they have to work” (CHP #5, 2013, p. 5).

For the other three CHPs, a more mixed group of both men and women are present. The Burmese CHP mentions that some men are attending the cooking demonstration classes but that they are primarily elderly, retired-aged men and the youth population (2013, p. 2). It is interesting to note that Burmese youth boys and girls are actively participating in the programs and assisting their parents and grandparents to make behavioural changes. The Burmese CHP indicates that this is due to the youth being more acclimated to life in the United States and says, “Young people they stick up
for their family because of the language…their parents use them as their interpreter to community with other people…so I think the language barrier, the youth have to stick up for their family” (CHP #3, 2013, p. 3). While there are some youth boys participating, the Burmese CHP indicates that there are predominantly youth girls in the programs. The CHP for the English-Speaking Community indicates that for the cooking classes recently there has been an increase in men, primarily husbands of women attending the classes who have been returning regularly (CHP #1, 2013, p. 1). For the Eritrean CHP, their community has the most mixed dynamic with both men and women actively participating and the CHP mentions the acceptability of men and women to share traditional roles due to their community’s culture, but also the shared history participants have in fighting for Eritrea. It is interesting to note that initially during outreach more single Eritrean men were involved in the programs due to the high refugee population, but now classes are half men and half women participants with no issues surrounding men and women participating together in programs. The Eritrean CHP explains, “First in my community, we have not female and male, everyone is participate in this…we have background in our culture even they are both male and females they fought in one for the independence” (CHP #2, 2013, p. 3).

For the Burmese, Eritrean and English-Speaking CHP being women CHPs is not necessarily hindering men from participating in the classes; rules regarding gender in the their communities permit men and women to share gender roles amongst each other. If men were scarcely coming to the programs, the three CHPs indicated that the men’s role as the main financial provider for their families is the main reason as to why men are not attending. For the example, the Burmese CHP says the following in regards to her efforts
to engage men to attend cooking demonstration classes, “I try but mostly they decline to come because they already work all day and they are too tired to come. I think they have already made up their mind and so they don’t open the mind like the women do” (CHP #3, 2013, p. 2). All three CHPs seem to indicate that men and women have a more unified sense of gender roles and have had more success in involving men into their programs in comparison to the Somali and Latina CHPs. Meanwhile, the Latina and Somali CHP are finding that in their attempt to involve men into a discussion on any of the healthy topics, they have to tread lightly with the norms regarding gender roles in their community; while for the other CHPs since the rules regarding these norms are more flexible, their approach to discussing the health topics with men is the same as the women. The Somali CHP shares, “I’m trying to approach them (male community leaders) on what we can do too because I don’t want to step on the norms and culture. I don’t want to mix things, it won’t work so I want to make sure that I’m not doing something that’s again you know…I want to preserve some of the things that are important to the community” (CHP #5, 2013, p. 4).

**Benefits of Impacting Women Participants**

While the Latina and Somali CHP mention their roles as female CHPs as hindering outreach for men in their community, both indicate that targeting women community members provides an indirect venue to influence healthy eating habits for their husbands and children. The Latina women attending the classes are actively trying to tailor the traditional cultural foods they cook at home to a healthier form such as substituting Mexican rice with wild rice or using whole grain tortillas instead of white
tortillas (CHP #4, 2013, p. 2). While the Latina CHP mentions that women are finding resistance from their husbands and children from making the dietary substitutions, she encourages the participants to make gradual changes and incorporating more flavours to the rice or tortilla to make it tastier for family members (CHP #4, 2013, p. 2).

The Somali CHP also indicates that she is encouraging the women to add variety into their diet by increasing vegetables and other foods that will reduce fat, cholesterol and sugars in their cooking (CHP #5, 2013, p. 2). For example, recently the Somali nutritionist introduced an almond crust to cook fish. Additionally, the Somali CHP mentions that she ties analogies that the women will understand to emphasize the importance of healthy changes, “I say this is something…you can do something about it and a lot of you know Islamic teachings always (says) you have to take care of yourself so you use the culture, religion to bring a bridge and say you know God did not say don’t take care of yourself” (CHP #5, 2013, p. 2).

Similarly to the Somali and Latina CHPs, the others also mention mixing traditional foods and incorporating new concepts to promote healthy changes in the household. The Eritrean CHP mentions this concept particularly when discussing the impact of unhealthy foods in the U.S. the children will be eating, “I told them (women) let’s try different, from different cultural and we can learn at the same time health food…we can have a choice of different because our kids they are grow not in our back (home), so they will eat unhealthy food when they are a little bit grown they are not maybe interested in our culture foods…so let’s from we can prepare ourselves for our kids when eating unhealthy foods” (CHP #2, 2013, p. 4). The Burmese CHP mentions that while fish is a healthier meat option, some community members do not eat fish due
to personal beliefs, instead she encourages the portion control method and other healthier cooking methods appropriate to the individual’s beliefs (CHP #3, 2013, p. 1). In regards to whether behavioural changes are also influencing other family members, the Burmese CHP says, “Yes, they’re changing their cooking style and then they’re the one that prepare the food for the kids so I think it’s impacting everyone in their family” (CHP #3, 2013, p. 2). The CHP for the English-Speaking Community has recently teamed up with the Global to Local Chef to provide cooking demonstrations focusing on increasing vegetables in the diet and discussing serving sizes, meat alternative and suggestions for picky eaters (CHP #1, 2013, p. 3). Similar to the other CHPs, she also mentions the affect of behavioural changes in the home, “I think for the women that I have coming who don’t bring a partner, I think that they definitely are still affecting them just through the suggestions and different recipes they are going to try” (CHP #1, 2013, p. 7).

All of the CHPs mention the value in targeting women and mothers to influence other family members to make behavioural changes. By incorporating traditional foods and as well as introducing new healthy foods, all of the CHPs seem to indicate that by investing in women’s health education you are indirectly also impacting the health of other family members who are not necessarily participating in the classes. Referencing back to the earlier discussion regarding mothers mentioning their children as their drive to come to programs, besides the women making behavioural changes for themselves, all of the CHPs mention the women’s children as another important recipient of the intervention. As the Somali CHP says, “Somali women are the backbones of our communities, I mean they do a lot and we as a community if we don’t have woman then we don’t have anybody, they keep things together” (CHP #5, 2013, p. 3).
Discussion

The results of this qualitative research indicate that culture and gender roles significantly impact the CHPs’ work. Results suggest that culture, gender roles and even religion can impact both the way CHP deliver programs to their community and also the group dynamics of participants attending programs. CHPs appropriately tailor programs to be culturally and gender appropriate for their community such as incorporating healthier versions of traditional foods, including only female participants due to the gender role norms of the community and finding other healthier options of food if there are cultural restrictions. Predominantly women attend the CHP-led programs, with the exception of the Eritrean CHP who has the most mixed gender group. The results suggest that mainly women attend the programs due to traditional gender and cultural roles present within the community: women as the primary caretakers of the children and men as the breadwinner of the family. Additionally, results suggest that the topics covered by the programs especially the cooking demonstration classes attract more women, and the primary drive for women participants to come to CHPs’ programs is their desire to become educated for the sake of their children.

An additional layer - on top of the traditional gender and cultural roles - influencing the predominantly female attendance is also economics. Women’s lower economic status as compared to the men is apparent throughout the interviews, especially for the Latina CHP who indicates that about 90 to 95 percent of her participants are women and about 50 to 60 percent of them are stay-at-home moms (CHP #4, 2013, p. 4-5). Specifically for the Latina community, the Latina women’s undocumented status also
plays a role into the predominantly female attendance of the CHPs’ programs. The program supervisor mentions, “I’m not saying that there aren’t men interested in the cooking (class) but I think it is because of the economic status of the people we’re working with, we do tend to see you this sort of attitude like well that’s the women’s role” (Program Supervisor, 2013, p. 12). Tradition, gender norms, women’s motherly instincts, as well as women’s lower economic status as stay-at-home mothers also influence the dominant female attendance and minimal male presence. Results indicate that men do not have the same drive as the women to attend the programs due to their economic status and obligation as the main financial provider of the home.

Evidence from this research indicates that despite the fact that CHPs are predominantly working with female participants in their programs; there are indirect values in focusing on women when delivering health interventions. Results seem to indicate that by targeting women, you are also affecting the rest of their family members, especially their children, to make behavioural changes. As the CHP for the English-Speaking Community mentions, “I have heard this with other things but you really do make an even greater impact when you work with women because they are influencing different generations, their families and so it kind of spreads from them…and thinking what is on my mind right now, I’m noticing that a lot” (CHP #1, 2013, p. 8).

Conclusion

Global to Local CHPs continue to make an impact with their respective community to make healthy changes in order to prevent diabetes, improve nutrition and increase physical activity. The value the CHPs provide in delivering health interventions
that are culturally and gender appropriate for their community is immense. Not only because of the positive behavioural changes they are seeing on individual women, but also the impact CHPs have on children, families and the larger community as a whole. When asked in regards to what the CHPs have gained in working with the communities, all of the CHPs mention the amount of knowledge they have been able to learn from the individuals participating in their programs and the gratitude they feel in being able to provide something for their community. As one of the CHPs says, “If communities are given the opportunity, they are willing to take that, it’s just the way you approach it and people you use to engage them…and it just makes me happy that we have something to offer” (CHP #5, 2013, p. 8).
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