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UNDERSTANDING WELLBEING IN REFUGEE YOUTH FROM THE AFRICAN
GREAT LAKES REGION

BY

Victory Osezua, MPH

B.Sc., Covenant University, 2012

MPH., University of Louisville, 2015

A Dissertation

Submitted to the Faculty of the
School of Public Health and Information Sciences
of the University of Louisville
in Partial Fulfilment of the Requirements for the
Degree of
Doctor of Philosophy in Public Health Sciences

Department of Health Promotion and Behavioral Sciences

University of Louisville

Louisville, Kentucky

December 2021

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A Dissertation Approved on

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DEDICATION

To

All refugees, you show strength and perseverance despite the pain of leaving your countries to start over in a new land.

All refugees in a camp hoping for peace to be restored in their country or resettlement in another country. My heart and prayers are with you.

Thank you for inspiring this study.

To

My parents

For being more than I could ask for, believing in me, supporting me, praying for and with me, and investing in my life.

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It took a village!

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ABSTRACT

UNDERSTANDING WELLBEING IN REFUGEE YOUTH FROM THE AFRICAN GREAT LAKES REGION IN LOUISVILLE, KENTUCKY.

Victory Osezua

December 1, 2021

Young refugees are a vital and growing population in the United States that experience health inequities that make them vulnerable to adverse health outcomes. The health inequities that are evident between refugees and the general population elucidate the disparate power relations between the outcomes of the colonial past and postcolonial present. Although research shows that colonialism and their more recent experience of racism may have adverse long-term impacts on young people's health, it is essential to understand the contexts that shape their wellbeing. While the westernized model of wellbeing focuses on the individual, this study prioritizes the prevention of illness and maintenance of wellbeing at the different levels of the socioecological model- individual, community, organizational, and policy levels. This dissertation explored the African Great Lakes region refugee youths' experience with wellbeing, how they interpret their experience, and the meanings ascribed to wellbeing. A descriptive qualitative study used twelve in-depth interviews, two-member checking focus groups, and observational field notes for data collection to understand the influence of holistic wellbeing on African Great

Lakes refugee youth. Data coding and analysis was conducted in Dedoose using the constructivist grounded theory approach.

The study findings suggest that the African Great Lakes Region youth view the combination of physical, mental, social, and cultural health to maintain wellbeing. Also, participants interpret wellbeing on a community level rather than an individual level. The findings also suggest that colonialism is a form of racism that shapes and hinders young refugees from maintaining wellbeing. Racism has a huge influence on Black refugee youth from Africa which was evident in the refugee health policies, education system, refugee resettlement process, and the social determinants of health.

The study offers implications for research, policy, and practice. There is the need for partnership between community programs and immigrant communities. This study provides practical recommendations for developing programs to educate and enlighten youth refugees on the use and benefits of health insurance. This study informs strategies for developing and implementing policies to provide more funding for culturally competent refugee programs.

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CHAPTER I

INTRODUCTION

Research context and problem statement

Wellness in the literature is defined from different perspectives centered on conceptualizing a state of complete physical, mental, and social health (WHO, 1967). Some scholars agree that wellbeing is beyond the absence of disease (Travis & Ryan, 1988; Saracci, 1997; Shah & Marks, 2004; Dodge et al., 2012). According to Travis & Ryan (1988), wellbeing is a dynamic process of individuals moving towards better health or impelling the opposite towards disability described on the illness-wellness continuum. A person's health has a significant impact on their quality of life, which is a pivotal aspect of their wellbeing. Wellbeing research has historically been approached from a westernized perspective that asserts the individual has personal responsibility for health and prioritizes treatment over preventive health care (Armentrout, 1993; Witmer & Sweeney, 1992).

Additionally, young people find their wellbeing shaped by the society in which they live; the nature of their environment and society determine their development, status, aspirations, opportunities, and health (UNDESA, 2013; Isiugo-Abanihe & Oyediran, 2004). Young people 18 to 25 years represent 22% of the United States population (Goodkind et al., 2014; Park et al., 2014). In the US, 23% of young Americans live in poverty, which is responsible for some of the youth's health problems (Children Trends, 2019).

Compared to the general statistics of young people, those living in poverty have poorer health outcomes such as low poor mental health outcomes, malnutrition, higher rates of asthma, unintentional injuries, and obesity (Birken & MacArthur, 2004; Clarke, 2003; Lethbridge & Phipps, 2005; J. A. Leine, 2011; Santiago, Kaltman, & Miranda, 2013; Warren, Hoffman, & Andrew, 2014).

Although research suggests that young people are generally considered healthy (Park, Scott, Adams, Brindis, & Irwin, 2014), the formative age of this group might lead to sensitivity to risk factors from the social environment (Sawyer, 2012). Moreover, marginalized youth, including young refugees, may experience health inequities that make them vulnerable to adverse health outcomes such as low quality of life, low school enrollment, poor nutrition, housing insecurity, and financial strains (Chang, 2019; Castañeda et al., 2015).

The Centers for Disease Control and Prevention (CDC) reported that the number of obese youth has tripled since the 1970s, with 1 in 5 school-age children overweight (Fryar, Carroll, & Ogden, 2018). Kentucky was also ranked 3rd among the 50 states and the District of Columbia, with 20.8% of their youth being obese in 2017-2018. Kentucky's youth had the third-highest obesity rate out of 43 states in 2017 Behavioral Risk Factor Surveillance System (BRFSS) Jefferson County, 2017). The incidence of HIV is also high among young people. The YRBS (2017) reported that youth aged 13-24 accounted for approximately 21% of all new HIV diagnoses in the United States, most occurring among 20-24-year-old. Additionally, 14% of high school students engaged in illicit drug use, 1.5% used injection drugs, and 14% involved in prescription opioids misuse (Youth Risk Behavior Survey report, 2017).

Moreover, the national mortality rate (per 100,000 population) of young people aged 10-14 was 15.5. For 15-19 years, it was 51.5, and for 20-24 years was 95.6 (Kochanek, Murphy, Xu, & Arias, 2019). Non-Hispanic Blacks had the highest death rate nationally, 787.5 deaths per 100,000. In contrast, non-Hispanic Whites had 1,083.2 deaths per 100,000. However, Whites comprised 76.3% of the total U.S. population. Also, the U.S. Youth Risk Behavior Survey revealed that the leading cause of youth death in 2019 was unintentional injuries with motor vehicle accidents at 48 percent (48%) followed by homicide (13%) and suicide (11%) (Underwood et al., 2020). Likewise, in Kentucky, the mortality rate was higher than the national mortality rate of young people; the rate was 919 (per 100,000 people) in 2014; 10 -14 years was 256, 15-19 years was 819, 20-24 years was 1,572, and 25-29 years is 2,162 per 100,000 population (Behavioral Risk Factor Surveillance System (BRFSS) Jefferson County, 2017).

Also, the National Vital Statistics Report revealed that the birth rate of women aged 15 to 19 years was 17.4 per 1,000 women (Martin, Hamilton, & Osterman, 2017). This report revealed that although the national teen birth rate has decreased by 9% for women aged 15-17 years and 8% for women aged 18-19 years; ethnic inequities persist among teens; the birth rates (per 1,000) for Hispanics (28.9) and Black teens (27.5) were two times higher than the rate of White teens (13.2). At the same time, that of Native Americans was three times higher (32.9) (Martin, Hamilton, & Osterman, 2017).

Globally, there are 79.5 million displaced people, and almost 26 million are refugees aged 18 years and younger (UNHCR, 2020). Among the global young refugee population, infectious diseases such as waterborne diarrhea, lower respiratory tract infections, neonatal deaths, malaria, and malnutrition are the leading causes of death

(UNHCR, 2020). Also, refugees may experience adverse health outcomes in the host country due to a combination of factors such as language difficulties, culture shock, non-recognition of educational qualifications, limited social networks, discrimination, and racism (El-Bialy & Mulay, 2015; Foner, 2016; Priest et al., 2013; Richmond, 2001). Compared to the general population, refugees arrive in the United States with higher levels of mental health issues such as Posttraumatic Stress Disorder (PTSD). PTSD affects wellbeing through symptoms such as emotional numbness, disturbed sleep patterns, depression, low self-esteem, stress, anxiety, adjustment (Brough, Gorman, Ramirez, & Westoby, 2003; Brown et al., 2010; De Jong, Scholte, Koeter, & Hart, 2000; Hannah, Brassington, & King, 2014; Johnson et al., 2010). To understand underlying causes of these adverse outcomes, it is important to understand the historical context of refugee displacement and replacement.

Historical Context of Refugee Displacement

Frantz Fanon in his book "The Wretched of the Earth," asserts that the imposition of western culture and ideals caused by colonization influenced how Africans view themselves and are viewed by the society at large (Fanon, 1963). He explains that white supremacy is a form of violence that is affirmed by the aggression that penetrated through the values system placed on the culture of non-westerners. Consequentially, the colonizer only stopped "breaking in the native" (that is, mocking the colonized) when the colonized accepted the white man's values' superiority (Fanon, 1963). Nevertheless, in efforts to regain freedom, the colonized had to reject the White man's values, a process that Fanon refers to as decolonization (Fanon, 1963). Fanon describes decolonization as a process of

changing the world's order by joining two opposing forces: colonized and colonizer (Fanon, 1963).

Colonialism does not lead to the entire country's exploitation; rather, only the country's significant regions with natural resources are exploited for economic and political gains (Fanon, 1963). In many colonized African countries, the exploitation of natural resources necessarily means that prosperous areas such as those rich in diamond, cocoa, and crude oil dominate the entire country's economic and political identity. In contrast, other parts of the country remained impoverished and underdeveloped. This underlying disparity led to discord among tribes, regions, and governments. Fanon (1963) illustrated that rivalries resurfaced in the former Republic of the Congo in the late 19th century because of the pronounced economic inequalities among several tribes. For example, the Katanga secession war in the former Republic of Congo resulted from the struggle to gain power over the natural resources in Katanga by the Europeans. One of the provinces of the Belgian Congo, Katanga, in the 1900s accounted for an abundance of natural resources such as copper, uranium, diamond, radium, tin, and half of the world's supply of copper (Birchard, 1940; Ndikumana & Emizet, 2003). During the independence from Belgium, two Congolese political leaders, Patrice Lumumba and Moïse Tshombe held opposing views on what post-independence could resemble (Ndikumana & Emizet, 2003). Lumumba's idea on post-independence was that the Congolese government should have equal political power with the Western countries but preserve the national sovereignty over Congo's natural resources (Ndikumana & Emizet, 2003). On the other hand, Tshombe wanted to advance the Belgians' neocolonial interests by creating a patrimonial relationship, where individuals or groups were not powerful enough to challenge the

Belgium rulers (Ndikumana & Emizet, 2003). The anti-western opinion of Lumumba attracted hatred from the Western government, including Belgian, the United States, and the United Nations government, which led to the Katanga secession war that cost Lumumba his life and created unrest for the Congolese people. In addition to effect of the war and unrest in Congo, there was also Exploitation of the rubber industry during the King Leopold II, a Belgian, rule. This human right issue was termed “crime against humanity”, characterized by brutal enslavement of people.

Postcolonialism explores the effects of decolonization and continuing the anti-colonial deconstruction of western domination (Young, 2020). Using the postcolonial framework lens, Gagné (1998) found out that the end of the colonial era in Africa marked the beginning of inter-ethnic rivalries during the fight for control of emerging nations. Besides the ethnic and geographic conflicts that have become the legacy of postcolonial Africa, African countries were typically patterned after the colonizer's value system (Gagné, 1998). Postcolonialism started in the 1970s and has worked to disrupt the assumption that western knowledge is objective and universally relevant. It also criticizes the notion that western science is the source of knowledge that uncovers health inequities stemming from colonization and neo-colonization (McLeod, 2020; Quayson, 2000; Racine, 2003; Xie, 1997). Postcolonialism also questions Western ideologies and opinions about non-western populations and considers historical contexts (Philip, 2004). This exploration involves unraveling the omission of White ideologies' exclusionary effects that oppress other types of knowledge (Quayson, 2000). Fanon (1963) explained that long colonization period promoted the European colonizer's superiority over the colonized. Rwanda's long colonization period favored the Hutus' European facial features over the

Tutsis. This favoritism led to the Rwanda Genocide civil war when the Hutus majority killed 800,000 Tutsis. As a result of the genocide, many Rwandese were internally displaced and sought resettlement in other countries (Prunier, 2008; Wallis, 2014). Likewise, colonial experiences furthered ethnic wars in Burundi and the Democratic Republic of Congo in the 21st Century when natives fought for land ownership and natural resources were sold to western industries and countries (Khadiagala, 2006, Adunimay, 2017, Githaiga, 2011).

These conflicts birthed the chronic displacement crisis in some African countries, including those in the Great Lakes Region (GLR). The Great Lakes Region (Figure 3) is a sub-region consisting of East and Central African countries (Adunimay, 2017). Although the name "Great Lakes Region" originated from the freshwater lakes and river basins within the central and eastern parts of Africa, there is no consensus on the countries that form this region (Shyaka, 2008). The United Nations African Union International Conference on the Great Lakes Region classified this region to include eleven countries: Rwanda, Burundi, Democratic Republic of the Congo (DRC), Republic of Congo, Uganda, Tanzania, Zambia, Central African Republic (CAR), Kenya, South Sudan, and Sudan. The GLR has experienced some of Africa's most intense violence and conflict in the last half-century, signified by the genocide in Rwanda, civil wars in Burundi, and cross-border conflicts in the DRC (Khadiagala, 2006, Githaiga, 2011).



Map No. 4004.1 UNITED NATIONS
January 2004

Department of Peacekeeping Operations
Cartographic Section

Figure 1: Map showing the Great Lakes Region.

As a result, over eight million GLR citizens have been displaced, most of whom now seek protection in either urban or rural refugee camps and asylum in western countries (United Nations High Commissioner for Refugees, 2019). For refugees unable to return to their home country, the United States is a resettlement country of choice. General to the immigrant experience, the United States is seen as the land of opportunity, and individuals who can "pull themselves up by their bootstraps" can succeed with diligence and perseverance (Kluegel & Smith, 1986). This success is seen mostly as achieving the American Dream, and everyone has an opportunity for prosperity. The American Dream follows the meritocratic worldview that social rewards and success are achieved by

individual merits, talents, and diligence (Kluegel & Smith, 1986; Marger & Churchill, 1999; Kluegel & Smith, 1986). McNamee & Miller (2009) agreed with Kluegel & Smith (1986) that meritocracy propagates the belief that "those who are the most talented, the most diligent, and the most virtuous should get the most rewards." This means that if the status hierarchy is earned by merit, people with higher status must be more talented, diligent, and smarter than those of a lower social level.

Despite the evidence that supports the influence of socioeconomic status on health outcomes, forms of oppression such as racism, sexism, and ableism are non-meritocratic factors that determine these outcomes (James, 2003; Napier, Mandisodza, Andersen, & Jost, 2006). James (2003) argued that the American system rationalizes wealth inequalities as a failure on the individual rather than the structural inequities and policies failing the people. The meritocratic ideology that everyone gets a chance to succeed diverts attention from oppressive systems that build barriers to success (Napier, Mandisodza, Andersen, & Jost, 2006). Napier, Mandisodza, Andersen, and Jost (2006) further explained that a system of justification could overlook meritocratic beliefs. Kwate and Meyer (2010) asserted that people rationalize the status quo and divert attention from structures that make it impossible for racial and ethnic minorities to thrive.

Meritocratic beliefs are also held by refugees and immigrants who arrived in the United States for resettlement. In their examination of the relationship between meritocracy, ethnicity, and collective action among Latino immigrants, Wiley, Deaux, & Hagelskamp (2012) found that first-generation Latino immigrants believed that the effect of racism could be overcome or avoided through hard work, while second-generation were less likely to hold these meritocratic beliefs. The American Dream neglects the power of

systems and structures that enable certain people to excel and others to fall short by focusing entirely on individual aspirations (Hochschild, 1995). Moreover, Rus (2009) acknowledged that flaws to the American Dream achievement and meritocracy are in its failure to account for racism's inequities.

Refugee Resettlement in the U.S.

Upon migration to the United States, African immigrants often find that they are evaluated with the same stereotypes ascribed to African Americans by the dominant culture and are sometimes also stereotyped negatively by African Americans as less civilized people (Tradore 2004). Shaw-Taylor (2007) argued that Black immigrants do not identify as African Americans to avoid discrimination. Racism is central to reviewing the acculturative experiences of Black-Africans (non-Black Africans) in the United States (Constantine et al., 2005). Before moving to the United States, most Black-Africans have no experience of the concept of racism and consequently may not have had the opportunity to develop the capacity to cope with such situations (Bagley and Young 1988; Phinney and Onwughalu 1996; Lee and Opio 2011). Manyika's (2001) study indicated marked discrimination towards Blacks and Black-African students on many campuses in the U.S. It was also reported by Blake (2006) that many Black-African students, even at historically Black institutions, were discriminated against by instructors and students alike.

The United States resettled 31,250 refugees in 2019; this is part of the three million refugees settling in 50 states of the U.S. since 1975 (Department of State Bureau of Population, Refugees, and Migration Office of Admissions, 2020). The U.S. Refugee Resettlement Program also prioritizes resettlement for the most vulnerable populations with critical medical conditions and disabilities (Department of State Bureau of Population, Refugees, and Migration Office of Admissions, 2020); this means that refugees arrive in the U.S. with adverse health conditions. Since 2000, the United States has resettled nearly 410,000 refugees from African countries, 11,000 from the African Great Lakes Region (Office of Refugee Resettlement- ORR, 2016). Of the refugees resettling in the U.S. from the Great Lakes Region, 55% were youth and adults aged (15-44 years) (ORR, 2016). The Great Lakes Region in Africa, including the Democratic Republic of Congo (DRC), Rwanda, Uganda, Burundi, Kenya, and Tanzania, has been affected by civil strikes for over 20 years (International Rescue Committee, 2014). Refugees from the Democratic Republic of Congo accounted for nearly 13,000 resettled refugees in the U.S. in the fiscal year 2019.

Moreover, Kentucky received 15,847 refugees between January 2014 and December 2018, with 5,286 aged between 15 to 30 years on arrival. Of the 15,847 refugees, 7,450 (47%) were females and 8,391 (53%) were males (Kentucky Office for Refugees - KOR, 2020). The Kentucky Center for Economic Policy revealed that Kentucky takes in more than twice the national average of refugees (KOR, 2020). At the end of the Fiscal Year 2019, Kentucky was ranked 5th nationally in the number of refugee arrivals compared to other U.S. states (KOR, 2020). According to the Kentucky Office for Refugees (2020), arrivals of refugees in Kentucky between the fiscal year 2015 and 2019 were from Cuba (4,900), the Democratic Republic of the Congo (2,456), and Somalia (1,100).

Due to President Trump's Administration Executive Order on Refugees and Travel Ban, popularly known as the "Muslim Ban," the refugee admission ceiling reduced drastically from the previous designation of 110,000 to 50,000 in the fiscal year 2017; this marked the lowest number since the enactment of the Refugee Act of 1980 (Pierce & Meissner, 2017). The Refugee Act was enacted for the admissions and resettlement of refugees in the U.S. (Kennedy, 1981). Likewise, the Trump Administration enforced the Muslim Ban which reduced the refugee admission to 30,000 and 15,000 in the fiscal year 2019 and 2020, respectively (Forum, 2020). This ban limited refugee resettlement from the countries of Iran, Iraq, Libya, Somalia, Sudan, Syria, Yemen, and North Korea, leading resettlement to originate primarily from non-Muslim countries such as the Democratic Republic of Congo, Burma, Ukraine, Cuba, Bhutan, etc. (Pierce & Meissner, 2017). The federal reductions in refugee admissions have impacted Kentucky's refugee population; demographics indicate that arrivals from the Democratic Republic of Congo represent the highest number, followed by Cuba and Syria (Kentucky Office for Refugees, 2020).

The most recent Annual report from the Kentucky Refugee Health Assessment (RHA) (2018) revealed the health status of 1100 children and adult refugees in Kentucky. Results indicated that 66% of the patients had Tuberculosis, 11% had hypertension, 7% had Eosinophilia, half of all newly arriving refugees in 2017 were obese, 18% had abnormal vision exams, and 8% reported mental health issues. The top health issues of new refugees differed from the general Kentucky population (Kentucky Refugee Health Assessment Report, 2018). Many refugees arrived in the U.S. with communicable diseases due to health care inadequacies in refugee camps, which could affect their resettlement process, employment, and quality of life (Kentucky Refugee Health Assessment Report,

2018). These inadequacies might place refugees at risk for health disparities, leading to adverse health outcomes in the long run. The current health inequities between refugees and the resettlement community elucidate the disparate power relations between the outcomes of the colonial past and postcolonial present (Anderson, 2000; Reimer-Kirkham & Anderson, 2002). Although research shows that refugees may have adverse long-term impacts on young people's wellbeing, it is essential to understand the contexts that shape refugees' wellbeing.

While there have been extensive studies in other regions of the world, the African Great Lakes Region (GLR), an intricate political, economic, and geographical area, has not been extensively studied, and the evidence on GLR refugee youth's health is still limited. Also, little is known about the socio-cultural and socio-environmental factors that influence wellbeing for the GLR population that reside in the U.S.

The review of the literature explored the health and wellbeing of the general population, ethnic minorities, refugees, and young people using the socio-ecological model as a guide. While the literature on youth wellbeing exists, most studies do not refer to African refugee youth. There is a lack of credible data concerning young refugees' wellbeing emigrating from African countries to the U.S. Many studies generally failed to include a detailed understanding of refugee youth wellbeing, indicating the need for examining the meaning of wellbeing to Great Lakes Region youth. There is also a paucity of published studies on holistic models to help understand the variety of factors that influence the refugee youth population's wellbeing. Hence, the need for this study to addresses this gap. Although systemic and structural barriers may prevent young people

from maintaining wellbeing, there is a dearth of literature on these factors and even less on African Great Lakes refugee youth.

It was also noticeable in the refugee literature that many studies on racism among the refugee population include participants from Australia, Canada, and Europe. Given the United States' history with the pan-African slave trade and terrorism of the African countries, there is not enough known about refugee youth experiences in the U.S. in terms of racism and discrimination (Eltis, 2007; Horne, 2007). Understanding the effect of racism and colonialism on Black-African refugees is critical for answering questions about the effects of youth displacement and being refugees. Thereby, this dissertation explores the role of racism in GLR youth experiences in the U.S.

Purpose of the Study

The purpose of this study is to explore the African Great Lakes region refugee youth's experience with wellbeing, how they interpret their experience, and the meanings ascribed to wellbeing. This study will focus on the region's youth residing in Louisville, Kentucky. This research study answers the following research questions:

1. How do refugee youth from the African Great Lakes Region understand and make meaning of wellbeing?
 - a) What are the components of wellbeing for refugee youth from the African Great Lakes Region?
2. What are the socio-cultural factors that influence wellbeing among refugee youth from the African Great Lakes Region?

3. What are the influences of institutionalized racism on the wellbeing of refugee youth from the African Great Lakes Region?

Conceptual framework

The conceptual framework (figure 1) assembles the critical elements from three frameworks and literature on wellbeing, drawing substantially from work by the World Health Organization (1968), Travis and Ryan (1988), Myers and Sweeney (2004), Dodge, Daly, Huyton, and Sanders (2012). The framework conceptualizes African refugee youth wellbeing within a context characterized by interactions that influence African refugee youth's physical, social, and mental health and wellbeing. The Indivisible Self Model of Wellbeing by Myers and Sweeney (2004) provides an understanding of the physical, social, and mental aspects that make up wellbeing while the Socioecological Model and the Critical Race Theory give an account of the contextual factors that influence an individual's behavior (Bronfenbrenner, 1994; Delgado & Stefancic, 2000).

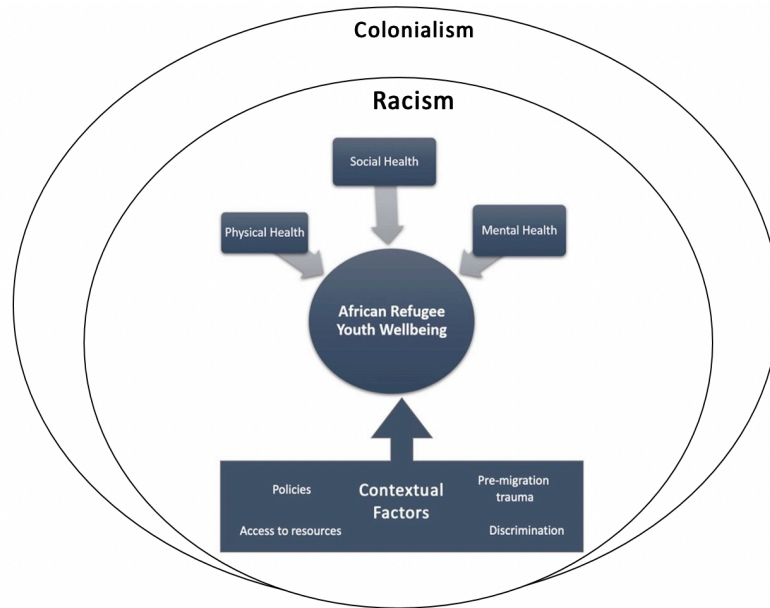


Figure 2: Conceptual framework of understanding the meaning of wellbeing to refugee youth from the African Great Lakes Region

Definition of terms

Wellbeing: A holistic process that is situated in the physical, mental, social, and cultural contexts of refugee youth understanding and making meaning of ways to achieve wellbeing (Myers & Sweeney, 2004; Dodge et al., 2012).

Youth: The period of change from the dependence of childhood to adulthood independence (UNDESA, 2013). The United Nations and the Center for Disease Prevention and Control (CDC) define youth age between 15 and 24 (UNDESA, 2013; (Control & Prevention, 2015) while the African Union defines youth age as 15-35 years. Although there is no universal definition of youth age, this study adopts 18 – 30 years as an effective age range for examining the African Great Lakes region refugee youth experience with wellbeing, how they interpret their experience, and the meanings ascribed to wellbeing.

Refugee: A refugee is “someone who has been forced to flee his or her country because of persecution, war, or violence; they have a fear of persecution due to race, religion, nationality, political opinion, or membership in a particular social group” and are most unlikely to return home or are afraid to do so (Robinson, 1952).

African Great Lakes Region (GLR): The African Great Lakes Region (GLR) are countries within the central and eastern parts of Africa. This dissertation focuses attention on five countries, Burundi, the Democratic Republic of the Congo (DRC), Rwanda, Tanzania, and Uganda because they have an interconnected nature of conflicts, political, cultural, and economic interactions.

Organization of the Study

This dissertation is divided into five chapters. Chapter 1, the introductory chapter presents an overview of this study containing the statement of the problem, purpose, research questions, and the conceptual framework. Chapter 2 contains the review of related literature concerned with exploring the meanings of wellbeing and the individual, interpersonal, and community levels of the socio-ecological model that influence wellbeing of youth. Chapter 3 presents the methodology for this study, comprising a detailed description of the design, sampling methods, data collection, data management, and ethical considerations. Chapter 4 presents the findings and analysis of the study and Chapter 5 contains the discussion, implications, recommendations, and conclusion.

CHAPTER II

LITERATURE REVIEW

Introduction

This chapter discusses the different meanings of wellbeing and the terms' evolution through the years. It also draws on the Socio-Ecological Model (SEM), the Indivisible Self Model of Wellbeing, and the Critical Race Theory (Bronfenbrenner, 1994; Delgado & Stefancic, 2000; Myers & Sweeney, 2004). This literature review examines different socioecological framework levels to identify how these constructs impact vulnerable populations' health and wellbeing. It reflects on specific factors that determine the realization of socio-environmental and socio-cultural understanding of wellbeing among these populations.

Meanings of Wellbeing

Wellbeing is described on an illness-wellness continuum, a dynamic process of individuals moving towards greater health or propelling towards the opposite or disability (Travis & Ryan, 1988). Although the literature has considered wellbeing and health as similar concepts, wellbeing is different from health (LaFountaine, Neisen, & Larsen, 2007; Roscoe, 2009).

LaFountaine, Neisen, & Larsen (2007) explained wellbeing as health behaviors such as love, sense of worth, nutrition, and stress management, while Roscoe (2009) proposed that wellbeing is an integration of various health determinants, such as emotional, intellectual, physical, social, spiritual, environmental, and occupational factors. The preceding definitions of wellbeing have used the World Health Organization's (1967) conceptualization that wellness is not just the absence of disease but a state of complete physical, mental, and social health.

As scholars continue to advance these definitions, several perspectives to understanding wellbeing have developed. Aaron Antonovsky (1987) proposed the Salutogenesis approach to wellbeing. This approach defined wellbeing as the mobilization of resources to manage stressors and move along the health/disease continuum, either towards wellbeing or disease (Antonovsky, (1987). Current traces of salutogenesis have informed the emerging conceptualizations of wellbeing (Ryan & Deci, 2001 & Dodge et al., 2012; Schwanen & Wang, 2014; Morgan & Aleman-Diaz, 2016). Morgan & Aleman-Diaz (2016) built on the salutogenic approach to show that wellbeing attained through policy and program development enables people to mobilize resources and make connections through social capital. Additionally, Travis & Ryan (1998) emphasized that beyond the absence of illness, wellbeing conceptualizations focus on a balance that can be affected by various life events or challenges. Later researchers such as Shah and Marks (2012) supported the notion earlier espoused by Travis and Ryan (1988) that wellbeing is beyond diseases. Dodge et al. (2012) defined wellbeing as a fluctuation between challenges and resources and a seesaw where the change in different factors could lead to the tilting of the equilibrium towards ill-health or wellness.

Other researchers agreed that wellbeing is a holistic process (Witmer, 1985; Witmer & Sweeney, 1992; Shah & Marks, 2004; Williams et al., 2007). Witmer (1985) described that the holistic approach moves the research focus on wellbeing from an individualistic concept to a multilevel concept. This multilevel concept was influenced by factors such as physical activities, a healthy Body Mass Index, nutrition, stress management, effective coping mechanisms with life events, environmental sensitivity, and positive lifestyle changes (Witmer, 1985). The holistic concept of wellbeing was expanded by Witmer & Sweeney (1992) to mean a connection between physical health outcomes, life responsibilities, friendship, work, love, and self-regulation. Likewise, Williams et al. (2007) also agreed that wellbeing is holistic and transcends the traditional clinical conceptualizations of health to fully engage and resonate with individuals, communities, and local authorities. This explains that by engaging the different socioecological aspects of wellbeing, an individual can achieve physical, mental, social, and environmental health.

The Socioecological Approaches to Wellbeing

The socioecological viewpoint of wellbeing posits that the causes of disease and other health conditions at different levels (individual, community, organizational, and institutional) do not act independently but rather interact in intricate ways to bring about health and disease (Krieger, 2001). Young people find their lives shaped by the society in which they live; the nature of their environment and society determine their development, status, aspirations, opportunities, and health (UNDESA, 2013; Isiugo-Abanihe & Oyediran, 2004). Factors that shape young people's development range from the social, economic, cultural, and political conditions of the broader society to those that characterize their living situations (Isiugo-Abanihe & Oyediran, 2004). Hence, approaching the concept

of wellbeing from a socioecological perspective allows for a holistic view into the complexities of refugee youth understanding of wellbeing. This approach employs the three levels of the socioecological model, individual, interpersonal, and community.

Individual Level

Wellbeing can be maintained at the individual level when people possess social, psychological, and physical resources to meet life's challenges (Dodge et al., 2012). The individual level of wellbeing includes physical health, diet and nutrition, mental health, stress, acculturation, resilience, and socioeconomic status.

Physical health

Physical wellbeing is the ability to perform physical and social activities without hindrance by the physical limitations of the body and health factors (Capiro, Sit, & Abernethy, 2014). Varied physical health problems experienced by refugees, including infectious and chronic diseases, affect wellbeing outcomes (Bischoff & Schneider, 2011; Liu et al., 2009). In a retrospective study of the urban Northeast region of the U.S., chronic illnesses were prevalent among 180 adult refugees (interquartile range 25–40 years) in a refugee health program; this study found that 51% of the adult refugees had at least one chronic disease and 9.5% had three or more chronic diseases (Yun et al., 2012). It is noteworthy that Taylor et al. (2014) specifically reported that while Iraqi refugees were more susceptible to chronic diseases such as diabetes, high lipid profile, and cardiovascular diseases, refugees from other parts of Asia were more likely to have a high prevalence of communicable diseases and malnutrition. Although studies have expounded on the high prevalence of infectious and chronic diseases among refugee populations, Vergara et al. (2003) noted that much

less attention is given to preventive physical health care in the refugee literature. While physical health is an important factor in maintaining wellbeing, studies have examined the effect of diet and nutrition on wellbeing.

Diet and Nutrition

Research has explored the roles food and dietary practices play in wellbeing across various populations (Chisholm, 2015; Dale, Brassington, & King, 2014; Dercon & Singh, 2013). A study by Levine, Lloyd, Greene, and Grown (2008) further explained that females in some developing countries in South Asia and Sub-Saharan Africa face systematic nutrition disadvantages. Similarly, a multi-country study of nutrition reported that gender differences implicate wellbeing outcomes; Ethiopia, India, Peru, and Vietnam showed that females are at a disadvantage for health due to the presence of a gender gap regarding access to healthy nutrition (Dercon & Singh, 2013). Compared to their male peers, girls and young women were less healthy due to limited access to healthy foods, which led to a high prevalence of stunting and underweight (Dercon & Singh, 2013).

Diet also played an essential role in improving youth health and wellbeing (Firth, Gangwisch, Borisini, Wootton, & Mayer, 2020; Jacka et al., 2011; Owen & Corfe, 2017; Rucklidge & Kaplan, 2016). Jacka et al. (2011) conducted a prospective study on the importance of diet quality and its role in modifying the Pediatric Quality of Life of young Australians. This two-year study of 2,915 students (mean age = 14 years) reported that healthy diet scores were associated with increased Pediatric Quality of Life Inventory (PedsQL) scores (adjusted standard deviations (β -z): 0.21; $p < 0.001$) while unhealthy diet scores were associated with reductions in PedsQL scores (adjusted standard deviations (β -z): 20.13; $p < 0.001$ (Jacka et al., 2011). In this study, an increase in healthy diet led to

an increase in quality of life and an increase in unhealthy diet scores is associated with reduction in the quality of life scores (Jacka et al., 2011). The effect of nutrition on wellbeing alongside other physical health factors is relevant in youth wellbeing. In addition to diet and nutrition, mental health also is a factor that influences the wellbeing of an individual.

Mental health

The World Health Organization estimated that mental, neurological, and substance use disorders (i.e., schizophrenia, depression, epilepsy, dementia, and alcohol dependence) accounted for 7% of the global burden of disease and affected more than 1 billion people globally in 2016, with mental illness exceeding both cardiovascular diseases, HIV, and cancer (Rehm & Shield, 2019). Likewise, mental and substance use disorders were the leading cause of disability in children and youth, which accounted for 54.2 million Years Lived with Disability in 2015 (Erskine et al., 2015). One-fifth of the population in high-income countries experience depression and anxiety; this prevalence is most significant among young people aged 16-24 years (Greene, 2019). Mental illness is also common in the United States, with nearly 1 in 5 adults living with a psychological disease. An estimated 46.6 million accounted for adults 18 years or older who had a mental illness in 2017 (Abuse, 2017).

Mental illnesses contribute to wellbeing in various populations (Brough, Gorman, Ramirez, & Westoby, 2003; Brown et al., 2010; Hannah, Brassington, & King, 2014). Specifically, refugees have a unique experience that could put them at risk for mental illnesses among leading to adverse health outcomes (Vergara et al., 2003; Fazel, Wheeler,

& Danesh, 2005). Refugee populations fleeing violence in their home countries reported exacerbated mental illnesses, which led to psychological risks for social and economic wellbeing (Dubois, Huyghebaert, & Brouillet, 2007; Lindert, von Ehrenstein, Priebe, Mielck, & Brähler, 2009). Studies of refugee youth reported symptoms of Posttraumatic Stress Disorder (PTSD) that affect wellbeing including emotional numbness, disturbed sleep patterns, flashbacks, and other mental health challenges such as depression, low self-esteem, stress, anxiety, adjustment, and conduct disorders (Beiser, 1990; Bemak & Chung, 2017; Betancourt et al., 2020; Colucci, Minas, Szwarc, Guerra, & Paxton, 2015; Guruge & Butt, 2015; Heidi, Miller, Baldwin, & Abdi, 2011; Marshall, Butler, Roche, Cumming, & Taknint, 2016). Evidence from a systematic review and meta-analysis confirmed that refugees are at higher risk than the general population for different psychiatric disorders (Lindert, von Ehrenstein, Priebe, Mielck, & Brähler, 2009). In this review, there was a high prevalence of depression and anxiety among migrants and refugees; depression was 44% among refugees and 20% among labor migrants; anxiety was 40% among refugees and 21% among labor immigrants (Lindert et al., 2009).

De Jong, Scholte, Koeter, and Hart (2000); Geltman et al. (2005); Pham, Vinck, Kinkodi, and Weinstein (2010) emphasized that refugees arrive in refugee camps and resettlement countries with psychological challenges such as poor memory, nightmares, sense of foreshortened future, and mistrust of government officials. De Jong et al. (2000) examined a random sample of Great Lakes Region refugees (aged 15 and older) in Rwandan and Burundian camps for the prevalence of mental health problems. The study reported a prevalence of mental health problems was estimated at 50% which was higher than the cut off score of 14. Using the General Health Questionnaire, they estimated a 50%

prevalence of mental illness (Standard error 12%) in refugee camps (De Jong et al., 2000). Likewise, a sample of individuals in the Democratic Republic of Congo revealed an approximately 42% met the criteria for post-traumatic stress disorder (PTSD), and 27% met the criteria for depression (Pham et al., 2010).

Similarly, a descriptive study assessed the mental health of Sudanese unaccompanied refugee minors, popularly known as the Lost Boys of Sudan, on arrival to the U.S. (Geltman et al., 2005). This study found that 20% of the minors had a PTSD diagnosis and had low functional and behavioral health scores due to exposures to war and violence. These three studies referenced that mental health illnesses contributed to refugee youth wellbeing. Due to the experience of hardship during wars, famine, or persecution and difficulties upon resettlement, refugee youth may experience mental illnesses (De Jong et al., 2000; Geltman et al., 2005, Pham et al., 2010).

Additionally, factors such as stigma, literacy, cultural differences, and inadequate access to health care services influence young people's help-seeking behaviors to access mental health services (Gulliver, Griffiths, & Christensen, 2010; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Salaheddin & Mason, 2016). A systematic review that consisted of 22 studies explored the perceived barriers and facilitators of help-seeking behaviors in young people aged 11-17 and 18-31 years found that only 18% and 34% respectively of young people with high levels of anxiety and depression sought professional help (Gulliver et al., 2010). The most significant barriers to seeking mental health services were stigma, embarrassment, poor mental health literacy, and self-reliance preference (Gulliver et al., 2010). Likewise, in a cross-sectional study of 230 youth aged 18–25, Salaheddin and Mason (2016) measured the association between psychological

distress, help-seeking preferences, and barriers to accessing mental health services. They found that 35% of participants with mental health challenges did not seek help due to perceived mental illness stigma, difficulty expressing concerns, and preference for self-dependence (Salaheddin & Mason, 2016). These studies revealed that despite the prevalence of mental illnesses and psychological symptoms among the refugee population, some young people might find it challenging to seek help due to stigma and literacy. Besides the effect of mental illnesses on refugee wellbeing, stress is also a risk factor for adverse health and wellbeing outcomes.

Stress

Stress plays a role in wellbeing outcomes (Birman, 2006; Ehntholt et al., 2005; Thomasand & Lau, 2002; Gee, Spencer, Chen, & Takeuchi, 2007). Stress may influence adaptability, temperament, and maintaining positive self-esteem among the young population (Warfa et al., 2012; Ehntholt et al., 2005; Thomasand & Lau, 2002). Turner (2010) specifically mentioned that personal psychological characteristics such as self-esteem, optimism, and agency reduce the effect of stress exposure on health status. While Fernando (2010) agreed with Turner (2010) that individual factors such as self-esteem, optimism, and agency modify the effect of stress exposure on health status, it was argued that the effects might not translate across all ethnic groups because the psychological variables were tested to fit a western population (Fernando, 2010).

Among different ethnic groups, the source of stress varied (Warfa et al., 2012; Kirmayer et al., 2011). A mixed study of Somalian immigrants in the United States and the United Kingdom revealed that stressors such as family separation, unemployment, and

immigrational uncertainties led to adverse psychological wellbeing (Warfara et al., 2012). Further, Carlsson, Mortensen, & Kastrup (2005) and Tempany (2009) discovered that daily stressors such as unemployment, discrimination, language barriers, and social exclusion had higher effects on the health and wellbeing of refugees than past traumatic experiences. This finding reveals that while stress is a risk factor for mental illnesses, daily socioeconomic factors can exacerbate health outcomes.

On a different note, Kirmayer et al. (2011) argued that refugees experience other stressors during the resettlement process (pre-migration, migration, and post-migration). Before migration, refugees experience stressors related to interruptions in their social and educational attainment due to the displacement associated with wars. During migration, many children and adolescents experienced stress due to a lack of social support (Kirmayer et al., 2011). During resettlement in a new country, young refugees found it difficult to adapt to the new culture, negotiate cultural identity, and handle discriminatory experiences that may affect their wellbeing (Kirmayer et al., 2011).

Additionally, financial difficulties affect refugees' health (Porter & Haslam, 2005; Khawaja et al., 2008). A metaanalysis by Porter and Haslam (2005) discovered that financial stress was related to poor mental health outcomes. Khawaja et al. (2008) further reported that participants experienced financial stress due to unemployment, learning to speak English, and problems with providing for their large families. In contrast, Porter & Haslam (2005), Baranik et al.'s (2018) reported that there was no significant association ($p < 0.05$) between financial stress and higher levels of anxiety among refugees. To handle the effects of their different experiences, young refugees may also develop resilience to maintain wellbeing.

Resilience

Resilience is the “ability to sustain competence regardless of difficult life circumstances” (Adger, Hughes, Folke, Carpenter, & Rockström, 2005; Walsh, 2012). Research has revealed that resilience creates the condition to promote wellbeing among young people (Sanders, Munford, Thimasarn-Anwar, Liebenberg, & Ungar, 2015; Ungar, 2011; Ungar, Liebenberg, Dudding, Armstrong, & van de Vijver, 2013). Resilience mediates the impact of risk factors on wellbeing outcomes among vulnerable youth, and its understanding is critical for developing health promotion efforts (Ungar et al., 2013). Also, narratives around resilience vary by one’s experience, making resilience a process rather than a present or absent dichotomy (Ungar, 2008; Lenette, Brough, & Cox, 2013). In a study by Sanders et al. (2015), youth who received services that empowered them reported enhanced resilience, and this higher resilience level improved wellbeing outcomes. This finding revealed that resilience may occur over time as people receive supportive services.

Research also confirmed that resilience is an observed attribute among refugees pre-and post-migration (Borwick et al., 2013). The unique experience of moving away or being forced to flee their natural community generates resilience as a protective factor for wellbeing among refugees (Blount & Acquaye, 2018; Shishehgar, Gholizadeh, DiGiacomo, Green, & Davidson, 2017). Shishehgar et al. (2017) and Blount & Acquaye (2018) emphasized that refugees often employ resilience to cope with life after displacement. Although Stempel et al. (2017) and Borwick et al. (2013) support the concept that resilience occurs during migration, they argued that it is generated by factors such as social network, proficiency of the English language, acculturation, value systems, a sense of future, and spirituality that lead to wellbeing (Borwick et al., 2013). On the other hand,

Denzongpa & Nichols's (2020) study of resilience among refugees concluded that resilience was a response to traumatic experiences faced around gender issues, culture, displacement, and resettlement (Denzongpa & Nichols, 2020). This suggests that resilience is a coping strategy for dealing with the effects of traumatic experiences that prevent wellbeing among refugees. Carlson, Cacciatore, and Klimek (2012) study found similar results to Denzongpa & Nichols's (2020) but delved into resilience among Sudanese refugee minors and concluded that positivity, healthy coping mechanisms, and religiosity, and social network were resilience factors that improved wellbeing. For young Sudanese refugees in Goodman's (2004) study, wellbeing improved through resilient factors such as having a sense of community, meaning making of the refugee experience, and hopefulness. The field of Public Health criticizes the overreliance on resilience. This field is more interested in promoting structural changes that promote the improvement of wellbeing rather than examining factors that influence one's ability to be resilient under disparaged circumstances such as poverty, racism, classism, and sexism. (Morton & Lurie, 2013; Ungar et al., 2013). While literature suggests that resilience promotes wellbeing outcomes, it modifies various socioeconomic factors.

Socioeconomic status

Socioeconomic status (SES) plays a role in health status and is an indicator of wellbeing (Ahnquist, Wamala, & Lindstrom, 2012). Family income and educational attainment are measures of the SES that play an essential role in wellbeing (Ahnquist et al., 2012; Viner et al., 2012).

Family Income

Family income is a measure of socioeconomic status that determines one's health (Meara, 2001). An analysis of the Nigerian Demographic and Health Survey from 2003 to 2013 estimated the social, demographic, and household risk factors predicted wellbeing for young people in Nigeria (Ushie & Udoh, 2016). Evidence from this cross-sectional study revealed that wellbeing was positively associated with high income due to employment and educational attainment. Also, parental literacy (i.e., having parents with secondary education) improved wellbeing (Ushie & Udoh, 2016). Similarly, studies on refugee populations also reported that income was associated with positive health outcomes (Thomas & Lau, 2002; Ehntholt et al., 2005; Easthope & White, 2006; Bourke & Geldens, 2007; Simich, Este, & Hamilton, 2010). Becchetti, Corrado, and Rossetti (2011) and Easthope & White (2006) affirmed that low income generate high dependence on social service and unemployment, associated with adverse health outcomes.

Educational attainment

Education is a crucial component of understanding wellbeing because it offers knowledge that shapes people's health behaviors that impact wellbeing and illness (Lahelma, 2001). Research has shown that higher educational attainment is associated with lower health risk behaviors (Choi, 2007; Stuart et al., 2008; Valois, MacDonald, Bretous, Fischer, Drane, 2002; Chomitz et al., 2009; Field, Diego, Sanders, 2001). While Castriota (2006), Chen (2011), and Jongbloed (2018a) agreed that education has an impact on wellbeing, they suggested that the impacts were indirect, as post-secondary educational attainment provides access to resources such as employment, social networks, skills, and knowledge that improve individuals' wellbeing.

Moreover, education and schooling promoted the wellbeing of refugee individuals and communities as they navigated the processes of resettlement (Alexander, Boothby, & Wessells, 2010). Despite the adequacy of education upon resettlement, Mosselson et al. (2017) and Hamilton (2005) asserted that refugee youth might find it challenging to benefit from the advantages associated with educational attainment due to limited language proficiency, lack of education before resettlement, and social exclusion. These studies uncovered that education leads to socioeconomic status, which is associated with improving individuals' wellbeing. However, different factors such as access to education, social exclusion, and English language proficiency may modify educational attainment.

The Interpersonal level

As with all factors, individual-level factors do not exist in isolation from interpersonal level factors. The presence of social support, social network, and social ties was associated with wellbeing (Greene, 2019; Kawachi & Berkman, 2001; Kawachi, Bird, Fremont, & Zimmermans, 2010; Luke & Harris, 2007; Song, 2011; Tsai & Papachristos, 2015). Social support has also been described as a determining factor for youth wellbeing (Ehnholt & Yule, 2006; Correa-Velez, Gifford, & Barnett, 2010; Simich, Este, & Hamilton, 2010; Turner, 2010; Fernando, 2010). One essential form of social support that promoted wellbeing among young people was the presence of an adult or parental guidance in their lives (Correa-Velez, Gifford, & Barnett, 2010). Besides parental guidance, young people identified wellbeing as having healthy relationships and friendships (Easthope & White, 2006; Bourke & Geldens, 2007). According to (Idoniboye-Obu, & Whetho (2008), Sulamoyo, (2010), and Sambala, Cooper, & Manderson (2020), most African youth used

a collectivist worldview that can be likened to the Zulu proverb, Ubuntu, which means “*I am, because we are.*” This worldview reveals the importance of social support and cohesion among Africans (Idoniboye-Obu, & Whetho, 2008).

Also, the literature suggested that refugees and young ethnic minorities were more likely to rely on their peer group than formal mental health care services (Selvamanickam, Zgryza, & Gorman (2001). Similarly, Cauce et al. (2002) agreed that this behavior was recounted among young people who were more likely to seek help from informal networks such as family, friends, religious advisors, and spiritual healers. In young refugee populations, family factors are essential to resilience and consisted of attachment to at least one parent, close parental support, and stability (Derluyn & Broekaert, 2007). In addition to parental support, Weine et al.'s (2014) study of Burundian and Liberian refugee youth revealed that the presence of a parent or guardian in a young person's life and families' financial stability promoted resilience and improved health outcomes.

Furthermore, refugee youth were more likely to utilize other sources of help such as friends, religion, and schoolmates (De Anstiss & Ziaian, 2010; Ellis et al., 2010; Halcón et al., 2004). Somali refugees (Ellis et al., 2010) and second-generation Cambodians were more receptive to the idea of mental health services than the older generations (Daley, 2005). In addition to the barriers mentioned above to mental health help-seeking, McCann, Mugavin, Renzaho, and Lubman (2016) found other barriers among young Sub-Saharan African immigrants in Australia. They discovered three barriers: lack of mental health literacy in parents and young people, perceived lack of cultural competency of formal help sources, and financial costs that prevented access to mental health services (McCann et al.,

2016). While literature revealed that social support is associated with wellbeing, research also revealed that acculturation influences wellbeing on the inter-personal level.

Acculturation

Acculturation played an essential role in refugees' wellbeing (Berry, 2003; Ward, 1996). Although some researchers described acculturation as an individual characteristic of learning and adopting the culture of one's environment (Berry, 2003; Sam & Berry, 1997; Ward, 1996), other researchers explored the impact of acculturation on wellbeing through community support and interaction (Berry & Hou, 2016; Brand, Loh, & Guilfoyle, 2014; Poppitt & Frey, 2007; Yoon et al., 2013). It is noteworthy that the acculturation process varied between refugees and immigrants; since refugees are often unable to select the resettlement location based on its social and cultural resources, while other migrants may select their destination (Lindert et al., 2009). This discrepancy made the acculturation process for refugees more complicated or difficult to achieve (Lindert et al., 2009). Some of the challenges associated with acculturation that impacted wellbeing included adapting to a new life, learning a new language, and understanding a new environment's policies and culture (Asanin Dean & Wilson, 2010; Dyck & Dossa, 2007; Yu et al., 2007). Additionally, the experience of cultural loss due to acculturation lead to heightened levels of depression (Berry, 2006). Stressors such as racism, conflicting cultural values, educational gaps, language difficulties, poverty, and isolation were barriers to refugees' acculturation (Asanin Dean and Wilson, 2010; Dyck and Dossa, 2007; Yu et al., 2007).

Despite the barriers that could hinder acculturation among refugees, Ali (2008) and Moinolmolki (2016) identified acculturation as a protective factor for refugee wellbeing.

Moinolmolki (2016) agreed that refugees can attain acculturation by understanding the resettlement country's culture and systems while still maintaining their cultural identity and social relationships that improve an individual's wellbeing. For example, in Ali (2008), Somali immigrants thrived in their community through the interactions and support of closely knit relationships, while young Bhutanese refugees acculturated to their environment and reported positive health status attained through social capital received from close family members. This suggests that regardless of the various means to acculturation among different populations, access to social capital and local community groups could help to maintain wellbeing. Although research confirmed that acculturation played an important role in wellbeing, it may be difficult to achieve due to structural and external factors on the community level.

The Community Level

At the community level, wellbeing is associated with various factors that influence individuals and their communities (Krieger, 2001). Further, a narrow emphasis on individual behaviors or outcomes proved insufficient for understanding wellbeing, thus, requiring an examination of root causes (Castañeda et al., 2015). Literature that reviewed the community level of wellbeing included community-level resilience, social exclusion, and inclusion, and education is discussed below.

Community Level Resilience

While an abundance of research reveals that resilience occurs on an individual level, researchers have studied the effect of resilience on the community level to achieve wellbeing. While resilience is an individual attribute that promotes wellbeing by specific

social characteristics among vulnerable youth (Ungar, Liebenberg, Dudding, Armstrong, & van de Vijver, 2013), the success of individuals was dependent on the positive functioning of the community; therefore, understanding the protective processes impacting community-level resilience is important (Ungar, 2011). The relationship between the individual and community-level resilience is reciprocity; many individuals in a community having sufficient resources to maintain resilience may positively impact community wellbeing (Frounfelker, Tahir, Abdirahman, & Betancourt, 2020). Therefore, resilience elements are operationalized on the individual level and nested within communities (Patel, Rogers, Amlôt, & Rubin, 2017).

Community resilience built on the strength of individuals in the community; for example, if a community had the substantial social capital, resources, and supportive individuals, resilient outcomes were more likely to occur among individual members (Kirmayer et al., 2009; Ungar, 2011). A systematic literature review by Patel et al. (2017) identified elements that described community-level resilience factors such as local knowledge, preparedness, communication, social network, access to resources, strong leadership, economic investment, and a positive mindset. These findings suggested the critical roles that local communities play in building wellbeing at the community level.

Community-level resilience factors were also linked to wellbeing among resettled refugees; they included social support, community integration, social inclusion (Correa-Velez, Gifford, & Barnett, 2010; Fazel, Reed, Panter-Brick, & Stein, 2012; Pieloch, McCullough, & Marks, 2016). Frounfelker et al. (2020) and Denzongpa and Nichols (2020) identified community-level resilience as a protective factor to manage stressors and improve refugees' health and wellbeing at the community level. In comparison, Frounfelker

et al. (2020) discovered that community-level resilience resulted from a commitment to community building and spirituality among Somali Bantu refugees in the U.S. Denzongpa and Nichols (2020) found that resilience was important in managing the intersecting stressors of gender and migration to improve health and wellness for Bhutanese refugees in the U.S.

Social Exclusion and Inclusion

Social exclusion results when a complex set of variables, often present within an organized system, prevents an individual or group from accessing the resources necessary to maintain social, economic, cultural, and political wellbeing (Pierson, 2002). Social exclusion also occurs when inadequacies within the society fail to ensure that all individuals and communities fully participate (Association, 2000; Power & Wilson, 2000). Studies have shown that immigrants experience culture shock and a feeling of powerlessness due to a limited understanding of their new environment (Winkelman, 1994). Additionally, new refugee's prejudicial treatment in various settings may inhibit their sense of belonging and social inclusion (Caxaj & Berman, 2010; Khanlou et al., 2008; Edge & Newbold, 2013).

On the other hand, Candelo, Croson, and Li (2017) asserted that while the strength of cultural identity has a positive impact on wellbeing, the perception of social exclusion significantly decreased contributions to wellbeing among Hispanic immigrants. (Fangen, 2010); Herz and Johansson (2012); Wray-Lake, Syvertsen, and Flanagan (2008) found similar results with Candelo et al. (2017) but asserted that discrimination was a tangible form of social exclusion that affected the health and wellbeing of young immigrants and could be more harmful because the youth's age was essential in the exploration of identity

and establishing a place within society. In addition to discrimination, Osezua, Sato, and Harris (2020) discovered that dehumanization and loss of identity were forms of social exclusion for emerging adult refugees from the African Great Lakes region during pre-and post-migration in the US.

In contrast, social inclusion is the degree to which people feel integrated into various relationships, participate in dynamic organizations, sub-systems, and are connected to structures that establish everyday life (Balenzano, Moro, & Cassibba, 2019). Social inclusion includes social justice and opportunity for equal human rights and enlarges each human being (Gidley, Hampson, Wheeler, & Bereded-Samuel, 2010). For young people, social inclusion requires opportunities to participate in society and belong to their cultural community (Correa-Velez et al., 2010). For refugees, the experience of social inclusion depends on a range of factors offered by the host country, such as the climate, cultural and linguistic competency resources, educational opportunities, proximity to members of one's ethnic group, and job locations (Correa-Velez et al., 2010; Osezua et al., 2020).

Education

Schools and educators also play an important role in facilitating the wellbeing of young refugees. McBrien (2005) agreed that some educators were not well trained to understand refugees' experiences. Educators' cultural incompetence could lead to young refugees experiencing social exclusion, discrimination, and marginalization as educators may not be equipped to work with refugees and immigrants (McBrien, 2005). Discrimination is one of the most significant barriers to wellbeing for immigrant and refugee students in the education system (Suárez-Orozco, 1989; Trueba, Jacobs, & Kirton, 1990; Birman et al.,

2001; Berry & Hou, 2017). McBrien (2005) affirmed that discrimination within schools had lasting effects on the self-confidence, mental health, aspirations, and accomplishments of young people.

Also, underlying pre-migration factors influenced the educational experience of refugees after resettlement. According to the United Nations Children's Fund UNICEF (2019), nearly 175 million children affected by conflict did not attend primary school. This included refugee youth who spent most if not all their young lives in refugee camps or other unfavorable living conditions that disrupted the normal education process (El-Bialy & Mulay, 2015; Kanyangara, 2016). Thus, some refugee youth arrived in resettlement countries with low literacy and numeracy skills; if refugees were of school age, they may experience delay in catching up with their peers (Mosselson et al., 2017). If past the school age, refugee youth may not meet requirements for tertiary education or other training institutions and may be pressured to take low-paying jobs to support family members and other dependents or remain underemployed as their educational degrees and work experience were not recognized in their host country (Baranik et al., 2018). This stress when added to other challenges created a likelihood of adverse health outcomes (Marshall et al., 2016).

Policy Level

Various factors influence refugees and refugee communities' wellbeing at the policy level (Bache & Reardon, 2016). Since refugee youth are legal U.S. residents, they are entitled to the same benefits of policies that apply to an average U.S. Youth. The literature reveals that the difficulty lies in implementing these policies to reach vulnerable youth (Fernandes-Alcantara, 2020). Vulnerable youth are young people that are more likely to experience

adverse outcomes due to exposure to risk factors (McWhirter, McWhirter, McWhirter, & McWhirter, 2016). Immigrant youth and youth with limited English proficiency are categorized as vulnerable youth at risk of experiencing poor health outcomes (Fernandes-Alcantara, 2020).

Specific policies support vulnerable immigrant youth, such as the Workforce Innovation and Opportunity Act. This Act funds employment training and academic services for youth aged 14 to 24. Refugees who arrive in the U.S. above 18 years with no high school diploma receive training through these programs. The drawback of this policy is its distribution and application to refugee and immigrant communities (Fernandes-Alcantara, 2020). Literature suggests that this policy can be more effective when funding is better allocated to libraries, schools, and organizations that serve the immigrant population (McHugh & Doxsee, 2018).

Other policies that influence the wellbeing of young refugees are Titles III and IV of the Every Student Succeeds Act (Skinner & Kuenzi, 2015). Title III covers language instruction for English learners and immigrant students by providing funding to states to improve English proficiency for immigrant children and youth (Skinner & Kuenzi, 2015). Title IV-B, 21st Century Community Learning Centers, offers grant funding to after-school programs for people with limited English proficiency (Skinner & Kuenzi, 2015). These programs provide opportunities for academic excellence for youth. It may be difficult for these programs to reach immigrant youth with limited funding and awareness (Fernandes-Alcantara, 2020). Moreover, some refugees experience difficulties attending these programs due to daily stressors and responsibilities such as language barriers,

unemployment, employment, and caring for family members (Carlsson, Mortensen, & Kastrup, 2005 & Tempany, 2009).

In the fiscal year 2003, the White House Task Force for Disadvantaged Youth under President George W. Bush's administration collected a list of 300 programs that target the most vulnerable youth (Washington: GPO, 2007). This task force found that the federal government does not provide services for specific groups, including immigrant youth (Washington: GPO, 2007). This inadequacy has not changed as no specific policy coordinates services for immigrant youth. Also, the federal government is yet to develop an all-encompassing policy to support vulnerable youth, like the Older Americans Act program for the elderly (Fernandes-Alcantara, 2020). As research endorsed the importance of policy development and implementation on youth wellbeing, it also revealed the effect of racism and discrimination on youth wellbeing.

Racism, Discrimination and Youth Wellbeing

Race and ethnicity are also strongly linked to a person's phenotypical appearance in the U.S. but, in most refugees' countries of origin, ethnicity involves different factors such as nationality, tribe, parent's nationality, and race (Haines, 2012). Since refugees must become accustomed to life in the U.S., it is vital to explore the effect of demographic markers such as race, which holds strong relevance and confer disadvantage. Systemic racism poses challenges to young people's health and wellbeing in multiple ways. Studies have reported the effect of racism on the health and wellbeing of youth (Brody et al., 2014; Caputo, 2003; Fisher, Wallace, & Fenton, 2000; Mansouri, Jenkins, & Walsh, 2012; Pachter, Bernstein, Szalacha, & García Coll, 2010; Priest, Paradies, Gunthorpe, Cairney, & Sayers, 2011;

Priest et al., 2013). Racism has been connected to outcomes such as poor mental health, violence, and academic achievement across ethnic minority studies (Brody et al. 2006; Wong et al. 2003). Pachter et al. (2010) also discovered similar findings with the youth of racial minorities in the U.S.; youth reported experience with racial discrimination in schools, community, from police, and peers. For low-income youth in Australia who are racial minorities, discrimination by the police and private security personnel was familiar and presented the most negative effect on the health of immigrant minority students (Priest et al., 2011).

Despite the experiences of discrimination among racial minority youth, Pascoe and Richman's (2009) research showed that a strong social support network reduced mental health outcomes' adverse effects. However, having this network may not apply to improved physical health. Edna A. Viruell-Fuentes, Miranda, and Abdulrahim (2012) asserted that perceived discrimination was associated with health outcomes and led to poor access to healthcare and adverse health behaviors among Black, Latino, and Asian immigrants (Edna A. Viruell-Fuentes et al., 2012). While Schulz and Mullings (2006) and Viruell-Fuentes et al. (2012) agreed that the interconnectedness of race, gender, and class played an essential role in health outcomes among racial minorities, Viruell-Fuentes et al. (2012) added that immigration was an added modifying factor on the health outcomes for immigrants.

In addition to the experience of racism, J. Lee and Opio (2011) further explained that Black-African international students may be discriminated against based on accents, cultural differences, and negative stereotypes, which increased acculturative stress. Lauderdale, Wen, Jacobs, and Kandula's (2006) study of immigrants' perceptions of discrimination in the U.S. healthcare system revealed that an individual's place of birth

played an essential role in discrimination experiences, and participants were more likely to report health disparities. In this study, 13.8% of Blacks, 16.8% of Latinos, and 8.4% of Asians, and 33.1% of American Indian/Alaskan Native were more likely to report racism or discrimination in health care compared to 3.3% of Whites (Lauderdale et al., 2006). The wellbeing of immigrants and refugees in low-income neighborhoods was also affected by the effects of structural racism such as unconducive neighborhoods, high violence, concentrated poverty, poor housing conditions, and inadequate recreational facilities (Edna A. Viruell-Fuentes, 2007).

It is noteworthy to attest that there is a substantial amount of research on perceived discrimination and health in ethnic minority literature. Still, the term "perceived" obscures the effect of institutionalized racism on minorities. According to Jones (2000), institutionalized racism is a systemic difference in access to goods and services and opportunities by race; this varies across access to a healthy environment, good education, employment, voting rights, and resources (Jones, 2000). Institutional racism was also responsible for the association between socioeconomic status and race in the U.S. (Jones, 2000). The wellbeing of immigrants and refugees in low-income neighborhoods was also affected by structural racism such as unconducive neighborhoods, high violence, concentrated poverty, poor housing conditions, and inadequate recreational facilities (Edna A. Viruell-Fuentes et al., 2012).

Much of the literature that explored coping mechanisms employed by Black-African students with racism in the U.S. failed to delve into the role of the institutions regarding this issue (Constantine, Anderson, Berkel, Caldwell, & Utsey, 2005; J. J. Lee & Rice, 2007; Manyika, 2001). Also, acculturation into the western culture seemed an ideal

way to alleviate discrimination and racism; this strategy placed the responsibility on the young Black immigrants rather than on institutions (Jackson & Cothran, 2003; Mwangi & Fries-Britt, 2015; Yao, George Mwangi, & Malaney Brown, 2019); thereby reinforcing the realization of the white supremacist system. Boafo-Arthur (2014) advised considering more research on institutions' role and responsibility regarding Black students' experience with race and racism. Boafo-Arthur (2014) recommended that more studies examined institutions' role and responsibility regarding Black students' experience with race and racism.

African refugees are not excluded from the racial discrimination that African Americans experience in the U.S., which is also responsible for the adverse health outcomes in this population (Kaestner, Pearson, Keene, & Geronimus, 2009; McEwen & Lasley, 2002; Pillay, 2005). Contradictorily, some researchers have argued that immigrants had better health status than US-born residents (Cunningham, Ruben, & Narayan, 2008; Singh, Rodriguez-Lainz, & Kogan, 2013; Vang, Sigouin, Flenon, & Gagnon, 2017). This research failed to account for the impact of refugee status, race, and gender on wellbeing. Additionally, ethnic minorities from Africa, Asia, and Latin America who migrated to western countries experienced more severe socioeconomic deprivations, that affect their wellbeing, than immigrants from European countries due to racism ingrained in eurocentrism and White Hegemony (Fisher, Wallace, & Fenton, 2000; Jackson & Cothran, 2003; McGettigan, 2019; Richmond, 2001; Blount & Acquaye, 2018).

Addressing Gaps in the Literature

While there have been extensive studies in other regions of the world, the African Great Lakes Region (GLR), an intricate political, economic, and geographical area, has not been extensively studied, and the evidence on GLR refugee youth's health is still limited. Also, little is known about the socio-cultural and socio-environmental factors that influence wellbeing for the GLR population that reside in the U.S.

The review of the literature explored the health and wellbeing of the general population, ethnic minorities, refugees, and young people using the socio-ecological model as a guide. While the literature on youth wellbeing exists, most studies do not refer to African refugee youth. There is a lack of credible data concerning young refugees' wellbeing emigrating from African countries to the U.S. Many studies generally failed to include a detailed understanding of refugee youth wellbeing, indicating the need for examining the meaning of wellbeing to Great Lakes Region youth. There is also a paucity of published studies on holistic models to help understand the variety of factors that influence the refugee youth population's wellbeing. Hence, the need for this study to addresses this gap. Although systemic and structural barriers may prevent young people from maintaining wellbeing, there is a dearth of literature on these factors and even less on African Great Lakes refugee youth.

It was also noticeable in the refugee literature that many studies on racism among the refugee population include participants from Australia, Canada, and Europe. Given the United States' history with the pan-African slave trade and terrorism of the African countries, there is not enough known about refugee youth experiences in the U.S. in terms of racism and discrimination (Eltis, 2007; Horne, 2007). Understanding the effect of racism

and colonialism on Black-African refugees is critical for answering questions about the effects of youth displacement and being refugees. Thereby, this dissertation explores the role of racism in GLR youth experiences in the U.S.

The Conceptual Framework

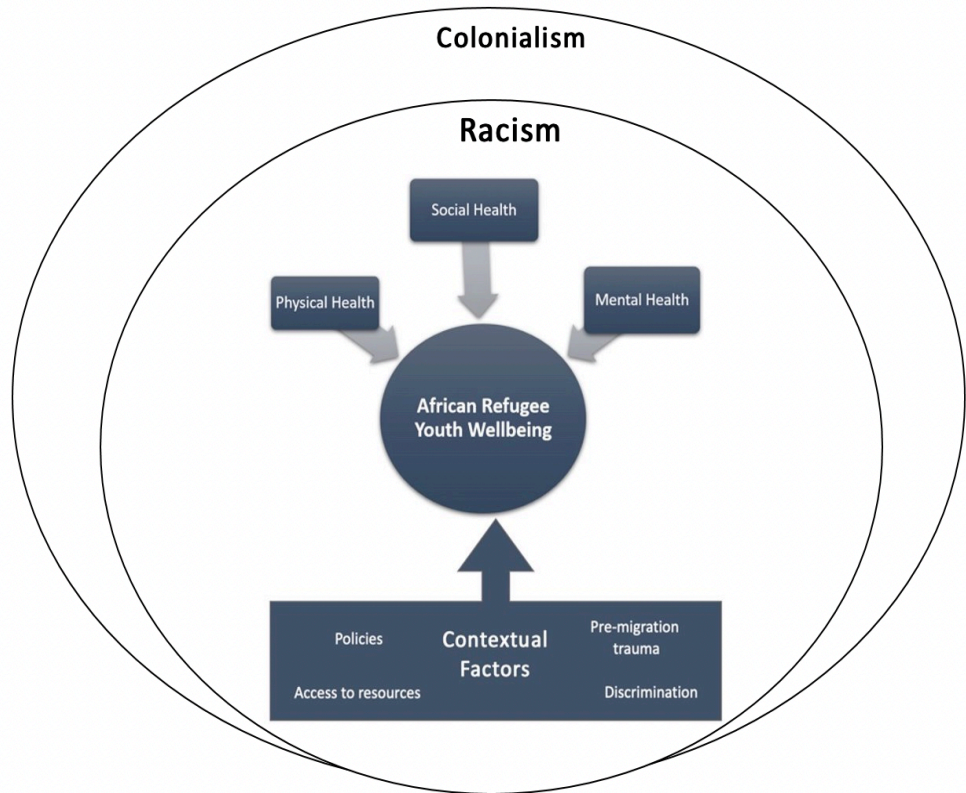


Figure 3: Conceptual framework of understanding the meaning of wellbeing to refugee youth from the African Great Lakes region

Research Questions

Directed by the conceptual framework, this study utilizes a qualitative study design to answer three distinct research questions:

Research Question 1: How do refugee youth from the African Great Lakes Region understand and make meaning of wellbeing?

a). What are the components of wellbeing for refugee youth from the African Great Lakes Region?

Research Question 2: What are the socio-cultural factors that influence wellbeing among refugee youth from the African Great Lakes Region?

Research Question 3: What are the influences of racism on the wellbeing of refugee youth from the African Great Lakes Region?

CHAPTER III

METHODOLOGY

Overview

This chapter explains the qualitative methodological approach used to understand wellbeing among African Great Lakes Region refugee youth in Louisville, Kentucky. Also discussed is the applicability of a constructivist grounded theory approach to this study. The chapter includes descriptions of the: (a) setting, (b) philosophical assumptions, (c) theoretical foundations (d) selection criteria of participants and recruitment, (e) data collection, (f) analysis method, (g) techniques used to account for trustworthiness, and (h) ethical considerations.

Research Setting

Louisville, Kentucky, is a mid-sized Mid-Western city situated within Jefferson County. The racial demographics of Louisville comprise of White (65.8%), Black (23.5%), Native Americans (0.2%), Asian (2.7%), and Hispanic (5.4%) (U.S. Census Bureau, 2019). Refugees reside across the Louisville area, with highest concentration in the Southside and West End. Louisville is unique for a mid-sized city in that there are several resettlement agencies such as Catholic Charities of Louisville, Kentucky Office for Refugees, Kentucky Refugee Ministries, The Refuge, Immigrant and Refugee Services & Resources, International Center of Kentucky, and La Casita Center making it a preferred community for refugee resettlement.

Lastly, this site was selected because of the investigator's affiliation with refugee resettlement organizations and relationships with key "gatekeepers" that assist in refugee communities.

Philosophical Assumptions

This study's philosophical assumptions are embedded in social constructivism, described as interpretivism by Denzin and Lincoln (2011). Social constructivism developed by Lev Vygotsky in 1962 seeks to understand the world participants live and work in, leading to developing varied and subjective meanings of their experiences and understanding within historical and cultural settings (Salazar, Crosby, & DiClemente, 2015). This worldview holds that realities or meanings are socially, culturally, and historically developed (Salazar, Crosby, & DiClemente, 2015).

Also, social constructivist researchers recognize their background may shape interpretation and position themselves to account for their biases and personal experiences (Creswell & Poth, 2016; Denzin & Lincoln, 2011). This study uses the social constructivist worldview to examine refugee youth's diverse experiences from the African Great Lakes Region by purposefully recruiting youth with varied experiences and substantial knowledge on the research topic (Creswell, 2013). Thus, this study builds upon the underpinning of social constructivism to explore understandings of wellbeing while recognizing the importance of intrapersonal, interpersonal, socio-cultural, and socio-environmental factors.

Research Design

This study examines the culturally specific meanings of wellbeing to African refugee youth using a Qualitative Descriptive Design.

Inclusion and Exclusion criteria

To be eligible for the study, participants must:

- identify as a refugee from the African Great Lakes Region
- be 18 to 30 years
- Speak English
- Have resettled in the United States for not more than ten years before participating in this study
- live in Jefferson County, Kentucky.

During recruitment, participants who did not identify as African Great Lakes Region refugees, were less than 18 and over 30 years, and were non-residents of the Louisville area were excluded from the study.

Sample size

Qualitative research is more concerned with the depth of information collected, and less concerned with sample size but emphasize sampling adequacy (Charmaz, 2014; Glaser, 2002), and not generalizability, representativeness, or sample size (Creswell, 2013; Merriam, 1998). This study aimed to understand the deep meanings of wellbeing among refugee youth by recruiting 12 youth from the African Great Lakes Region and conduct interviews until data adequacy was achieved.

Sampling

The logic of a purposeful sampling strategy lies in selecting information-rich cases to that yield insight and understanding to the phenomena under investigation (Creswell & Poth, 2016). The concept suggests that the researcher selects individuals and sites for the study because they can purposefully understand the research problem and central phenomenon in the study (Creswell & Poth, 2016).

Unlike quantitative studies that utilize random sampling procedures based on statistical probability that enable generalization, the goal of most qualitative research and this study is to describe in-depth, context-based experiences. This strategy's primary purpose was to gather rich information about participants' lives and saturate categories of wellbeing among refugee youth in Louisville, Kentucky.

Participant recruitment

The Institutional Review Board at the University of Louisville approved all materials for this study before participant recruitment. Flyers (Appendix A) describing the study were distributed by local refugee groups and organizations (Americana Family Health Centers, Catholic Charities, Kentucky Refugee Ministries, Lead to Empower, and Americana Community Center) via email lists and social media platforms targeting the demographic of refugee youth. The Co-principal investigator sent out WhatsApp messages using text from the recruitment email script (Appendix B) to local youth organizations requesting that they share information for the study with youth who met the study criteria.

Participants who agreed to take part in the study selected convenient times to meet on a virtual platform (Zoom). Each participant selected a non-identifying pseudonym to ensure anonymity (see ethics).

Data Collection

There are two main data collection phases: a socio-demographic survey and in-depth qualitative interviews, and member checking focus groups.

Phase 1: Socio-Demographic Survey & In-Depth Interviews

The survey (Appendix D) measured socio-demographic attributes such as age, gender, educational level, employment status, country of birth, and total household income. The survey data was collected before interviewing participants.

Qualitative research adopts informational, investigative, and intensive interviewing strategies. Informational interviewing gathers accurate facts about demographics and descriptions of events; investigative interviewing gathers accurate responses and uncovers hidden actions and intentions (Charmaz, 2014; Creswell, 2013). Intensive interview, on the other hand, is a technique mostly used in grounded theory research that employs informational interviewing and explores participants' substantial experiences with the research topic (Charmaz, 2014).

The in-depth nature of intensive interviews encourages participants' interpretation of their experience while participating in the interviews. Intensive interview was appropriate for this dissertation study because it enabled the researcher to explore the African refugee youth's experience with wellbeing, how they interpret their experiences, and the meanings they ascribed to wellbeing. A pool of 12 Great Lakes Region refugee youth were interviewed using a virtual online platform. Hence, the interviewer asked participants to describe or reflect upon experiences in everyday life while listening and observing with sensitivity.

This study used the in-depth qualitative interview guide (Appendix E) to engage participants. All interviews were audio-recorded and lasted approximately 60-90 minutes. After the interview, the researcher transcribed the digital audio file. Data collection continued until saturation was attained. Data saturation was realized when no new data analysis provided more material to add to the categories and sufficiently described categories (Birks & Mills, 2015). For example, data saturation occurred when all categories and properties of the meaning and interpretations of wellbeing were well covered. The data saturation point determined the final number of participants.

Phase 2: Member-checking Focus Group

Utilizing a member checking focus group increases the trustworthiness and credibility of the analysis from Phase 1 of data collection (Creswell & Miller, 2000; Merriam, 1998). Therefore, the member checking focus group presented the study's findings to the participants to gain valuable feedback and resolve any gaps in the data. The researcher conducted two member checking focus group via a virtual online platform. Participation was dependent on initial consent. The focus group ran between 60 and 90 minutes and was audio recorded. The focus group method ensured that the study's results accurately reflected experiences of participants. It also invited interviewees to review the study results, clarify answers to interview questions, and allow interviewees to resolve possible incomplete information.

Data Analysis

Constructivist Grounded Theory Analysis

Constructivist grounded theory analytic techniques (Charmaz, 2017) were used for data analysis. Researchers used the Constructivist Grounded Theory (CGT) to examine the meaning of wellbeing to refugee youth from the African Great Lakes region. The CGT helps researchers explain the process, action, or interaction shaped by participants (Creswell & Poth, 2017). Constructivist grounded theorists attest that researchers are part of the research situation, and their positions, privileges, perspectives, and interactions influence the research (Charmaz, 2000, 2017; Charmaz & Belgrave, 2007; Clarke, 2007). To understand participants' meanings, researchers must probe deeper than surface meanings and search for views and values, and facts; this is accomplished by searching for beliefs, ideologies, situations, and structures (Charmaz, 2000). The Constructivist grounded theory analysis involves creating a rapport with respondents to share stories in their terms (Charmaz, 2000; Charmaz & Belgrave, 2012). Such analysis was appropriate for this study because researchers asked participants open-ended questions and were asked to share stories about their experiences.

The CGT analysis generates powerful insights into public health and social justice research for the implications of research, practice, and policies within real-life contexts (Charmaz, 2020). Several articles have applied grounded theory across various public health disciplines (Hoare & Decker, 2016; Law, Daftary, Mitnick, Dheda, & Menzies, 2019; Mulugeta, Williamson, Monks, Hack, & Beaver, 2017; Shim, 2014; S. J. Song, Tol, & De Jong, 2014; Thornberg, 2015). Charmaz (2014) also outlined non-linear and iterative strategies such as initial coding, focused coding, drawing on data to develop inductive

abstract categories, memo writing, and theory generation. By understanding the process of wellbeing and the various factors that influence wellbeing for refugee youth from the Great Lakes Region, this qualitative descriptive design informs future research and youth development.

Theoretical Foundations

Qualitative researchers use sensitizing concepts to stimulate the researcher's possible lines of inquiry (Blumer, 1969). Sensitizing concepts also provide beginning points for initiating data analysis and points of departure to think analytically about the data (Charmaz, 2014; Glaser, 1978).

The study employs theoretical sensitizing concepts from five theories: the Indivisible Self-Model of Wellbeing, Socioecological Model, Critical Race Theory, Postcolonial Theory, and Symbolic Interactionism. This study used these theories to develop the interview guide, data analysis, and understand the meanings and interpretations of wellbeing.

The Indivisible Self Model of Wellbeing

The Indivisible Self Model of Wellbeing (IS-WEL) is an evidence-based model for evaluating holistic wellness; it incorporates aspects of individual psychology, quality of life, longevity, and healthy living (Myers & Sweeney, 2008). The IS-WEL framework explains that wellbeing is holistic/indivisible, and the understanding of human behavior involves the interaction between the different parts of a person, physical, essential, social, creative, physical, and coping self as well as the social and environmental contexts in which individuals are situated (Myers & Sweeney, 2008). This model conceptualizes wellbeing

using different factors such as coping self, social self, essential self, physical self, and creative self. The multidimensional nature of this model renders its relevance to refugee populations. The Indivisible Self Model of Wellbeing offers an efficient approach to understand holistic wellbeing among some across ethnic minority groups such as refugees and immigrants (Blount & Acquaye, 2018; Fetter & Koch, 2009; Myers & Sweeney, 2008).

The Socioecological Model

The Socioecological Model (SEM) is a theory-based framework for understanding the multifaceted and interactive factors that determine behaviors and intermediaries for health promotion within communities (Centers for Disease Control and Prevention). The socioecological model emerged from Bronfenbrenner's (1977) Ecological Systems Theory of Human Development that explored individuals' interactions and their social and physical environment. McLeroy, Bibeau, Steckler, and Glanz (1988) developed the socioecological model for public health promotion with five different SEM levels: individual, interpersonal, organizational, community, and policy. Castañeda et al. (2015) argued that individualized theories place accountability for behavioral change on individuals rather than social systems to account for adverse health outcomes. This model is also useful for understanding the societal and political factors influencing wellness (Bronfenbrenner, 1994; Myers & Sweeney, 2004). Researchers argue the need for research, policy, and practice around wellbeing to move beyond individualistic psychological models toward utilizing models that involve the family, community, and organizational dimensions constructs as sensitizing concepts to explore the meaning of wellbeing to African GLR refugees.

Critical Race Theory

Critical Race Theory (CRT) explores how society has been socially constructed by race, leading to the systemic oppression of underrepresented populations (Delgado & Stefancic, 2017). The five central tenets of the perspectives of the Critical Race Theory applied to research include: (1) centrality of race and racism and their intersection with other forms of subordination; (2) challenge to dominant ideology; (3) commitment to social justice; (4) centrality of experiential knowledge; and (5) applying a transdisciplinary perspective (Delgado & Stefancic, 2017). Therefore, the CRT perspective is essential to exploring the oppressive structures that influence African Great Lakes Region youth refugees' wellbeing. One of the tenets of CRT is a commitment toward social justice and empowering underrepresented populations (Matsuda, 1991; Yosso, 2006a, 2006b). This perspective uncovers the hegemony of white supremacy and seeks to eradicate oppression and the empowerment of oppressed groups. The Critical Race Theory examines how participants understand the socio-contextual influences of racism and colonialism on wellbeing (Delgado & Stefancic, 2017). Participants in this study are Black Africans and may experience racial discrimination as African Americans. The Critical Race Theory provides sensitizing concepts in understanding racial discrimination on African youth refugees.

Postcolonial Theory

The postcolonial theory explores the relationship between social issues that affect the colonized (Wolfe, 1997). It holds that colonized people form identities developed using western ideologies (Wolfe, 1997). Postcolonialism asserts that the imposition of western culture and ideals caused by colonization influences how Africans view themselves and how society views them (Fanon, 1963). Although study participants did not experience

colonialism directly, colonialism has a trickle effect on the lives of refugee youth and their wellbeing (Odhiambo-Abuya, 2005). The postcolonial theory explores how postcolonialism influences the meaning and interpretation of wellbeing to refugee youth from the African Great Lakes Region.

Symbolic Interactionism

Symbolic Interactionism (S.I.) Theory explores the meanings that emerge from the interaction between people in a social environment (Blumer, 1969). An interpretative process between individuals infers these meanings. Also, S.I. focuses on how people interpret or react to certain relationships and interactions (Blumer, 1969). S.I. reinforces that there can be a multiplicity of socially constructed interpretations, realities, truths of similar experiences (Charmaz 2014, Merriam, 1998). In this study, the experience was the resettlement and process of maintaining wellbeing. According to Blumer (1969), agreement about these realities occurs through ongoing social interactions. In this study, S.I. explores the different realities that includes the meanings participants make of their wellbeing and how they interpret their experience.

Coding

This study employs two phases of coding, initial and focused, to answer the research questions (Charmaz, 2014; Corbin & Strauss, 2008). Coding categorizes the data with a short name called codes that simultaneously summarize and account for pieces of data (Creswell, 2013). By doing this, the researcher moves beyond specific statements in the data to making analytical meaning of statements, stories, and observations (Charmaz, 2014).

Initial coding involves labeling each word, phrase, line, or segment of data (Charmaz, 2014; Corbin & Strauss, 2008). During initial coding, the investigator explores any possibilities that can be recognized in the data by answering the following questions: "what is this data a study of?" "what do the data suggest, pronounce, or leave unsaid?" "from whose point of view" and "what theoretical category do the specific commentaries indicate?" (Glaser Barney & Strauss Anselm, 1967; Glaser, 1978). The initial coding grounded theory technique uses the application of gerunds (Charmaz, 2014), which defines the subtle meanings and actions and describes how participants interpret and handle situations in the data (Charmaz, 2014). After reading each interview transcript, the investigator begins coding by using gerunds to interact, study, and develop links between the data processes.

Focused coding involved selecting codes that appear more frequently and hold more significance to categorize large amounts of data (Charmaz, 2014; Glaser, 1978). Focused coding is the second coding technique employed to direct the analysis. The researcher used a comparative process to assess the accuracy of initial codes (Charmaz, 2014). The researcher also developed properties of characteristics that are common to all the concepts of wellbeing in the categories.

Qualitative analysis software

A computer-assisted qualitative analysis software, Dedoose, was used for data management and data analysis. Focused codes were transferred to the software Dedoose and collapsed into families and themes with descriptions. While not the fundamental coding source, Dedoose strengthens data analysis.

Situational Analysis

Situational analyses use maps to capture and discuss critical situations, variations, or differences in the data (Clarke, 2003). The purpose of situational maps is to define the human and non-human elements in the data. During the situational analysis, the researcher mapped out situational factors of refugee youth wellbeing using a messy map. The messy map answers the following questions: "Who and what are in this situation?" "Who and what matters in this situation" "What elements make the difference in this situation?" (Clarke, 2003)

Ethics

Preamble Consent Process

Prior to participation, refugee youth receive a recruitment email (Appendix B) from refugee resettlement organizations. To enable informed decision-making, potential participants were informed about the research study, its voluntary nature, confidentiality, rights to terminate participation at any time without consequences, and audio-recording of interviews (Appendix C). Those interested in participating click a link to an online Qualtrics survey that asks questions to see if the participant fits the study's inclusion criteria. If eligible, the next button leads them to select a date and time to schedule an online survey and in-depth interview.

Data handling and storage, and protection

The P.I.s and study personnel monitor and protect all data from exposing identifying information collected. Researchers code the data using pseudonyms for the survey and in-depth interview component. Only PIs and study personnel have access to the data. All documents with personal information such as names, addresses, phone numbers, email

addresses, signatures, and study data are stored in a password-protected folder on the University of Louisville CardBox storage device. The study notes are stored for five years following study completion. Also, to protect the privacy and security of research participants, the video conferencing platform is only accessible via an invite from a project team member.

Minimizing Risks

There are no known risks associated with participating in this study. However, to minimize any possible risks associated, data that includes identifying information (audio recordings of in-depth interviews and focus groups, and participant recruitment data) are placed in a secure folder on the University of Louisville CardBox storage service. Family Health Centers' refugee medical case managers' receive study personnel contact information for medical and behavioral health to study participants

Benefits

While there are no direct benefits to participants involved in this research, findings from the study can help others. Gaining an understanding of African refugee youth experience with attaining and maintaining wellbeing and the factors that influence wellbeing may lead to an improvement in policies and practices involving refugees by service providers and policymakers.

Human Subjects Protection

Researchers participating in all aspects of this study, including participant recruitment, interviewing, note taking, data analysis, and data dissemination, were required to complete CITI training before submitting to the IRB. If researchers were added to this project after IRB submission, an amendment was submitted to the University of Louisville IRB for

approval before viewing or interacting with participants or data. Researchers report breaches in data security or adverse events of data collection immediately to the University of Louisville IRB.

Precautions Taken Due to COVID-19

To complete this project and continue to practice CDC regulations of social distancing amidst the Covid-19 pandemic, all project meetings occurred over virtual meeting platforms. Data collection took place over a secure video conferencing platform.

Researcher Positionality and Reflexivity

Positionality

Constructivist researchers recognize that their background shapes their interpretation, and therefore "position themselves" in the research to acknowledge how their interpretation flows from their own personal, cultural, and historical experiences (Creswell and Poth, 2016). Researchers convey how their background informs their interpretation of the study's information and what they can gain from the study. I approached this study with multiple positionalities. I consider myself an "outsider" because I am not a refugee from the African Great Lakes Region. Also, I approached the study as an "outsider" as I examined participants' understanding of wellbeing.

On the other hand, I share some similarities with the target population that may make me close to an "insider." I am an African immigrant and may have similar cultural practices with youth from the African Great Lakes Region. Additionally, I have been active within the African refugee and immigrant communities, so I have some understanding of the process of migrating to a westernized country, fleeing injustice, and familiarity with stories about some crisis in Africa. I am also aware of my privileges as an English

Language speaker, an economic immigrant, and a doctoral candidate. I must consciously respect the African Great Lakes Region's traditional beliefs, even if different or similar to mine, and respect all participants in the study. To handle concerns about being an outsider, I partnered with local community organizations and gatekeepers who are community youth leaders to foster trust and reflect on my position during and after the interviews.

Reflexivity

Reflexivity is a concept where researchers "position" themselves and are conscious of biases, values, and experiences they bring into the research. Reflexivity is usually written clearly in words (Hammersley & Atkinson, 1996). Creswell and Poth (2016) recommended that researchers engage in reflexivity in two ways, discussing one's experiences and how they shape the researcher's interpretation of the phenomenon. Reflexivity is also a continuous process that enables researchers to construct and articulate their positionality throughout all stages of the study, using tools like reflective memos, field notes, and journals (Finlay, 2012). Observational field notes (Appendix E) records events seen or heard during the interview, interpretations of the interview, self-reflection, and self-critique of the interview (Clarke, Friese, & Washburn, 2015). I engaged in reflexivity by using observational field notes and memo writing for each interview. Memo writing enabled me to examine the research experience, positions, and interpretations of the data. Also, I took notes of my general experiences, questions, reflections as I conceptualized the study.

Moreover, I reflected on my positionality as a social justice researcher. This research occurred during a time of heightened social justice and health equity discussions both locally and nationally. The conversations around social justice were due to an eruption in response to the killing of Breonna Taylor and racial disparities in Covid-19 deaths (Miah,

2020; Mude, Oguoma, Nyanhanda, Mwanri, & Njue 2021). Many participants shared their experience with social justice and its association with wellbeing. Throughout the study, I took observational notes and memos to reflect on my personal feelings on social justice to ensure I amplified the study participants' voices.

Finally, as the researcher, I reflected on my relationship with the study and participants while implementing measures to ensure the trustworthiness of the study findings.

Strategies for Ensuring Trustworthiness

Applying Lincoln & Guba's (1985) criteria for trustworthiness ensured a rigorous study.

This study used three criteria: credibility, transferability, and confirmability.

Credibility is the confidence in the study's truth; Lincoln & Guba (1985) proposed using techniques such as prolonged engagement in the field and the triangulation of data sources, methods, and investigators to establish credibility. In this study, member checking focus groups and peer debriefing enhanced credibility. Further, member checking authenticates study findings with participants (Lincoln & Guba, 1985). Data was collected and coded separately by research team members who met regularly to debrief and identify themes and meanings. Transferability involves showing that the study findings have applicability in other contexts. A thick description of the data was conducted through the research process to achieve transferability. Also, this study employs observational field notes. Confirmability is the degree of neutrality or the extent to which the study's findings are shaped by the respondents and not the researcher's bias.

The research team conducted an inter-coder reliability test ($\kappa = 1.0$) to ensure code agreement. A triangulation of the study data sources (interviews, observational field notes, and situation analyses) gathered and analyzed data in more than one way at more than one

time to increase the rigor of this study (Creswell & Miller, 2000; MacMillan & Koenig, 2004). Observational field notes such as events seen or heard during the interview, interpretations of the interview, early hunches, self-reflection, and self-critique were conducted during data collection and reviewed during data analysis (Schatzman & Strauss, 1973). The study also conducted situational analyses to describe the situational factors related to refugee youth wellbeing experience using a messy and ordered map (Clarke, Friese, & Washburn, 2017).

Summary

This chapter outlined the research methods used to answer the research questions. A descriptive qualitative approach was applied to answer the three research questions using a social constructivist paradigm. This study used constructivist grounded theory analytical techniques to examine the meaning of wellbeing to refugee youth from the African Great Lakes region. This study aimed to examine the meaning of wellbeing to refugee youth from the African Great Lakes Region who reside in Louisville, KY. A socio-demographic survey, in-depth interviews, and member checking focus groups were employed to answer the research questions. The chapter included the research methodology, conceptual framework, study participants, recruitment, data collection, data analysis, and ethical considerations. Researcher examined the meanings of wellbeing and the factors that influenced refugee youth's wellbeing from the African Great Lakes region in Louisville, Kentucky.

The next chapter presents study findings, an analysis of the findings, and the researcher's conclusions.

CHAPTER IV

RESULTS

Introduction

This study aimed to explore wellbeing from the perspective of refugee youth from the African Great Lakes Region, including how they interpreted their experience, and the meanings they ascribed to wellbeing. Results in this chapter addressed the following research questions:

1. How do refugee youth from the African Great Lakes Region understand and make meaning of wellbeing?
2. What are the socio-cultural factors that influence wellbeing among African Great Lakes Region refugee youth?
3. What are the influences of racism on the wellbeing of refugee youth from the African Great Lakes Region?

Participants

A total of twelve African Great Lakes Region refugee youth refugees were interviewed. The table below details the demographic profile of the sample (Table 1). There were 58.3% male and 41.7% female participants ranging in age from 18 – 26 years (mean = 21.25, S.D = 1.96).

Participants had lived in the U.S. from one to six years (mean = 4.25, S.D = 1.01). Of that number, 83% of participants were born in DRC while, 8% were from Tanzania and Burundi. Although they were born in these three countries, participants had lived in one or more countries including Rwanda and South Africa. With respect to educational level, most respondents had some higher education: college degree or higher (25%), some college or an associate degree (58.3%). Those with a high school degree or less made up the smallest percentage (8.33%). Regarding employment, 50% of study participants worked full-time, 41.67% worked part-time, and 8.33% were students.

Length of time in the U.S

The duration of time spent in the US impacts how these refugee youths describe social issues such as racism, health policies and other systemic concerns. As this study shows, the longer the duration of time they have been residing in the US, the better their understanding of these issues. For instance, Jason, who has been residing in the US for 10 years could articulate the influence of institutionalized racism and importance of health policies on youth wellbeing. On the other hand, Richard, who only recently got into the U.S., was unable to articulate an understanding of racism and the meaning of health policies. Basically, Richard was unable to describe these issues because he has not been exposed to them in a way that could aid a better knowledge of the policies and program implementation.

Gender differences

There are four (41.7%) female and seven (58.3%) male refugee youth in this study. Participants expressed their understanding of wellbeing and unique experiences associated with their gender identities. For example, Gift, a female refugee youth described her

experiences with managing her responsibilities as a student and mother. She explained that for women in her community, caring for the home and children takes precedence over educational attainment which might be different from the general U.S. community. On the contrary, Steve described his encounters with racial profiling as a Black man living in the U.S. He explained that as a Black man, it is common knowledge that Black men are more susceptible to being confronted by the police in America. So, as a black refugee immigrant, Steve is constantly aware of that reality, which in turn constrict his understanding of wellbeing.

Table 1: Demographic Characteristics of Participants

Characteristics (n=12)	Normal Weight N (%)
Gender	Male: 58.3% Female: 41.7%
Age 18 – 26 years	(Mean = 21.25, S.D = 1.96)
Highest Education Grade	
College graduate or above	25%
Some college or Associate Degree	58%
Employment status	
Full time	50%
Part time	42%

Characteristics (n=12)	Normal Weight N (%)
Years in the U. S*	
1- 2 years	4 (34%)
3 years or more, but less than 5 years	3 (25%)
5 years or more, but less than 7 years	5 (41%)
Country Lived in Prior to Resettlement	
Democratic Republic of Congo	8 (37%)
Rwanda	2 (9%)
Tanzania	4 (18%)
Burundi	4 (18%)
South Africa	3 (13%)

* Showing values with the highest frequency

The Conceptual Framework

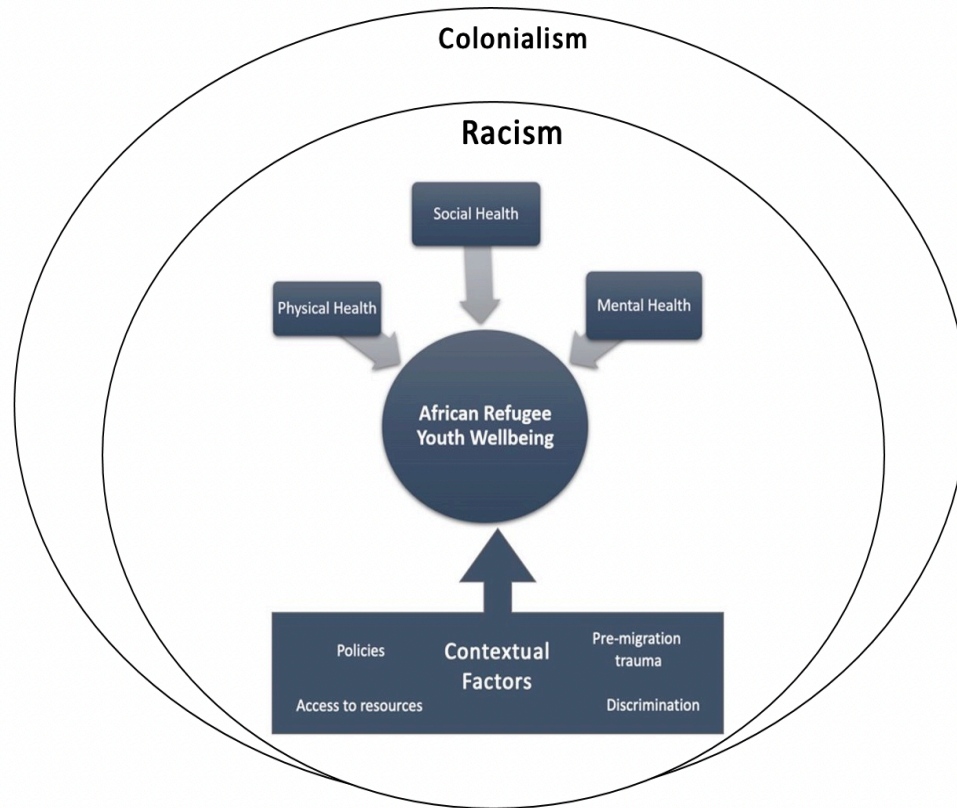


Figure 4: Conceptual framework for understanding the meaning of wellbeing to refugee youth from the African Great Lakes region

The conceptual framework for this study is intended to guide the understanding of refugee youth wellbeing including contextual factors, overarching context of racism and colonialism, and components of wellbeing. It assembles essential elements of wellbeing using the Socio-Ecological Model (SEM), the Indivisible Self Model of Wellbeing, and the Critical Race Theory (Bronfenbrenner, 1994; Delgado & Stefancic, 2000; Myers & Sweeney, 2004).

The framework outlines the relationship between components of African Great Lakes Region refugee youth wellbeing, contextual factors, racism, and colonialism.

African Great Lakes Region refugee youth wellbeing. The conceptual framework posits African youth wellbeing within three components: physical, social, and mental health. These components reveal how refugees understand wellbeing. These components also have both dependent and independent effects on wellbeing.

Contextual factors. The framework also reveals that refugee wellbeing is influenced by the interaction of the following factors: policies, access to resources, pre-migration trauma, and discrimination. The conceptual framework posits the direct and indirect influence of the contextual factors on wellbeing.

Racism and colonization. The conceptual framework reveals how racism and colonialism encompass both the components and contextual factors of African refugee youth wellbeing. It outlines the direct and indirect effects of racism and colonialism on wellbeing.

Study Categories

The findings of this study are organized under the following major categories that emerged from the analysis, each containing several sub-categories and properties. The major categories of the study are, the meaning of wellbeing, holistic wellbeing, racism and wellbeing, racism and wellbeing, and colonization and wellbeing.

The Meaning of Wellbeing

Refugee youth developed their understanding of wellbeing at a young age both before and after their arrival in the U.S. Before immigrating to the U.S, participants viewed wellbeing as the absence of sickness, of wars, and of continuous movement from camp to camp.

Being alive, and having abundant resources constituted their understanding of wellbeing. Joanna, an eighteen-year-old female explained: “I thought about it like as long as you are alive, you have good health.”

For some participants, reflecting on their previous understanding of wellbeing brought about new interpretations of meaning. For example, once arriving in the U.S., refugee youth recognized differences between their definition of wellbeing in the U.S. and in their home countries or refugee camps. They realized that wellbeing meant more than having food and safety and started considering other aspects of wellbeing that were neglected while living in the refugee camp. Jason, a twenty-six-year-old male who lived in a refugee camp for twelve years explained,

I think it's in the United States that I've come to sort of be more aware and start acknowledging whether I have good wellbeing or not. Before coming to the United States, my understanding was more of the basic level of just having something to eat and being alive in general. (Jason, 26)

Having basic needs met became a common theme for participants when discussing wellbeing. Roland, a twenty-one-year-old refugee youth who has lived in the U.S. for over three years explained:

Wellbeing is having the things that we need every day to live. Yeah, first I need to eat every day, I need a place to live like a sitting room or bed, you know? (Roland, 21)

As youth described the meanings of wellbeing, their interpretations became more reflective as they compared past to present experiences. Some youth reflected on their experience in

the refugee camps and changes that occurred after arriving in the U.S. Life in a refugee camp was largely based on survival. Some youth explained that their understanding of wellbeing had changed once arriving in the U.S. Roland likened wellbeing to survival and explained that people who were able to effectively manage limited resources in the refugee camp were healthier.

I was born in Congo, Democratic Republic of Congo, and then grew up in a refugee camp in Burundi for 10 years. Life there is very opposite to life here (U.S.). So, what I meant by saying that wellbeing is survival is because the UNHCR give refugees food at the beginning of the month, you have to manage your food through the end of the month which is not enough for the whole month; you have to survive through it. (Roland, 21)

While for other refugees in the camp, wellbeing meant having enough food to eat. This meant those who had sufficient meals to eat felt they were healthy and not having enough food meant you were poor.

Gift explained,

I would say the difference between wellbeing in the U.S. and Africa is eating. I now eat anytime. If I feel like eating right now, I can always have it. (Gift, 24)

Another participant agreed with Gift that wellbeing was seen as having food to eat. He explained, “The way we understood wellbeing was just having food to eat.” (Jason, 26)

In contrast, participants who had not lived in a refugee camp described a healthier life in Africa than in the U.S. For these refugees, it was easier to engage in sports, physical

activity, and eat healthy foods in Africa than in the U.S. For example, Sarah a 24-year-old female who did not grow up in a refugee camp, said,

In Africa, I was always active. I grew up in South Africa and we had like a lot of sports. I was always active. So, I always thought like good health is you keeping your body in shape, exercising, eating healthy, it's not always been like that since I got here.
(Sarah, 24)

Basic Needs for Daily Living

Ascribing meaning to wellbeing varied considerably whether the participants were discussing their past or present understandings of this term. Given that wellbeing was not a term considered by refugees living in poverty and in hostile environments, it was important to understand the evolution of the term and its meaning. As the participants adjusted to life in the U.S., they realized the need for basic things for daily living. Some participants described wellbeing as having daily needs met such as a home, living home, bedroom, and daily meals. Roland explained:

Wellbeing is having the things that we need every day to live.
Yeah, first I need to eat every day, I need a place to live like a sitting room or bed, you know? (Roland, 24).

Like Roland, some participants attached the meaning of wellbeing to meeting basic needs, primarily, nutrition and physical activities. However, meeting basic needs was determined by access to resources in the new environment and resettlement neighborhood.

Access to Resources

Although most participants mentioned basic nutrition and freedom from war as essential to their understanding of wellbeing, once immigrating to the U.S., they realized the importance of access to socio-economic and educational resources in maintaining wellbeing. Youth were aware that there is an availability of resources and opportunities to succeed in the U.S. but, the barrier was the lack of access and means to finding the resources. For example, it is widely known that there is a plethora of opportunities such as university scholarship, internship, and employment in a non-factory setting but, youth experienced difficulties understanding the application or process involved with getting these benefits.

One of the participants explained:

One barrier is a lack of opportunities. This may be very confusing because we know there is a lot of opportunity out there, but lack of access to get these opportunities is something that's really stressful for not only me, but a number of refugees. People tell refugees, you have opportunity to do this and that, but there is no one to show the step-by-step process to get what or where you want. So, you have to figure that out on your own. And it's really stressful that we don't have enough resources and people who are familiar with this country and the different application process.

As expressed by Ali, many refugees felt that lack of opportunities was not the barrier to living a fulfilling life rather the lack of access to resources and information could hinder navigating social and economic opportunities could improve wellbeing. Also, study participants compared these meanings of wellbeing to freedom.

Wellbeing as Freedom

For participants who included the concept of freedom in their definition, wellbeing meant freedom to be themselves, to be happy, and to achieve long and short-term goals. Although participants attested that there was no word for wellbeing in their local language. Some Swahili speakers likened it to Uhuru, the Swahili word for freedom. In literal terms, Uhuru goes beyond the English dictionary meaning of wellbeing. It means wellbeing that comes with freedom to find peace, joy, be oneself. For example, Isco explained that Uhuru meant being free with oneself and who one is becoming as well as finding peace within oneself. He explained,

I feel like wellbeing is like being free, having freedom and peace.
Like do what you want to do. Having happiness and joy and being
able to be the best you can. (Isco, 18)

For Isco, the freedom that led to wellbeing was having happiness, peace, joy, and being the best version of himself.

Also, this context of wellbeing as freedom was likened to access to opportunities and resources and achieving one's goals. Some refugee youth felt that true freedom comes through access to resources and opportunities to succeed. The success in turn makes it easier to stay well. Ali, a refugee youth, reflected on the interpretation of freedom as wellbeing. He is a college student and works full time. The freedom to achieve these goals of being employed and a student was likened to wellbeing.

Wellbeing is when you have freedom but it's not like freedom of not being in jail. Not being in jail does not mean you are free. Some people are free, like they are out in the communities, but they are not that free. They cannot even chase their dream. This may be due to lack of opportunities, uh, lack of resources. There is a freedom by saying it, or by writing it in the paper, but in the reality, people don't have that freedom of achieving their goals or having the resources they need to move forward in their lives. That's true. (Ali, 22)

Freedom was used as a metaphorical explanation of wellbeing where the availability of resources and opportunities was applied to the meaning of wellbeing. Furthermore, youth expressed the meaning of wellbeing in their community.

Refugee youth loved supporting their families and expressed the importance of wellbeing on a community level. Study participants expressed the importance of wellbeing at a community level. This was termed the *African Spirit*. They explained that they felt happier and healthier when their community was healthy and happy.

You don't only care about yourself. You care about your family. And then, because we have this family thing, you have your parents, grandpa, and your aunt. We also live with our families. So that's like African spirit, you feel happy, or you feel achieved when you see that everything and everyone around you feels good or is happy. You know, that's when you have like a full health. (Baha, 24).

As explained by Baha, youths elucidated the meaning of wellbeing from an African perspective. They felt happy and healthier when their family members and community was

also happy. Study participants described a continuum of progress toward achieving wellbeing, beginning with safety, having their basic needs met, access to resources, achieving wellbeing as a community, and moving toward physical, mental, and emotional wellbeing. Then, youth tailored these meanings to holistic wellbeing including physical, mental, and social wellbeing.

Holistic Wellbeing

While most participants ascribed the meaning of wellbeing to nutrition, physical activities and having basic needs met, some participants specified that wellbeing encompassed physical, mental, and spiritual health. Holistic wellbeing also included the influence of culture, workplace, school, and policies on wellbeing.

Isco, an eighteen-year-old male who lived in a refugee camp for ten years explained that in addition to the absence of illness, wellbeing meant physical, mental, and social fitness. He explained,

I describe being healthy or health as being physically, mentally and socially fit. Wellbeing is not having any disease, not having any, like, not being sick more often. (Isco, 18)

Gift agreed that wellbeing included physical, mental health, and the absence of disease. She said:

I would say wellbeing is when your body is not feeling sick, you are able to do exercises that will make your body look good. It also means you have a good mental health to take of yourself. (Gift, 24)

Gift explained that wellbeing included not feeling sick, exercises, good mental health. These descriptions of wellbeing encompassed two components of wellbeing, physical and mental health. In addition to these descriptions, some participants explained that wellbeing also involved spiritual health which means a connection to God.

I looked at wellbeing beyond physical health. We need to consider factors like your emotional, mental, and spiritual wellbeing. I mean, it's whatever you believe in, whatever that keeps you going, like your belief in God and staying connected with God. (Pearly, 25)

This participant explained that wellbeing surpasses physical health to include spiritual health which is a connection with God and belief in God. Some refugees also described other meanings and ways to achieve physical health such as physical exercises.

Physical Wellbeing

Nearly all participants described their understanding of physical health as engaging in exercise. Often, refugee youth in the U.S. achieved physical wellbeing by visiting gyms and engaging in sports as part of extracurricular activities in school and within their communities in the U.S.

For physical health, I do exercise regularly. I really love running, but these days I'm not doing that. During the past few weeks, but my schedule for the past four weeks for now is super busy. So, I'm not doing that regularly. And I think that is bad for my health is like not doing those kinds of exercise. (Ali, 22)

While participants understood the importance of maintaining physical health, they expressed difficulties in engaging in exercise and practicing healthy eating. Some of these barriers included limited access to resources, and balancing school and work. Sarah did not live in a refugee camp; she had an experience with physical wellbeing that differed from other participants. She explained:

I was doing sports and physical activity in Africa but, when I moved here, I didn't get time to do any of that. I used to play soccer, netball, and all those sports in school. Here the schedule is different. You just work, work, work, and then they expect you to participate in after school. Some people don't have transportation to drive around and depend on school buses. Then some of us work after school. In Africa, we don't have to work after school. When I say my wellbeing or health, I was healthier in South Africa than I am here. (Sarah, 24)

For some participants, lack of understanding about the means to achieving physical health was a barrier to staying well. A youth believed that some young people might be ignorant or negligent of their health. He felt that some young people know how to get good physical health but do not think it is important. One participant explained:

I can say the only thing I can think that people do is ignorance. Whenever you say like physical health, it is good for your body. If you know about it and how you can proceed in achieving that, then that's being ignorant because they just feel it is not important. (Richard, 24)

Securing physical health in the form of exercise, several participants expanded their definition of wellbeing to include mental health.

Mental Wellbeing

Mental health included various interpretations, yet many participants agreed that their mental wellbeing included the health of the mind. The concept of wellbeing as maintaining mental health was less concrete than obtaining physical health because exercise and nutrition were more familiar concepts for participants.

For example, Richard explained, “Your mind functions when everything works like your mind is clear,” while Gift described mental health as “a life without stress. It's very hard to live without stress, but the issues are trying to eliminate all the stress in your head.”

For other participants, mental health meant depression, “mental health means when I feel depressed” (Baha, 24).

Also, participants described different ways they achieved positive mental health. For example, some participants danced with friends, took long rides, read a book, attended social gatherings, or engaged in art therapy. One participant described:

Good mental health is to have good physical health. So, dancing really helps me cool down. I go to social gatherings, and sometimes I spend time alone. (Sarah, 24)

Although understandings of mental health varied among participants, the stressors were much the same among participants. The added responsibilities of going to school, working, and supporting their families made maintaining good mental health difficult.

A youth explained that certain responsibilities such as taking a lot of classes and a full-time employment might make it difficult to stay well. She also attested that some women have more responsibility such as taking care of a home and children that might be stressful.

If I'm a student and I know I'm taking a lot of classes, I have to go to work and do overtime. As a married woman, I might also have a kid and need to take care of the house. So, my mind will be going around and around and on different things, it takes a healthy mind to control all that. (Gift, 24)

Pre-migration Trauma

The hardship that some refugees faced in the U.S could be both traumatic presently and resurface past traumatic experiences. Many refugees came to the U.S. with hopes of a better life but instead were faced with the challenges of finding a job, discrimination, and difficulties mastering the English language. These difficulties led to added hardship with thriving in their new environment and maintaining wellbeing. Also, some refugees experience hardships that make it difficult to heal from previous traumatic experiences and sometimes brings back the memories of previous war memories.

One participant explained:

I know that 99 to 100% of refugees have gone through a lot of traumatic events to make it here. Before they get here, they'd be like, well, when I get to the U.S., I will be good and the negative trauma thoughts will be over. They start being that happy on their way here. But as they get here, they'll be like I better go back because if I'm in my home country, life will be easier. So that's affecting them even more than how they were back in the refugee

camps or back to their own country. The hardship here brings back the war memories of what they went through. So that it's really affecting people mental health negatively. (Ali, 22)

Most refugees associated hardship to war memories. Hence, on getting to the U.S., some refugees might experience some difficulties that might remind them of the war in their countries. This experience might lead to a re-traumatizing experience that could relieve past traumatic events and affect their mental health. Likewise, Jason explained that this re-traumatizing experience was an unending vicious cycle that some refugee youth experience in the U.S. He explained:

In the U.S., refugees go to work and can't understand their supervisors. They experience discrimination as black people and African immigrants who are illiterate or who don't speak English. It becomes sort of like a cycle where people who grew up in a refugee camp never thought about mental health. And with all the traumatic experiences they've experienced, they come here to experience discrimination over and over. People say I've been through war, I've lived in a refugee camp and survived, so this hardship can't affect me, but these traumas continue to add up to the traumatic experiences and begin to affect them. (Jason, 26)

Although some refugee youth might be unaware of the re-traumatization effect of discrimination, it could exacerbate mental health issues. Since present hardships experiences can trigger past traumatic experiences participants experience a wave of emotions in terms of their overall mental health. It might be difficult for some youth to

predict what current experiences exacerbate their mental health challenges and struggle with how best to improve their situation.

In contrast to other refugee participants, one study participant admitted to using another method, therapy and medication, to achieve mental health to improve his mental health. He explained that, over time, he became comfortable taking medications and seeing a therapist to manage his mental health issues. He described:

Mental health is something that I wasn't very comfortable doing but, as time goes by, because it's becoming much more comfortable for me. So, I don't know if the medication counts, but I do take them. I was prescribed to take some medication for that. It turns out that I need medication for that too. So, I got to a place where I do that and see a therapist. I have a therapist and I also have a mentor that I speak with, uh, at least once a month. So just go over things and, and, you know, just talk about anything that I feel comfortable saying. (Steve, 25)

Although the path toward mental health varied among participants, most refugee youth described mental health as the health of the mind, a life without stress and depression, and expressed that good mental health is enhanced by balancing responsibilities, and, for one participant, medication, and therapy. In addition to the description and strategies for achieving mental wellbeing, refugee youth elucidated the effect of racism on mental health.

The Effect of Racism on Mental Health

Participants described the negative effects of racism on the mental health of young people. Refugees felt that racism affects a person's mental health when people perceive them differently based on their skin color. This experience of racism can engender feelings of insecurities and demoralization in refugee youth. A youth explained:

When people look at you differently because of your skin color and stuff that has to affect you in a lot of ways. Being seen less than other people in this country is hard. Like a lot of Black Americans don't go to school because they know at the end of the day, a White person would not give them the job. So, I know as a Black person, I'm the least preferred in the whole world and I know black people face these issues all over the world. (Blake, 24)

Blake explained that racism occurs globally and being seen less than other people is hard. Also, he explained that racism affects mental health as one might view things that are not racist to be racist.

I think racism begins to affect you mentally and stuff in different ways and sometimes, something will not be racist, but you call it racist cos we are already programmed that way. (Blake, 24)

Racism might lead to anxiety around seeing everything as racist. Youth in this study explained that they found themselves internalizing the experience of racism which affected their wellbeing.

Furthermore, some participants also described negative experiences with the police that affected their mental health and sense of wellbeing. A participant recalled an experience with the police that affected his wellbeing:

I have experienced racism many times, yes, so many times, but one that has stuck with me even to this day is because it's stuck with me because I almost lost my life and I never talked about it because there was Trayvon Martin protest going on in 2012. I was coming out of a parking lot and four police cars pulled up to me. I had a black hoodie, and they came out and pulled out the guns on me. I was 18 at that time. They kept looking at my face and around me and was like this is a wrong person. Fortunately, they did put the guns away and they asked me to leave. Later on, I found out they were looking for a young man that broke into somebody's car. Now even when I go to that parking lot, even today, I can see where everybody was standing, like even myself in the middle. Like it never went away. I can still see the picture. It's just crazy. (Steve, 25)

This participant explained his experience with racism as a Black male in the U.S. Steve was mistaken for an offender and this experience cost his life. Although this encounter with the police was 7 years ago, the effect still persists. Racism can have long term effects on the wellbeing of an individual. In addition to the effect of racism on mental health, refugee youth also described the role stress plays with mental health and different coping mechanism for managing stress.

Managing the Effect of Stress on Mental Health

Stress is an essential factor of mental health, and many participants understood its negative effects on wellbeing. For example, Roland explained,

Mental wellbeing is a life without stress. I mean, um, it's very hard to live without stress, but the issue is to try to eliminate all the stress in your head and live freely. (Roland, 24)

Following Roland's assertion, stress is inevitable, the challenge was to manage the stressors and prevent it from affecting one's mind. This led to the discussion on approaches for managing stress. Participants revealed intrinsic strategies used to managing stress. Individual traits like positivity and self-motivation were helpful strategies for promoting mental wellbeing for some participants. Joana explained, "staying positive always helps. It's like most of the times I try not to stress too much or overthink." Regardless of their attempts to maintain a positive mindset, some participants reported that stress-induced mental health problems resulted from a lack of parental guidance, challenges in school, and substance abuse. One participant emphasized:

Stress is most likely the main cause of mental health issues, you don't feel love from parents because your parents don't have control over you, you kind of control yourself, stress about school, and doing drugs and stuffs like that. (Baha, 24)

It was explained that stress might occur when youth do not receive support from parents. The lack of support could induce stress and exposure to vices such as substance use.

In this study, the presence of negative stress resulted from managing family responsibilities, struggling with English language proficiencies, and striving to understand the American system. The young age of the participants in this study made managing their stress more complex. Coupled with their individual stressors, refugee youth assumed different roles within the family unit because they were the ones most often asked to speak English and represent family members in public and educational forums. Participants' role in the family unit proved to be complex and multilayered. Many family responsibilities ended up falling on some youth expressed that it felt like they were the head of their household.

I'm number six of 12 children. So, I have to do a lot for my family. I start thinking like, why am I doing this if I'm the sixth born? I have older siblings who are in this city that could be doing all these things. And everybody's just so dependent on me, so that gives me stress. A lot of refugees and immigrants will tell you that they ended up being the head of the household in the family because, you know, they speak English and know which avenues to go for certain things. (Jason, 26)

Learning to balance family responsibilities was essential if participants were to achieve healthy mental wellbeing. As Pearly explained, "mental health is being able to cope with what's going on around you without losing it". Although some participants received support from family, life could still be stressful when responsibilities were not well managed, and elder family members relied on young refugees.

My family was supportive, which is good but, I just found myself more stressed because I was surrounded by babies. So, like taking care of them plus going to school. I feel like this added more stress to my life. (Sarah, 24)

Sarah explained that it is difficult to manage the stress of taking care of children and going to school. Although her parents were supportive, she was still felt stressed. On the other hand, some participants balanced their family responsibilities by employing seeking help. One participant explained that he was able to balance his significant responsibilities by seeking help. Roland explained:

In life, I never get very stressed, but I have seen many people get stressed because of school, job, and life. For example, most of the time when I have a lot of tasks to do, I call somebody to help. We need people and advisors. You can never always do all this stuff by yourself. You still need somebody to give you some advice. (Roland, 24)

Based on Roland's assertion, stress is inevitable so asking for help and seeking advice might help with balancing the different responsibilities of a young person. In addition, youth identified components of holistic wellbeing such as physical, mental, and spiritual health. Most participants also described the effect of stress and racism on the mental health of refugee youth.

Mental Health, Trauma, and Wellbeing

This study also focused on refugee youths' understanding of community influences on the mental wellbeing of young people. For participants in this study, conversations around mental health often included a discussion of culture and its significant influence on

mental health. Youth explained that there were inadequate conversations on mental health within their communities. One explanation of this could be that most community members did not relate to the concept of mental illness. “I don't think we talk about it a lot because we don't have that. We don't have people who have that kind of issue. So yeah. We don't talk about it or are aware of it”. (Richard, 24)

The lack of awareness about mental illnesses within their communities led to a lack of conversation to handle such issues when problems arose. Although there was a limited understanding of mental wellbeing among immigrant community members, some youth related traumatic memories of the wars. Refugee youth most likely experienced traumatic events that may have included wars, famine, witnessing killings, and intergenerational traumas reported to them by family members. Even years after settlement in the U.S., the memories of wars and past traumatic experiences left indelible adverse effects on refugee youth's mental health. Jason explained:

I do not like being in the dark here. Like I can't turn off the light in the house without thinking somebody might be in the house, you know, well, now I can, but you know, in my earlier years in the U.S., I couldn't do that. (Jason, 25)

Although there is no ongoing conversation on mental health, refugees have mental health challenges that originate from past traumatic experiences and influence their wellbeing.

Refugee youth experienced intergenerational traumas due to the war stories told by their parents and older relatives which include negative experiences in refugee camps. Participants shared intergenerational traumas that began when they were children.

There are different experiences that, you know, my parents experienced during the war, during the migration process, and the refugee camp, it trickles down to the children, and they end up internalizing the same things that their parents experienced, and the next generation, the generation after that. (Jason, 26)

For another participant, losing her parents due to the war was a traumatic experience. She never received counseling or resources to handle this trauma and found healing by encouraging herself.

I grew up thinking I had my own parents, but when I was eight years. I was told I didn't have my parents because they died in the war. So, I was living with my auntie. When I was told, I started thinking that I need to start taking care of myself and be more responsible. (Sarah, 26)

As Sarah explained, she did not have the time to process that she had become an orphan due to the war. Her more immediate needs included taking responsibility for herself and finding ways to meet her daily needs. Young people had to prioritize their needs to survive through their various responsibilities.

In addition to existing trauma related to their refugee status, the Covid-19 pandemic appeared in the U.S. and added to the past trauma and existing mental health stressors of refugee youth.

I don't think I've found time for that (mental health) since I started going to the University of Louisville. I started during the COVID-19. So, it's like moving to online classes, and I didn't like it. I feel like I just had so many things thrown at me, and I was not ready

for it. So, I don't find any time to seek help because I've been depressed. I won't lie. I've been very stressed, very depressed, to a point where like I just want to throw my life away. Like, I closed my social media and spent less time with my friends to focus on school. (Sarah, 24)

The Covid-19 pandemic resulted in a reduction of in-person meetings and social gatherings. Sarah, a college student, acknowledged that this change was stressful and proved a barrier to her wellbeing. During the pandemic, some youth tried various strategies to promote mental wellbeing.

I tried to stay busy with school homework, watching something like watching TV or reading books. So, that helped me to go through the lockdowns and stuff. In my community, we go to church, and that also helped. We used to have something like youth meetings and stuff. We do it when young people gather and then talk about Africa, what they can do for Africa. (Baha, 24)

As Baha described, some youth employed different challenges to promote their wellbeing. Besides spending time at home, some people met in smaller group to communicate and create community in the midst of the social isolation engendered by Covid-19.

Social Wellbeing

Social wellbeing was used to delineate wellbeing from personal/individual and familial wellbeing within the public setting. Participants described social wellbeing as receiving support from friends, family, and organizations. For some participants, social support came less from the educational institutions but rather from individual teachers.

I had this teacher in my senior year who taught me time management. He is from Cuba. I didn't have any idea how to do good time management. So I went to him and said I want to be successful as you. He asked me to stay after school and gave me a lot of advice to be good with time management. (Roland, 21)

For several participants, spending time with friends and family was the means to staying well. Gift explained, "I try to be around people that I love or being on the phone or talk to somebody. I would go to my parent's house, and we share stories." Expanding their social circle, including building relationships with friends from school or work and engaging in extracurricular activities, helped build a social wellbeing network. Talking to friends and participating in games helped youth maintain social wellbeing.

Whenever I'm not feeling good in my mind, I just play a game outside and play soccer with friends because we have a team. Like we can play soccer anytime we want to play. So, we can just talk, and by that, I get good mental health. (Isco, 18)

In addition to providing a social and physical outlet, support through friendships provided the opportunity for participants to develop solutions to address the barriers to wellbeing.

I had one friend who is alone here cos all his family is back in Africa. He was very stressed about finding another job. And he asked for my help. I was like, I'm not very familiar with finding people jobs, but I have my brother. He works at Kentucky refugee ministries for job finder. I can connect you with him, and you can find a job. So, I called XXX. The same day, XXX cleared him, and they filled out the application. Then next I remember, uh, he started the job. So that was very quick. (Roland, 20)

Social relationships developed slowly for some participants, where friendships grew through shared experiences and a shared understanding of the challenges of being a refugee youth in Louisville. These relationships often formed webs of support that included education, job opportunities, and access to entertainment.

Culture and Wellbeing

Culture also influences the health and lifestyle of young people. Although refugee youth and their families left their home countries, they still carry their culture and tradition while living in the U.S. These ingrained beliefs and customs characterized their views on wellbeing and impacted life in the home and public. One participant explained, "I would say even though we live in America, we eat our natural home food. We believe in eating our homemade African food, which makes you feel better" (Joana, 18). As discussed previously, the meaning of wellbeing was significantly influenced by cultural beliefs. For example, one participant explained that he did not learn different ways to stay healthy other than finding a cure to an illness or having a stable home to live in. He explained:

We don't have a lot of hospitals where I come from. I come from the village, so we don't have enough information to seek help, but we know that you don't have any problems when you have a house, you have good health. So that's been considered as good health. (Richard, 24)

Particular cultural views were barriers to the wellbeing of young refugees, especially young females. These participants often complained that they were unable to engage in outdoor activities like men.

Most women are more likely to be plus size because they are supposed to be home and take care of their children and husbands. When are you going to go to the gym? When you have a husband? So, I asked my dad why husbands do not allow their women to go to the gym to exercise and school? They believe that women shouldn't be out there when they have a husband. She has to be home to cook and care for the children. (Sarah, 24)

Another cultural dimension of wellbeing is that most participants did not need a doctor if they were not ill. Preventative care was a unique concept. From a cultural viewpoint, wellbeing means not seeking care. Ill people seek care.

Gift explained:

I haven't felt sick. So, I'm like, then I don't need it. The people who feel sick are the ones who need it go to the doctor. But if I'm not feeling sick, then there is no problem. (Gift, 24)

Most youth explained that they only went to the hospital/clinic when they were very ill and did not seek medical care for a yearly screening or a routine physical examination. This belief was reinforced among participants as they confided that they do not go to the hospital except when one was seriously ill.

Also, participants further explained that culture played a role in maintaining the wellbeing of young refugee women. In some cultures, women were not allowed to socialize, earn a higher education or seek employment. Some participants explained that despite immigrating to the U.S., their communities still followed this tradition. A female participant explained:

Some women do not work or go out. My sister-in-law doesn't work. Her husband told her not to work; she had to stay home and care for the kids because he did not want them to go to the daycare. Africans believe that daycares do not know how to take care of children. So a lot of people I know are still following the culture. I've seen changes a lot where some have adapted to the American culture. However, there is a majority still doing that. (Sarah, 24)

Some women found it more challenging to manage their wellbeing because of the cultural expectations of their roles. As Sarah explained, many married women must receive approval from their husbands to achieve specific personal goals. It is also believed that American daycares do not provide effective childcare, and women are asked to care for their children at home. Although some people adapted the American culture of gender equity, it does not apply to most refugee communities.

Additionally, another cultural influence on youth wellbeing was the appreciation for ethnic meals. Although refugee youth and their families left their home countries to immigrate to the U.S., they still carried their culture and tradition. This tradition characterizes their views on wellbeing and determines the level of participation within the new culture. One participant explained, "I would say even though we live in America, we eat our natural home food. We believe in eating our homemade African food, which makes you feel better" (Joana, 18)

Although participants had increased opportunities to enhance individual and social wellbeing, the beliefs of their culture restricted youth from seeking health care. Whether based on the development of relationships, engagement outside of one's home, or choices

in nutrition and medical care, culture proved to be a facilitator, and a barrier, in establishing wellbeing among refugee youth from the African Great Lakes region.

School and wellbeing

As described previously, participants in this study used various definitions to understand wellbeing. They interpreted both from their country of origin, their time in refugee camps, and once immigrating to the U.S. Although wellbeing is an overarching term that includes various factors, refugee youth described wellbeing as occurring primarily in school and the workplace.

Educational experiences differed depending on whether the student's attended college, high school, or other educational settings. However, all participants agreed on a definition of the meaning of wellbeing within the school setting. Jason explained,

I would say people have understandings of wellbeing from school. In middle school or high school here in the U.S., like you take health classes and wellness is a part of that. (Jason, 26)

Based on Jason's explanation, many youth learned about wellbeing from health classes in schools. In contrast, some participants expressed how bullying within the school system affected their wellbeing negatively.

Most people be getting bullied at school for their English accents. The people who bully others are the ones that think they're gangsters, the people that think they know everything. If you are being soft, they'll keep bullying you. But if they bully me, I just go off on them. (Isco, 18)

Isco explained that youth were bullied in school because of their accents. Isco advocated for himself but, another participant, Steve, explained that he could not advocate for himself due to limited English language proficiency.

Bullying is very real. I was one of those kids locked into a locker cos I was so small enough to fit in a locker. So, people took advantage of that. There wasn't really a lot of advocacy at that time where people could believe you if you reported. Plus, I didn't really know the English language to fully explain myself. Even today, I still struggle with expressing myself. (Steve, 25)

Workplace and Wellbeing

As young students enrolled in elementary school, participants engaged more fully in the school's offerings. However, as they entered middle school and high school, many found jobs. For most participants, their work experiences were not favorable to their sense of wellbeing. Most participants worked in a factory or warehouse requiring long work hours with no employment benefits creating an unfavorable environment for wellbeing. Sarah emphasized some difficulties of working at a warehouse.

I work at [warehouse1], so like [warehouse 1] and [company 1] they're all about work. They have programs that tell you about mental health. All you have is your 15 and 30-minute lunch break, and they expect you to do those stuff during your breaks. I mean, I only have 15 minutes. When am I going to like, relax? So, what time are you going to get to attend those health classes? (Sarah, 24)

For refugee youth who worked in factories, it was challenging to find a balance between working because the time schedules were not flexible to allow for healthy lifestyle.

In addition to challenging work schedules and limited breaks, issues of communication, discrimination, and racism impacted their feelings of wellbeing. Some youth refugees experienced difficult situations at work, such as lack of communication due to language barriers, discrimination, and racism among supervisors and other workers.

Many people go to work but can't understand their supervisors and coworkers. They experience discrimination as black people, discrimination as African immigrants who are illiterate or who don't speak English. (Jason, 26)

Some participants complained that resettlement organizations did not provide adequate mental health and resettlement services for newly arriving refugees. A youth explained:

Resettlement organizations should be prepared on how to welcome refugees and not only teach them English. Of course, we do have organizations like [Resettlement Agency]. They provide different services, but they are not for us to have wellbeing or be mentally stable. They teach us English, which is good. They teach us about the culture, but they don't know what refugees go through before moving here. We have to approach refugees differently so that they're not that stressed. (Ali, 22)

The issues refugees brought from the refugee camps, such as trauma, untreated mental illness, health issues, and contradictory cultural beliefs, were not addressed before participants entered the educational setting or workforce. For this reason, the wellbeing of youth immigrant refugees was and continues to be challenging for them to maintain.

Policy and Wellbeing

In addition to individual, family, social and organizational factors impacting refugee youth's wellbeing, policies play an essential role in wellbeing. For example, there may be policies that apply to refugees, but these policies are not disseminated to refugee youth with a level of cultural competency that adds to understanding. One participant explained, "the policies could be there, but there's just not a priority to inform people of the policies" (Jason, 26). Participants explained various refugee policies, but education about these policies was not available to members of their communities. The influence of policy on youth wellbeing was characterized as insurance coverage and healthcare affordability. Some participants explained that the lack of insurance and affordability of health care prevented them from visiting the doctor. One participant explained:

If you don't have money, you cannot go to the doctor. But if I have insurance, when I have a little pain in my body, I would just go straight to the hospital because I know my insurance is covering me, but if I know I don't have any insurance and my money is not enough, I would just avoid it. (Gift, 24)

It was believed that the lack of insurance caused youth to stay away from a clinic despite illness. Some participants also perceived that Medicaid was not affordable.

I haven't been going to the hospitals. I heard some people had Medicaid issues or [insurance company] issues with medical insurance companies. So whatever amount of money, they gotta cut out of it for insurance and spend their own money. Plus, they already do not have enough finances to support their kids. (Richard, 24)

Even if refugee youth understood the policies regarding healthcare, their basic needs take precedence over healthcare. For instance, when some refugee youth prioritize their needs, they determine that the cost of insurance is not a top priority. Understanding policy issues and applying for services associated with policies is a low priority for refugee youth. Although policies related to healthcare have the potential for the most significant impact, most participants had neither the time nor ability to focus on policies to improve wellbeing. Participants further illustrated the effect of racism on wellbeing.

Racism and Wellbeing

Interviews with participants suggested that racism influenced the wellbeing of refugee youth by the existence of barriers around mental health, access to safe and affordable neighborhoods, and employment opportunities. Youth who have lived in the U.S for over seven years found it easier to articulate the meaning and effects of institutionalized racism.

In this study, some youth interpreted racism as the structure of the built environment in low-income neighborhoods. These neighborhoods represent the landing place for most participants involved in the study. One youth explained his understanding of how racism is associated with the built environment by saying that refugees are positioned in impoverished neighborhoods that make it difficult to flourish. In the long run, refugees remain in a cycle of poverty and may never attain or maintain wellbeing.

Refugees are placed in poor neighborhoods that are struggling to develop because that's the only neighborhood refugee resettlement organizations can afford. I'm saying this cos that's the argument that's given. Um, so right there and then you are keeping people in the same cycle. They will never thrive or develop as people. So

that is the first problem that the majority of refugees and immigrants face when they come to this country. (Jason, 26)

Respondents in the study clearly understood the inequities in their environment and the limited access to resources that influence the wellbeing of refugee youth. In terms of access to resources, participants voiced concern that their neighborhoods did not include healthy food options within proximity to their homes. For example, compared to more affluent areas, the neighborhoods where refugees are placed are food deserts with inadequate healthy food options, including grocery stores. Refugee youth talked about the connection between their low-quality living environment and the negative impact on their mental health.

In some neighborhoods, it's so easy to access food and the food is fresh there. Um, we live in bad neighborhoods, and nobody cares about us. The community I live in has mostly black people. So, everywhere you go there's a fast-food restaurant and a liquor store next to it, but if you get into a white neighborhood, it will be really hard to find a fast-food restaurant. In my area, we only have two grocery stores but, if you go into a white neighborhood, you will find a grocery store everywhere. Compared to the grocery store we have here in my neighborhood, it is the complete opposite. It's the same store but they are so different. Somebody doesn't have to tell you racist words, it's in our system. (Joana, 18)

A refugee youth might not experience overt racism but, they could observe the disparities. Not only was racism present in the built environment of neighborhoods, it also had a lasting effect on the social skills of a youth. Some refugee youth explained that they were

conscious of being the only Black person in a room filled with White people and experienced difficulties with communicating and being comfortable in these settings. Steve discussed the burden of the consciousness of being Black and the long-lasting effects of racism on the wellbeing of a young person when in a group setting.

Racism affects my wellbeing. It does because I'm conscious of it every single time when I'm in the meetings especially now that I'm finding myself in much more meetings with White people than I'm normally used to. Yeah. I'm conscious of it. So, I have to really organize my words to be understood. Uh, I wish it wasn't that way. I want to be able to communicate the way I feel comfortable. There's a heavy burden of feeling it, even when you're speaking to people that you respect and love. When you have a different skin color, you stay conscious. (Steve, 25)

As Steve explained, youth could experience difficulties due to fear of racism or consciousness of being the only Black person in a room. These difficulties occur while youth decide how best to communicate with group members of a different race.

Moreover, participants expressed frustration with the local and national government for not making structural changes to promote wellbeing for Black people. For instance, one participant whose interview took place during the protests following Breanna Taylor's death in Louisville and the shooting of Asians at a store in Georgia, expressed her pain resulting from the lack of changes made to reduce injustice in the U.S. She expressed her frustration with the government for not deciding on the case and the incessant killings of people of color in the U.S.

There's a lot of mental health issues in this country. Um, the government doesn't care about people. Like they know it's not fair, they've protested the death of Breonna Taylor and done everything they can, but again, the government is not doing anything. It's so just frustrating, spreading, and it kills all the love we have for this country. (Joana, 18)

Youth felt that the failure of the government to take decisions on these cases meant that the government did not have any regard for its citizens. This frustration also led Joana to lose her love for the United States. She explained that as she observes certain injustice, she starts losing interest in living in the U.S.

I used to love this country, but I've seen so much that I won't spend my future here anymore, I don't want to grow up here, I don't want my siblings to grow up here and I don't want to start a business in this country, or I don't want my kids to grow in such an environment. (Joana, 18)

While some youth believed that racism affected the wellbeing of young Black refugees, one youth disagreed that racism hindered Black people from finding gainful employment. He explained,

I can say that I haven't heard about anybody in my community experiencing racism, but we have this idea. They say if you're going to school, it's going to be hard for you to get a job here because of racism. But a lot of people are trying to tell you that whatever you doing, you gotta finish school and you gotta go back to the warehouses because that's where we belong because no white people will give you a job. But it's a myth I can say, nobody

has ever gone to have to find a career job and to come back say, Oh man! They did not give me because they said I'm black or because I'm this. So, we haven't had that issue, but it's in the mind of people. (Richard, 24)

After living in the U.S for five years he did not know anyone who had experienced the effects of racism; this led him to believe that the concept of racism might be a myth.

Difference In Perceptions of Racism Between Older Adults and Youth

On a community level, the existence of racism was better understood by the youth and less likely believed by their parents and older refugees. Youth described that older people believed that police brutality occurred as a result of people talking bad to the cops.

Like in my African community, what I hear of systemic racism is police brutality. Older people actually believe that if people don't like to talk back to the cops, nothing will happen to them. You know how like when the cops pull you over, you start giving an attitude and you start talking back. They're like, if they just talk nicely to the cop, um, the cop won't do anything to them. But I don't think that is true. I think if the cop intended to kill, he'll just kill you. It's not because you are having a bad attitude or whatnot. (Sarah, 24)

Furthermore, many youth were unfamiliar with the complete history of their countries, yet they understood from elders that they were a people ruled by Europeans. They also explained the influence of colonization on the refugee youth's wellbeing.

Colonization and Wellbeing

Colonization is another context that influences the health of refugee youth. Few participants discussed the lasting effect of colonialism on youth wellbeing. Since the era of colonialism as we know it has ended, the understanding was based on stories, movies, and history books. This understanding revealed the lack of understanding on the longer-term effect of colonialization on the economy, lifestyle, and perpetuation of racism for Africans.

Although the youth refugees interviewed for this study lacked direct experiences with colonialism, their development was impacted by the behaviors of their elders, and stories heard throughout their childhoods. One participant, Jason, who learned about colonization from history books spoke openly about the influence of colonialization on his understanding of wellbeing in terms of European colonies within Africa. He explained that colonialism was embedded in racism to Africans and its effect still lingers.

I think that another thing sort of helping a lot of young people now understand racism today is reading. There's a documentary that showed how the people of DRC were subjected during colonialism. Like if they did something they would cut off their limbs, hands, and feet. The experience in DRC is much terrible and gained a lot more attraction because of how horrific the things that were done there. Colonialism itself was racist. I think if we want to talk about racism, we need to start from the foundation of it. The idea that European countries who have pigmentations that are lighter in complexion can sit at a table and cut down an entire territory of people and divide amongst each other, imagine that! (*Jason, 26*)

It is plausible that colonialism played a role in the mental health, and therefore the indirect experiences of refugee youth. Another participant explained that due to the long-term effects of post-colonialism, certain ideologies have been passed down from the older generation, history, and movies to the youth. Some of these ideologies meant that Black people respect White cultures at the expense of their culture and wellbeing.

Things have been passed down, honestly, even if you watch the movies White people are always treated with much higher respect than the Black people, and also colonialism, I lived in [an East African Country], and it was colonized by the British. And before the sixties, the whole country was ruled by the minority who were White people. They were ruling the country even though they were the minority. That doesn't go away in people's minds cos we weren't treated very well, we still see White people as people who are higher than us. Um, so growing up in a camp, that was very prominent. Especially when we see a car, even a car that doesn't have a White person, you know, we thought it was a White person because you know, it's probably a MUZUNGU (White person) car, you know? You know, we see that even today, even in our own lives (in the U.S). When we as young Black people find ourselves in a room of mostly White people, we tend to even change the tone of the way and how we talk. So, it goes with that unconsciously, we just do it. (Steve, 25)

Finally, Steve described how some negative experiences of Black people might be rooted in post-colonialism ideologies. While living in the refugee camp, he associated nice things with White people. As a young adult, he still sees himself unconsciously acting differently in meetings with mostly White people. He explained that some Black people are

conditioned to hold White people in higher esteem than Africans. As Steve explained, when in a company of White people, refugees are conditioned to change the tone of their voice to fit in with the crowd. These feelings of being inferior can affect the mental and social health of a youth negatively.

CHAPTER V

DISCUSSION

The purpose of this study was to explore the African Great Lakes Region refugee youth's experience with wellbeing, how they interpret their experience, and the meanings they ascribed to wellbeing. This chapter includes a discussion of major findings related to the literature on wellbeing and refugee wellbeing. This chapter will discuss the study's results to the research questions and conclude with a discussion of the study limitations, implications for practice, policy, and future research.

Research Question 1

How do refugee youth from the African Great Lakes Region understand and make meaning of wellbeing?

Participants in this qualitative study were youth refugees from the African Great Lakes Region now living in Louisville, KY. Refugee youth shared a wide variety of examples detailing their understanding of wellbeing. This study revealed that participants in this study understood wellbeing based on their individual, social, organizational, and institutional experiences, and perceptions.

Although participants agreed that wellbeing included the absence of illnesses, there was more to wellbeing than living without illnesses (World Health Organization, 1967, LaFountaine, Neisen, & Larsen, 2007; Roscoe, 2009).

Some participants explained that the absence of illness was a sign of wellbeing, but a more lasting way to maintain good health was to control aspects of their lives. For example, many participants did not feel healthy in the refugee camp because the control of their daily lives and future were in the hands of the camp security, government, and the United Nations High Commissioner for Refugees. Additionally, this study agreed with Travis & Ryan (1998) and Dodge et al. (2012) who emphasized that wellbeing extends beyond the absence of illness but requires finding a balance despite various life events or challenges. For participants in this study, the major life event was leaving a war or refugee camp and resettling in the U.S. For refugee youth, wellbeing involved achieving balance between work, life, and community responsibilities. Participants in this study were emerging adults (Arnett & Tanner, 2006) who came to the U.S. and found themselves with certain responsibilities, such as working full-time, earning a post-secondary education, serving their communities, and taking care of their families. Many participants viewed wellbeing as achieving balance within their different roles and responsibilities, and felt healthier when they engaged in exercise, social activities, maintained employment, and excelled academically.

Refugees defined wellbeing in terms of absence: the absence of sickness, of wars, of continuous movement. The components of wellbeing including basic survival: of being alive and having an abundance of resources. After spending time in the U.S., youth expanded their definitions to include the components of having dreams and living beyond “eating and being alive.” These findings aligned with research that illustrated that social determinants of health were essential facilitators for improving wellbeing (Krieger, 2001; Ahnquist et al., 2012).

As is indicative throughout the research findings, participants defined wellbeing using terms and experiences unique to their past and present living environments. Exiting the camps brought freedom for them to explore different ways to achieve wellbeing. Participants could now pursue an education, find quality healthcare services, and seek employment to improve their socioeconomic status. These elements of choice advanced their definition of wellbeing. However, for some refugee youth, this freedom was short-lived. The meaning of wellbeing that participants expected, both from the Western definitions learned in refugee camps, and early expectations of resettlement, proved hollow given that maintaining wellbeing was more difficult than expected.

An emergent theme revealed that participants understood wellbeing to mean freedom. In this context, wellbeing meant freedom to be themselves, freedom to be happy, the liberation of a free mind and freedom to achieve long and short-term goals. Although participants attested that there was no word for wellbeing in their local language, the word Uhuru, the Swahili word for freedom, was the closest. In literal terms, Uhuru has a more complex meaning than the U.S. English dictionary meaning of wellbeing. For example, Joana explained that Uhuru meant being free with yourself and who you are becoming. This supports Sen's (2021) explanation that wellbeing-freedom is an individual's capability to freely choose different directions by which to achieve wellbeing.

Research Question 1a: What are the components of wellbeing for refugee youth from the African Great Lakes Region?

Overall, this study revealed three major components of wellbeing: physical, social, and mental health. Study participants described the different elements of wellbeing, which often combined components. For example, Sarah explained that wellbeing was maintaining good physical and mental health. Another participant, Joana, described other components of wellbeing as doing things that makes one feel happy mentally and physically. This is consistent with Myers & Sweeney (2004) who described wellbeing as a process that is positioned within physical, social, mental, and cultural contexts. Most participants in this study affirmed that wellbeing was an individual and community experience. Participants explained that they felt healthier when community members were healthy. This meant that they did not only care about self, but the community (family, friends, and neighbors) becomes the priority. Refugee youth assumed different roles within the family unit because they were the ones who most often spoke English and were asked to represent family members in public and educational forums. Participants' roles in the family unit proved to be complex and multilayered. Many family responsibilities fell on the youth who expressed that it felt like they were the head of their household. Participants emphasized that true wellbeing occurred when every community member was healthy. This finding agreed with the Zulu proverb, Ubuntu, "*I am because you are,*" where wellbeing is a collective process (Idoniboye-Obu, & Whetho 2008; Sambala, Cooper, & Manderson, 2020; Sulamoyo, 2010).

Also, it was difficult for youth to describe the meaning of mental health in a cultural context. They explained that there was no word for mental health in participants' local

languages. As a result, many participants did not understand the term mental health as part of wellbeing before coming to the U.S. Consequently, they were more likely to relate to “stress” as a synonym for mental illness. For example, some participants explained that having good mental health was living a life devoid of stress that gets into one’s head and festers. Although participants agreed that it was inevitable to avoid stress, the challenge was one of preventing stress from affecting one’s mind as a strategy to prevent mental illness. Despite the difficulties with defining mental health, the study result revealed that mental wellbeing was described as the health of the mind and how the individual dealt with toxic stress.

Daily stressors were factors such as unemployment, racism/discrimination, language barriers, and social exclusion. Also, daily stressors triggered mental health issues such as posttraumatic stress disorder. This study finding supported literature exploring the association between daily stressors and the wellbeing of refugees (Carlsson, Mortensen, & Kastrup, 2005 & Tempany, 2009). Some youth also believed that mental health was important but not a priority in their daily lives. The demands of finding a job, going to school, taking care of their families, and understanding the U.S. system positioned mental health care as a low priority. These findings agreed with studies that ascribed the burden of daily stressors as underlying reasons for the non-prioritization and the reluctance to address mental health issues (Heidi, A. B. Miller, H. Baldwin and S. Abdi, 2011; Monteiro, 2015; Salami, Salma & Hegadoren, 2019). The burden of daily stressors results in mental health issues, but refugee youth are not likely to admit to it. It is possible that this is because they do not have the language for mental health and do not seem to associate it with health of the mind.

Research Question 2

What are the socio-cultural factors that influence wellbeing for refugee youth from the African Great Lakes Region?

Social wellbeing was an integral part of refugee youth wellbeing, achieved in different forms such as social interactions between individuals and communities, resilience, social inclusion, and social exclusion. Study findings linked community-level resilience factors such as social support, community integration, and social inclusion to the wellbeing of refugee youth. Many participants felt healthier, or believed they would feel healthier, when community members looked out for each other and actively worked to improve the wellbeing of their community. These findings agreed with the concept of community resilience (Rounfelker, Tahir, Abdirahman, & Betancourt, 2020). Although this study's finding agreed with other studies that supported the need for resources to maintain community-level resilience (Ungar, 2011, Frounfelker, Tahir, Abdirahman, & Betancourt, 2020), it further adds to the research by Bronfenbrenner (1994) and Krieger (2001) in suggesting that communities need capacity building, institutional, and policy changes to develop efficacy for wellbeing.

In addition, this study's results revealed that resilience creates a healthier community, and it revealed that systemic barriers and poverty undermines the positive effect of resilience for refugee youth. Many refugee youth were resilient and had plans to invest in their community, but explained that resources were inadequate or unavailable in their primarily low-income neighborhoods. This inadequacy made success unattainable for most refugee youth lacked the motivation to invest in building the community, revealing the underlying effects of systemic barriers on youth wellbeing. This agrees with a

systematic review by Priest, Paradies, Trenerry, Truong, Karlsen, & Kelly (2013), that reported a strong positive relationship between systemic barriers and negative health outcomes.

In terms of social exclusion, this study revealed that social exclusion is a threat to the health of refugee youth. Social exclusion occurs when society is structured to prevent certain groups from fully participating and accessing resources necessary to maintain wellbeing (Pierson, 2002). Although participants were active members of their immediate local communities, they felt excluded from the American community and did not know much about the American system in terms of programs, policies, and culture. In this study, discrimination was a tangible form of social exclusion that affected the health and wellbeing of young immigrants and was especially harmful to youth as they are still developing identities and establishing their place within society. This agreed with Osezua et al.'s (2020) work that revealed that emerging adult refugees from the African Great Lakes Region described discrimination, dehumanization and loss of identity as forms of social exclusion occurring during the resettlement process. Not only did the experiences of exclusion and dehumanization create threats to participants' social wellbeing, but the resulting marginalization impacted mental wellbeing as well.

Violence. Although trauma from violence was experienced individually, it became a collective process when communities were traumatized and affected over the course of history (Audergon, 2004; Bowers & Yehuda, 2016; Hirschberger, 2018). In this study, participants' reflections supported previous findings that refugees shared a sense of collective trauma. Findings suggested that participants did not recall war experiences themselves but recalled stories told by their parents, community, and family members.

These war stories and the collective trauma experiences associated with these stories were passed down from generation to generation. African GLR refugee youth agreed that they internalized their parents' trauma and expressed fear that this trauma might be passed down to their own children.

Gender Norms. Gender, and the strict roles associated with gender, played an essential part in the understanding of whether wellbeing was equally accessible for females and males. For example, in some African cultures, women were not allowed to socialize, gain higher education, or seek employment. In some study participants' local communities, women were perceived as caretakers of the home, children, and husbands; they needed approval from their husbands to perform roles outside of the home. Some female refugee youth reacted to these norms with resistance by pursuing their dreams of getting a post-secondary education. Others felt discouraged to oppose the status quo and pursue personal goals. This finding agreed with studies on the relationship between gender norms and African Great Lakes Region girls' wellbeing (Isimbi, Mwali, Ngabo, & Coast; Toma, S., & Vause, S. 2010; Sommer, 2018). The literature suggested that gender norms exacerbated symptoms of mental illnesses and affected how individuals respond to these symptoms (Addis, 2008). Wellbeing for participants was tied both to previous experiences, collective experiences, and gender differences. Attempting to hold on to the aspects of culture that supported their goals toward wellbeing was difficult when trying to add components of the new culture.

Health Care. This study revealed that general health policies were not tailored to improve the health of their communities, although health policies were perceived as an integral part of health care affordability through health insurance. Also, most participants did not know

the different policies in the U.S. and how these policies applied to their lives. This finding agreed with White, Bruce, & Ritchie's (2000) and Weiss (2020) study findings that many youth had minimal knowledge of U.S policies. Also, African Great Lakes Region refugee youths who had been in the U.S for over seven years stated that they had adequate knowledge of the U.S policies but explained that educators and the local government did not place priorities on policy education and implementation. The discussion of policies was limited to access and payment for healthcare services.

Another key finding of this study regards affordability of health care services for African GLR refugee youth. Since healthcare affordability has been a major issue in the U.S. in general, it is not surprising that accessing and paying for health care was a significant challenge in the refugee community. Most participants in this study who were not dependent on their parents or above twenty-six years of age complained that health care was a luxury, not a priority, when compared to other needs. Since many refugees worked in factories and held low-income hourly wage roles that did not include benefits and to receive Medicaid coverage, they would have to reduce their work hours. Lower incomes clearly affect the refugees' ability to fulfill their key priorities and the lack of insurance coverage led participants to neglect their healthcare, which resulted in adverse health outcomes.

Research Question 3

What are the influences of racism and colonialism on the wellbeing of refugee youth from the African Great Lakes Region?

Participants explained that the influence of institutional racism was associated with discrimination. On the other hand, the influence of colonialism was seen as discrimination, myth of the American dream, and the collective trauma of refugee experiences once arriving in the U.S.

Discrimination. Many refugee youth were surprised to experience discrimination from U.S. born African Americans in schools, communities, and workplaces. This discrimination experience aligned with Freire (1996) who explained that the oppressed could become the oppressor. In *Pedagogy of the Oppressed*, oppressed people internalize the image of their oppressors as the model of humanity because their thoughts had been conditioned to be oppressors (Freire, 1996).

As new students in the U.S., they often tried to befriend African Americans, but were not accepted and experienced bullying from people who looked like them. For example, a participant complained that he wished to be friends with African Americans because they shared physical characteristics, but instead he was forced to make friends with other international students. This study finding disagrees with Shaw-Taylor's (2007) argument that Black immigrants do not identify as African Americans in order to avoid discrimination.

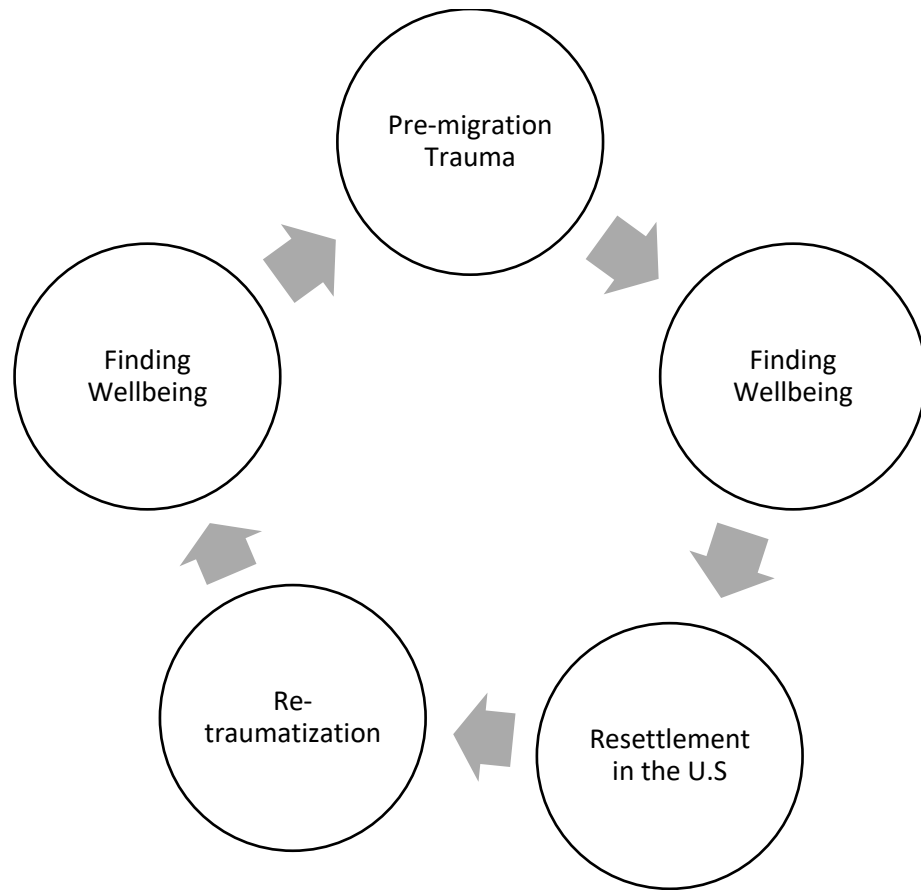


Figure 5: Life becomes a cycle influencing the dynamics of wellbeing attainment.

Unending Traumatic Experiences

Based on the result of this study, wellbeing was likened to an unending cycle of re-traumatization (Figure 5). This process was described as an *invivo* code, “*life becomes a cycle;*” participants explained that the traumatic experiences accrue over time. Refugee youth feared that they might never heal because the trauma accumulated over the years was compounded by more trauma experienced while living in the U.S. Discrimination and the associated trauma that results from it impacts youth refugees’ sense of wellbeing on all levels.

Black youth and Black refugee youth may be unable to attain or understand wellbeing until the power structures of white supremacy are demolished (Fanon, 1963). In her book *In the Wake: On Blackness and Being* (Duke University Press, 2016), Christina Sharpe created a metaphor linking institutionalized racism and weather. She explained, “*the weather is the total climate; and the climate is anti-black.*” Sharpe further explained a global anti-black climate that affects the wellbeing of Black Study participants expressed their frustration with the global anti-black climate as it seemed to them that Africans may never be truly free. For example, some participants explained that there was an unending trauma because some parts of Africa were not safe and living in the U.S. might also not be the safest country for a black person. This belief aligns with refugee youth literature; before arrival in the U.S., refugee youth may have experienced traumatic events such as wars, famine, killings, and loss of family and loved ones; once arriving in the U.S., they experience acculturative stress, discrimination, and racism (El-Bialy & Mulay, 2015; Foner, 2016; Priest et al., 2013; Richmond, 2001).

This study also affirmed Erikson’s (1994) study that revealed that collective trauma generates a “centrifugal force” that pushes a socially marginalized population away from their culture. In other words, Erikson recognized that collective trauma possibly changed community functioning and identity and forced change upon an entire culture. This finding also agreed with Gagné’s (1998) lens focused on postcolonial framework stating the effect of colonialism. This effect caused African countries to shift away from their fundamental beliefs and towards a value system established by colonizers and western knowledge. The western beliefs formed the new standard for many colonized countries and became the lens through which children were educated about their country. For

participants, wellbeing, whether defined as stress, illness, or access to freedom, cannot be viewed clearly without considering the impact of collective trauma. These shared experiences, whether individual or generational, became reinforced with overt and covert signs of racism.

Also, refugee youth explained that they were not well educated on the history of the wars and colonization of African countries. Moreover, the education system used the western standard, which did not explore African history and culture thoroughly. As a result, some African GLR youth grew up thinking White was the standard and preferred over their culture. This feeling of insecurities or less than a White person was considered a barrier to the wellbeing of a young person. The never-ending feelings of insecurities can be a mental health stressor that prevents youth refugees from thriving and living a health life. It appeared that refugees do not only see themselves as inferior to White people, but the society is also structured to reflect these views. During the resettlement process, refugees are placed in deprived neighborhoods that lack resources that promote wellbeing such as grocery stores and K-12 schools with good ratings. Therefore, it is plausible that living in an impoverished neighborhood could make it more difficult for a refugee youth to maintain wellbeing. In addition to the influence of colonialization on refugee wellbeing, the American Dream played a role in the health of a youth.

The Myth of the American Dream. This study provides evidence on the effect of meritocracy on the wellbeing of African Great Lakes Region refugee youth. Before arriving in the U.S., refugee youth believed that the U.S. was a land of opportunity. Success and attainment of the American Dream came through hard work. However, as participants spent more time in the U.S., they realized that the story of the American dream was

inaccurate. Refugee youth discovered that finding a well-paying job was challenging with limited English language proficiency. As a Black African living in the U.S., they found it was more difficult to find a job compared to White youth in their community. Additionally, police brutality was a threat to their peace, and some U.S. policies were unfavorable toward immigrants. Youth also shared that to achieve the American dream, one must sacrifice their happiness (characterized by spending time with family, playing sports, social gathering) to work and attend school full-time. These experiences exposed them to the flaws of the American Dream.

This study findings were similar to a study on meritocracy among Latino immigrants where first-generation Latino immigrants believed the effect of racism could be overcome through hard work, while second-generation were less likely to hold these meritocratic beliefs (Wiley, Deaux, & Hagelskamp, 2012). Likewise, in this study, youth who have spent longer time in the U.S. (5 years or more) were more likely to disagree with meritocratic beliefs. It is possible that as immigrant spend more time in the U.S, they get exposed to the myth of the American Dream and its effect of wellbeing.

Study Limitations

The main limitation of this study is language barriers with some participants. The researcher is not fluent in the native languages of the African Great Lakes Region. This limitation did not negatively impact the study because all participants spoke English fluently. It is plausible that some potential participants could not join the study due to study criteria that included English language proficiency.

Another limitation might be that the researcher is not a native of the African Great Lakes region. Qualitative research is best when the participants and researchers share a similar culture and language (Abma, Jonsson, & Deeg, 2010). The researcher likely missed some cultural interpretations during data collection and analysis. Member checking focus groups addressed this limitation by reviewing the conceptual framework and asking more questions to saturate categories of wellbeing.

Study Implications

The primary purpose of this study was to explore the African Great Lakes Region refugee youth experience with wellbeing, how they interpreted their experience, the meanings ascribed to wellbeing, and factors that influenced wellbeing. The following implication emerged from study findings.

Implications for Practice

Stories shared by participants indicated acculturative stress resulting from the immigration process, attempts to fit into their new environment, and healing from migration trauma. As students transitioned into their new life, their entry into the educational system proved to be a negative experience due to bullying and racism. This finding informs the education systems to promote anti-bullying environments in the school systems. These findings agreed with the recommendation by McBrien (2005) that school administrators, counselors, and teachers, and refugee resettlement administrators should be educated about the refugees' experiences and potential for bullying.

This study also provides implications for training and education regarding the pre-migration experience of refugee youth. Participants spent their formative years in the refugee camp or fleeing wars; these experiences played an essential role in youth

conceptualization of wellbeing. Community and educational programs can employ this understanding to tailor trauma-informed and culturally competent interventions for refugee youth. These interventions could be applied to English-as-a-Second-Language tutorials, refugee orientation events, employment services, and educational programs.

This study informs strategies for developing and implementing policies to provide more funding for culturally competent refugee programs. Many participants discussed that although there are numerous community youth programs, there is a need for partnership between community programs and immigrant communities. More non-profit youth organizations need to include refugee and immigrant youth in their programming and board membership. This inclusion could provide more insights to reaching refugee communities and the development of equitable youth programs. The study implications also shed light on the need to include Black refugees in conversations around social justice.

Many youth in this study lacked understanding of the social issues that influence Black youth living in the U.S. The secondary education curriculum could provide context for understanding historical events and present national social justice issues. For example, teachers can educate all students on U.S. history, current local and global social justice issues, and provide instances of how they can join the conversation.

Beyond securing employment and enrollment in English as a Second Language programs, refugee youth need to be seen as contributing members of society and empowered to thrive in American society. African refugees should be encouraged to participate in school councils in high schools and universities. Study participants complained that local refugee and immigrant programs were underfunded, which led to

organizations struggling to serve the large number of participants they received and unable to provide long-term services.

In addition, there is a need for increased access to mental health services for refugee youth. Although there is a stigma against discussing mental health in refugee communities, some participants explained that mental health services were not readily available even if desired. Increased funding for refugee health programs will provide opportunities for therapy and mental health assessment. Refugee youth will benefit from increased access to mental health services during the arrival process and resettlement process in the U.S.

Implications for Policy

This study sheds light on the opportunities to develop and implement policies around youth wellbeing. One implication of this study is that refugee youth policy implementation should be conducted at the local level. Most participants did not understand the implications of the healthcare policies and the benefits of their insurance coverage. This study provides practical recommendations for developing programs to educate and enlighten youth refugees on the use and benefits of health insurance. Also, this study showed that general health policies were not tailored to improve the health of refugee youth. Also, Health in All Policies (HiAP) can also be applied to refugee policies. HiAP can improve refugees' health by integrating health and equity across various levels of policymaking.

Also, refugee youth will benefit from involvement in policy issue discussions at their local, state and national levels. It is suggested that refugee youth become more involved in knowing their legislators and council members. More refugee youth should be invited to community listening sessions so policymakers can hear first-hand the challenges experienced by refugees.

Implications for Research

Future research should explore wellbeing of refugee youth from other ethnic groups and countries. It is also recommended that a similar study be conducted with adult refugees on the topic of holistic wellbeing. Although there is a significant amount of research on the mental health of refugees, there is minimal research on holistic wellbeing among refugee youth. Further evidence is needed regarding social, cultural, and physical wellbeing.

This study revealed that wellbeing is a subjective term based on one's life experience. Refugee youth described the meaning of wellbeing as nutrition, ability to exercise, of freedom, the absence of sickness and wars, and safety. Clarification of terms and definitions could assist in data collection and limiting assumptions based on a western interpretation of the term wellbeing.

Also, it was evident from the interviews that African refugee youth revered the opinions of their parents and elder family members. Future research can include both youth and parents, or guardians, in exploring the meaning, barriers, and facilitators of wellbeing. Several young African GLR refugees expressed a desire that their parents and community members join in the conversation around racism, the Black Lives Matter movement, definitions of wellbeing and obstacles to achieving mental healthcare. To support future research, a study exploring knowledge of racism among parents of refugee youth is recommended.

Conclusion

African Great Lakes Region refugee youth have a unique experience in the U.S that might not equate to the general refugee experience. The unique culture of participants plays a role in their interpretation of the meaning of wellbeing. Besides culture and refugee resettlement, race also plays a role in African Great Lakes Region youth's health outcomes as residents of the U.S. Also, participants interpret wellbeing on a community level than an individual level. The findings also suggest that colonialism is a form of racism that shapes and hinders young refugees from maintaining wellbeing. Also, institutionalized racism influences refugee communities. These influences are evident in the education system, refugee health services, and refugee resettlement process. The study's main findings suggest that African Great Lakes Region youth view the combination of physical, mental, social, and cultural health to maintain wellbeing and are influenced by the overarching context of racism and colonialism.

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APPENDICES

Appendix A: Recruitment Flyer

PARTICIPANTS WANTED FOR A RESEARCH STUDY

Are you a **youth** from **Burundi, the Democratic Republic of the Congo, Rwanda, Tanzania, or Uganda**? We are conducting a research study to **understand how young people stay healthy**.

To be eligible for the study, you must be under **refugee status** and be aged between **18 and 30 years**.

Your participation in this study will involve the completion of a **brief survey and an interview**.

Study participation is between March 1 – May 1, 2021.

Participants will be compensated with a \$15 gift card.

This research is conducted by Victory Osezua, PhD Candidate and Dr. Muriel Harris with the School of Public Health, University of Louisville.



Appendix B: Recruitment Email

Hello,

My name is Victory Osezua. I am a doctoral candidate at the University of Louisville School of Public Health & Information Sciences conducting a study titled “understanding the meaning of Wellbeing in Refugee Youth from the African Great Lakes Region in Louisville, KY”.

The purpose of my study is to understand how young people from the Great Lakes region of Africa stay healthy. To participate you must be aged between 18 and 30 years, be a refugee from the Great Lakes region (Democratic Republic of Congo, Burundi, Rwanda, Tanzania, or Uganda), have been in the United States not more than 10 years, and live in Louisville or a city/county within Louisville. Due to COVID, the interview will take place over the internet and will require an electronic device.

By participating in the study, you will complete a basic demographic survey and an in-depth interview. Researchers from this study may follow-up with you after your interview to participate in a focus group discussion with others like you to confirm the results of the study. The approximate time required for study participation is March 1 – May 1, 2021. You will be compensated with a \$15 gift card.

Please follow the link for more information about the study and how to enroll: [insert Qualtrics survey link].

You can contact the principal investigator for the study, Dr. Muriel Harris by phone at 502-852-4061 or email at mjharr08@louisville.edu if you have any additional questions about the study.

Thank you.

Victory Osezua MPH

Ph.D. candidate, School of Public Health and Information Sciences

University of Louisville

Muriel J Harris, PhD, MPH

School of Public Health and Information Sciences

University of Louisville

Appendix C: Preamble Consent

Refugee Youth Wellbeing Study

2021

A study to Understand the meaning of Wellbeing in Refugee Youth from the African Great Lakes Region.

You are invited to participate in a research study that involves an online survey, interview, and a possible focus group, as part of research through the University of Louisville School of Public Health and Information Sciences. The purpose of this study is to explore the African Great Lakes region refugee youth experience with wellbeing, how they interpret their experience, and the meanings ascribed to wellbeing. This study is conducted by Dr. Muriel Harris and Victory Osezua of the University of Louisville School of Public Health and Information Sciences. The approximate time required for study participation is March 1 – May 1, 2021. You will be compensated with a \$15 gift card. There are no known risks for your participation in this study. The information collected may not benefit you directly but will be helpful to others because it will help us understand the experiences of African refugee youth with wellbeing which may lead to an improvement in policies and practices involving refugees. The survey will take approximately 15 minutes to complete, the interview will take 60 to 90 minutes, and will be audio-recorded for later analysis. The recordings will be stored on a secure server at the University of Louisville. The study interviews will be conducted through an online video platform.

Individuals from the School of Public Health, the Institutional Review Board (IRB), the Human Subjects Protection Program Office (HSPPO), and other regulatory agencies may inspect these records. In all other respects, however, the data will be held in confidence to the extent permitted by law. Should the data be published, your identity will not be disclosed.

Participation in this study is voluntary. By checking the boxes below, you will be agreeing to participate in this study. You do not have to answer any question part at any time. If you have any questions, concerns, or complaints about the research study, please contact the principal investigator, Dr. Muriel Harris by phone at 502-852-4061 or email at mjharr08@louisville.edu.

If you have any questions about your rights as a participant, you may call the Human Subjects Protection Program Office at (502) 852-5188. You can discuss any questions about your rights as a research participant in private, with a member of the Institutional Review Board (IRB). You may also call this number if you have other questions about the research, and you cannot reach the research staff, or want to talk to someone else. The IRB is an independent committee made up of people from the university community, staff of the institutions, as well as people from the community connected with these institutions. The IRB has reviewed this research study.

If you have concerns or complaints about the research or research staff and you do not wish to give your name, you may call 1-877-852-1167. This is a 24-hour hotline answered by people who do not work at the University of Louisville.

Sincerely,

Muriel J Harris, PhD, MPH

Associate Professor

Director, MPH Program

Department of Health Promotion and Behavioral Sciences

School of Public Health and Behavioral Sciences

University of Louisville

By checking all three boxes below and clicking the arrow to move to the next webpage you agree to participate in this study:

- I have no further questions regarding my being asked to complete a survey and interview about my experiences with wellbeing as a refugee youth from the African Great Lakes region.
- I have no further questions regarding my being asked to participate in a recorded online interview after completing the survey.
- I have no further questions regarding my participation in any and all parts of this study being voluntary, and I can decide not to participate at any time.

Appendix D: Socio-Demographic Survey

Thank you for agreeing to participate in this study titled “**understanding wellbeing in refugee youth from the African Great Lakes region in Louisville, Kentucky**”.

This study involves completing a demographic survey and an in-depth interview that will ask questions about your understanding of wellbeing.

1. What is your gender?

Female

Male

Prefer not to say

Self- describe _____

2. How old are you? _____

3. What is the highest grade or level of school you have completed or the highest degree you have received?

Less than 9th grade

9-11th grade (Includes 12th grade with no diploma)

High school graduate/GED or equivalent

Some college or Associate degree

College graduate or above

Don't Know

4. How long have you been in the U.S?

Less than 1 year

1 year or more, but less than 3 years

3 years or more, but less than 5 years

5 years or more, but less than 7 years

7 years or more, but less than 10 years

More than 10 years

Don't know

5. What is your employment status? (Please select one)

Full time

Part time

Unemployed

Unable to work

Student

Receiving/Awaiting approval for disability payments

Other (Please Specify) _____

6. Where were you born? _____

7. What countries have you lived in? _____

8. Where did you grow up and how long did you live there?

9. What is your household total income?

Under \$20,000

\$20,000 - \$29,999

\$30,000 to 49,999

\$50,000 or over

Don't know

Not applicable

Thank you again for completing this survey.

Appendix E: Interview Guide

Research Question 1: How do refugee youth from the African Great Lakes region understand and make meanings of wellbeing?

1. How do you explain health?
2. What does physical health mean to you?
3. What does mental health mean to you?
4. How do you explain good health?
5. Probe: Describe a day or a time when you feel like you had good health?
6. How do you explain poor health?
7. Probe: Describe a day or a time when you did not feel well?
8. How would you describe how you viewed good health before moving to the U.S.?
9. How, if at all, has your view of health changed?
10. Probe: How did your experience of living in another country or refugee camp influence your understanding of good health?

Research Question 1a: What are the components of wellbeing for African Great Lakes region refugee youth?

Physical Health

1. What do you think are the most important ways to achieve physical health?
2. Probe: How did you discover or create ways to achieve physical health?
3. Probe: For example, do you go to the gym, take a walk, practice healthy diet?
4. What if anything prevents you from achieving good physical health?
5. How has the COVID- 19 influenced your physical health?

Mental Health/ Stress

1. What kinds of things do you do to achieve good mental health?
2. Probe: for example, do you sing, go to church, dance, meditate, talk to friends, write stories, etc.?
3. What do other young people/your peers you do to achieve good mental health?
4. What are the ways you are still able to be with your family & friends during social distancing?
5. What are the different things that cause you stress?
6. Probe: school, world events, media, family, job, etc.
7. What helps you to manage stress?
8. What prevents you from achieving good mental health?
9. Do your friends, family, and community talk about mental illness?
10. If so, how is it discussed?
11. If not, why is it not discussed?
12. How has the COVID- 19 influenced your mental health?

Research Question 2: What are the socio-cultural factors that influence wellbeing for refugee youth from the African Great Lakes Region?

1. How does culture or tradition influence how you think about health?
2. What do people in your community do to attain good health?
3. What traditional means do people use to attain good health?
4. Probe: What barriers if any, prevent people from using traditional means to attaining good health?

5. What will you will like to see in your community that can improve their health of young refugees?

Organizational

1. What difficulties if any do you experience at school that influences your health?
2. What services if any do you have at school that influences your health?
3. What barriers if any do you have at your workplace that influence your health?
4. What services if any do you have at your workplace that influence your health?
5. What helps or prevents you from using healthcare services?
6. Probe: cultural differences, language, understanding, trust, and friendliness.
7. What needs to happen in organizations that can improve their health of young refugees?

Policies

1. What are the policies or rules that influence your health?
2. Probe: What helps or prevents you from getting healthcare services?
3. Probe: Cost (insurance), transportation, interpreter, location, and information.
4. What needs to happen in policies to improve the health of young refugees?

Research Question 3: What are the influences of racism on the wellbeing of refugee youth from the African Great Lakes Region?

1. What does racism/discrimination mean to you?
2. Probe: How was racism described to you when you arrived in the US and now?
3. Probe: When did you arrive at this meaning of racism?
4. How does race/racism affect your health in general?

5. What is the effect of racism on your ability to gain physical health?
6. Describe an experience that felt like racism to you that affected your life?
7. Probe: tell me about a time when racism affected your mental health.
8. In general, how does race and racism influence people in your community?
9. When you observe how Black people are treated around the world, what influence do you think it has on your health?

Closing

Is there something you would like to share that was not covered in the interview with regards to the theme of wellbeing that would be helpful for me to know?

Thank you for completing the interview! You may be eligible to participate in the second part of our study. It will be a focus group discussion about the result of the study. If you would like to be contacted, please provide us with the following information. If you do not want to be contacted for the second phase, please leave this section blank.

Name: _____

Address: _____

Phone: _____

Email Address: _____

Appendix F: Observational Field Note Template

IDENTIFIER: *Participant code*

DATE: *Month/day/year, day of week, weather, critical current event(s).*

TIME BEGIN: *Time onset of interview.*

DURATION: *Duration of interview in minutes.*

LOCATION: *Location and setting description.*

GENERAL COMMENTS: *General impressions of setting, participant. Participant reaction to observation/observer.*

EVALUATION COMMENTS: *Analytic, theoretical notes (interpretation of activities reported, behavior observed).*

METHODOLOGICAL NOTES: *Notes regarding methods, thoughts about approach being used, the need for modification, addition or deletion of strategies in the future.*

TECHNICAL NOTES: *Suggestions for future work*

PERSONAL NOTES: *Personal notes, impressions, reactions, feelings, related to the experience, concerns about the self as researcher, reflexive thoughts, judgment, bias.*

Time	Descriptive Notes	Reflective Notes

Appendix G: University of Louisville Institutional Review Board Outcome Letter



Human Subjects Protection Program Office
MedCenter One – Suite 200
501 E. Broadway
Louisville, KY 40202-1798

DATE: March 10, 2021
TO: Muriel J Harris, PhD, MPH
FROM: The University of Louisville Institutional Review Board
IRB NUMBER: 20.1020
STUDY TITLE: Understanding Wellbeing of Refugee Youth from the African Great Lakes Region in Louisville, Kentucky.
REFERENCE #: 720134
IRB STAFF CONTACT: Jennifer Hay 852.4535 jmhay001@louisville.edu

This study was reviewed and approved with changes on 02/24/2021 by a Vice Chair of the Institutional Review Board through Expedited Review Procedure, according to 45 CFR 46.110(b), since this study falls under Category 7: Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. The requested changes were received, reviewed and approved administratively on 03/10/2021.

This study now has final IRB approval from 03/10/2021 through 03/09/2024.

This study was also approved through 45 CFR 46.116 (C), which means that an IRB may waive the requirement for the investigator to obtain a signed informed consent form for some or all subjects.

The following items have been approved:

Title	Version #	Version Date	Outcome
IRB Study Application	Version 10	01/07/2021	Approved
IRB Protocol	Version 1.0	02/02/2021	Approved
Preamble Consent Cleaned Copy	Version 1.0	02/25/2021	Approved
Recruitment Flyer Cleaned Copy	Version 1.0	02/25/2021	Approved
Recruitment Email Cleaned Copy	Version 1.0	02/25/2021	Approved
Interview guide	Version 1.0	01/07/2021	Approved
Survey	Version 1.0	01/07/2021	Approved

IRB policy requires that investigators use the IRB “stamped” approved version of informed consents, assents, and other materials given to research participants. For instructions on locating the IRB stamped documents in iRIS visit: <https://louisville.edu/research/humansubjects/iRISSubmissionManual.pdf>

Your study does not require continuing review per federal regulations. Your study has been set with a **three-year** expiration date following UofL local policy. If your study is still ongoing at that time, you will receive automated reminders to submit a continuing review form prior to the expiration date. If you complete your study prior to the expiration date, please submit a study closure amendment.

All other IRB requirements are still applicable. You are still required to submit amendments, personnel changes, deviations, etc... to the IRB for review. Please submit a closure amendment to close out your study with the IRB if it ends prior to the three year expiration date.

Human Subjects & HIPAA Research training are required for all study personnel. It is the responsibility of the investigator to ensure that all study personnel maintain current Human Subjects & HIPAA Research training while the study is ongoing.

Site Approval

Permission from the institution or organization where this research will be conducted **must** be obtained before the research can begin. For example, site approval is required for research conducted in UofL Hospital/UofL Health, Norton Healthcare, and Jefferson County Public Schools, etc...

Privacy & Encryption Statement

The University of Louisville's Privacy and Encryption Policy requires identifiable medical and health records; credit card, bank account and other personal financial information; social security numbers; proprietary research data; and dates of birth (when combined with name, address and/or phone numbers) to be encrypted. For additional information: <http://louisville.edu/security/policies>.

Implementation of Changes to Previously Approved Research

Prior to the implementation of any changes in the approved research, the investigator must submit modifications to the IRB and await approval before implementing the changes, unless the change is being made to ensure the safety and welfare of the subjects enrolled in the research. If such occurs, a Protocol Deviation/Violation should be submitted within five days of the occurrence indicating what safety measures were taken, along with an amendment to revise the protocol.

Unanticipated Problems Involving Risks to Subjects or Others (UPIRTSOs)

A UPIRTSO is any incident, experience, or outcome, which has been associated with an unexpected event(s), related or possibly related to participation in the research, and suggests that the research places subjects or others at a greater risk of harm than was previously known or suspected. The investigator is responsible for reporting UPIRTSOs to the IRB within 5 working days. Use the UPIRTSO form located within the iRIS system. Event reporting requirements can be found at: <http://louisville.edu/research/humansubjects/lifecycle/event-reporting>.

Continuation Review Requirements

You are responsible for submitting a continuation review approximately 30 days prior to the expiration date of your research study. Investigators who allow their study approval to expire have committed non-compliance. Such lapses may require an audit by HSPPO compliance auditors and/or reporting to federal agencies. For additional information see: <http://louisville.edu/research/humansubjects/lifecycle/continuous-reviews>

Full Accreditation since June 2005 by the Association for the Accreditation of Human Research Protection Programs, Inc.



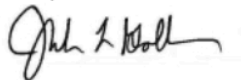
Payments to Subjects

In compliance with University policies and Internal Revenue Service code, payments to research subjects from University of Louisville funds, must be reported to the University Controller's Office. For additional information, please call 852-8237 or email controll@louisville.edu. For additional information: <http://louisville.edu/research/humansubjects/policies/PayingHumanSubjectsPolicy201412.pdf>

The committee will be advised of this action at a regularly scheduled meeting.

If you have any questions, please contact: Jennifer Hay 852.4535 jmhay001@louisville.edu

Thank you,



Julie L. Goldman, MD, Vice Chair
Biomedical Institutional Review Board
JLG/jmh

We value your feedback; let us know how we are doing: <https://www.surveymonkey.com/r/CCLHXP>

CURRICULUM VITAE

Victory Osezua

Department of Health Promotion and Behavioral Sciences,
School of Public Health and Behavioral Sciences,

University of Louisville

victoryosezua@gmail.com

EDUCATION

University of Louisville, Kentucky

Expected Graduation:

December 2021

Ph.D. Public Health (Health promotion and Behavioral Sciences)

(Dissertation Topic: Examining the meaning of wellness to African refugee youths in Louisville, KY)

Master of Public Health

May 2015

Covenant University, Nigeria

Bachelor of Science, Biochemistry

June 2012

TEACHING

University of Louisville School of Public Health

Course Instructor

Spring 2021

PHPB 301: Health Equity

- Lecturing a cardinal core course for first year – fourth year public health undergraduate students.

- Creating and organizing course material – syllabi, course lectures, activities, and class assignments for the course.
- Guiding students to understand inequities in health and health care, discussing the intersection of race, ethnicity, gender, socio-economic status, geography, sexual orientation, and other social factors that may exacerbate disparities.

Undergraduate Track in Social Justice & Health Equity

Fall 2020

Program Development Committee

- Developed the foundational competencies for the degree.
- Developed the course curriculum.
- Consolidated the curriculum to public health skills for students in the new Social Justice & Health Equity track.

Co-Instructor

Spring 2020

PHPB 300: Social and Behavior Foundations of Public Health

- Created and organized course material – syllabi, course lectures, activities, and class assignments for the course.
- Graded assignments and constructed assignment percentages.
- Challenged students to critically reflect on public health’s role in advancing health equity through social change when designing interventions.

Teaching Assistant

Spring 2020

PHPB 615: Advanced Program Evaluation

- Served as a facilitator for students to design and conduct an effective program evaluation using critical thinking and theoretical background.

Teaching Assistant

Fall 2019

PHPB 305: Public Health Education Principles and Strategies

- Assisted with lecturing a course for 90 first year – fourth year public health undergraduate students.
- Created and organized course material with the professor.
- Graded all assignments and constructed assignment percentages.

RESEARCH

Ph.D. Dissertation Research

Title: A constructivist grounded theory studying examining the meaning of wellbeing to African refugee youths in Louisville, Kentucky.

2019- 2021

- Coordinating virtual recruitment of youth.
- Conducting, coding, and transcribing in-depth interviews.
- Administering and analyzing sociodemographic surveys for data triangulation.

Research Assistant, Center for Social Justice Youth Development Research

2019-Present

University of Louisville, School of Public Health, and Information Sciences.

- Developing a youth advisory board for the center.

- Conducting research on strategies for developing a youth advisory board.

Research team member: PrEP Ghana Study, Ghana, West Africa 2020

Faculty advisor: Dr. Jelani Kerr

Study aim: Mixed Method Study exploring knowledge, attitudes, and readiness to prescribe Pre-Exposure Prophylaxis (PrEP) for HIV among physicians in Ghana.

- Coordinating recruitment physicians in Ghana.
- Conducting in-depth interviews, transcribing, and coding study data.
- Administering surveys for data triangulation and analyzing study data using Dedoose software.
- Conducting quantitative data analysis using STATA software.

Research Assistant, Our Emotional Wellbeing: Arts + Youth Leadership

2019-Present

Center for Social Justice Youth Development Research, University of Louisville, School of Public Health and Information Sciences.

Principal Investigator: Dr. Aishia Brown

Study aims: A mixed-method study to measure the impact that the Our Emotional Wellbeing (OEW) project had on participants of three different youth programs in Louisville. The goal of OEW is to use a culturally responsive process to cultivate youth leadership, hope, and emotional wellbeing of the community.

- Transcribing and coding in-depth interviews.
- Conducting qualitative analysis using Dedoose software.

Research Assistant, The West Louisville Outdoor Recreation Initiative research,
Louisville, KY. 2018 – 2020

Study aims: A multi-disciplinary study funded by the Louisville Metro Government and Aetna Foundation to promote address health outcomes of African American adolescents

- Facilitated and hosted focus groups for the development of the WLORI survey.
- Applied and received a \$50,000 with the group through ASTHO and NACCHO Improving Social Determinants of Health – Getting Further Faster project.
- Developed survey instruments to evaluate program effectiveness.
- Analyzed and interpreted data using SPSS software.
- Presented analysis results to the program directors and community stakeholders.

Evaluation Consultant, Bernheim’s Children at Play Network, Louisville, KY. 2019

Principal Investigator: Dr. Muriel Harris

Study aim: A Community Based Participatory Research mixed-method study funded by the Brown-Forman Corporation to evaluate the effectiveness of a program that promotes free play for African American children.

- Coordinating research project including recruitment and relationship with community partners.
- Conducting in-depth interviews, transcribing, and coding study data.
- Administering surveys for data triangulation.
- Analyzing qualitative study data using Dedoose software.

Research Assistant, Our World, Our Say Project, Louisville, KY and Vietnam. 2019

Principal Investigator: Dr. Lesley Harris

Study aims: An interdisciplinary study funded by the University of Louisville Cooperative Consortium for Transdisciplinary Social Justice Research.

- Organizing a summer camp for youth orphaned by HIV/AIDS.
- Transcribing and coding in-depth interviews.
- Conducting qualitative analysis using Dedoose software.

Co-researcher, District 3, Louisville Metropolitan Area, Louisville, KY 2019

Study aims: A quantitative needs assessment survey for the district 3 of Louisville metropolitan area to understand the needs of the community.

- Survey development for a need assessment study of a district for the city council.

Co-principal investigator, The Perceived Barriers and Facilitators for Attaining Post-Secondary Education among Youth Refugees from the African Great Lakes Region, Louisville, KY. 2018

Study aims: A qualitative study exploring the experience of refugee youths from East and Central Africa.

- Coordinated recruitment events with directors of refugee resettlement organizations, community centers, and churches.
- Conducted 20 in-depth interviews, transcribed and coded study data.
- Administered sociodemographic surveys for data triangulation.
- Received grant funding from the University of Louisville Graduate Research Award and the School of Social Work.

Research member, The S.H.A.P.E Study, Louisville, KY 2018

Study aims: A mixed method study of health and the perceived environment among African American adolescents.

- Collected data from adolescents using the SHAPE study questionnaire.

- Surveyed adolescents at health fairs, youth organizations, and community centers.
- Attended community networking events on behalf of the SHAPE study.
- Recruited participants for study by attending meeting with summer camp directors.

Research Assistant,

School of Nursing, University of Louisville, Louisville, KY 2014 – 2016

- Engaged in randomized control study in clinical research (Heart failure study, ICD study and Asthma study).
- Conducted mixed method studies to improve quality of life and physician-patient relationship.
- Recruited participants for research studies.
- Administered survey to patients using mixed method research approach.
- Organized and systemized data into REDCap, SPSS, and SAS for data analysis.
- Employed innovative strategies to reach target population and meet deadlines.
- Coordinating the research team to ensure progress of the study.

Research Assistant,

Healthy Hoops Home Visit Study, Louisville, KY. 2014 - 2017

Certified Asthma facilitator, American Lung Association - October 2014

Healthy Homes Certified - October 2014

- Detected asthmatic triggers that if removed can reduce allergens, prevent illness, and reduce injury from accident.
- Recruited families, adults, and elementary students, for healthy home inspections.

- Recorded asthmatic triggers and irritants during home visits following EPA’s asthma home inspection inventory.
- Conducted survey research and assessed homes for Asthma triggers.
- Engaged participants in Asthma education and followed up with the research team to ensure the project’s progress.

Public Health Practicum Researcher,

Global Health Initiative, Louisville

2014 - 2015

- Evaluated the University’s Refugee Immunization Program.
- Developed pre- and post-survey on Spanish and Arabic refugees’ satisfaction with Refugee Immunization Program.
- Data collection/analysis and report writing).
- Analyzed data with Microsoft Excel and SPSS.

PUBLICATIONS

Osezua, V., Sato, D., & Harris, L.M. (2020). Experiences of social exclusion and inclusion among emerging adult refugees from African Great Lakes Region. *Journal of Public Health Issues and Practices.*

Harris, L.M., Bloomer, R., Williams, S. **Osezua, V.** & Sato, D. “Not Strong Enough to Protect Children” Systems Risks Identified Among Youth who have Orphaned due to HIV/AIDS in Vietnam: A Photovoice Project. *Qualitative Health Research Journal* (In Review).

PROFESSIONAL EXPERIENCES

Graduate Research Assistant, Center for Social Justice Youth Development Research

Jan 2020 – present

University of Louisville School of Public Health

- Develop and manage program activities and ensure timely implementation of program goals.
- Coordinate the team in planning community-based programs.
- Coordinate quantitative and qualitative research on social justice youth development.
- Develop proposals for quantitative and qualitative research projects.
- Lead program staff and conduct internal and external youth program training while ensuring adherence to the state's standards and ethical guidelines.

Consultant, West Louisville Outdoor Recreation Initiative, Wilderness Louisville, Inc.

Dec 2020 - present

- Working across sectors (parks, health, and education) to address SDOH by improving equitable access to nature and the outdoors through research and practice.
- Addressing systemic barriers through data analysis to access with particular focus on addressing inequity in the ready availability of programming and supporting physical infrastructure for priority populations.

Data Analyst, University of Louisville Graduate School, Louisville, KY

July 2017 – Dec 2019

- Analyzed university data to analyze admissions, retention, and graduation rate.
- Managed data collection for graduate students' academic programs.
- Conducted various data visualization projects on the university graduate student's data using SAS Visual Analytics and Tableau software.
- Analyzed and interpreting data using Microsoft Excel and STATA software.

Program Coordinator, Louisville, KY

University of Louisville, Region IV Public Health Training Center (R-IV PHTC),

Aug 2017 – Aug 2019

- Managed and led data collection for classroom and online trainings.
- Managed the public health program, including calls for lectures, reviewed coordinated lectures and seminars with various experts in public health in the interest of training the public health workforce in Kentucky.
- Met with local and regional directors of health organizations for KY workforce training opportunities and field scholar opportunities for MPH students.
- Managed communications through media relations and social media.

HIV Prevention Specialist, Volunteers of America Mid-States, Louisville, KY

Sept 2015 – July 2017

- Interpreted public health data to key stakeholders and target communities.
- Effectively managed various projects and ensured all deadlines were met.
- Collected and analyzed data on high-risk individuals using Microsoft Excel and SPSS.

- Utilized community mapping, community events, social media strategies and graphic designs to identify and communicate with high-risk individuals, help promote HIV awareness following the CDC's standard.
- Conducted HIV testing including pre- and post- test counseling.

Vice President/Program Coordinator, Edo state, Nigeria. Nov 2012-Oct 2013

United Nations Millennium Development Goals Program

- Managed staff and ensured program goals were attained.
- Developed healthy communities using family and public health intervention.

INVITED PRESENTATIONS

Paper Presentations

Osezua, V., Sato, D., & Harris, L.M. (2021). Intrinsic and Extrinsic Coping Strategies of African Refugee Youth Attaining Post-Secondary Education: A Constructivist Grounded Theory Study. 17th International Congress of Qualitative Inquiry. Champaign, IL. May 2021.

Osezua, V., Bullock, N., Kerr, J., Amoako, H. (2021). Knowledge, Perceptions, and Readiness to Prescribe Pre-exposure prophylaxis among Ghanaian Physicians. 17th International Congress of Qualitative Inquiry. Champaign, IL. May 2021.

Harris, L.M., Bloomer, R. Williams, S., **Osezua, V.,** Sato, D, Byun, K., Hambrick, M. & Thang, N.D. (2021). "Our World, Our Say": The Use of Photovoice for Youth-Driven HIV Advocacy Efforts in Vietnam. 17th International Congress of Qualitative Inquiry. Champaign, IL. May 2021.

Harris, L.M., Bloomer, R. Williams, S., **Osezua, V.,** Sato, D, Byun, K., Hambrick, M. & Thang, N.D. (2021). "Not Strong Enough to Protect Children": Systems Risks

Identified Among Youth Who Have Been Orphaned Due To HIV/AIDS in Vietnam: A Photovoice Project. Sixteenth International Conference on Interdisciplinary Social Sciences, Oxford, England, July 21-23, 2021.

Osezua, V., Sato, D., & Harris, L.M. (2020). Experiences of Social Exclusion and Inclusion among Refugee Youth from the African Great Lakes Region: A Constructivist Grounded Theory Study. Location: 20th International Conference on Diversity in Organizations, Communities & Nations, Milan, Italy. June 9-10, 2020. (Virtual)

Sato, D., Bloomer, R., Harris, L.M., Williams, S. **Osezua, V.,** Byun, K. & Hambrick, M. (2020). "Not Strong Enough to Protect Children" Systems Risks Identified Among Youth who have Orphaned due to HIV/AIDS in Vietnam: A Photovoice Project. 16th International Congress of Qualitative Inquiry. Champaign, IL. May 20-23, 2020.

Poster Presentations

Osezua, V., Sato, D., & Harris, L.M. (2020). Breaking the Cycle of Environmental Health Disparities among Refugee Youth from the African Great Lakes Region. Location: Break the Cycle Conference 2020, Emory University, GA. April 20, 21, 2020.

Osezua, V., Aidoo- Frimpong, G., Bullock, N., Mott, D. & McDowell, J. (2020). February 2020. Perceptions of General Health Status among US Immigrants Based on Demographics and Socioeconomic Factors: An analysis of the 2016 General Social survey. Annual American Association of Behavioral and Social Sciences Conference (AABSS), Las Vegas, Nevada. February 24-25, 2020.

Mott, D., Bullock, N., **Osezua, V.,** Aidoo-Frimpong, G. & McDowell, J. (2020). Mapping out Jefferson County Kentucky's Life Expectancy Disparity. Annual American

Association of Behavioral and Social Sciences Conference (AABSS), Las Vegas, Nevada. February 24-25, 2020.

Aidoo-Frimpong, G., **Osezua, V.**, Mott, D., Bullock, N. & McDowell, J. (2020). Integrating PrEP as an HIV prevention strategy in Sub-Saharan Africa. Annual American Association of Behavioral and Social Sciences Conference (AABSS), Las Vegas, Nevada. February 24-25, 2020.

Bullock, N., **Osezua, V.**, Mott, D., Aidoo-Frimpong, G. & McDowell, J. (2020). Predictors of Miscarriage in Pregnancy: An analysis of the 2015-2017 National Survey of Family Growth. Annual American Association of Behavioral and Social Sciences Conference (AABSS), Las Vegas, Nevada. February 24-25, 2020.

Osezua, V. & Harris, L.M. (2019). November 2019. Policy recommendations for Reducing Social Exclusion Experiences among Refugee Youth from the African Great Lakes Region: A Constructivist Grounded Theory Study. Location: Kentucky Rural Health Association Conference, Bowling Green, KY. November 14, 2019.

Osezua, V., Sato, D., & Harris, L.M. (2019). Experiences of Social Exclusion and Inclusion among Refugee Youth from the African Great Lakes Region: A Constructivist Grounded Theory Study. Location: Research! Louisville, Louisville, KY. September 2019.

Osezua, V., Sato, D., & Harris, L.M. (2019). Experiences of Social Exclusion and Inclusion among Refugee Youth from the African Great Lakes Region: A Constructivist Grounded Theory Study. Location: International Conference on Diversity in Organizations, Communities & Nations, Milan, Italy. 15th International Congress of Qualitative Inquiry. Champaign, IL. May 15-18, 2019.

Osezua, V., Wilson, R., Knox, B. & Grissom, D., (2018). The West Louisville Outdoor Recreation Initiative: Improving community programs by using Exploratory Sequential Mixed Method. Location: Research! Louisville, Louisville, KY. Audience: University of Louisville Faculty, researchers, healthcare professionals, and staff.

Osezua, V. (2018). Conducting Research with Refugee Youth from Great Lakes Region. Location: Catholic Charities, Louisville, KY. Educative training for program directors of refugee resettlement agencies, education instructors, English as a second language teachers and principals.

Osezua, V., Kakar, R (2018). April 2018. Overview of Community Based Participatory Research and Assessment Tools. Location: Americana Community Center. Audience: Refugee community center staff and refugee community health workers.

Wilson, R. and **Osezua, V.,** (2015). Healthy Hoops Asthma Home Visits. Kentucky Public Health Association Conference; Owensboro, KY. April 2015.

Lecture Presentation/ Training

Osezua, V. and Carrico R. (2014). Global Health Initiative: Satisfaction among Spanish and Arabic Speaking Refugees Receiving Immunization in the University of Louisville Refugee Immunization Clinic. Research! Louisville, Louisville, KY. September 2015.

Osezua, V. (2019). Know Your Rights! Jua Haki Yako! Perceived Challenges and Strengths of African Great Lakes Refugee Youth Attaining Education after High School. Location: Americana Community Center, Louisville, KY. July 6, 2019.

June 2019. Summer Health Professionals Education Program (SHPEP): SPHIS Student Panel. PhD Candidate Selected to participate on panel. Location: Health Science

Campus Instructional Building. Audience: Shared equity experiences with over 50 undergraduates who attended colleges in multiple US regions.

Creative Products

Byun, K. Harris, L.M., Williams, S., **Osezua, V.**, Scoggins, C., Coleman, L., Bloomer, R. & Sato, D. (2020, January 10 – 2020, February 6). Our World Our Say Exhibition #1: Understanding HIV Risk and Resilience Among Adolescents Who Have Been Orphaned by HIV/AIDS in Hai Phong, Vietnam [Art-Advocacy Exhibition].

Harris, M., Elmore, S., **Osezua, V.**, (2020). Evaluation of The Seeds for Urban Play Project: A Partnership Between The Children At Play Network And Play Cousins Collective. Submitted to the Bernheim Children at Play Network.

HONORS AND AWARDS

Research Award Recipient 2021
University of Louisville Graduate Student Council Research Award.

Scholarship Recipient 2020
8th Annual Faculty Women of Color in the Academy National Conference

Travel Award School of Public Health and Information Sciences 2020
Awarded a scholarship for travel to present research study. 2020

Break the Cycle of Children’s Environmental Health Disparities Program
Emerging Scholar Award,

Diversity in Organizations, Communities & Nations, Italy 2019
Awarded a competitive international award for research accomplishment.

1st Place Doctoral Student Research Award 2019
Research! Louisville Health Sciences Research Conference

Travel Award University of Louisville Graduate School 2019
 Awarded a scholarship for travel to present research study.

Travel Award School of Kent School of Social Work 2019
 Awarded a scholarship for travel to present research study.

Research Poster Presentation Award 2019
 Kentucky Rural Health Association Conference

Research Grant Award Multicultural Association of Graduate Students 2019
 Awarded a competitive research grant for a research study. 2018 - present
 Kentucky Area Health Education Center (AHEC) Scholar
 Enrolled in a 2-year advanced learning nationally funded program by the Health Resources and Administration Association.

1st Place Master's Student Award
 Research! Louisville Health Sciences Research Conference, Louisville, KY 2014

Conference Discussant 2020
 University of St. Thomas Center for International Studies Senior Thesis Presentations
 23rd Annual American Association of Behavioral and Social Sciences, 2020

Healthy Hoops Kentucky Program, Louisville, KY 2014 - 2015
 Assisted in recruiting patients for an asthma research study and conducted survey research and assessed homes for Asthma triggers.

Intern, Colon Cancer Prevention Program,
Park Duvalle Clinic, Louisville, KY 2014 – 2015
 Conducting colon cancer test for at risk population and educating clinic patients on the colon cancer screening.

Intern Program Evaluator,

Family Health Center, Louisville, KY

2014

Developed a program evaluation plan for the Diabetes management program.

COMMUNITY SERVICE

Covid-19 Mass Vaccination

Jan 2021 - Present

Screening people to receive the Covid-19 vaccination.

Rise-Up Initiative, Kentucky Refugee Ministries

Jan 2021 - Present

Mentoring young African refugees to excel in college and university.

Tutoring refugee youth on college classes.

Lead to Empower Initiative

Secretary

2020 - Present

University of Louisville Multicultural Association of Graduate Students

Member

2015 - Present

President

2019 - 2020

Secretary

2018 – 2019

University of Louisville Student Government Association

Graduate Representative

2014

University of Louisville Compassion Clinic

2019

Volunteer

Facilitator, Culturally Effective Care Symposium

Summer, 2020

Trained first year dental, medicine, pharmacy, social work, and nursing students on develop culturally responsive intervention and to identify health, culture, and health care disparities in diverse populations.

Volunteer, Kentucky African Americans Against Cancer 2019 – Present

Educating communities on the importance of cancer screenings and presenting cancer education at community events and fairs.

Volunteer, Re: Center Ministries, Louisville, KY 2018 - present

Assisting with homeless day-shelter and serving participants warm meals, toiletries, and encouragement.

Planning committee, Kentucky Rural Health Association Annual Conference

2019 – Present

Organizing the agenda and selecting conference speaker for the annual Kentucky rural health conference.

Member, Steering Committee, West Louisville Outdoor Recreation Initiative

2018 - Present

- Planning for the dissemination of grant funding.
- Providing technical assistance for monitoring and evaluating to ensure facilitator obtains quality data.

PROFESSIONAL AFFILIATIONS

American Public Health Association 2014 - Present

North American Refugee Health 2014– Present

Kentucky Public Health Association 2013 - Present

Kentucky Rural Health Association 2013 – Present