

**CULTURE AND HEALTH: A QUALITATIVE STUDY OF SOMALI BANTU
WOMEN IN PITTSBURGH**

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The demographics of the United States are changing daily and the foreign population has increased with numerous languages currently spoken in the country. African refugees are one of the fastest growing populations of the U.S. many of whom have been displaced from their country due to civil unrest. An example of an immigrant population that is growing rapidly in the U.S. is the Somali Bantu whom like other immigrant ethnic populations do not have adequate access to health care because of their economic status, lack of health insurance, and cultural and language barriers. Due to these circumstances and lack of knowledge on health related issues, Somali immigrant women will choose to neglect their health over their children and spouses ignoring the importance of preventive, maternal, or reproductive health.

The Institute of Medicine (IOM) and many health care providers have observed that the root causes for disparities in ethnic groups are multifactorial and complex and exist due to a range of barriers such as language, education levels, geography, and cultural familiarity. Healthy People 2010 address the health concerns of the future of the nation and in order to meet the goals and eliminate health disparities, public health practitioners must reach out to immigrant populations.

This research paper presents an analysis of findings from a community-based assessment regarding the resettlement challenges and health care needs of the Somali Bantu immigrant population in Pittsburgh, Pennsylvania which is a public health issue that needs to be addressed.

This research paper will also propose steps to help improve the knowledge and quality of health care for the immigrant Somali Bantu in Pittsburgh through an intervention program with the focus on women and maternal health.

TABLE OF CONTENTS

PREFACE.....	IX
1.0 INTRODUCTION.....	1
1.1 PROBLEM STATEMENT.....	1
1.2 TARGET POPULATION.....	3
1.3 LOCAL SOMALI COMMUNITY IN PITTSBURGH.....	5
1.4 AIM.....	6
2.0 LITERATURE REVIEW.....	8
2.1 BACKGROUND ON IMMIGRANTS.....	8
2.2 NATIVE-BORN AND FOREIGN BORN.....	9
2.3 ASSURING THE HEALTH OF IMMIGRANTS	10
2.4 BACKGROUND-SOMALI REFUGEES.....	11
2.5 WOMEN AND MATERNAL HEALTH OF SOMALI IMMIGRANTS.....	12
2.6 CULTURAL PRACTICE LEADS TO POTENTIAL HEALTH RISKS	12
2.7 CULTURAL COMPETENCE TECHNIQUES.....	13
2.8 ACCESS TO HEALTH CARE	14
2.9 LANGUAGE BARRIER.....	15
3.0 METHODOLOGY.....	16
3.1 NEEDS ASSESSMENT DISCUSSION FORUMS.....	16

3.2	INTERVIEWS	18
3.3	COMMUNITY ROUND TABLE MEETING	19
3.4	AN INTERVENTION HEALTH PLAN	19
4.0	RESULTS	20
4.1	COMMUNITY NEEDS ASSESSMENT	20
4.2	WOMEN’S COMMUNITY NEEDS ASSESSMENT #2	21
4.3	KEY INFORMANT INTERVIEWS.....	23
4.4	SOMALI BANTU SERVICE PROVIDERS ROUNDTABLE.....	28
5.0	PROPOSED HEALTH INTERVENTION STRATEGY	32
5.1	HEALTH PROMOTION MODELS	32
5.2	THE PRECEDE-PROCEED MODEL.....	33
5.3	EDUCATION.....	34
5.4	MODEL AND EDUCATION	35
5.5	THE INTERVENTION PLANNING MODEL	36
6.0	DISCUSSION	40
	APPENDIX A PROPOSED RESEARCH STUDY PROTOCOL.....	42
	APPENDIX B SURVEY QUESTIONS	44
	BIBLIOGRAPHY.....	47

LIST OF TABLES

Table 1: Common Trends Observed in the Somali Bantu Immigrant Community	29
Table 2: Model to determine the implementation of the intervention model	38

PREFACE

Thank you Shawn for all the support you've given me over the years, Asante to the Somali Bantu community of Pittsburgh for taking me into your community and making this project possible. Many thanks to Rita and all the other dedicated health care providers at UPMC. Thank you to my thesis committee for mentoring me in my academic growth. And finally, many thanks to my very supportive friends and family, especially to my parents.

1.0 INTRODUCTION

1.1 PROBLEM STATEMENT

It is now commonly accepted that health is a fundamental human right and is defined by the World Health Organization (WHO) as a state of complete physical, social, and mental well-being, and not merely the absence of disease or infirmity (Nutbeam, 1998). The WHO states that all people should have access to basic resources for health and the promotion of health is a resource which permits people to lead an individually, socially, and economically productive life (Nutbeam, 1998). This is a positive concept emphasizing social and personal resources as well as physical capabilities.

“Health for All” has served as an important focal point for health strategies among organizations such as the WHO and it has provided goals based on the concept of equity in health. The United States has also been working to create a health strategy to provide health equity for all citizens. In the U.S, the Healthy People 2010 program was developed by the Department of Health and Human Services (HHS), as a comprehensive nationwide health promotion and disease prevention objectives to improve the quality of health of the Nation.

Healthy People 2010 makes use of scientific advances that have taken place over the past 20 years in preventative medicine, disease surveillance, vaccine, therapeutic development, and information technology to create success in health care (U.S. Department of Health and Human

Services). Healthy People 2010 also addresses health concerns for the future such as the growing diversity of the nation through gender, race and cultural differences, ethnicity, and the resulting health disparities that can or will occur due to economic status, education and equity (U.S. Dept. of Health and Human Services).

Leading health indicators show the behavioral patterns of immigrants are different from the U.S. born population which can have both positive and negative affects on their health. An example, of one such health indicator is that immigrants are less likely than the U.S. born population to participate in physical activities which reduce the risk of heart disease, diabetes, and obesity (Kandula, et. al., 2004). Another study shows that immigrants are initially less obese than majority of U.S. born citizens and an increase in obesity among immigrants occurs as they acculturate in the U.S. (Kandula, et. al., 2004).

One large group of immigrants settling in the U.S. are Somali refugees who began to arrive in the early 1990s to escape civil unrest and the collapse of the government in Somalia (Neria, 2003). While health practitioners are eager to improve the health of immigrant patients through culturally appropriate health education, this process can be difficult, especially among Somali women whose experience of health care in Somalia or refugees camps differs from care in the U.S.

For example, it is estimated that in Somalia, only 2 percent of all birth deliveries take place in a health facility and are attended to by skilled personnel. Therefore, the overall risk of women dying due to related complications is 1 in 7 (Neria, 2003). Health care providers have been faced with a challenge to reach this targeted population due to strong cultural beliefs, the lack of education among this population, and language barriers.

These examples show that it is important for health practitioners to recognize and understand the cultural variations of immigrants and to effectively work with different populations for prevention in order to improve the health care of immigrant populations.

One way this goal can be accomplished is to focus on comprehensive educational and community-based programs addressing issues such as maternal and women's health, which will improve the quality of health and knowledge to immigrant populations in Pittsburgh. This paper focuses on a needs assessment to determine what educational tools and community programs, can be used to develop health care approaches tailored to the Somali Bantu immigrants to improve the quality of women's and maternal health among this population.

1.2 TARGET POPULATION

The transition process can be difficult for refugees from the developing world as they are a highly vulnerable population and they experience a general lack of sensitivity by indigenes towards their culture, history and traditions. Acculturation consists of a balance of past cultural traditions with a blend of new lifestyles and cultural roles that can make adjustment difficult. For instance, some women are considered by their culture to be inferior and subservient to men. Therefore, many of these women will tend to have lower educational levels and seek less medical treatment which may lead to more health problems as they consider their health to be a low priority.

Women and their dependents constitute approximately 80% of the refugees and internally displaced individuals worldwide due to war, government abuse, or civil strife (Phares, et. al., 2004). Not only does the health of women deserve attention in its own right, but also as they are

the main caretakers of their families. Women are important decision makers in the household and are responsible for the development, health, and education of their children. Therefore it is critical for them to understand how improvement and care of their health leads to better health of their infants and children.

Currently, one of the fastest growing population groups of the United States are refugees. One group in particular immigrating to the U.S. at a growing rate is Somali immigrants, mainly from refugee camps in Northern Kenya where most have lived the majority of their lives. Refugees in camps in Northern Kenya have faced human rights violations such as various forms of torture, violence, trauma, and inadequate living conditions, and as a result suffer from severe psychological and physical problems. Examples of victimization the Somali refugees have encountered are death of family members by bullet fire, bombings, or rape; mutilation by bombings, knife, and fire; torture by electricity, beating, and detention, and rape; all perpetrated against both women and men, and constituting humiliation instead of humanitarian assistance (Ljubinkovic, 2005). Women in particular have experienced violent acts that are also inflicted upon them by members of their own families and community. Domestic physical abuse and sexual abuse can be a daily reality for refugee women and girls who arrived unaccompanied or as minors into the camps (Crisp, 1999).

Somali refugee women are denied the chance to develop the skills to rebuild their shattered lives and those of their families as a direct result of their past experiences. These women have experienced a range of health problems and lack of preventive health measures. Therefore, as they attempt to adjust to a new society, it is important to investigate how they experience their new environments in order to determine how the health care system can overcome cultural differences and health barriers.

1.3 LOCAL SOMALI COMMUNITY IN PITTSBURGH

The city of Pittsburgh is part of a government resettlement project to help place Somali Bantus from refugee camps in U.S. cities (Neria, 2003). The resettlement of immigrants in cities like Pittsburgh is beneficial because they help replenish neighborhoods, fill labor shortages, and increase ethnic diversity in different communities (Neria, 2003). Currently, the main groups of refugees relocated to Pittsburgh are the Somali Bantu from Northern Kenya, the Muscasian Turks from Russia, and Uzbekistani's from Romania (Neria, 2003).

Refugees come from similar situations; i.e. they have relied on relief aid from the United Nations, have lived in poor housing conditions, and face language barriers on arrival to the U.S. However, the Somali Bantu are more illiterate than other refugee populations because they were a minority group in their country and were barred from formal education (Kalson, 2004), thus placing them at a greater disadvantage than other groups of refugees who may be doctors, engineers, or teachers immigrating for other reasons such as prejudices or civil unrest.

The following paragraphs are based on a phone interview with an employee of Catholic Charities in Pittsburgh:

Most of the Somali Bantu families that live in Pittsburgh reside in the Lawrenceville area of Pittsburgh in close proximity to each other. Pittsburgh is currently home to approximately thirty Somali Bantu families that began arriving in the U.S. in 2004 from the United Nations refugee camps in Northern Kenya. These families range in size from approximately two members to thirteen and are continuously growing due to the high number of births.

The Somali refugees in Pittsburgh are from the Bantu ethnic group and were the poorest segment of the population in their homeland. Due to their poverty, most Somali Bantu had no access to education. However, if education had been possible, women would not have been educated or able to have access to conventional health care because of their social status.

After re-location, the Somali Bantu require an intense amount of support and social services by organizations such as Catholic Charities and other neighborhood

organizations that are involved in the re-settlement program for refugees. This is necessary because upon arrival in Pittsburgh, most of the families lack an understanding of cultural norms and the modernization of daily life in the U.S. The organizations, who work with the Somali Bantus hope they will be able to pay their bills, learn how to use buses, take their children to school, learn English, access local health care communities, and find employment. The overall goal is to help them become self-sufficient (Shakir Muhammed, 2006).

In summary, due to their lack of education and poor proficiency of the English language, the Somali Bantu have had difficulty finding employment, have low financial status, and do not receive proper health treatment. Additionally, the Somali Bantu have difficulty gaining acceptance into the communities where they reside, making integration into Pittsburgh extremely difficult.

1.4 AIM

The majority of the Somali women arriving in the U.S. have spent most of their lives in refugee camps thus they come from poor educational backgrounds and lack knowledge of reproductive health, anatomy, and maternal health. Due to their culture and religious practices, many of these women are denied adequate education that can help them understand the importance of preventive and maternal health care.

The target population under investigation for this study is the Somali Bantu women of Pittsburgh. The aim of this study is to gain a better understanding of the cultural background and educational level of the Somali refugee women through a literature review, needs assessment, and interviews. The findings can be used to assist health care providers with necessary information to design a health intervention plan to improve the health of Somali Bantu women. This paper can also inform the health care providers who work with the Somali Bantu in

Pittsburgh of the population's cultural and religious background as well as to enumerate the needs of the community.

2.0 LITERATURE REVIEW

A literature review of female Somali immigrants was conducted with a focus on women's and maternal health for the age group of fourteen to forty-five. Maternal health starts at an early age because the average Somali woman becomes pregnant for the first time around the age of fifteen (Owens, 2003) with an average of 7-8 children (Krause, 2000). This literature review references were from the following health databases sources: NIH, PUBMED, government websites, CDC Wonder, and Google scholar with papers being reviewed to establish trends and consistency in the data.

2.1 BACKGROUND ON IMMIGRANTS

Data from 2002 indicate that approximately 34.5 million immigrants who were not citizens at birth are currently living in the U.S., which represents about 12 percent of the population and these numbers are expected to increase (OWHC, 2002). It is estimated that 40 percent of Latinos and 60 percent of Asians in the U.S. are foreign born. These immigrants are an integral part of American society and contribute to the diversity and economy of the nation. Approximately one of nine people in the U.S. population is foreign born and are the driving force behind the future growth of the American population (OWHC, 2002). This diversity is a challenge for health care professionals and institutions especially concerning issues of how to address the needs of a

population with diverse languages and distinct cultural perceptions of health, the body, and the nature of certain diseases (OWHC, 2002). Demographic trends show that the health status of immigrants and their descendants will play an increasing role in shaping health outcomes in the U.S. (OWHC, 2002).

One of the health disparities that are observed in ethnic populations such as Somali immigrants is poor women and maternal health. The paper provides a review of the relevant literature on:

- A comparison of native-born and foreign born in the population
- Cultural competence techniques
- Cultural background of Somali immigrants in the U.S.
- Women and maternal health of Somali immigrants
- How cultural beliefs can lead to potential health risks
- Access to health care and language barriers

2.2 NATIVE-BORN AND FOREIGN BORN

It is important to study how native-born and foreign born populations compare in terms of their overall health. By using self reports of general health status, data have been collected to get a general overview on the attitude these groups have towards health. On average, immigrants that self report on their general health status are much younger than native born and so they are healthier because there is a correlation between age and health. Therefore, the foreign born have a much lower rate of chronic conditions than the native-born (Jasso, et. al. 2004). Also, data

indicate that when immigrants arrive, they are also influenced by forces that affect their health such as the economic conditions, prejudices, and discrimination that lead to high stress levels. This information is critical because prolonged exposure to high stress levels can lead to cardiovascular disease (Jasso, et. al. 2004).

2.3 ASSURING THE HEALTH OF IMMIGRANTS

Currently, the U.S. is experiencing one of the largest waves of immigration in its history (Jasso et al. 2004). Immigrants move from one environment with a set of health risks, behaviors, and constraints, to a different environment. This presents complex factors for understanding the origins of health disparities in these populations (Jasso et al., 2004). Therefore data collected from immigrants can be beneficial to health care providers because it can offer important knowledge for researchers from several disciplines, such as attempts to measure the impact of environmental factors such as diet, healthcare systems, and environmental risks (Jasso et. al, 2004). An organization obtaining information on immigrants is Center for Disease Control and Prevention (CDC) that has acknowledged, in general, there is a lack of information specific to African immigrants whose health differs in many ways from the health of U.S. born minority groups (Jasso et al., 2004).

2.4 BACKGROUND-SOMALI REFUGEES

According to United Nations High Commissioner for Refugees (UNHCR), an estimated 60 percent of Somali refugee world wide are under the age of seventeen and 31 percent are under the age of six (UNHCR). This is a result of the high rates of pregnancy among young Somali women. Marriage usually happens between 14-16 years of age with divorce and remarriage are common (Owens, 2003). Education levels among the Somali refugees are low and most adults have never attended school and do not read or write in their own language (Carroll, 2004). Before arrival in the U.S., many Somali refugees have not experienced modern living and have never lived with electricity. Many refugees existed on World Food Program rations such as maize, beans, and lentils, and thus do not recognize 99 percent of the food in U.S. supermarkets (Refugee Community Building Conference, 2003).

A psychosocial description of Somali women (Krause et. al, 2000) who arrive in the U.S. includes traits such as “reserved”, “passive”, and “submissive”. Most of these women and their families who arrive from refugee camps lack proper housing and employment (Owens, 2003). Living in poor conditions these refugee women lacked health care information, have limited utilization of public services such as health clinics, have inadequate resources, and have strong cultural beliefs and practices that affect their health conditions (Owens, 2003).

Most Somali women entering the U.S. as refugees seek security and safety after fleeing persecution, violence (including rape from soldiers and men in the camps), and famine (Horst, 2001). They have also suffered from separation from family, torture, humiliation, and other traumatic conditions as well as being put at an increased risk for psychological sequelae such as post traumatic stress disorder (PTSD) and sexually transmitted diseases (STIs). These

immigrants also enter the U.S. with tropical diseases from parasites that lead to health risks such as anemia, altered appetite/anorexia, diarrhea, and malabsorption of necessary nutrients for pregnancy and general health (Horst, 2001).

2.5 WOMEN AND MATERNAL HEALTH OF SOMALI IMMIGRANTS

Due to the lack of epidemiological data, the women and maternal health needs of Somali women are poorly understood (Davies, 2001). Somali women have large families with an average of 7-8 children (Horst, 2001). Some statistical data indicate that 19 percent of infants born to Somali refugees had a low birth weight (LBW), are undernourished, and are at a higher risk of dying in later infancy (Owens, 2003). Also, mothers have poor nutritional diets which start in their adolescent years and into their adulthood (Gerritsen, 2004). The poor nutritional status of Somali women and frequent pregnancies also interfere with breast and complementary feeding practices where they start weaning children before the recommended age of six months (Gerritsen, 2004).

2.6 CULTURAL PRACTICE LEADS TO POTENTIAL HEALTH RISKS

Over 98 percent of Somali women are circumcised (FGM - female genital mutilation) which can result in numerous complications such as tetanus, chronic pelvic infection, urinary tract infection, infertility, difficulty menstruating, and obstetrics complications such as; lacerations, obstructed labor, fistulas, and uterine rupture (Horst, 2001). Therefore, women of Somali origin

represent a high risk group in obstetrics with problems such as intrauterine fetal distress, emergency caesarian sections, low Apgar scores (test designed to evaluate a newborn's condition after delivery), and intrauterine death (Vangen et al. 2003). These conditions put the mother at risk for disability and death.

One of the results of FGM is that Somali women reduce their food intake in order to limit the size of the baby. This is done to prevent a difficult birth associated with a small introitus post-circumcision (Horst, 2001).

2.7 CULTURAL COMPETENCE TECHNIQUES

Even though the U.S. has had advances in science that has led to improved health, minority groups including immigrants still fare worse in terms of the leading health indicators including mortality, morbidity, and many underlying causes of disease compared to Caucasians (Jasso, et. al, 2004). The growing diversity of the nation presents a challenge and thus the need for cultural competent practices to improve health care for immigrants.

In order to be able to address immigrant maternal health issues, it is important to investigate what cultural and educational techniques are available for community health programs. The Institute of Medicine's Committee on Understanding and Eliminating Racial and Ethnic disparities in Health Care state that cultural competence is the term used to improve the ability of health systems in order to deliver appropriate health systems to immigrant patients (Jasso, et. al, 2004).

The literature states that in order to alleviate patient mistrust, a strong patient provider relationship has to be developed to increase the patient's satisfaction (Jasso, et. al, 2004). Brach

and Fraser (2002) offer a conceptual model that suggests improved cultural competence helps overcome barriers to health care by improving clinician/patient communication and forms a trust between the clinicians and patients which leads to treatment efficacy by enhancing an understanding of the patient's cultural behaviors and environment. The authors state the major techniques necessary for cultural competence are:

- To provide interpreter services
- To have a recruitment and retention policy for minority staff and offer training
- To coordinate with traditional healers and the community health care workers
- To practice culturally competent health promotions
- To expose health care providers into another cultures

2.8 ACCESS TO HEALTH CARE

Citizenship and language (English proficiency) play a large role in disparities in health coverage, access, and quality of services received for racial and ethnic minorities. Little discussion has occurred about the importance of immigration status and insurance (Ku and Matani, 2002). Minority immigrants are more likely to be uninsured than other minority populations who are not immigrants (Ku et al., 2003). Under the Welfare Reform Act, immigrants who enter the U.S. (legally) after 1996 cannot receive assistance except for emergencies during the first five years that they live in the country (Ku and Matani, 2002). High medical costs and no accessibility to affordable health care are barriers for immigrants seeking health care.

2.9 LANGUAGE BARRIER

One of the difficulties Somali women encounter while trying to communicate with health care providers is the language barrier. Poor communication with health care workers was noted to be the underlying problem in seeking health care information for non-English speaking women (Davis, 2001). Rarely do health practitioners provide interpretation services making it difficult for immigrants to get the adequate care they need (Davis, 2001).

In addition, Somali women state that understanding the different services that may be available to them in the multilayered organizational structure leads to confusion; therefore the women then choose to avoid care (Davies, 2001). Some women may choose not to seek care due to the long waiting times to see physicians. Appointments for non-English speaking patients can be delayed due to the lack of interpreters which are usually only available when the patient's health has deteriorated (Davies, 2001). Women believe that they do not receive appropriate care and treatment because they are perceived as being 'difficult patients (Davis, 2001). These issues must be addressed in order for immigrant women to receive adequate health care and should be addressed by health care providers who work with immigrant populations such as the Somali.

3.0 METHODOLOGY

3.1 NEEDS ASSESSMENT DISCUSSION FORUMS

Two group guided interview forums will be conducted to determine the health care needs of the Somali Bantu women. The group guided sessions will consist of a needs assessment; an investigation process that can help identify an individual's knowledge, skills, and attitudes that are relevant to a particular issue (Fallis, 1998). A needs assessment is necessary because it can help acquire accurate information on the strengths and barriers of the Somali women's health care needs (Fallis, 1998). Additionally, the project focus will be to help health care providers determine how best to improve the standard of health care for the Somali Bantu women. By analyzing the information collected from the needs assessment, health care providers can determine priorities and goals to develop an intervention plan.

The needs assessment will be conducted at the Lawrenceville Family Health Center, a University of Pittsburgh Medical Center (UPMC) neighborhood clinic located in the Lawrenceville neighborhood of Pittsburgh. The Lawrenceville Family Health Center is a neighborhood health clinic affiliated with the UPMC St. Margaret's Hospital, which serves communities through their family medicine fellowship program and community outreach medicine programs. The center serves the area where majority of the city's Somali Bantu families reside and thus seek medical care.

Recruitment of Somali Bantu

The recruitment of Somali Bantus will be conducted through the Lawrenceville Family Health Clinic where members of the community will be identified and verbally informed about the needs assessment group guided interviews. Somali Bantu community leaders will be identified and asked to participate in the recruitment process because they are a strong voice for their community and can help identify members of the community who should participate in the needs assessments. For language and communication purposes, the needs assessments will be labeled as community discussion forums. The term discussion forums will be used because the Somali Bantu as a community meet weekly to discuss issues or problems that have arisen in the community and are familiar with this terminology.

Health care personnel

Health care personnel from Lawrenceville Family Health clinic; two nurses, two family care doctors, as well as a representative from Magee Womancare International Program will participate in the needs assessments. Having health care providers present in the discussion forums will be beneficial because they can listen to the health care needs of the community they serve and as a result participate in discussion on specific health care topics.

Language

Language will be taken into consideration and to avoid barriers the discussions will be conducted in English and Kiswahili in order to allow all present to participate and voice their opinions which is necessary. The discussion sessions will take one hour. Light snacks and drinks will be served and the primary researcher will facilitate the discussions with the assistance of a community leader.

A Discussion protocol

A discussion protocol was developed to inform the participants of their rights to privacy and voluntary participation. The protocol will be read out loud to the participants before the start of the discussion. Participants will be assured of their privacy, and anonymity in this research study. In order to protect their confidentiality, participants will be identified numerically, i.e. woman #1, woman #2, woman 3#, etc. where applicable.

Exemption

Exemption status for this research study was granted as participants were under minimal. Exemption was applied by the University of Pittsburgh Institutional Review Board (IRB).

Analysis

Qualitative data will be collected from the needs assessments and will be analyzed from the notes taken during the discussions to identify specific trends that are present from the discussions.

3.2 INTERVIEWS

During the first phase of the needs assessment, it was determined that a minimum of five personal interviews would be conducted privately in order to determine if the women had the same concerns about health care needs without the influence of the community or men present at the discussion forum session. The interviews followed the same guideline as the needs assessment. The questions asked in the interview can be found in Appendix 1.

3.3 COMMUNITY ROUND TABLE MEETING

The researcher attended a round table meeting to observe the discussion between community stakeholders who work with the Somali Bantu population that was organized to share information about the needs and concerns of the Somali Bantu community. The meeting consisted of health care providers, the Pittsburgh Public School, the Greater Pittsburgh Literacy Council, and AJAPO (Acculturation for Justice, Access, and Peace Research), Catholic Charities, Big Brothers Big Sister, Magee Womancare International, and community volunteers. The issues discussed focused on challenges the Somali Bantu experience in Pittsburgh such as health care services, welfare, housing, language, and employment. Points discussed in the meeting are summarized in the results section of the paper.

3.4 AN INTERVENTION HEALTH PLAN

An intervention health plan will be designed to identify what steps can be taken by local health care providers working with Somali Bantu refugees to help improve the health of Somali women.

4.0 RESULTS

4.1 COMMUNITY NEEDS ASSESSMENT

The first discussion forum was conducted with Somali Bantu immigrants to voice their concerns and questions in regards to health care and other community issues. The meeting was intended to be conducted for the women of the Somali Bantu immigrant community. However, due to cultural practices the leaders and men from the Somali Bantu immigrant community chose to attend the meeting and said the women would be present at the second session.

Health concerns - The group identifies poor communication between patients and health care providers due to language barriers. One group member voiced concerns about confusion experienced as to understanding the content of an automated phone recording used by health care providers for appointment reminder calls. Thus, many of the Somalis who do not understand English hang up on the automated system. The group requested that the clinic change the recording to a language that can be understood by the Somalis. The community leaders also expressed concerns about the lack of discussion between health care providers and patients regarding medications that are prescribed to patients. A group member pointed out that they do not always understand their dosage for medication and therefore, do not follow the directions correctly. Another group member stated that many times doctors only wanted to ask them two

questions; “do you feel like you have been treated well? Do you understand the treatment?” The Somali leaders would prefer additional dialog with the doctors regarding their health issues and medical care.

The group members wanted more information about specialized medical procedures that they must undergo at hospitals. They stated the need for interpreters to be present during procedures and tests in order to explain what is being done to them. The group members also want translator services to be available for weekends in case of emergencies in order to translate questions to doctors on-call. Lack of interpretation was not only identified as prominent in the clinics, but also at other service organizations such as Catholic Charities and the welfare office. The group expressed confusion over medical billing because they do not understand what costs are covered by insurance companies and what will be directly billed to them.

Community Concerns - The Somali Bantu cited housing as the number one concern of the community. Most families are living in apartments and are not satisfied with their current living arrangement and the majority of their income goes towards rent with little left over for other basic needs. Members of the group expressed that they would like to have public housing and yet still wish to be located close to the other families in order to help each other to remain strong. The community members said they would like more information on subsidized housing; however the leaders said they have experienced a hard time learning who to contact about specific issues.

4.2 WOMEN’S COMMUNITY NEEDS ASSESSMENT #2

After the discussion forum with the community elders, a second forum was conducted to talk to the Somali Bantu women about questions and concerns they have with regard to health care and

other community issues. The meeting was attended by a nurse from University of Pittsburgh Medical Center (UPMC); St. Margaret Lawrenceville Family Health Center, a representative from Magee Womancare International, Somali Bantu women, and three male leaders from the Somali Bantu immigrant community.

Health concerns - The Somali Bantu immigrant women expressed concerns over the shortage of translators at the different agencies, such as the Lawrenceville Family Health Center and Catholic Charities. Some women said that because they do not speak Swahili well, and often this is the language being used for interpretation. The women would like to have interpreters that speak mai mai or kizigua (more traditional languages for the Somali Bantu). The women stressed that due to the lack of appropriate translation, they are misunderstood and may not receive the right treatment. A woman present at the meeting complained about the unavailability of translators for birth delivery at Magee Women's Hospital. The woman complained that the hospital staff tried to get a translator on a phone line but this could not be accomplished because of a two hour wait.

One woman complained about the service provided by American doctors versus the doctors in Africa. The woman complained that the wait time to see an American physician is very long and they insist on checking your whole body even though you have come in with only one problem. The women did not understand why a complete physical is necessary, or why doctors check your back when you tell them you have a problem with your chest.

A woman complained about coming to the clinic with a sick child and instead, she was requested to book an appointment and return to see a physician later in the week. The woman was concerned that the health center staff was not aware of how sick her child was because she did not speak English. Another woman was upset because medical forms needed to be filled out

for her son's school. However, she was not capable of filling out the forms because she cannot read, write, or understand English. A third woman complained of being sick, however, the doctors refused to give her medication. The nurse present tried to explain the differences in treatment between virus and bacterial infections and, when antibiotics are administered. However, the woman became upset, picked up her belonging and left the meeting.

The nurse present discussed the importance of gynecological exams and pap exams. However, several women in the meeting said they do not want the tests to be carried out their bodies. The women stated that they are aware that the tests are necessary if one chooses to be on birth control, and in that case, they would prefer to come off birth control. A woman shared her fears after experiencing a bad reaction from the birth control drug, *Depo-Provera*. The woman said she would rather be pregnant and have babies than be on medication. The nurse present tried to talk about alternative birth control methods; however, the women refused to discuss this issue and broke out into small discussions in order to avoid the subject.

Community Concerns- The first issue the women brought up was the cost of housing and the women felt they were paying too much on rent. One woman explained that when her son was sick, she had to miss work and lost her job so they relied on their husband's income which is not enough for their rent and basic needs.

4.3 KEY INFORMANT INTERVIEWS

At the second discussion forum that was conducted for the Somali Bantu women a few men attended the meeting. In order to rule out the presence of men inhibiting the women from

speaking openly, five interviews with women were conducted to see if the results from the meeting were the same as the discussion forums. The last interview is with a health care provider who works with the Somali Bantu women.

Key Informant Interview: #1 -We lived in refugee camps in Northern Kenya prior to moving to the U.S. We have lived in the U.S. for three years out of which eight months have been in Pittsburgh. We are in our early twenties and we do not speak English well. We have no formal education but attend English classes at the ESL center in Lawrenceville. We have four children who range in age from six years of age to eight months. All our children attend public school and the baby goes to day care in the neighborhood at another Somali family's house. We like Pittsburgh, but it is expensive especially the rent. Recently, we bought a car and can drive to visit family and friends, as well as do the grocery shopping and help others within the community.

We both have to work and do not have to speak English at our jobs. The government helps us with food stamps and WIC (Women Infant and Children) for the younger children. The government still supplies health insurance for our children but not for the parents. However, neither of us can afford health insurance. Therefore, we do not visit the clinic unless it is an emergency because it is too expensive. We have never seen a dentist, an eye doctor, nor had mental health evaluations done. I do not feel that female exams are necessary unless a woman is pregnant.

Key Informant Interview: #2 -We are in our mid- twenties and have lived in the U.S. for four years. We came from Somalia. I don't know how old I am. My age was made up before I traveled. We do not speak English and have three children, one attends school and the other two are watched by friends and family because we both work. However, my husband has a bad leg

(physical disability) and cannot work full-time. I am the main provider for the family. We rent a house in Lawrenceville and we like the community very much, but, the rent is very expensive. We do not have an education but we are taking English classes. My job provides our family health insurance; however, we do not make visits to the clinic unless someone is ill. I was placed on birth control (Depo-Provera) because life is too expensive to raise children in the U.S. and I cannot afford day care. I have to have female exams because if I don't they will not allow me to be on medicine. The children do see dentists but no one in the family had ever had their vision checked.

Key Informant Interview: #3 - We arrived in the U.S. three years ago from refugee camps in Kenya. Our identification cards say we are born in the 1970's because this was the age immigration officers placed on our documents. However, that is not our age. We have twelve children that range in age from twenty one years old to one and a half years of age. We also have four relatives that live with us. We like the neighborhood; however, rent is very expensive and we struggle to pay utilities especially heat. We do not speak English, read or write but we both are employed in jobs where language is not required. I am taking English classes at the ESL center in Lawrenceville. We still qualify for health assistance under the federal immigration plan but we do not make visits to the doctor unless we are ill. We never go for tests. What for? We do not visit the dentist. Our teeth are fine and so are our eyes. I do not have female exams. Those are considered to be necessary during pregnancy.

Key Informant Interview: #4 - We lived in a refugee camp in Northern Kenya for nine years before moving to the U.S. where we have lived for the past two and a half years. We have eight children that range in age from twenty years of age to one and a half years old. We live in Lawrenceville and like the neighborhood. We will not move because we rely on the help of

fellow Somali neighbors even though the house is small with only two bedrooms. We are not educated, do not speak or read English. All our children are in school. We have health insurance and the children have yearly physicals because they are required to for school and immigration. We do not see the doctor unless it is necessary. I do not have yearly pap exams or mammograms. Exams are only for pregnancy. I am not on birth control. Children are a gift from God.

Key Informant Interview: #5 - We have lived in the U.S. for the past two years and came from a refugee camp in Northern Kenya. We have seven children that range in age from eighteen years to one and a half. All my children go to school except the baby that stays at home with me. We like living in Lawrenceville and will not move because of the community support. We are not educated but have been taking English classes. We still have medical coverage through a government program for immigrants. Our children mainly visit health care practitioners and the dentist, but I do not have yearly pap exams. Those are only necessary during pregnancy and my breasts are fine, therefore I will not go for a check up.

Key Informant Interview #6 (Health care provider) - Most of the Somali refugees arrive in Pittsburgh from camps where they have been living for the past twelve years. The average age of most is late twenties but, many do not know their real age because their families did not keep records of their birth year or date which makes it difficult when treating a patient because we do not know their age. The women have an average of 5-6 children because they believe this will insure they are not deported. Since the September 11th attacks on the World Trade Center, most Somali's worry that the U.S. government will deport them because they are Muslims. These refugees feel that if they give birth to U.S. born children, it will reduce their chances of being deported.

The women are very poorly educated and have very strong cultural beliefs. The women have very little knowledge of reproductive health, maternal health, nutrition, lead poisoning, and the importance of breastfeeding. The women have no knowledge of the need for a pap examinations, or mammograms and often refuse to undergo medical examinations or procedures. However, since they are on birth control, they now have to have yearly exams. One of the biggest problems we have in delivering services to the Somali women is the language barriers and therefore, we work through interpreters. Most of the interpreters used for the Somali women are female unless an in emergency and then whoever is available is contacted. However, problems still exist because even though the language is translated, the Somali women still have a poor understanding of the health issues.

We also have difficulty sending patients to hospitals for specialized tests because they do not know how to get there, they cannot speak English and so most of our patients do not keep their appointments. The Somali women do not believe that an education will make a change in improving their knowledge on health; however, we are trying to work through the children who are going to school, learning to read and write, learning English and being exposed to U.S. culture.

We have had a difficult time trying to get the Somali's to think about family planning who culturally believe that children are a blessing from God who also determines how many they will have. However, we have started to conduct workshops to help them understand family planning by using financial planning as a receptive tool. We hope this will help encourage women to reduce pregnancies and increase the period between pregnancies.

4.4 SOMALI BANTU SERVICE PROVIDERS ROUNDTABLE

The round table discussion is based on concerns of community stakeholders who work with the Somali Bantu population. This discussion was organized to share information about the needs and concerns of the Somali Bantu community and what challenges they face in Pittsburgh for services such as health care, welfare, housing, language, and employment.

Health- Stakeholders present identified that some of the Somali Bantu are starting to lose health insurance coverage on family members such as children who are turning twenty one years of age. They identified that families would like to know if they can keep their children's benefits especially since most of them are still attending public high school. Another stakeholder mentioned how Somali families had expressed concerns about receiving a reduction in government benefits when they work full-time and how there was a lack of information on medical clinics that provide free health services or subsidized care. There was also a concern that Somali Bantu immigrant patients are not receiving adequate care with tropical diseases and health care providers need to address this issue. A stakeholder present also identified that the Somali Bantu have complained about the lack of interpretation services and that they plan to approach UPMC health system in order to improve their interpretation coverage.

Community Concerns- A stakeholder discussed how the Somali Bantu do not understand welfare coverage, how it is applied and would like it to be explained to the community. Stakeholders identified that they would like interpreters to go with the Somali Bantu to their welfare office visits. Another stakeholder discussed how the City of Pittsburgh is trying to address the Somali Bantu housing concerns. The Greater Pittsburgh Literacy Council discussed how they have seen a reduction in women in English classes because they are now working. Therefore, in order to accommodate working Somali Bantu parents, they have started evening

classes that are being attend by the men. The literacy council also identified that the men in the Somali community are ahead of the females in education, language, and acculturation.

The following pages consists of a table that identified the common trends observed in the discussion forums, key informant interviews, and the community round table meeting of the Somali Bantu Immigrant community.

Table 1: Common Trends Observed in the Somali Bantu Immigrant Community

Groups	Health Care	Language and Education	Housing other Services
1 Somali Bantu leaders and men	<p>Lack of communication between patients and health care providers</p> <p>Don't understand medicine dosages</p> <p>Want information on specialized procedures</p> <p>Want interpreters present for specialized procedures</p> <p>Want interpreters on call over weekends in case of emergency</p> <p>Do not understand medical billing</p>	<p>Language barrier</p>	<p>Lack of affordable housing</p> <p>Want information on subsidized housing</p>
2 Somali Bantu women	<p>Lack of translation between patients and health care providers</p> <p>Unavailability of translators at birth deliveries</p> <p>Long wait times to see physicians and delays in immediate appointments</p> <p>Do not understand why medications are not given if a person is sick</p>	<p>Do not speak or English language is poor</p> <p>Lack of education to understand or fill out medical forms</p> <p>Cannot read or write</p>	<p>Lack of affordable housing</p>

Groups	Health Care	Language and Education	Housing other Services
	<p>Do not want pap or gynecological exams</p> <p>Fear of birth control</p>		
<p>3 Key Informant Interviews with Somali Bantu Women</p>	<p>Cannot afford health insurance on our own</p> <p>Children have medical visits because is required by schools and Homeland Security</p> <p>Do not see doctors unless necessary</p> <p>Will use birth control because life in the U.S. is expensive</p> <p>Pap and mammograms are for pregnant women</p>	<p>Do not speak English well</p> <p>Do not have formal education</p>	<p>Rely on government subsidies</p> <p>We use WIC</p> <p>Rely on government health plans</p>
<p>Key Informant Interview with Health Care Provider</p>	<p>Is difficult to treat patients when they do not know their exact age</p> <p>Women have very little knowledge of reproductive, maternal, nutritional health.</p> <p>They have high rates of lead poisoning.</p> <p>They do not understand the importance of breastfeeding</p> <p>The women do not understand pap or mammogram tests and refuse to have them</p> <p>Have very high birth rates. Are trying to get them on birth control</p>	<p>Are very poorly educated</p> <p>Language is a barrier</p> <p>Also do not understand certain health issues</p>	

Groups	Health Care	Language and Education	Housing other Services
	<p>Have problems sending patients to hospitals for specialized care (will not go, language)</p> <p>Have difficulty having them understand family planning</p>		
<p>4 Community Round Table Meeting</p>	<p>A shortage of interpretation services</p> <p>Starting to lose health insurance coverage from the government</p> <p>Would like more information on free medical clinics</p> <p>A fear that they are not receiving adequate care for tropical diseases</p>		<p>Are receiving a reduction in government benefits due to employment</p>

5.0 PROPOSED HEALTH INTERVENTION STRATEGY

Health promotion is the process of enabling people to increase control over, and to improve their health and comprehensive approaches to health development (Nutbeam, 1998). Promotion of health is most effective when used in combination with specific strategies such as the participation of people, health literacy, access to education and information, and empowerment of people and communities (Nutbeam, 1998). The proposed intervention plan will use health education as the main strategy to help promote women's and maternal health care in the Somali community of Pittsburgh. The design of this intervention can be used to help change the behavior of Somali immigrant women in order to improve the quality of women and maternal health.

5.1 HEALTH PROMOTION MODELS

Adverse health outcomes can often be prevented by modifying lifestyles and assuring appropriate medical health care that is critical for women. It is also important for women to increase their knowledge of nutrition and to seek routine medical exams in order to stay healthy. Health care providers, individuals, and community organizations can work together in helping to change health behavior and to encourage preventive practices.

Health strategies have been used to prevent poor health habits as well as for interventions that improve behavior. Strategies used with communication, empowerment, policy, and skills

development play a critical role in promoting good health. Many models have been proposed to explain the adoption of health risk and health enhancing behaviors such as psychological models aimed at modifying individual behavior, as well as health promotion models and strategies.

5.2 THE PRECEDE-PROCEED MODEL

The PRECEDE-PROCEED model developed in the 1970s by Green and colleagues will be incorporated in this design to help assess the health and quality of life needs of the Somali Bantu immigrant women to help encourage healthier behavior.

The PRECEDE-PROCEED model is a comprehensive structure for assessing health and quality of life needs, and for designing, implementing, and evaluating health promotion and other public health programs (Green et. al, 1999). The PRECEDE process (Predisposing, Reinforcing, and Enabling Constructs in Educational Diagnosis and Evaluation) are part of the planning process to assist in the development of targeted public health program (Green et. al, 1999). The PROCEED section of the program (Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development) guides the implementation and evaluation part of the program (Green et. al, 1999).

The PRECEDE section of the model contains five main phases; phase 1, determine the quality of life, social problems, or needs of a given population, phase 2; identify the health determinant of this population and needs, phase 3; analyze the behavior and health determinants of the health problems, phase 4; what factors predispose to, reinforce, and enable the behaviors and lifestyles identified, phase 5; what health promotion , health education will best be suited to

encourage the desired changes in the behavior or environment (Green et. al, 1999). PROCEED consists of four sections to that are mainly intervention, implementation, and evaluation.

5.3 EDUCATION

In developing countries, education is still a fundamental tool in the promotion of health (Carroll, 2004) and can be used as a key intervention strategy in this health model to help individuals become knowledgeable and use information to promote and maintain good health. Also, by using education, health care providers can develop a strong strategy because it takes into account the social, economic, and cultural circumstances of individuals in order to achieve the results which are to be expected in terms of the impact on health behavior (Nutbeam, 2000). Also, health education activities can assist immigrant women increase improved knowledge and understanding of health determinants which can lead to changed attitudes and increased motivation in relation to health behavior, as well as improved efficacy in relation to defined tasks (Nutbeam, 2000).

The health model should be tailored specifically for Somali Bantu immigrants; therefore, all data collected for the intervention shall use adapted materials that are culturally sensitive, are in a language that is understood by the audience or interpreters should be available, and the educational level should be appropriate to their characteristics and needs. Not only should the model be used with the goal to change the individual behavior of the Somali women but, it should extend beyond promoting individual health to include the control over an individuals health issues, and the reduction of negative impact of a broad range of health determinants such as one's socioeconomic environment. Also, with the use of health models, health care providers

can help explain shifting of resources towards prevention rather than treatment, and helps one change their views from health being viewed as a physical disease to include mental, social, and spiritual (Ontario Women's Health Council, 2000).

Health education is aimed at improving health, raising awareness, and securing support for positive health protection measures among a population. Also, health education helps individuals gain competence and knowledge about health and illness and raises their awareness about social, political, and environmental factors that influence health (Ontario Women's Health Council, 2000). Through acculturation, immigrants can adopt attitudes, beliefs, and behaviors of their host country and their perception of health problems and attitudes will evolve. Therefore, to help the process, the health model will be tailored to Somali Bantu women and use messages and materials that are consistent with their cultural characteristics and beliefs.

5.4 MODEL AND EDUCATION

One of the main features of the PRECEDE PROCEED model is that health education is dependent on voluntary cooperation and participation which allows personal determination of behavioral practices, therefore; the degree in change in knowledge and health practice is directly related to the degree of active participation of the individual (Green *et. al.*). The PRECEDE PROCEED model helps the community participate by prioritizing their own problems and solutions which will encourage change and success leading to a better quality of life.

The precede portion of the model has intensive requirements for the assessment asking the community what the levels or status of the quality of their life is, and what they consider to be important. This is critical because the weight of a needs assessment in a health education and

intervention program is extremely beneficial in addressing the concerns of a community and their involvement which also leads to stronger programs. Community participation can be seen in the PRECEDE phase of the model where the community can participate in the social, behavioral, and environmental diagnosis phases. Community participation can be achieved through activities such as community forums, nominal group process, and focus groups, and needs assessment.

Recruitment - After being re-located to the U.S., most refugees live in close proximity to each other for community support purposes. Participants will be recruited from the family health clinic where the Somali immigrants go for health care. Immigrants can also be recruited through the help of community based organizations that work to help the population resettle in the country.

5.5 THE INTERVENTION PLANNING MODEL

This model will focus on four main stages in the education strategy for health promotion. 1. Needs Assessments, 2. Program Planning, 3. Implementation and 4. Evaluation.

Stage 1- Assessments - A social assessment will be conducted to determine the individual's perceptions on their own needs and quality of life. This assessment can be done through focus groups among the Somali Bantu immigrant women. Focus groups will be conducted with approximately 8-10 women per group. An incentive can be given to the women in order to obtain an acceptable level of enrollment.

A behavioral and educational assessment will be conducted to assess what problems contribute to poor maternal health among Somali immigrants. This assessment can be conducted through personal interviews. The interviews will be conducted by a health care provider and can

be based on survey questions designed to give the health care providers information on the individual's knowledge, beliefs, and attitudes. Health care providers will fill out survey forms on maternal visits to the clinic. Each Somali woman who answers a survey can be given an incentive to encourage participation. Data should be collected from the assessment to produce a baseline that can be used in the evaluation.

Stage 2 Program Planning: Health Education - In this intervention approach, health education should not only be approached as the communication of information, but it should also be approached as promoting motivation, skills, and confidence (self-efficacy) which are necessary to improve health. Secondly, the target population will be defined as Somali immigrant women between the ages of fourteen and forty five. Also, a logical model can be created to help determine how to implement a successful program.

Table 2: Model to determine the implementation of the intervention model

Output	To improve maternal health in Somali women	Activities to be Used
Outcome 1 (individual benefit)	<p>Improve the knowledge of health risks, good health, and health services that are available</p> <p>To improve their capacity to act independently, be motivated and self confident</p> <p>To improve their social and economic adversity</p>	<p>Interpersonal contact, available media.</p> <p>Counseling and skill development sessions.</p> <p>Training in prevention Communication through facilitators, social support groups,</p>
Outcome 2 (social benefit)	<p>To increase their participation in population health such as screening</p>	<p>combination of communication channels, help through community development</p>
Goal	<p>Improvement in health literacy and personal development skills, empowerment</p>	

Stage 3 Implementation of Health Promotion “Health Education” - Health education can be implemented by health care providers. Health care providers and community leaders can encourage women to attend training sessions. The sessions should be offered in a language that the women can understand. Education can be offered as part of a program or reactively in response to a client’s request (ACT Health, 2006). Training sessions on maternal health can also be conducted by professional groups and educators. Examples of training sessions can be to:

1. Improve knowledge of health risks and services available which can be conducted through workshops that will use media and counseling. Healthcare providers will set up workshops with culturally appropriate documentaries in a language that the Somali women understand to help them become more knowledgeable on issues pertaining to good maternal health.
2. Cultural health education classes for health care providers can be implemented at the clinics to conduct culturally sensitive training sessions to help health care provider's understand the education levels and cultural issues of the Somali immigrant women. All clinic staff who will come in contact with Somali immigrant patients can attend a session.

Stage 4 – Evaluation - The evaluation of the intervention can be conducted by health care providers who work with this population to determine if the goal of the project, the improvement in women and maternal health and health literacy, has been achieved in the Somali Bantu immigrant population. The evaluation can compare data that was collected in the baseline assessment to the post intervention data.

6.0 DISCUSSION

“Health for All” is a focal strategy used by organizations such as the WHO and can be achieved if health care providers identify what barriers exist that make it difficult for populations such as the Somali Bantu to receive adequate care (Nutbeam, 1998). In my opinion, the use of techniques such as a needs assessment and key informant interviews used in this research study have helped to identify barriers among the Somali Bantu. Therefore, in order to improve the health care needs of the Somali Bantu women, health care practitioners will need to identify methods that can be implemented in a culturally competent way. Health care practitioners should also make sure that the methods used are educationally appropriate, and they should take language into consideration with the services they provide that will help remove barriers in health care in order to improve the quality of Somali Bantu women’s health.

The literature review conducted for this research paper identified that even though the U.S. has advanced in technology that has led to improved health, minority groups including immigrants still fare worse in health indicators compared to Caucasians. Therefore, it is important for health care providers to use cultural and educational techniques available to improve community health programs and cultural competency to improve health systems in order to deliver appropriate care.

The community needs assessments, interviews, and discussions conducted in this research study identified the gaps in health care provided for the Somali Bantu immigrant

women in Pittsburgh centered on communication between the patient and provider. Communication and health education were the two main barriers identified between the health care providers and the Somali immigrant women. Members of the Somali Bantu community voiced concerns about the language barrier and the lack of discussion between health care providers and patients. This relationship should be addressed in a culturally appropriate manner in order to improve doctor patient relationships which will encourage the women to seek better preventive medical and maternal care, and increase the quality of care and patient satisfaction.

Health promotion models have been developed in order to help people improve the quality of their health and these models can be effective when used with community participation. Health care providers should work to implement behaviorally focused strategies in their health education programs that are targeted to immigrants such as the Somali Bantu women. This will help increase their knowledge of the importance of prevention and the importance of routine medical exams. Educational and community-based programs can be developed that address issues such as maternal and women's health that will improve the quality of health care and knowledge for immigrant populations in Pittsburgh.

APPENDIX A

PROPOSED RESEARCH STUDY PROTOCOL

The aim of this research is to determine through group discussion if the health care needs of the Somali Bantu women are met by health care providers in Pittsburgh.

The discussion sessions will be conducted in Swahili and English and each discussion session will be one hour.

This research will be a minimal risk study and the discussion sessions will consist of approximately ten adults. No children will be used in the study.

When the women attend the discussion, the reason for the research discussion will be explained to them again as follows:

“Hello, I am Lorraine. I am a graduate student at the University of Pittsburgh, Graduate School of Public health. I speak Swahili and this discussion will be conducted in Swahili and I will be facilitating the conversation. The discussion will take one hour. I am conducting this research study to learn more about how Somali Bantu immigrant women in Pittsburgh

communicate with health care providers and their doctors. I would like to see if certain trends exist that can result from a language barrier. I am inviting you to take part in this group discussion with 10 other Somali Bantu immigrant women where I would like to explore relevant issues. Your participation in this discussion is voluntary and if you choose not to participate you can withdraw at any time and, it will not affect the care you receive from Lawrenceville Family Health Center. Please be assured that if you participate you will remain anonymous in order to protect your privacy and your basic rights. The study report will identify you numerically, for example as woman #1, which will help me to protect your confidentiality.

If you choose to be part of this discussion, these are the topics we will discuss in the group that are non-invasive and will help me facilitate the conversation.”

Question

How difficult is it to communicate with your doctors?

Do you feel that using interpreters helps the communication process?

Are you happy with your doctors?

Do you get annual exams such as pap smears, mammograms, and if so, are they explained to you in a language you can understand?

Do you prefer to have a female doctor?

APPENDIX B

SURVEY QUESTIONS

Survey #: _____

Date of Birth: ____/____/____ Gender: **M** **F**

Country of Origin _____

Length of time in the United States _____

Length of time in Pittsburgh _____

Language spoken at home _____

Family

How many children or other dependents do you have? _____

Age(s): _____

Are they living with you? _____

Anyone else in your household? _____

Do you use day care? _____

Housing

What neighborhood do you live in? _____

Are you happy with your neighborhood? _____

Where are you currently living?

Are you satisfied with your current housing? _____

Employment

What is your employment status?

Have you used any of the following programs?

Did you use an interpreter?

Temporary Assistance for Needy Families (TANF) _____

Unemployment _____

Food Stamps _____

Women, Infants, and Children (WIC) _____

Social Security (SSI or SSDI) _____

Child Support _____

Other: _____

What other services do you use interpreters for? _____

Education

What is the highest level of education you have completed _____

and where? _____

Are you currently in school or training? **Yes** **No**

If so, where? _____

What kind of education/training would you be interested in (if any)?

Have you taken English as a Second Language (ESL) classes? **Yes No**

If so, where? _____

Health

Do you have health insurance? **Yes No**

Do your children have health insurance? **Yes No**

Does your insurance cover medications? **Yes No**

Do you have a yearly physical? **Yes No**

Do you visit a dentist? **Yes No**

Do your children visit a dentist? **Yes No**

Do you get your eyes checked? **Yes No**

Have you ever had a mental health evaluation? **Yes No**

Do you have any physical disabilities? **Yes No**

Were they addressed before you came to the United States? **Yes No**

Have they been addressed in the United States? **Yes No**

Have you had a Pap exam? **Yes No**

When was the last time you had a Pap exam? _____

Have you had a Mammogram? **Yes No**

When was the last time you had a Mammogram? _____

Do you use birth control? **Yes No**

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