Title (*revised*): Cultural Competency and African Women's Health Services
Original title: Cultural Competency and Maternal Health in African Women

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Structured Abstract

Purpose (1) Explore contextual factors that affect provision of health services to Somali refugee women (2) Identify cultural competency techniques to improve healthcare quality to this community
Scope Changing immigration patterns create a need to assess healthcare services in newly emerging, growing groups, such as African immigrants and refugees. Cultural competencies show promise for improving health disparities in women's health services.

Methods We conducted individual interviews of 34 resettled Somali women in Rochester, NY. Participants were asked about health promotion, prenatal care, and use of preventive healthcare services. Eligible women were >18 years and born in Somalia. Interviews were audiotaped, transcribed verbatim, and analyzed using the grounded theory approach. A professional interpreter listened to interviews to check translation and transcription accuracy. Limitations were initial logistical difficultird in recruiting women and obtaining adequate interpreting assistance.
Results Though all women were familiar with basic health promotion practices, immunizations, and routine medical examinations, few understood cancer prevention services. Three women (9%) recognized that the purpose of Papanicolaou tests was to screen for cervical cancer. Six women (18%) had heard of mammography. Themes indicated the importance of maintaining good hygiene (70%), having an adequate source of safe food and water (59%), having access to a regular source of healthcare (74%), and being able to function well at home (65%). Other themes were that health maintenance for acute survival took precedence over long-term prevention of disease and use of both US-based and traditional techniques to prevent illness.
Key words Women's health, refugee, Africa, preventive healthcare, health promotion, cross-cultural issues

[word count=250]

Purpose (Objectives)

This study aimed to elucidate the cultural, experiential, and religious underpinnings of understanding of health and preventive healthcare in Somali refugee women. We assessed Somali women's experiences and beliefs about health promotion, prenatal care, and preventive health services in the US and explored ways to improve access, quality, and cultural competency of these services. In order to improve primary care for Somali women, we addressed the following questions:

- What are Somali women's beliefs about health promotion?
- How knowledgeable and familiar are Somali women about prenatal care and preventive health services in the US?
- What cultural competencies, from the perspective of Somali women, can improve their healthcare quality?

Scope

About 25 million refugees and immigrants comprise about 10% of the US population (Bureau of Population, 2001). Immigrants and refugees from Africa represent one of the fastest-growing groups resettling in the US. Forty-five percent of African refugees in the US are of Somali origin, and some 13,000 Somali Bantu refugees (Peel, 2002) are predicted to resettle in the US by 2005 (Office of Refugee Resettlement, 2003).

The Somali Bantu have been a historically marginalized and persecuted minority group in Somalia; literacy level is lower than that of the larger Somali population, as educational opportunities have historically been denied to the Somali Bantu, especially women (Van Lehman & Eno, 2002). Though we lack accurate up-to-date data, the Somali Bantu literacy level is estimated to be well below the United Nations estimate of 24% for the general Somali population. The Somali Bantu have distinct historical and cultural background and traditions as well as linguistic differences that distinguish them from other resettled Somali refugees in the US (Van Lehman et al., 2002). Healthcare providers and systems are often uncertain about how to communicate with such patients, who come with vastly different experiences about basic aspects of their health, especially because linguistic interpretations may not fully represent cross-cultural differences in conceptualizations of health (Carroll, 2004).

Literature addressing the health of refugee and immigrant women, especially from the African continent, is sparse. Prior work in the field has focused on specific issues pertaining to infectious disease, childbirth, female circumcision, and/or the development/assessment of educational intervention programs. We have been unable to find research that systematically explores traditional belief systems of African women about health promotion and compares these beliefs to principles of preventive healthcare endorsed by the US.

The few studies focusing on African refugees and immigrants' beliefs about both access and quality of healthcare provide conflicting information. One study among resettled Somalis in the US reported fewer problems with transportation, language, payment, and physical examination than predicted by their healthcare providers (Adair, Nwaneri, & Barnes, 1999). Another study (Plaisted, 2002) found that women varied greatly in certain aspects of their heatlhcare experiences and utilizations.

Somali women interviewed in the UK reported poor communication as a problem in seeking information from providers and fears of loss of confidentiality as a limiting factor in the use of interpreters (Davies & Bath, 2001). These respondents believed that Somali women were denied health information due to negative attitudes and prejudicial views among healthcare workers.

Ethnic and racial disparities exist when it comes to preventive services for various minority groups (Fiscella, Franks, Gold, & Clancy, 2000; Fiscella, 2003; Gornick, Eggers, Mentnech, Fitterman, Kucken et al., 1996). Language represents a key barrier (Fiscella, Franks, Doescher, Schulman, & Saver, 2002), but specific information is very limited for African immigrants and refugees. Previous studies, however, have described the challenges clinicians in Europe and the US have had in delivering preventive healthcare services to refugee women according to accepted standards of care, showing that refugee women receive fewer preventive services (Burnett & Peel, 2001; Gammell, Ndahiro, Nicholas, & Windsor, 1993; Bariso, 1997). Many of these studies comment about an 'understanding divide,' also called 'cultural differences,' that results in limited access to care, possibly due to differences in health beliefs, health literacy, or barriers to healthcare access. There are numerous differences between approaches to health undertaken in African, and especially refugee camp, curative health centers and primary care clinics in Europe and North America.

Methods

We conducted in-depth interviews with a community-based sample of resettled Somali women. Inclusion criteria were as follows: adult age (>18 years old); female gender; Somalia as country of birth; and living in the Rochester, NY, area. Exclusion criteria were the following: child age (<18 years) and acute illness or other condition that limited ability to participate in discussion. Initial publicity about the study to eligible participants was by word of mouth using key informants and primary care provider referrals. Recruitment was continued via the snowball technique. With the help of key informants' contacts, efforts were made to include a broad range of newly resettled Somali women as well as those who had been resettled in the US for longer periods of time. This study protocol was approved by the University of Rochester Research Subjects Review Board (Rochester, NY, USA).

The purpose of the interview, explained to participants, was to learn more about their health experiences in order to improve healthcare for Somali women. Snacks and a $10 grocery gift card, as well as reimbursement for transportation when needed, were given to participants.

Individual interviews explored several key concepts: women's health promotion and prevention practices, prenatal care, preventive health services, and views on culturally competent, respectful treatment. Some questions were adapted based on prior work in the field (Plaisted, 2002). Questions were revised based on emerging data, interviewers' input, and feedback from key informants in order to maximize reliability and technical and conceptual validity. Appendix A shows the interview template.

The principal investigator (JC), a family nurse practitioner (EV), a family medicine resident (LK), and a medical student (KD) conducted individual interviews at a time and place convenient to the participant. Interviews were audiotaped and were 45-60 minutes in duration. Forty-five women were recruited to participate.

Only one woman declined, because of time constraints and difficulty with language. Of the remaining 44 women, 34 were interviewed to achieve sufficient data saturation. The order of the interviews was determined randomly.

Two professional and two lay interpreters (all women) were used for non-English-speaking participants and for any participant who preferred to speak in their primary language. Audiotaped were transcribed verbatim. One of the professionally trained interpreters (SO) reviewed audiotapes of all interviews occurring with lay translators to check accuracy of translation, making written corrections and other notations for transcripts as needed, which were integrated into the analysis.

Analysis

A multidisciplinary team used grounded theory, a coding/editing approach, to conduct data analysis (Miller & Crabtree, 1999; Addison, 1999). Emerging codes were systematically developed from the data by three coders; one (JC) coded all transcripts, and two (EV, KD) coded other transcripts, each about one third of the total (12 transcripts), to check accuracy. For each transcript with multiple coders, the codes were compared for reliability. The primary analysis team (JC, EV, KD, SO) met regularly to discuss coding issues and emerging categories and themes. Any discrepant codes were discussed. Recoding was done based on group consensus.

Throughout the data collection and analysis, six community Somalis---four women and two men (KA, IA, NG, FM, AA, SO)---served as key informants and/or interpreters. They assisted with participant recruitment, interview template design, and revision, and they verified accuracy and validity of emerging themes.

Emerging categories and themes were then reviewed at a series of meetings with a secondary analysis team consisting of senior faculty with advanced qualitative research skills (RE, NC, KF). The purpose of this phase of the analysis was to identify and confirm the most salient themes; search for any discrepancies or nonconforming data; develop linkages between the present study and prior work in the field; and brainstorm about persistent ambiguous or contradictory issues needing further clarification.

At the final phase of analysis, a focus group was conducted to check the validity of emerging themes and clarify questions posed by the interim analysis of the completed individual interviews. The focus group was also helpful for checking contradictory and ambiguous issues. The focus group was conducted in two languages, Somali and Maay Maay (a language commonly spoken by Somali Bantu). SO acted as interpreter for Somali, Maay Maay, and English, with KD and JC present as cofacilitators. The group consisted of six women (n=4 Bantu and n=2 non-Bantu Somali); five women had completed individual interviews, and one was a new participant. Focus group members were purposively chosen to represent a mix of (1) Bantu women and other Somali women; (2) more recently resettled women and those who had lived in the US longer than 5 years; and (3) English and non-English speakers. The focus group was audiotaped and transcribed, with SO reviewing the audiotape and transcript to make any necessary corrections in the translation or transcription.

Results

A total of 34 women participated. Fifteen (44%) were Bantu Somali women, and 19 (56%) were other (non-Bantu) Somali women. Ages ranged from 18 to 53, with the median age being 27 years. Duration of residence in the US ranged from 2 months to 9 years. Table 1 summarizes sociodemographic characteristics.

Table 1. Summary of Participant Characteristics

	Somali		Bantu		Total	
	N	%	N	%	N	%
Translator used						
Yes	10	52.6%	13	86.7%	23	67.6%
No	9	47.4%	1	6.7%	10	29.4%
Missing	0	0.0%	1	6.7%	1	2.9%
Education						
No Schooling	4	21.1%	13	86.7%	17	50.0%
Grade School	8	42.1%	2	13.3%	10	29.4%
High School	3	15.8%	0	0.0%	3	8.8%
Community College	4	21.1%	0	0.0%	4	11.8%
Years in the USA						
<2	0	0.0%	12	80.0%	12	35.3%
2-5	7	36.8%	3	20.0%	10	29.4%
6+	10	52.6%	0	0.0%	10	29.4%
Missing	2	10.5%	0	0.0%	2	5.9%
Marital Status						
Married	10	52.6%	11	73.3%	21	61.8%
Unmarried	2	10.5%	0	0.0%	2	5.9%
Separated	4	21.1%	2	13.3%	6	17.6%
Missing	3	15.8%	2	13.3%	5	14.7%
Children						
Yes	18	94.7%	14	93.3%	32	94.1%
No	1	5.3%	0	0.0%	1	2.9%
Missing	0	0.0%	1	6.7%	1	2.9%
Employed outside home						
Yes	11	57.9%	3	20.0%	14	41.2%
No	8	42.1%	11	73.3%	19	55.9%
Missing	0	0.0%	1	6.7%	1	2.9%
Total	19	100.0%	15	100.0%	34	100.0%

Compared with non-Bantu women, Bantu women were younger (median age 24 vs. 32); had been in the US a shorter time (median 1 year vs. 7 years); were less likely to be employed outside the home or to have had any formal education; and were more likely to have needed the assistance of a translator during the study interview. Bantu women had usually lived in refugee camps for a longer period of time---up to 10-12 years---compared with other Somali women. Among women who worked outside the home, occupations included farming (5), factory work (5), housekeeping (2), nursing assistants (2), and interpreter (1). The Bantu women primarily spoke Maay Maay; one also spoke Kezwa. The non-Bantu women primarily spoke Somali; one also spoke Barawa, and another spoke Somali, Barawa, and Swahili.

1. Beliefs about health promotion

The initial portion of the interview asked participants about maintaining good health. For example, they were asked, *"Many Somali women want to stay healthy so that they can take care of their families, work, and care for their children. How does a Somali woman stay strong and healthy?"* and *"What health problems do Somali women worry about?"* Most participants discussed general health promotion by speaking about their own personal sense of well-being, often contrasting their health experiences in the US with those in the refugee camps. The resulting themes, described below, highlight the importance of (1) good sanitation, (2) adequate nutrition and exercise, (3) traditional remedies and rituals, (4) access to healthcare and medications, (5) improved opportunity for education and personal freedom, and (6) safe living conditions as cornerstones of health promotion and personal well-being.

<u>Hygiene/sanitation</u>

A common theme was practicing good personal and home hygiene and sanitation (n=24). Responses discussing cleanliness, hygiene, and sanitation were especially common among more newly resettled Somali Bantu women compared to other Somali women. Women commonly spoke of the importance of hand washing and maintaining a clean home to prevent against infections for themselves and other family members.

009
S: If I am gonna stay healthy in my house I have to [keep away] germs [from] my body. If I have relationships [with others] who have a sickness, maybe it can affect me and my health…You have to clean. Everything is clean, your house clean, no germs. You stay healthy.

003
You have to control your food first and clean – you stay healthy that way.

Adequate nutrition and physical activity

Twenty participants also spoke of the importance of having access to a stable food supply and eating a balanced diet with fresh fruits, vegetables, dairy products, fish, and meats. Some spoke of challenges maintaining good nutritional habits in the US, both because of uncertainty about nutritional content and value of pre-packaged foods and the wide availability of fatty foods. The following woman provides an example of maintaining a balanced diet:

029
To me I think my health is number one: to eat good diet, well-balanced diet. [Somali] People they like to cook with a lot of oils. Fried food and all this thing. Try to eat a lot of good foods. Try to eat from all the food groups. I try to eat a lot of fruits. I like to drink a lot of water. More than juice and other stuff. And then mix of food like protein and carbohydrate.

Again, most women contrasted the US with Somalia in discussing this, highlighting differences between the US and Somalia in terms of availability of food and refrigeration capacity. The over-abundance of fast foods and fatty foods in the US was also discussed by a few (n=3) participants.

010
In Somalia they get food, but here [in the US] it's more fat food, like fat too much. So here, they [Somalis] gain the weight because they don't go outside and they eat fatty food. Yeah, they don't do exercise.

Relatively few (n=7) additional participants spoke of the importance of regular exercise, such as walking, to maintain good health. Two participants stated that it was more difficult to exercise adequately in the US compared to Somalia or Kenya due to the comparatively sedentary lifestyle in the US and unfavorable weather conditions. An example of how relative lack of exercise can lead to a "new" problem of obesity among Somali women in the US is highlighted below:

030
Most of the Somalis [women] they don't do much exercise [be]cause most of them stay home take care of the kids. Some of them they don't know where to go to do the exercise. [It's] a problem. It's better [for doctors] to give them idea where to go, prescription to do the exercise. They like [exercise] but they don't know where to go to do the exercise.

Traditional healthcare networks, remedies and rituals

Several participants also mentioned using traditional healers and healing ceremonies, prayer, and various foods and home remedies for treating or preventing illness. These were often used before accessing the healthcare system, even in the US. Traditional healers were also described as "helpers," "midwifes," or "community." The following excerpt provides a description of the role of a traditional healer:

029
They [traditional healers] give out medications or to treat people in different ways. They read in the Koran, and they help you when you are sick. Sometimes a woman can be having a baby and be having seizures. We don't rush to the medicine for that. They read the Koran, and help and things will go away.

A number of participants (n=13) described important traditional remedies for protecting the body against illness and preventing development of more serious illness by treating certain symptoms early. Herbal and nutritional remedies were described to treat a variety of ailments, including headaches, gastric problems, body aches, and diarrhea.

004
The child wake up in the nighttime with stomachache and no one knows what cause it. They give them, you know, herbs. Things like garlic, lemon because the stomachache will go away in a while.

Six participants spoke of healing ceremonies by traditional doctors that are still practiced. Though the number of women who gave detailed accounts of traditional practices was small, these women felt that seeking help from both modern and traditional medicine was commonly accepted practice among Somalis. A few participants (n=3) described aspects of a traditional ceremony called Rohani that could be applied for many reasons but was traditionally done as a ritual to protect newborns from illness. Rohani could also be used as either a preventive or treatment option for adults with “soul” or “spiritual” pain, or when medications weren’t working, as a supplement. The following respondent comments on Rohani in the latter example:

017
Did you hear about Rohani? The spiritual feeling comes on them [ceremony participants]…They [Somalis] even practice here. Yes, and this thing comes and they [ceremony participants] talk. They talk different languages. Some don't even speak Somali. They get so sick; doctors can't cure them. They got special people. The one I told you about the Catholics? The incense they burn in the fire? They put incense under them then they talk to them. There's a way they do it …they talk and when they talk you ask them things…like psychics, yeah. Sometimes people have this [because] they get so sick. They go to the hospital. They not cured until they do this thing…[they say] ‘we want you to do this and this’ and then be cured. Sometimes you don't even know the language so you have to get the people who know the language they are talking in. I wish you could see some of this.

<u>Role of religion</u>

Though not specifically asked, 14 participants (41%) volunteered the role that God or religion---specifically, Islam---played in influencing their personal health promotion [staying healthy], behaviors/practices [circumcision], decision making about health [surgery], and avoidance of risky health habits [avoiding tobacco and alcohol].

One respondent illustrates the view expressed that prayer and reading the Koran could help maintain well-being and cure illness:

008
Elderly people have like priest or people pray for them so that they can get better at home. It's just what they believe – it's kind of cultural thing. Like religious people, so they can pray for them and they feel better.

Other participants stated that they avoided use of tobacco and alcohol, as these behaviors are expressly forbidden in the Koran.

Faith in God as a higher power was expressed in terms of overseeing one's life and well-being, and this was especially so in cases of extreme illness or life-threatening conditions.

027
I only believe in God---it's good to be healthy. And whenever you're sick, you get sick and you take care of yourself. I don't worry because God will take care of it.

Faith in God was also evoked in the context of making decisions about serious illness or major surgery. For example, the following excerpt is from a discussion with a woman about whether or not a cesarean section would be acceptable to her.

034
[It] depends what God has planned for [me]. [I] don't know right now. It depends what God has planned for [me]. I'll accept it if it's between death and life.

Access to healthcare and medications

Participants frequently reported that access to medical care and medications was essential for staying healthy by treating illness (n=25). These participants commonly contrasted the ease of access to medical care and doctors in the US compared to Somalia and whilst living in the refugee camps. Almost all women (n=33) felt that the US healthcare system was "better" in terms of availability of physicians, abundance of medications and treatment options, and affordablility (i.e., paid for by insurance). Seeking prompt medical care at the earliest sign of sickness was endorsed as an ideal for many; yet, other respondents stated that many Somali women tend to stay at home and not seek medical care until they are very ill, often due to fear of the unknown (i.e., what would happen during the medical encounter) or lack of knowledge about appropriateness of use of health services (i.e., not thinking that their symptoms justified a medical visit). Most women expressed faith that early/prompt medical care would allow them to be treated effectively. This is described more, below.

002
Africa and here is big difference. When we came here we have more opportunity for health [care]. [In Africa], the woman, if she is pregnant, has the baby in the house. They never see the doctor. If they have a headache they go without medicine…I see a big difference if I go to the doctor in the U.S. with my health issues. I don't have any problem about getting medicine if I get sick all the time and we continue to go to appointments. Life is very good. We don't feel any hunger, pain and if you feel sick, you get medicine. When we came, we go to the TB clinic and we get a flu shot and immunizations. We have a good life here and we don't have any problem and always [we] thinking about back in Africa - [my] sister, mother, and father, [we] left there - and I'm glad that [I] came here and I'm glad [I] got help.

Improved opportunity for education, sense of personal freedom

Some Somali women discussed other factors, such as changes in traditional gender roles, the need for personal "space" or freedom, and opportunities for education, as key for women's health and well-being. These women observed that differences in lifestyle in the US create new opportunities for women to improve their health by exposing them to new possibilities for employment, education, and time spent outside the home.

012
Some [Somali women] are afraid to go [to medical appointments]. They are afraid of what's going to happen. They don't know about health. Some of them know, some don't know. Education is very important for person to know different things. If you are educated---education means that you are allowed to go to school, learn to write, read and get health in community---for community to get education about how to provide for family.

2. Beliefs about personal well-being

Focus on survival – past and present stressors

A salient theme, especially for more recently resettled Bantu refugee women, was a focus on immediate survival rather than long-term, future-oriented health status. Until relatively recently, while living in the refugee camps, many of these women did not think about their future; healthcare, and indeed health and well-being overall, was expressed in more immediate terms.

Many women described past or present challenges they endured that had caused worry, stress, or adverse health consequences. More commonly---and especially true for the Bantu participants---women of spoke of hardships in their lives before resettling in the US:

002
Questions you ask me I could not answer in Africa, because my stomach is not full. I don't have food to eat over there. They have more nutrition over here and that's why I

can answer any question that you ask. Now food we have here, we can eat because we enjoy it. If you have more hunger and more sickness and I don't get any help, if you ask me a question, I start crying.

Other participants also described challenging and stressful aspects of living in the US. The following excerpt illustrates the changes that women can experience in their health due to social isolation, unemployment, and a change in diet and activity after resettling in the US.

010
It's different [between] Somali women and American women ---American women, they get help from the husband---husband and wife, they help each other. Us---they don't help each other. All the time [we] do housework and the men, they go to work and come home. Some men, they do help, some men don't….But most women, they need help, to get a job, take a break, go out.

Good health is a key priority to function in role(s)

Most women (n=22) defined their personal health and well-being in terms of their ability to function in the home and maintain responsibilities of childcare. One woman spoke especially clearly about how her prior health problems had adversely affected her ability to carry out duties. Several participants also stated that good health allowed them to function well in their relationships with others. The following excerpt illustrated how her experience with illness adversely affected her relationships and her role in the family:

017
Health is life. When somebody is sick you don't have life. And when you're healthy you [have] life. When I was sick, [I was] angry even to the kids. [I] was not communicating to the kids. [I couldn't] do anything. But now it's different because I can talk to the kids and do stuff and [play with the kids]. Now the communication is much better. [I] can do everything for [myself]. Which means [I am] healthy.

3. Knowledge and interest in US preventive health services

Low knowledge of Papanicalaou testing and mammography

Portions of the interview explored participants' familiarity with two common women's preventive healthcare services in the US: Papanicalaou tests and mammography. A little over half (n=18) recognized the term "Pap test," "GYN check-up," or "pelvic exam" and understood it to mean a vaginal examination done to check for infections, especially during pregnancy. Three women knew that the purpose of Pap testing was for cervical cancer screening; these women had been resettled in the US for greater than 5 years, were fluent English, and had experience working in the US healthcare system. Many (n=13) did not recognize the word "Pap testing," even when the procedure was described to them. Mammography (either the word or the test procedure) was recognized by only six women.

One of the few women who did understand the purpose of mammography screening explained her opinion about it:

008
You never know what you may have. You may have cancer. It's good because I know that I am healthy. Yes, they check your breast to see if you have breast cancer. That [breast cancer] kills a lot of women everywhere, in the United States, everywhere. You have to know if you have a problem with your breasts.

Most (n=25) of the women did not recognize or understand the term "cancer," both because the word itself was difficult to translate and the disease process itself did not appear to be understood. Those that recognized the term "cancer" described it as an unfamiliar, fear-provoking illness that causes death and is more common in the US than Africa:

030
They [Somali women] not used to cancer and all these different diseases that are in America. They tend to be scared. They don't want to know, you know? They'd rather not know. Go [to a medical appointment] and have them [doctors] say you have this disease, that disease. Make them scared you know. And stressed. They don't want to know. Most of them they don't go to those checkups. I don't know what cancer means. I just know heart cancer, breast cancer. I don't know where it comes from or what it is. I never heard anybody talking about cancer.

012
Some people don't know what the word means or sometimes people don't like to talk about it. They're afraid you know. I don't know. Some people are afraid of things they don't understand. They don't like cancer. They don't have that much cancer in Africa. They don't know what is cancer.

<u>Universal recognition, acceptance of "check–up" and immunizations</u>

Participants were most familiar with getting a physical examination or "check-up" and blood and urine tests; 26 (76%) mentioned them as the most common examples of routine medical care. Most participants stated they would not go to the doctor if they weren't sick. Routine check-ups were usually only mentioned in the context of prenatal care. With the exception of prenatal care, only four respondents stated that they would go even if not sick. These women said they would go if they received a letter or prompt from the office to come in, or if they had a follow-up appointment. These four women were all English-speaking Somalis who had been resettled in the US for 5 years or longer.

Not surprisingly, all participants (n=34) were familiar with the terms "immunizations" "vaccinations," or "shots." Most participants were able to name diseases that

immunizations could protect against, such as measles, polio, flu, varicella, tuberculosis, and hepatitis B.

Discussion

This study compares Somali women's views of health promotion with knowledge of US based preventive health services, findings not previously documented in the literature. Results showed that in our sample of Somali women, certain principles of health promotion and disease prevention strategies are well understood, highly valued, and addressed in women's everyday health practices, whereas others are relatively neglected. Knowledge of aspects of disease prevention varied from universal familiarity and acceptance of immunizations to near absence of understanding of cancer and cancer screening services.

Our results also highlight the social and cultural context of beliefs about preventive healthcare services and the influence that migration and acculturation status can have on beliefs about health promotion. These participants represented a variety of phases of acculturation and spoke of their health beliefs and practices in transition as well. Despite similarity in general definitions of health promotion, personal well-being was conceptualized and expressed differently between Bantu Somali women and other Somali women. Bantu participants tended to describe their personal well-being as grounded in the present "here-and-now," often contrasting this immediacy to the hardships they had experienced or that family members were still experiencing. Bantu women were on average resettled in the US for much shorter time periods compared to other Somali women and had lived in refugee camps much longer than other Somali women, as many as 10-12 years. Thus Bantu women often contrasted their definition of well-being to recent memories of suffering and hardship they had endured whilst in the refugee camps. Other (non-Bantu) Somali women usually did not frame discussions of their personal health in this way, tending to discuss their well-being in terms of enhanced opportunities for work or education. Longer residence in the US is presumably associated with greater Western acculturation, including changing gender roles, empowerment, and educational opportunities. Preventive health programs for Somali women, therefore, need to take into account factors such as duration of residence in the US and length of residence in refugee camps; these factors were closely related to Somali women's definitions of health promotion.

Findings from this study point to similarities and differences in conceptual frameworks of health prevention cross-culturally. Participants endorsed similar healthy lifestyle habits promoted by US preventive health guidelines (US Preventive Health Services, 1998), such as eating a healthy diet, exercising regularly, having access to a regular source of medical care, and avoiding adoption of risky health behaviors such as tobacco and alcohol use. However participants also described unique traditional treatments and cultural traditions for protection against sickness, citing use of indigenous botanicals, herbs, and religious healing ceremonies to both protect against and treat various forms of illness. Health promotion programs for Somali women and their families should build on existing positive health behaviors, such as promoting

healthful African diets rather than a typical American diet with its overabundance of high-fat, processed foods. Such programs should also promote a regular program of exercise, which had already been identified by these women as starting to decline once they resettled in the US. Such programs should address barriers cited by these participants, such as provision of childcare of exercise that is also a form of social interaction, such as group programs.

As reported in other studies (Meadows, Thurston, & Melton, 2001; Plaisted, 2002), many women identified spirituality and religious faith as integrally related to their health. Many participants gave specific examples of Islamic teachings that influenced overall well-being, dietary habits, family function/roles, and serious or life-threatening health decisions, such as surgery. Health promotion and disease prevention programs should incorporate spiritual and religious underpinnings of such health beliefs.

Self-reported good health among these women is consistent with previous literature (Naish, Brown, & Denton, 1994; Meadows et al., 2001) addressing health behaviors and prevention practices of immigrant and refugee women. Most participants reported their health to be very good, with relatively few worried about their health. This is likely due to a variety of factors. Refugee women who have survived living in camps for many years are likely to be healthier than those who did not survive. US immigration policy selects for immigrants and refugees who show the greatest potential to contribute to the workforce, education, and economy. (Hyman & Guruge, 2002) Refugee women may also use a different standard for judging their health and well-being than non-refugee American women do. Consistent with other qualitative work with immigrant women (Meadows et al., 2001), personal health often was expressed in terms of physical well-being and ability to function in a family-centered way. Participants in this study also defined their well-being in terms of being able to function in their role as mother, wife, and caregiver of the family, maintaining the household structure. Women who had concerns about their health or spoke of others in poor health often did so by describing how their health impaired their ability to perform household duties and care for their children. It is possible that symptoms that did not interfere with these role functions were devalued and that, given our exclusion criterion of acute illness, sicker participants were less likely to be recruited by key informants.

Knowledge the rationale of commonly recommended preventive health services, such as Pap and mammography, was low. Possible reasons include lack of familiarity with the healthcare system for recently resettled women; limited experience of having discussed these matters with their physician; language barriers, such as incomplete or unclear translation; and “shyness” about discussing such matters. Previous work has also shown that immigrant women tend to receive fewer Pap and mammography services. For this sample of women, acceptance of cancer screening services could be challenging both because of lack of knowledge about the services but also because they view cancer as an unfamiliar, frightening, potentially stigmatizing illness. Efforts are needed to improve informed decision making for this population---specifically, helping Somali women understand the nature of cancer; understanding the purpose of Pap and mammography testing and its consequences; explaining limitations, uncertainties, or alternatives; and encouraging a decision consistent with the woman's

own preferences or values (Briss, Rimer, Reilley, Coates, Lee, Mullen et al., 2004). Possible interventions that have shown promise in other populations (Lam, McPhee, Mock, Wong, Doan, Nguyen et al., 2003; Weinrich, Holdford, Boyd, Creanga, Cover, Johnson et al., 1998; Brach & Fraser, 2000) to promote culturally competent, informed decision making about cancer screening include use of Somali female health workers for community outreach; targeting Somali women in their homes via community networking groups; and/or using in-person discussions or media campaigns rather than printed materials for women who are unable to read.

Limitations

Methodological limitations include a possible interviewer effect. The interviews were conducted by healthcare providers, which may have influenced the participants' response to questions requiring them to critique the healthcare system. To minimize this effect, the research team interviewed women with whom they had little or no direct patient contact. Similar questions also were asked in various formats and sections of the interview and cross-checked for consistency. Finally, the focus group conducted checked for the validity of themes that had emerged with individual interviews.

In cross-cultural research, the format must be sensitive to inherent cultural differences in social interaction. Social pacing in interactions may have negatively affected the comfort level of participants in answering personal questions. In order to decrease these situational influences on participant responses, the interviewers tried to maintain an open dialogue with the participants avoiding the effects of direct questions.

Language barriers must also be acknowledged in cross-cultural qualitative research. Initially, the project required the use of lay translators. The team was eventually able to coordinate interviews with a professional Somali, female translator who then listened to transcripts with lay translators to address fidelity of translation. She made an average of nine lines of corrections per transcript; the average number of lines per transcript was 394. Some participants were difficult to engage in the interview process, perhaps because they were unfamiliar with cultural interview norms and expectations. Cultural beliefs on gender roles and norms regarding publicly revealing personal viewpoints may have impeded the discussion.

Conclusion

Somali women in the US have distinct beliefs about health promotion and incorporate a variety of techniques to prevent illness. Efforts should be made to increase Bantu women's knowledge about the rationale for preventive services, such as cancer screening. Future programs should build upon Somali women's existing healthy habits, such as promoting healthy African diets, exercise, spirituality, and continued avoidance of tobacco and alcohol. Research is needed to address the effectiveness of community-based women's health promotion programs for Somali women.

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List of Publications and Products

1. Health promotion and preventive services among Somali women, manuscript submitted.
2. Cultural competency and healthcare service provision to Somali women, manuscript in progress.
3. Prenatal and obstetrical care: use of US vs. traditional care models in African refugee women, manuscript in progress.
4. Carroll JC. Health Promotion and Preventive Services among Somali Women. North Atlantic Primary Care Research Group; 2005 Oct 15-18; Quebec, Canada. Quebec: North Atlantic Primary Care Research Group; 2005.
5. Carroll JC. Health Promotion and Preventive Services among Somali Women. University of Rochester Cancer Center Symposium; 2005 Nov 10; Rochester, NY. University of Rochester Medical Center; 2005.
6. Carroll JC. Cultural Competence and Healthcare Quality for Refugee Women. Society for Teachers of Family Medicine Annual Spring Conference. 2006 Apr 26-28; San Francisco, CA. San Francisco: Society of Teachers of Family Medicine; 2006.
7. [abstract submitted] Carroll JC. Health promotion and preventive services among Somali women. Society of Behavioral Medicine Annual Meeting; 2006 Mar 22-26; San Francisco, CA. San Francisco: Society of Behavioral Medicine; 2006.
8. [abstract to be submitted] Carroll JC. Cultural Competence and Healthcare Quality for Refugee Women. European Association for Communication in Healthcare. 2006 Sept 5-8; Basle, Switzerland. Basle: European Association for Communication in Healthcare; 2006.
9. [abstract to be submitted] Carroll JC. Cultural Competence and Healthcare Quality for Refugee Women. American Public Health Association. 2006 Nov 4-8; Boston, MA. Boston: American Public Health Association; 2006.