

An Investigation of Somali Women's Beliefs, Practices, and Attitudes about Health, Health Promoting Behaviours and Cancer Prevention

S.A. Francis, F.M. Griffith & K.A. Leser

Volume 6, No. 1 (2014) | ISSN 2161-6590 (online)
DOI 10.5195/hcs.2014.119 | <http://hcs.pitt.edu>



New articles in this journal are licensed under a Creative Commons Attribution 3.0 United States License.



This journal is published by the [University Library System](#) of the [University of Pittsburgh](#) as part of its [D-Scribe Digital Publishing Program](#), and is cosponsored by the [University of Pittsburgh Press](#).

Abstract

This pilot study examined Somali women's perception of health/access to care, examined their knowledge and attitudes about cancer prevention, and discussed strategies to improve service provision and education.

Using a multidisciplinary approach, twelve face-to-face interviews were conducted with Somali women ages 18 and older, residing in a mid-western city. Open coding was used to categorize and reflect the interview statements and to identify reoccurring themes.

Somali women are concerned about a variety of health issues and cited the role of culture and religion in developing prevention strategies. Participants emphasized the use of religious leaders, health care advocates, oral traditions, and translators in providing culturally appropriate health care services.

Religion and culture play a prominent role in the Somali community and impact beliefs about health and wellness. Health practitioners need to work closely with individuals and community leaders to tailor services that are culturally appropriate and accessible.

Keywords: *United States; Somali women; women's health; cancer prevention*

An Investigation of Somali Women's Beliefs, Practices, and Attitudes about Health, Health Promoting Behaviours and Cancer Prevention

S.A. Francis, F.M. Griffith & K.A. Leser

I. Introduction

Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion (DHHS, 2010).” Poverty, lack of health insurance and other barriers prevent individuals from receiving preventive care, screening, and treatment. Individuals from ethnic and racial groups are, on average, more likely to be disproportionately affected by cancer and are less likely to be diagnosed early (Ohio Cancer Facts, 2010). As a result of these disparities, numerous public health advocacy organizations, including the American Cancer Society and the NIH, seek to address and eliminate these disparities. Although the causes of health disparities are complex; researchers have confirmed that they are associated with inequalities in wealth, income, education, housing, standard of living, and other social barriers that may impede access to quality detection and treatment (Cancer Facts & Figures, 2010). Additional factors that contribute to health disparities include: language, cultural and religious beliefs, and literacy level (Ohio Cancer Facts and Figures, 2010).

Global migration patterns and population changes have led to an increase in ethnic diversity in Europe, Canada, and the U.S. Currently about 25 million refugees and immigrants comprise approximately 10% of the US population. As a result, health care providers are no longer serving a monolithic community. These major demographic shifts emphasize the need for health care policies and services that address the needs of this population. Immigrants and refugees from Africa represent one of the fastest-growing groups who resettle in the United States, Canada, and Europe (Carroll et al., 2007a; Carroll et al., 2007b). According to the Migration Policy Institute, the number of African immigrants in the U.S. grew 40-fold between 1960 and 2007 from 35,355 to 1.4 million (Terrazas, 2011). About 1/3 of Africa immigrants are from West Africa but there are also large numbers of East Africans (Terrazas, 2011). Forty-five percent of African refugees in the United States are of Somali descent (Carroll et al., 2007a). In 1991, civil war in Somalia led to forced migration and displacement of over three million Somalis; over one million fled to neighboring countries while the remaining two million were displaced internally (Carroll et al., 2007a; Carroll et al., 2007b). According to Carroll et al. (2007a, 2007b), between 1991 and 2000, approximately 100,000 Somalis arrived in the United States as refugees, asylum seekers or through family sponsorship (Refugees international, 2006). According to data from Columbus and Franklin County, in 2008 there were approximately 35,000 – 80,000 Somali immigrants and refugees residing in central Ohio, making this the second largest Somali community in the US, second only to Minneapolis, Minnesota (Johnson, et al., 2009). This community continues to grow as individuals migrate from other parts of the country and from Canada.

Compared to other immigrants, Africans, on average, tend to be highly educated and speak English well, and about two of every five African foreign-born adults have a bachelor's degree or higher (Terrazas, 2011). However, on average, Somalis may have lower literacy rates and be less fluent in English, which can be attributed to interrupted education (e.g. civil war led to dismantling of educational system) (Johnson et al., 2009). In addition, Somalis are less likely to be insured and have a regular source of care (Noor, 2011). Although the health care system in pre-civil war Somalia consisted of "Western" style hospitals and clinics as well as traditional healers, most Somalis were familiar with western medical concepts such as immunizations, rehydration, and the use of antibiotics to treat illness. Somalis were also familiar with traditional approaches to treating ailments including prayer and religious ceremonies and/or use of herbs and other herbal remedies (Plaisted, 2002). However, the civil war displaced Somalis to live in refugee camps, which lacked resources and facilities to adequately address health problems. Furthermore, many refugees had to rely on episodic, emergency based care. Therefore, many refugees may have little exposure or familiarity with preventive care (Carroll et al., 2007a).

Although there are large numbers of immigrants settling in the United States, extensive empirical evidence documents numerous racial and ethnic disparities in providing preventive health care services to this population (Fiscella et al., 2002; Abdullahi et al., 2009). For example, Somali women were found to be at increased risk for complications during pregnancy, were less likely to have a Pap smear, and were less likely to have a regular source of care (David et al, 1997; Siegel et al., 2001; Carroll et al., 2007a; Carroll et al., 2007b; Pavlish et al., 2010). Findings from these early studies found that numerous social determinants were associated with health behaviors e.g. health beliefs, cultural norms, and language barriers. However, it is important to understand the perspective of Somali women in order to understand what public health practitioners can do to increase their own cultural sensitivity, decrease Somali women's barriers to care, and better tailor health promotion and prevention initiatives to meet the needs of this population. In order to eliminate current health disparities among immigrant and refugee populations, we must have a better understanding of their health needs, acknowledge and address barriers to care, increase access to screenings, and provide individuals with culturally appropriate health education.

II. Theoretical Framework

McFarland (2003) conceptualized the Health Behavior Theory model to address the relationship between knowledge and belief about cervical cancer and Pap smear tests among women in Botswana. The author posits that according to the health behavior model, individuals assess the following: preventive actions based on susceptibility to a disease, perceived acuteness of the disease, and perceived advantage and obstacles of preventive action. Furthermore, the author notes that certain characteristics alter behaviors, including demographic characteristics, socio-psychological and structural factors. This study utilizes the Health Behavior Theory model, to understand the following issues:

- (1) To examine Somali women's beliefs about optimal health and health promotion e.g. how do Somali women conceptualize health and health promotion?
- (2) To examine Somali women's attitudes, knowledge, beliefs and practices around their health/health promotion e.g. specifically with regards to cancer prevention
- (3) To explore Somali women's attitudes, knowledge, beliefs and practices around cancer prevention (e.g. breast and cervical cancer) and;
- (4) To identify potential strategies to optimize health.

III. Methods

Study population

Somali women were recruited between April and July 2012 in Columbus, OH by word of mouth, through key informants, and flyers. The principal and co-investigator worked closely with Somali leaders (e.g. project consultants) to identify study participants. To be eligible for the study, participants must:

- 1.) Be a female age 18 or older,
- 2.) Be born in Somalia or be of Somali descent, and
- 3.) Currently resides in Central Ohio metropolitan area

Data collection

Once potential study participants were identified, they were contacted by email or phone. At the initial point of contact, it was explained why they were being contacted and they were provided with background information about the PIs, the research study, and were invited to participate. All individuals contacted agreed to participate in the interviews and were then scheduled for an interview at their convenience. Reminder calls, emails, or texts were sent to study participants.

Twelve in-depth, face-to-face interviews were conducted. Interviews took place in a private conference room in a local library. All interviews were conducted in English, were digitally recorded for accuracy, and took between 40 to 60 minutes allowing time for verbal, informed consent. Participants were given \$25 to compensate them for their travel and time. Verbal consent was used because written consent in immigrant/refugee populations tends to be problematic as members of this community often have fears about their privacy, confidentiality, and who may have access to shared information (Johnson et al 2009). Interviews were audiotaped for accuracy. During the interviews, one staff member transcribed the interview while the other facilitated the interview. A research assistant reviewed the audiotapes and transcripts for accuracy, to make written corrections, and other notations for transcripts as needed. The institutional review boards at both Denison University and the Ohio State University approved the study.

Analysis

Open coding, which requires analyzing, categorizing, and describing the themes from the interviews, was used to organize the data. Once all data was entered, data was coded to reflect interview statements. Three research team members (Leser, Francis, Griffith) analyzed and identified themes. Quotations were selected that best illustrated the themes of interest. The interviews explored the following themes:

- (1) How Somali women conceptualize health e.g. what are Somali women's beliefs about health and health promotion
- (2) Most important health issues affecting Somali women
- (3) Barriers to and facilitating factors to accessing care
- (4) Potential strategies to reduce barriers
- (5) How culture and religion impact health
- (6) Attitudes and beliefs about health and;
- (7) Identify strategies ways to work with Somali community to improve health

Results

Demographics: Twelve participants were interviewed. The mean age of participants was 33.67 ± 10.92 years [range: 22-65]. Eight participants (67%) were single, three (25%) were married, and 1 woman (8%) was a widow. Four (33%) of the twelve participants' reporting having children. Nine women (75%) reported being employed outside of the home. On average, participants had lived in Columbus, Ohio an average of 7.74 years.

The interview guide was broken down into the following six content areas:

- Perceptions of health
- Access to healthcare
- Barriers to receiving healthcare
- Perceived health problems in the Somali Community
- Cancer prevention
- Strategies to improve health

IV. Perceptions of Health

When asked to describe what they think of when they hear the term health, participants provided a variety of answers including: physical, mental, and emotional health, as well as, being free from disease and taking care of one's self. In addition, participants noted that prayer can be used to help increase health and that good health also consists of eating a healthy diet and being physically active. When asked to describe what factors impact health, participants primarily noted that access to healthcare impacts health. Lifestyle choices such as diet and physical activity were also mentioned as behavioral factors that have a large impact in health. Prayer, proper sleep, social support, stress and demographic characteristics were also mentioned as variables that influence health status:

Quote #1: Even people with insurance access, if you're living a high stress lifestyle and keeping company with not the best people, of course that will have an impact on your health. So I think there are many things that can impact your health.

Quote #2: I know many things like smoking, the environment, not eating right will affect you, not exercising or being able to move a lot, especially in this country because people don't walk a lot compared to in my country where people walk a lot and here people don't walk a lot and don't eat healthy food and that can cause a lot of chronic illnesses like depression and stress.

Quote #3: Practically everything can affect a person's health such as the environment, stress, being high strung, what they eat and their attitudes towards health care.

When asked to describe how their Somali culture impacts their health and wellbeing, the majority of participants noted that God impacts health and that alternative medicines and prayer should be used to deal with health problems. It was also consistently noted among participants that Somalis lack trust in their health care providers, and only seek medical help when they are severely ill, indicating that members of the Somali community tend to seek out very low levels of preventative care. Participants shared the following comments about culture and health:

Quote #1: We think God gives us health, and we are going to deal with it. You don't go to the doctor in Somali unless you're really sick. Coming here [United States] has been hard for a lot of people because they feel like my culture does not impact my health. For me, my culture does not stop me from going to the doctor.

Quote #2: Culture plays a big thing because people have their own beliefs of how they see things. For instance, if they get used to seeing a home doctor that worked for them, they would mistrust another doctor.

Quote #3: In the Somali culture, there's always been a sense of acute care. If I'm really really sick, I'm having crazy chest pains or a huge headache then I'm going to see the doctor. But the idea of seeking care for a cold or flu or stomachache does not exist in our community.

Participants were asked whom they talked to about their health concerns, the majority of participants noted that they prefer to talk primarily to their family and friends; participants noted that they would talk to healthcare providers but that it was not preferable. Participants indicated that they talk about a variety of health concerns with others including: diet, sleep habits, stress, allergies, high blood pressure, alternative approaches to healing, and how to maintain their current health status:

If something is very serious, then I will talk with a doctor, but usually I do not see the need to talk with a doctor. I think that's very cultural as I said. We don't run to the doctor for everything single thing. We only got to the doctor is something is serious.

Access to health care

When asked who made the decisions about their own health, ten out of twelve (83.3%) participants noted that they made their own healthcare choices, while one allowed her husband to make the decisions and another allowed her healthcare provider to make health decisions. Participants reported seeing their health care provider anywhere from once a month to every four years, with most indicating that they go only when sick or for annual appointments. When asked the reasons why they see a healthcare provider, a wide variety of reasons were reported including: reproductive health, digestive health, sleep problems, asthma, allergies, pain problems, and dental care. Participants shared the following thoughts about access to care:

Compared to my kids, I only go when I am sick. I try to get things over the counter. When I am pregnant, I am up to date on everything with the doctors' visits. I don't remember that last time I went. Last time was with my gynecologist after the birth of my daughter.

Only 33% of participants had children, but of those with children, the large majority said that their husbands or other family members work together with them to make health decisions for their children. Again, there was a range of frequencies reported for how often participants take their children to see a healthcare provider, with some reporting "as often as needed" while others reported taking their child to a healthcare provider up to twice a year. One mother shared, "If they have a fever or other problems, throwing up. I'll wait a couple of days. An experienced mom doesn't rush to the doctor."

Barriers to receiving health care

Participants were asked to describe a time when they needed to go to a healthcare provider but decided not to seek medical help. The large majority of participants indicated that the financial costs (e.g. co-pays, lack of health insurance) associated with doctor visits were the primary reasons for not receiving medical care. Another participant noted that she did not go to see a doctor/nurse the last time she needed to because her husband was sick at the same time:

Quote #1: Most Somali women don't have insurance and they don't go, and they usually go to urgent care and they will get treatment.

Quote #2: I had the flu and at the same time my husband was sick and I waited and then went to the ER. My role is as the mother, family giver, I am the bone. I try to stay health and act like I am not sick because I have to be the caregiver.

Other reasons given for not seeking medical attention include: not being familiar with how to navigate the healthcare system, wanting to see a female doctor and it simply being a hassle to go to the doctor. Two participants indicated that they always go to the doctor/nurse when needed because they have health insurance/willing to pay for care:

Quote #1: I am Muslim, so I try and see if a women is available. Religious accommodation and I don't like going to the hospital. I prefer to take care of myself.

Quote #2: Probably the hassle of it, if it's not something pressing, then it's not for me unless I am in excruciating pain.

Participants were then asked to describe the concerns they have about seeking medical care and a wide range of responses were given, with financial concerns/lack of health insurance being the primary concern. Participants also mentioned: concern over cultural competency/language barriers of healthcare providers, fear of getting the best quality of care, difficulty finding a doctor, being afraid of the medical results and being embarrassed to discuss certain health problems with providers. Participants shared the following concerns they have about seeking medical care:

Quote #1: Financial reasons because I don't have health insurances and sometimes it gets embarrassing for me to discuss some intimate details.

Quote #2: Whether or not they will understand my religious beliefs. Gender and proper care competence are important, and getting the best quality of care. I don't like entering a situation without knowing about it.

Perceived health problems in the Somali Community

Participants were then asked to describe health issues that are important to the entire Somali community and a wide range of health concerns were described including: obesity, cancer, mental health, high blood pressure, diabetes, heart disease, stress, aging, high cholesterol and autism. Of those listed above, the primary recurrent health concerns among participants were diabetes (6/12) and cancer (5/12). In regards to the health concerns for the Somali

female community, reproductive health issues were noted as the primary concern (5/12), while obesity, mental health, and vaccinations were also mentioned as health concerns impacting the Somali female community:

Quote #1: Obesity is a concern because you have women who were once very active eating natural foods, and now after coming to the US they are leading very stagnant lives, living in an apartment most of the time and they are eating with their family so rising rates of obesity are important.

Quote #2: Single mothers particular are more depressed than men. They mostly raise children and they have a lot of pressure to cook and clean, and are more depressed than others because they are always thinking about their children.

Cancer Prevention

Participants were asked, “When you hear the word cancer, what comes to mind?” and the large majority (8/12) of the participants stated “death.” In addition, participants noted that cancer is “painful” and “scary” and that it is often diagnosed among Somalis in the later stages of disease progression, and that some cancers may be prevented through lifestyle choices:

Quote #1: When in Somalia you are only sick if you can't walk or can't move. People believe cancer is due to God. It is an upper power. Cancer is the worst but people do not feel sad because it comes from God. Somalis do not kill themselves when they find out they have cancer; instead they celebrate and live life because it's from God.

Quote #2: That person is going to die, and need helps and me nice. It is a shock and it is not normal.

Quote #3: Bad--I think that is the common consensus. It's a life sentence that leads to death. It's negative, and I will add that many people wait until something serious happens in the community. This has benefits and negatives, so many people are presenting to doctors with Stage 4 cancer when nothing can be done about it. So in our community, unfortunately it is usually a death sentence.

Nine of the twelve participants knew someone who had cancer. When asked how knowing someone with cancer had affected them, participants indicated that they felt sorry for the person and that it made them more aware of cancer screening and the need for preventative healthcare; however, most participants indicated that they were not personally affected by knowing someone with cancer. Eight of the twelve participants stated that they had been previously screened for cancer (range of last screening: two months ago- four years ago). Four of the eight participants who had been screened for cancer had been screened for breast cancer, one had been screened for cervical cancer and three had been screened for both breast and cervical cancer:

Quote #1: My friend's relatives told her not to take the medicine, and she went to get chemotherapy and got really small, lost her hair and nails and later on she is much better, she gained weight, and her hair grew back and treatment gave her a chance at life.

Quote #2: If breast cancer affected her, it can affect me

Quote #3: I'm very skinny, so I was told that people who are skinny have very lumpy breasts. I was concerned about breast cancer, so I went for a screening and they said that was just the way I am.

Strategies to improve health

Participants were then asked a series of questions about how to improve the health of members of the Somali community. The importance of focusing on Somali culture and religion in future interventions/educational programming was a recurrent theme:

There's a huge belief that it is God's will, whatever happens to me must be meant for me—
programs should reiterate that we have choices.

Participants also recommended that promoting health awareness and health education is very important in this community, as Somali women are lacking essential health information. The primary methods recommended for educational programming were: an educational health video (in Somali language), educational classes (at mosques/Somali malls with a strong emphasis on Somali culture), and holding health fairs. It was also suggested that children be involved with health training for their mothers. Using oral approaches to education were consistently recommended over the use of print material among members of the Somali community. In addition, educational opportunities that increases social support among members of the community was suggested as a way to promote health.

Quote #1: I think educating them and offering classes. For example eating healthy and workshops and show them the right food, screening them would be a real effort.

Quote #2: Education is really important and involve Somali nurses and doctors because it will be easier to listen to someone you can trust.

Quote #3: We need more health care practitioners meeting people face to face. We need more people, as I said, in the communities working with families but all of it has to be oral. Providing written materials is not going to do much.

Participants were then asked what resources would be needed to maintain/achieve health in their community. There was a general consensus that Somali language and culture is a significant barrier for Somalis receiving healthcare in the Western world. Participants recommended that more female interpreters and/or doctors familiar with the Somali culture are needed to work with the growing Somali community. It was also recognized that many Somali women might not trust their interpreter and therefore do not share important information with their healthcare providers.

Quote #1: Most of the time they don't speak English, they do not trust the translator.

Quote #2: Sometimes women are put with a male interpreter, so of course they will not disclose information.

Quote #3: There is a sense that the Somali community does not want to integrate into American society and that they want to keep their culture and be isolated from everybody. There are a lot of negative perceptions of Somalis in Columbus, Ohio and a lot if it is lack of access and people do not recognize that.

Quote #4: Somali clinicians understand the culture, religion and everything, all of the hindrances to an issue.

Quote #5: A lot of our doctors are providing them with these very exclusive options, this or that; these doctors have no understanding of how things are done traditionally.

Participants were then asked to describe possible methods for motivating members of the Somali community to take better care of their health, and no consistent themes emerged; however, several ideas were offered. Aside from education, participants mentioned that identifying a community health leader in the mosque would be helpful for gaining support for health education, as well as, having females in the community role model healthy behaviors to their Somali peers. In addition, it was recommended that researchers/clinicians need to allow Somali women to have their voices heard so that trust can be built in the healthcare setting.

Quote #1: First the leaders should be educated, and then the people will follow. Women and men are separate in the mosque but hear the same message.

Quote #2: Leaders of the mosque can tell people and they will listen, then the message will be passed on.

Quote #3: Having open talks, because Somalis have something to say about everything. So have open conversations where you give your point of view and then try to understand their point of view.

V. Discussion

This study sought to: 1) explore how Somali women conceptualize health, 2) examine Somali women's attitudes, knowledge, beliefs and practices around their health, 3) explore Somali women's attitudes, beliefs, knowledge, and practices around cancer prevention, and 4) identify potential strategies to optimize health. The key findings included: 1) Participants have a holistic view of health, as they incorporated physical, mental, and emotional health as well as being free of disease as part of the concept of health. 2) Culture and religion play a strong role in their health and wellbeing. 3) A reoccurring theme was a lack of trust in their health care providers and the practice of only seeking medical care for acute conditions vs. preventative care and 4) Participants reported being concerned about a variety of health issues with cancer, mental health, and obesity the most frequently cited. Participants were not only concerned about their own health status but were also concerned about their families' health as well as the health of members in the Somali community.

An important consideration in terms of working with Somali individuals or the community is to recognize the significance of religion and culture. The majority of Somalis are Muslim and their views about health are shaped by the religious and cultural traditions (Abdullah et al., 2009). Most of the participants defined health as inclusive of mental, physical, spiritual and emotional health. However, when asked about health issues, they expressed concerns about cancer, obesity, reproductive health, and mental health issues, which is consistent with findings from previous studies (Pavlish et al., 2010; Kroll et al., 2011). In terms of concerns about cancer prevention, in our interview, two participants referred to cancer, as being the "will of God" and that there was nothing that could be done about it. However, while some women shared this fatalistic view, other participants identified several factors that shaped health including lifestyle choices and access to health care. In addition, 67% of participants reported being screening for either breast or cervical cancer within the last two months to four years. However, participants expressed that lack of insurance was a barrier to accessing health care services and seeking preventative care. Another barrier to care was the concern about cultural competency and language barriers (Carroll et al., 2007a,b; DeStephano et al., 2010; Venters et al., 2011). Participants expressed lack of trust for medical

providers and being embarrassed to discuss certain health problems with providers. Participants did not feel that most providers understand Muslim culture (e.g. the need to see a female provider versus a male provider) and expressed a need for cultural competency training in this area. Previous research by Beach and colleagues found that among other U. S. minority groups, being treated in a respectful manner is associated with better adherence to treatment recommendations. In addition, gender concordance was found to be significant. Gender concordance between the patient and provider may help build respectful and effective communication between the patient and provider and are associated with improved satisfaction with and use of services (Carroll et al., 2007a).

Participants in this study also expressed the needs for additional interpreters. Although they did not emphasize that the interpreters must be female, given the importance of their religious tradition and the importance of gender roles, we believe that participants would be satisfied with additional male and female Somali interpreters and would require translators who were gender concordant to the patient. Cross-gender interaction can be more awkward and uncomfortable for patients, thus the presence of a female interpreter (for those who need it) and a female provider would be acceptable and appealing to many female Somali patients. According to Carroll et al., (2007a), “interpreters may work to reduce disparities by functioning in an expanded role as cultural liaisons and advocates, assisting patients in navigating the health care system to ensure appropriate follow-up and adherence to treatment plans.” Based on previous research and the interviews, the interpreters are beneficial to the participants as it was expressed that the American health care system is confusing.

Given the narrative that participants shared about their experiences with health and within the health care system, the data suggest that prevention efforts should focus on education, and cultural competency, which would involve developing relationships and partnerships with the Somali community. Johnson et al (2009) focus on the process used to establish community-based partnerships in the Somali community to facilitate access to health care and health education. The suggested strategy was to utilize community based participatory practices (CBPR) as the building blocks for partnering with the Somali community. CBPR is defined as research that is conducted as an equal partnership between traditionally trained "experts" and members of a community. In CBPR projects, the community participates fully in all aspects of the research process. CBPR projects start with the community based on what the community deems as important. Key strategies for working with communities and using CBPR include: (1) recognizing the community as a unit of identity, (2) building on the strengths and resources within the community, (3) facilitating collaborative partnerships in all phases of the research, (4) integrating knowledge and action for mutual benefit of all partners, (5) promoting a co-learning and empowering process that attended to social inequalities, (6) involving a cyclical and iterative process, (7) addressing health from both positive and ecologic perspectives, and (8) disseminating findings and knowledge gained to all partners (Johnson et al., 2009). While we suggest the consideration of CBPR. the current study as well as previous studies has recognized the use of oral and visual media to facilitate education and prevention (e.g. use of health education DVDs/videos with Somali actors/participants). Previous studies have also supported the appropriateness of culturally tailored videos for low literacy, minority, and immigrant populations and indicated an increase in health knowledge, health screening, and reduction in cultural barriers to medical interventions (Abdullah et al., 2009; DeStephano et al., 2010). Given the importance of the oral tradition to the community, the findings suggest this would be a useful strategy for disseminating prevention messages. In addition, participants also expressed the importance of buy-in from religious and community leaders who could help disseminate messages throughout their mosques and community contacts. While we have focused on the experience of women from a qualitative lens, it is also important to design quantitative studies that will assess Somali health in a systematic and representative manner. The multi-method analysis will provide researchers and educators a better understanding of the physical, environmental, social, and cultural determinants associated with health and access to health care in the Somali community.

Strengths and Limitations

This study has several limitations and strengths that should be noted. Due to the study's exploratory nature and small sample size, reported findings are descriptive in nature and are only generalizable to the target community. The strengths of this exploratory study include exploring perspectives of health, access to health care, barriers to care, perceived health care issues in the Somali community, and strategies to improve health from the perspective of individuals who are part of this community. The study also offers potential suggestions to guide the development and dissemination of prevention education to the Somali community.

Our study findings illustrate that religion and culture are an integral part of the Somali experience and that women are concerned about health care issues both for themselves, their families, and their community. Health educators and providers need to work closely with the Somali community to better address their health care needs and tailor services and programs that are sensitive to their cultural and religious traditions.

Acknowledgements

The current study was supported by research grants awarded by the Office of Diversity and Inclusion at the Ohio State University and the Denison University Research Foundation at Denison University. The contents of this presentation are solely the responsibility of the authors and do not necessarily represent the official views of the Office of Diversity and Inclusion, the Denison University Research Foundation, the Ohio State University, or Denison University. The authors would like to thank Hibo Noor, MPH, Hanna Adan, and Roda Hassan, MS for their feedback and assistance with this study.

References

- Abdullah, A., Coppig, J., Kessel, A., Luck, M., Bonell, C. (2009). Cervical screening: Perceptions and barriers to uptake among Somali women in Camden. *Public Health* 123: 680-685.
- American Cancer Society. Cancer Facts and Figures (2010). <http://www.cancer.org/Research/CancerFactsFigures/CancerFactsFigures/cancer-facts-and-figures-2010>
- American Cancer Society. Ohio Cancer Facts and Figures (2010). <http://www.cancer.org/InYourArea/Ohio/LocalResearch/ohio-cancer-facts-figures>
- Carroll, J., Epstein, R., Fiscella, K., Volpe, E., Diaz, K., Omar, S. (2007a). Knowledge and beliefs about health promotion and preventive health care among Somali women in the United States. *Health Care for Women International* 28: 360-380.
- Carroll, J., Epstein, R., Fiscella, K., Gipson, T., Volpe, E., Jean-Pierre, P. (2007b). Caring for Somali women: Implications for clinician-patient communication. *Patient Education and Counseling* 66: 337-345.
- Daillard, C. (2003). HPV in the United States and Developing Nations: A Problem of Public Health or Politics? *The Guttmacher Report on Public Policy*. August 2003: 4-6.

David, R., Collins, J.W. (1997). Differing birth weights among infants of U. S. born blacks, African-born blacks, and U.S. born whites. *New England Journal of Medicine* 337 (17): 1209-14.

DeStephano, C.C., Flynn, P.M., Brost, B.C. (2010). Somali prenatal education video use in a United States obstetric clinic: a formative evaluation of acceptability. *Patient Education and Counseling* 81: 137-141.

Fiscella, K., Franks, P., Doescher, M.P., Saver, B.G. (2002). Disparities in health care by race, ethnicity, and language among the insured: findings from a national sample. *Medical Care*. 40:52-3.

Johnson, C.E., Ali, S.A., Shipp, M.P. (2009). Building community-based participatory research partnerships with a Somali refugee community. *American Journal of Preventive Medicine* 37(6S1): S230-S236.

Kroll J., Yusuf, A.I., Fujiwara, K. (2011). Psychoses, PTSD, and depression in Somali refugees in Minnesota. *Social Psychiatry and Psychiatric Epidemiology* 46 (6): 481-493.

McFarland, D.M. (2003). Cervical cancer and Pap smear screening in Botswana: knowledge and perceptions. *International Nursing Review* 50: 167-175.

Noor, H. (2011). Somali Community Project: Access and utilization of health care services for the Somali population living in Columbus, OH. Developed with support from the Columbus Public Health Office of Minority Health. City of Columbus, OH.

Pavlish, C., Noor, S., Brandt, J. (2010). Somali immigrant women and the American health care system: discordant beliefs, divergent expectations, and silent worries. *Social Science and Medicine* 71: 353-361.

Plaisted, L. (2002). Improving primary health care provision to Somalis: focus groups with Somali women. Minnesota International Health Volunteers.

Refugees international. (2006). Somalia field reports and in-depth reports. <http://www.refintl.org/where-we-work/africa/somalia>

Siegel, J., Horan, S.A., Teferra, T. (2001). Health and health care status of African-born residents of metropolitan Washington D. C. *Journal of Immigrant Health* 3(4): 213-24.

Terrazas, A. (2009). African Immigrants in the United States. Migration Policy Institute. <http://www.migrationinformation.org/usfocus/display.cfm?ID=719>

United States Department of Health and Human Services (DHHS). (2010). Disparities. <http://www.healthypeople.gov/2020/about/DisparitiesAbout.aspx>

Venters H., Gany F. African Immigrant Health (Review). (2011). *Journal of Immigrant and Minority Health* 13(2): 333-344.