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Background

Each year, refugees are forced to leave their homes and country due to result of wars or political turmoil. According to the National Office of Refugees, 2.6 million refugees have settled in the United States (U.S.) since 1975[1]. Idaho is a state in which refugees are resettled. The majority of refugees in Idaho are located in the capitol city of Boise. The refugees come from over the globe including Latin America, Europe, Africa and the Middle East.

African refugees represent a unique population in the United States and throughout the world. Many African refugees represent a preliterate population; they have no native written language. The refugees speak several different African dialects, with few African refugees who speak English. Many of these refugees are from countries embroiled in civil war, and they have spent years in resettlement camps in countries such as Kenya before achieving permanent placement in the United States (U.S.).

Health disparities

Communication barriers related to language or culture have been linked to health disparities and significantly impact access to and quality of health care. Limited English proficiency and poor health literacy are barriers to medical comprehension and increase the risk of adverse medication reactions[2]. Poor health literacy has been associated with decreased ability to participate in shared decision-making in health care. The 2006 Institute of Medicine Report, Preventing Medication Errors, cited poor patient comprehension and misuse of prescription drugs

as causes of medication error and worsened health outcomes[3]. People with limited literacy are at greatest risk for these sequelae. African refugees represent a preliterate or low literate population with significant health literacy difficulties leaving them highly vulnerable for problems related to health disparities.

In *Examining the Health Disparities Research Plan*' published by the National Institutes of Health, African Americans in general show higher age specific and age adjusted death rates than other ethnic groups[4]. Many African Americans earn lower incomes and have less access to health care providers than other racial groups. The data from the Health Disparities Research Plan, however, fails to distinguish differences within groups or in sub-groups such as African refugees. Thompson notes in order to completely understand health disparities, we are required to examine subgroups of the races despite difficulty we may have in obtaining data[4].

Health status of refugees

The Federal Department on Global Health lists potential health problems for the Somali Bantu population as malnutrition, infectious disease, parasites, oral care, reliance on traditional healers, and mental health problems exacerbated by language difficulties[5]. Although medical examination is required for refugees upon entry to the United States; no central repository for the refugees' health information was uncovered once they located in the U.S.

Research on the African refugee population is sparse, although we do know African refugees are at high risk for stress and anxiety disorders caused by trauma in Africa. They have low immunization status, and suffer from parasites not seen in the U. S.[6]. Refugees experience higher rates of some illnesses than the U.S. population as a whole, but no correlation has been linked to their health promoting behaviors. In most cases, refugees coming to the U.S. are of lower-income and are underserved by health promotion interventions[7]. States such as Georgia and Minnesota have aggregated health data on refugees who arrive in the United States. The researchers are unaware of any data collection related to ongoing health issues of African refugees.

Between 2004-2007, Idaho received over 2200 International refugees[1]. The population of Idaho is predominantly Caucasian and the state has limited resources. Providers who now face an increased number of refugees are challenged by the linguistic and cultural issues. Initial work with the African refugee population in Idaho indicates very few refugees speak English well and even fewer African refugees read English. Initial research with this population indicates they have little wealth and have low socio-economic status. Health disparities are posited to exist due to race, ethnicity, socioeconomic position, and acculturation/language usage; leaving this population at very high risk for health problems[8].

Many of the African refugees in Idaho are from the country of Somalia located in the South East portion of Africa. Somalia is a heterogeneous country. It is comprised of many diverse communities, with up to a third of the population being minority groups. The population of Somalia is estimated to be approximately 7.5 million, with only about 600,000 who are Bantu. Many of the Bantu from Somalia trace their roots back to tribes from southeast Africa, who were resettled in Somalia as slaves. The Bantu, physically distinct from other Somali with easily distinguishable curly hair are subject to discrimination in Somalia. They are excluded from all but the lowest occupations, and excluded from the course of political and economic development[9]. Somalia is politically unstable due to civil war that started in 1991. In 1992, the Bantu began to leave Somalia, moving to refugee camps, mostly in Kenya, and also in Tanzania[9]. The Somali refugees arrived in Southwest Idaho primarily in 2004.

Little is known about the current health status of the Somali Bantu refugees, yet they are a population at high risk for significant health problems. These problems are due to past disease and nutritional deficiencies while in Africa as well as cultural and language issues since arriving in the U.S. A decision was made by the University nurse researchers to approach the Somali Bantu community to determine their interest in forming a partnership to focus on health needs in their community.

Purpose

The purpose of this research was to complete a community and cultural assessment of Somali Bantu refugees in Southwest Idaho, that focused on their health needs. Community assessment involves becoming familiar with a community[10]. The goal of cultural assessment is to discover culturally relavant information to guide care[11].

Design

A descriptive qualitative design using the principles of Community Based Participatory Research (CBPR) was employed[13,14]. An effective way to address health disparities in vulnerable populations is through community based research. CBPR employs the experience of the community members most affected by health problems and those who have control of community resources in the research process[14]. Current biomedical research in the US

tends to focus on individual risk factors for disease and development of regimens to minimize these risks. This approach fails to recognize the importance of social and environmental conditions which contribute to health, as illustrated by the growing health disparities between Caucasians and ethnic and racial minorities[15, 16]. Although biomedical research has contributed significantly to health knowledge, the practical application of that knowledge does not always follow. Researchers and community leaders concerned with affecting social change to improve public health increasingly acknowledge health must be examined within the context of the communities. Within the framework of CBPR, qualitative descriptive research seeks to describe events in everyday terms from the perspective of the population studied. It is used to obtain answers needed by practitioners and policy makers and the data obtained are richer than quantitative descriptive results[13]. Data for a community assessment frequently includes reviewing known statistics, a windshield survey, surveys and interviews with the community that are often descriptive in nature. This makes qualitative descriptive techniques a good assessment technique for CBPR[17].

The first step in performing a community assessment is to become familiar with the people in the community. This project began when the research team identified two volunteers who were integrated into the Somali Bantu community. The research team met with the volunteers to explain our desire to interact with the Somali Bantu community to learn more and to assist with their health needs. The volunteers agreed to act as a cultural liaison for the research team. They asked the Somali Bantu community members to attend a meeting with the research team to foster a cooperative relationship. Twenty Somali Bantu attended the first meeting. Introductions were made, the Somali Bantu told the research team about their lives in Africa and in Boise and the research team expressed the desire to work with the community. As a result of this initial meeting, an advisory board was formed consisting of the research team and ten members from the Somali Bantu community including both men and women. Members from the advisory board were involved in all aspects of the project from the inception of the project idea through all data collection, in assisting with analysis of the data, and in contributing to the development of the first manuscript from the research. Institutional review board (IRB) approval for the study was obtained from Boise State University.

Ethical considerations

The Somali Bantu represent a vulnerable population due to limited English speaking skills and significant cultural differences. These issues make this population vulnerable to coercion or undue influence. IRB approval required researchers to participate in a full review board review and provide extensive methods to ensure no coercion such as telling the refugees many times they have the right to not participate in research. This information needed to be reinforced by those close to the refugee community. Because this population is preliterate, most have never read in any language. Thus the use of translated materials was not an option. The consent was written in English at a level understandable for this population and approved by the IRB. This consent was then read to an interpreter who obtained verbal consent for each participant.

Theoretical frameworks

The research was guided by combining a community assessment model, a cultural assessment model, and a vulnerable population framework. "Community as Partner" is a nursing framework focusing on community assessment and the nursing process. The framework consists of eight community subsystems (1) physical environment, (2) economics, (3) education, (4) safety and transportation, (5) politics and government, (6) health and social services, (7) communication, and (8) recreation[10]. These eight subsystems interact affecting the health of the community. Nurses assess the community in these areas, make diagnoses on the health of the community, and then implement interventions to improve the community health.

Giger & Davidhizar developed a cultural framework to use in assessing cultures. The unique expressions people have are referred to as cultural values. These values guide actions and decision making and play a large role in cultural behaviors[11]. For the most part, people are ethnocentric; seeing the world through their own cultural eyes, thus there is a need to learn how others view the world. This is especially important for nurses and other health care providers who diagnose and plan interventions that need to be culturally congruent to be accepted. Giger & Davidhizar's cultural assessment framework was developed with the belief that practitioners need culturally relevant information to develop appropriate interventions[11]. The framework postulates each person is culturally unique and assessment should be focused around six areas (1) communication, (2) space, (3) social organization, (4) time, (5) environmental control, and (6) biological variations[12].

The community assessment was utilized to gain understanding of the resources and interaction the Somali Bantu have within the Boise, Idaho community. The cultural assessment was important for the reserachers to gain understanding about the community with which they were intereacting. While some overlap was noted between the

community and cultural assessment frameworks, both were needed to fully describe this unique population, and its ability to interact and function in their new home. These two frameworks were integrated and redundancy was eliminated.

Flaskerud & Winslow's model of vulnerability was also used to enhance the research as the team sought to understand this vulnerable population[18]. This framework posits that resource availability, relative risk, and health status all inter-relate. The model focuses in the importance of communities rather than individuals in ensuring the health of populations. Assessment in these areas was needed to thoroughly understand the Somali Bantu as a vulnerable population.

Final areas assessed included: (1) worldview and demographics (2) ethnicity, (3) values, beliefs, history, (4) physical environment, (5) education, (6) safety and transportation, (7) politics and government, (8) health and social services, (9) communication, (10) economics, (11) recreation, (12) biological variations, (13) time, and (14) social orientation. The health and social services areas were significantly expanded as this was the primary area of interest for the research team. Data related to the vulnerability model were assessed appropriately under each of the above areas.

Methods

The community and cultural assessments were conducted using a literature review, informal encounters with the Somali Bantu community, and formal interviews with the Somali Bantu community members, volunteers who serve the community, and health care providers. The Somali Bantu community speaks primarily two languages; Af Maay Maay and Kizigua. The research team used two interpreters from the community to assist with the informal encounters and formal interviews with the Somali Bantu.

Data collection forms for each of the three assssment areas (literature review, informal encounters, and formal interviews) were developed using the theoretical framework as a guide. Huer and Saenz stress the importance of asking the right question when engaging in cross-cultural research[19]. Several strategies were used to help ensure that the questions asked had appropriate meaning and were culturally appropriate for the Somali Bantu. Formal interview questions were developed by the research team and were then trialed with members of the Somali Bantu community from the advisory board in a committee approach. Three additional meetings were held with small groups from the Somali Bantu community; questions were asked using an interpreter. The community members listened to each question, responded as to the appropriateness of the wording of the question, and then answered the question. If the question was determined to not be appropriate as worded, the question was re-worked with the community. Once the wording was approved, the research team evaluated the response given to the question by the community members. Occasionally, the answers given by the community group did not make sense to the researchers, thus indicating a difference in understanding by the community members. Discussion would occur between the researchers and the Somali Bantu until the question was re-worded so that conceptual equivalence of the concepts was obtained[20].

Literature review

Scholarly data bases were searched for references related to refugee health and Somali Bantu health. Little formal research was located about this population. Internet searches were then undertaken with a focus on Somali Bantu to learn more about the population. Several states such as Minnesota and Georgia have information on websites that aided the research team to get a general understanding of cultural customs of the Somali Bantu. All information gleaned from the Internet and scholarly sources was noted and categorized according to the theoretical framework.

Informal encounters

Members of the research team engaged in frequent "visits" to the main housing areas where the Somali Bantu live. These informal encounters were similar to the "Go-Along" interview as described by Carpiano[21]. These informal encounters were conducted as researchers accompanied members of the Somali Bantu community during routine events. A total of thirteen (13) informal encounters occurred with each visit lasting one to three hours. Research team members visited with the Somali Bantu in their apartments, attended community functions, and attended English and cooking classes with the Somali Bantu refugees. All engagement was aided by the presence of an interpreter from the Somali Bantu community. Notes were taken based on conversations with Somali Bantu community members and observations. Notes were organized according to the theoretical framework. Informal encounters were always attended by at least two researchers. Researchers compared notes and agreed upon findings.

Formal interviews

Formal interviews were completed with Somali Bantu community members, volunteers who serve the community and health care providers who treat the African refugees. Twenty-two (22) formal interviews were conducted. Researchers interviewed twelve (12) members from the Somali Bantu community; four (4) were female and eight (8) were male. All Somali Bantu participants had experience with the health care system in the U.S., with four participants having chronic illnesses and two having children who also interacted with health care providers. Five Somali Bantu were self-described as "older" and the rest self-described as "younger". Interviews with the Somali Bantu were conducted through an interpreter. Five health care providers who work closely with the Somali Bantu were interviewed (two physicians and three nurses). The last five participants were volunteers or workers who worked closely with the Somali Bantu as apartment managers, through the resettlement agencies, or as community volunteers. At least two researchers attended every formal interview with the Somali Bantu to ensure good field notes were taken.

Analysis

At least four (4) members of the research team met for each analysis session. Analysis sessions consisted of reviewing data searching for similarities and themes. Much time was devoted to negative case analysis as researchers struggled to ensure ontological authenticity[22].

Formal interviews were tape recorded but were not transcribed. The researchers were unable to find reliable transcription services in Af Maay Maay and Kizigua, therefore relied on notes taken and on listening repeatedly to the interpreted interviews. Notes were taken at the formal interviews by a second researcher attending the interview. Notes were compared and both researchers agreed on the findings. To validate interpretation, tapes from two interviews were sent to an independent interpreter to validate the accuracy of the interpretation[20].

Analysis began with review of the notes from the informal encounters. The research team repeatedly reviewed findings, developing a list of recurring themes from informal encounters in each of the areas assessed. A list of "what we know" was developed after half of the informal encounters were completed. The remaining informal encounters were focused on areas in the assessment the research team felt were not well understood. The research team then reviewed results of the Somali Bantu formal interviews. A list of themes was developed after three formal interviews were completed and again after six formal interviews were completed. These lists were compared with the results of the informal encounters. Areas were identified where clear understanding was lacking. The team focused on these areas in the remaining formal interviews. A final list of themes from the Somali Bantu formal interviews and informal encounters was developed. The team then reviewed the formal interviews done with volunteers and health care providers and a theme list from non-Somali Bantu participants was developed. The two theme lists (Somali Bantu and non-Somali Bantu) were compared and final results developed. The final results were compared with what was known from the literature review.

Rigor

Results of the research were shared with members of the Somali Bantu advisory board to ensure findings were accurately portrayed from the perspective of the community. Trustworthiness of the data was ensured using the principles of credibility, confirmability, and transferability[2, 22]. Credibility is focused on ensuring the realities discovered by evaluators matches the realities of the respondents. Credibility was enhanced using prolonged engagement, peer debriefing, negative case analysis, and member checking. The research team worked with the Somali Bantu refugees and those close to the community for 18 months conducting this study. The research team met an average of 6 hours per month discussing the data. Several meetings were held with participants to share the researchers' understandings. These actions increased credibility of the findings and increased ontological authenticity[22]. During research team meetings, negative cases were examined to determine why there was a discrepancy in the themes that were emerging to the research team. Discussions about preliminary findings were held with peers who have performed cross-cultural research, but who were not engaged with this population. Questions arising from those discussions led the research team to go back to the data and back to the field to better understand the assessment data. Confirmability was improved through reflexivity by having multiple investigators. Transferability was enhanced through thick descriptions[22].

Findings/results

Findings and results are discussed using the framework for data collection as a guide.

Worldview and demographics

The Somali Bantu in the Boise area have been in the U.S. for 3-4 years. Ages range from infant to elderly. Most elderly are female as the older males were killed in the civil war in Somalia. Most of the refugees were affected deeply by the civil war through torture and rape.

Ethnicity

The Somali Bantu are a distinct group from the native or indigenous Somalis. There are two subgroups of Somali Bantu in Southwest Idaho, one with mostly older and traditional members and one group with younger and less traditional members. They describe themselves as two groups who work as one.

Values, beliefs, and history

Most Somali Bantu are of the Muslim faith, with women wearing traditional Somali dress and Muslim headscarves. Somali Bantu attend religious services at the Mosque on a routine basis on Fridays and state they live their lives according to the tenants of the Muslim faith. There is little evidence of drug or alcohol use or sexual activities outside of marriage as examples of community values and beliefs. The Somali Bantu stated few use drugs or alcohol due to their Muslim faith.

Physical environment

Most of the Somali Bantu live in apartments for lower income tenants. The apartments are clean and decorated with bright colors. Colorful mats and linens are on floors and walls. Furniture is sparse. Typically, 6-9 people live in a 1-2 bedroom apartment with multiple generations represented in the family unit. The Somali Bantu described being thankful for a place to live but were surprised how complicated it is to live in the U.S. They described having to learn a lot of rules and that everything requires money.

Education

Younger men were educated in the refugee camps in Kenya but women were generally not educated. Women are now learning English and learning how to drive through community based classes. The state of Idaho provided driving training and the refugee center provides English classes. Children attend public schools and are doing well in school. The Somali Bantu adults desire to obtain a GED, however they fear failing so few are enrolled in classes.

Safety and transportation

Most of the younger Somali Bantu men have licenses and drive cars. Some of the women are now driving. The Somali Bantu live in a fairly high crime ridden area; however there is very little crime within their community. Somali Bantu believe the lack of crime is due to the watchfulness of the refugees of their community. The men watch the community and are aware of who is entering and leaving the apartment complexes. The Somali Bantu report some fear of the police here, yet they report feeling much safer here than they were in Africa.

Politics and government

The Somali Bantu are formed into two organizations in Boise and describe themselves as two organizations under one Chief. The organizations tend to be divided along age lines; however this is not an exact representation. Both organizations have websites and letterhead. Members from the younger group have begun to get involved in city politics and they follow National politics.

Health and social services

The women still use some traditional healing methods for themselves and the children although the herbs and plants they need for healing are not available here in the U.S. The Somali Bantu men reported much faith in the U.S. health care and really discounted traditional healing methods. Many of the Somali Bantu refugees indicate a great deal of faith in Western medicine. Most Somali Bantu interviewed believe they should receive a prescription for pills when they go to the doctor. If they go to the doctor and do not receive pills, they resist paying as they do not believe they have received appropriate service. These refugees have not yet been acculturated to the importance of life style changes and their significance to health.

The Somali Bantu report great joy in having fresh vegetables and fruits here in the U.S.. The Somali Bantu have taken cooking classes yet still remain confused about how to prepare many American foods. The children have become accustomed to sugary snacks and were often observed with candy or soda.

Accessing social services to obtain payment for medical services was reported as an area of concern for most Somali Bantu members. Few Somali Bantu have insurance and have difficulty in filling out the forms required for public assistance. Refugees reported not knowing their ages or birthdates. Refugees were assigned birthdates when they entered the U.S.

The refugees report having Medicaid for the first 6 months they are in the country. If the refugees are over 65 or permanently disabled, they report having either Medicare or Medicaid. The remainder of the adult refugees described frustration with the complexity of forms to obtain health insurance and the high costs of insurance and health care. Most of the Somali Bantu receive health care at three clinics in the area. These clinics are governed by a hospital with a mission to treat the poor or are free clinics run by a religious group. Most frequently reported diseases in the community are asthma, diabetes, and high blood pressure. Somali Bantu interviewed reported approximately ½ of their children are immunized. The Somali Bantu do not report mental health problems but did discuss a high level of stress due to lack of money as many have lost jobs.

Communication

The Somali Bantu in this area speak primarily two languages, Af Maay Maay and Kizigua. The younger men who understand English and some of the children function as interpreters for the rest of the community. Decisions are made collectively. The normal decision making method is to get a large group of males together to discuss a topic and arrive at consensus. Consultation with the elders before decisions are made is very important to the community. The Somali Bantu indicate women are able to give opinions on all topics; they however have child rearing responsibilities and cannot get away to take part in many decision making meetings.

Communication among the Somali Bantu occurs freely either in person or via cell phones. The women speak primarily to other women; however we observed women speaking freely in meetings where men were present.

Economics

The Somali Bantu men primarily have service/labor jobs such as janitorial work. They have been disproportionally impacted by the recession with many Somali Bantu losing their jobs. Many Somali Bantu have an entrepreneurial spirit and grow vegetables in a community garden which they then sell in community farmer's markets. They struggle with finding money to pay for medical appointments and medicine.

Recreation

Children (both boys and girls) play soccer, basketball and other games in the open areas of the apartments. The women state that they enjoy dancing. The men report playing soccer for recreation.

Biological variations

The men are lean and the women tend to be more overweight.

Time

Time is a very fluid concept within the Somali Bantu community, with many of the refugees being early or late for appointments or missing appointments all together. Providers report some frustration with time management as close to 50% of the refugee appointments are "no shows".

Social orientation

Somali Bantu are highly social, visiting each other often and staying touch with other Somali Bantu groups across the U.S. Somali Bantu tend to marry during the late teen years. Weddings and dances are social times. Women take care of the children.

Discussion

This community and cultural assessment revealed a community that is vulnerable in terms of health disparities. Flaskerud & Winslow's model of vulnerability was developed to guide research, practice, and policy development/analysis and provides a framework for discussion of the findings[18]. The model describes the interactions between resource availability (socioeconomic and environmental resources), relative risk (ratio of those exposed to risk who have limited resources to those with resources who are not exposed), and health status (disease prevalence, morbidity, and mortality rates).

Resource availability

The Somali Bantu, health care providers, and those close to the population all describe the refugees as being poor socioeconomically. Most refugees live in low income apartments. If the refugees have work, it is in service jobs and health insurance is not provided. Refugees have Medicaid, Medicare, or are uninsured. Refugees have few material possessions. Few adults have any formal education and even fewer females know how to speak, read, or write English. These literacy limitations further exacerbate the socioeconomic disparities seen in this population. Few refugees have any social status in a community outside of their own population.

Social connections outside the African refugee population are limited due to language and cultural barriers. Environmental resources such as fresh food and water were noted as a positive part of relocation by most refugees and were felt to be responsible for improved physical health by the refugees. Accessibility to health care was not described to be a problem by the refugees; they went to the Emergency Department if they were very sick. The ability to communicate adequately with their providers was listed as an area of concern for both refugees and health care providers. Many refugees do not understand health instructions given by practitioners, thereby increasing the risk for misunderstanding.

Relationship between resource availability and relative risk

While relative risk cannot be quantitatively calculated from this research, as the framework suggests relative risk will be high due to low resource availability. The lack of socioeconomic resources combined with cultural differences and linguistic barriers faced by the refugees hinder their ability to make healthy choices and avoid illness or injury. Risky health behaviors such as smoking, excessive drinking, and sex outside marriage are rarely seen in this population, however preventative behaviors such as routine exercise were not observed. Inadequate financial resources limit the ability of the refugees to obtain routine health screenings increasing the relative risk.

Relationship between relative risk and health status

This relationship cannot be directly measured by this study. The researchers identified self-reported high rates of high blood pressure, heart disease in adults, and asthma in children; however these were all self-reported and were unable to be validated. The final relationship to close the loop between health status and resources in this study is believed to be as theorized with high risk of health disparity perpetuating the low resources and vice versa.

Implications for practice

It is important for health care providers to get consent to share health information with family members when working with Somali Bantu. Involving family in health care instructions should increase the abilities of the refugees to follow the instructions. If health care decisions need to be made, it is important to remember the Somali Bantu are collective decision makers. This takes more time than traditional Westerners are accustomed to taking. Balancing the privacy requirements of HIPPA with the need for the refugee to involve many others in health care decisions can be difficult. In addition, the Somali Bantu refugees visit each other frequently. During visits the Somali Bantu share stories and remedies. Providers need to be aware of the risk for misinterpretation and the chance for patients to misunderstand because of guidance received from another Somali Bantu visiting and bringing advice.

There are many opportunities for miscommunication related to language and the use of interpreters. Effective communication using interpretation especially related to health care requires knowledge and skill on the part of the interpreter, including familiarity with both the non-English speakers' language and culture, and that of the English speaking researcher or health care provider. There are limited numbers of Somali Bantu who understand English enough to serve as interpreters. Using interpreters with limited English ability and understanding of the health care (as the Somali Bantu interpreters are prone to be) limits the ability to communicate by both health care providers and the non-English speakers. When assessing language used by the refugees, health care providers should ask refugees what language is spoken, not the country of origin of the refugee. Somali Bantu have been provided with Somali interpreters which is very uncomfortable due to the genocide against the Somali Bantu who are the ethnic minority in Africa. Colloquial phrases that make sense to natives will be meaningless to the refugees. For instance, when asked about body image or inherited diseases, the Somali Bantu had no idea to what the

researchers were referring. Many of the phrases American health care providers may use have no meaning for these refugees. Providers also need to be aware that the refugees may not question the provider, as the Somali Bantu are used to being in a subordinate position.

The Somali Bantu engage in story-telling and it may take a great deal of time to gain an adequate health history. Providers can use this to make a connection with the refugees by engaging in story-telling when giving patient instructions. Because time is a relative concept to the refugees, providers should expect refugees to be late for many appointments and to not show up for others. This is not considered rude by the refugees who simply need some additional information on the importance of schedules to American providers. It is important to provide verbal instructions appropriately through an interpreter. Written material is less helpful, however pictures may be useful.

Providers should be aware of the limited resources many Somali Bantu have in their households. Few refugees have funds to be able to purchase medications or expensive over the counter treatments for ailments. Many refugees are on Medicaid yet lack the literacy necessary to fill out required paperwork. Many refugees can benefit from public health education related to personal safety in areas such as food handling and the use of bicycle helmets. Self-report from the respondents indicates less than 50% of the refugee children are immunized. Life spans were short in Africa and the concept of preventative health care is totally new to the refugees. This is an area that can be enhanced through public health visits.

All Somali Bantu interviewed denied mental health concerns were a problem. Health care providers, however, saw stress reactions from trauma in Africa and the strain of adjustment to the U.S. Those familiar with the Somali Bantu indicated there was fear of discussing mental illness. Stress was handled by spiritual leaders among the refugees. Providers can work with the spiritual leaders to assist with the bad dreams and stress many refugees have.

Limitations of the study

Study results represent a small sample and results cannot be generalized to the larger population of Somali Bantu refugees here in the United States. Due to the qualitative nature of the study, researchers were unable to verify self-report data obtained.

Areas for future research

Information acquired in this study was self-report; as validation was beyond the scope of this study. Further research should seek to validate the resource availability of the African refugees. In addition, future research should seek to directly measure the health status of this group. Studies that can compare direct report to actual medical records would allow researchers to verify the health status of the population and give insight into the ability of the population to accurately describe their health. Finally more research into the area of relative risk should be undertaken. This is especially challenging as this population does not have a cultural understanding of many of the preventative behaviors that would be studied.

Conclusion

The Somali Bantu refugees represent a population relatively new to the U.S. health care system. Researchers spent 18 months with this community using a CBPR approach with qualitative descriptive techniques. Both emic and etic perspectives were explored by interacting with the Somali Bantu as well as health care providers and community volunteers. It is impossible to accurately assess a community whose cultural views are diverse from the researchers without doing a cultural assessment. Performing a community assessment combined with a cultural assessment was an effective way to assess this community. The overlaps of assessment categories allowed for streamlined data collection. Using the descriptive qualitative format allowed researchers to dwell in the data and revise questions as the research developed and the team needed more information. Using a CBPR framework allowed the researchers to expand knowledge and explore areas in more depth that the community saw as most important.

Performing a community assessment from the diverse perspectives of the community members, health care providers to the community, and volunteers with the community allowed the researchers to learn about both etic and emic perspectives.

The research team realizes we still know little about the Somali Bantu even after spending eighteen (18) months with this community and assessing from both etic and emic perspectives. Findings did point to a high degree of vulnerability of this population with increased risk for health disparities.

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