THE ELDERLY SOMALI BANTU EXPERIENCE OF AMERICAN HEALTH CARE:

THE NEW WAY

by

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ABSTRACT

A paucity of research exists involving the emic, or insider perspective, of the elderly Somali Bantu as it pertains to their experience of health care. The purpose of this qualitative, descriptive study is to gain insight into the factors that influence the elderly Somali Bantu’s experience of American health care in Boise, Idaho based on their perspective. The elderly Somali Bantu refugee has experienced many changes since their resettlement to the United States from United Nations’ refugee camps in Kenya four to seven years ago. The majority of this population is illiterate and has no native written language. This is a particular challenge when adjusting to new American systems such as health care, insurance, and getting to doctor’s appointments on mass transit. The participants (n = 14) of the study are a subset of the larger Somali Bantu community of Boise, Idaho and are self-described as “elderly” (50+ years of age) as per their cultural norm. An initial community assessment was conducted over an 18 month period, utilizing theoretical frameworks from cultural and community assessment models. A thorough description of methodology and results are provided. The results of the assessments are discussed as well as the implications for health care providers and policy makers. The findings of this study indicate that the elderly Somali Bantu refugee experiences are complex, influencing factors related to their health and navigating new systems such as health care. This, in turn, creates vulnerability and places them at increased risk for health disparities. Further research is needed to obtain actual health
data on this vulnerable population to determine its health needs and to plan culturally appropriate health interventions.

**Key words:** Somali Bantu, community assessment, cultural assessment, elderly refugee, refugee health, vulnerable populations
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CHAPTER 1: THE RESEARCH PROBLEM

Refugees are marginalized populations who are forced from their countries of origin: victims of ethnic and/or religious persecution, civil war, and political disenfranchisement. The Office of Refugee Resettlement (2010) reports that 2.6 million refugees have come to the United States (US) since 1975. The Somali Bantu from Africa is an ethnically diverse group from the Juba River Valley who has little experience with American culture, complex health care systems, and the English language.

A particularly vulnerable subset of this population is the elderly. From a historically pre-literate society with no written language, the elderly Somali Bantu struggle to learn English even four to seven years since their arrival in the US. This hampers their communication with health care providers, impedes their self-management of multiple health conditions and medications, creates a barrier to understanding and completing health insurance forms, and slows their navigation through the health care system. This qualitative, descriptive study will give the reader an emic, or insider’s view, of the elderly Somali Bantu’s experience of health care in Boise, Idaho. The influence of factors such as biological changes related to aging, culture, socio-economic status, and literacy are described in terms of how they influence the elderly refugee’s adjustment to new systems such as health care.

The Somali Bantu population of Boise, Idaho is comprised of approximately 246 individuals (Idaho Office of Refugees, 2008) who resettled here from United Nations’ (UN) refugee camps in Kenya from 2003-2006. Before their arrival, they had no
experience with Western culture, technologies, or American health care. The historically agrarian ways of this group influence their ability and speed of adjustment to the ways of an industrialized and technology-driven American society; their life experiences and standards of living being vastly different. According to Van Lehman and Eno (2003), the Somali Bantu were agriculturalists who farmed the Juba river valley in southern Somalia; this region was considered the “backbone of agricultural production and national and international markets in southern Somalia” (p. 2). The standard of living was low in southern Somalia, with no electricity or running water in their homes.

Today, as a part of UN refugee programs resettlement efforts, the diaspora of Somali Bantu continue to learn English, hold jobs such as janitors and home health care givers, send their kids to school, manage finances and households, and navigate the various systems of American society. However, the American health care system is especially challenging as the elderly Somali Bantu adjust to Western time standards, appointments, insurance forms and coverage, medical terminology, medication and treatment regimes – things that have no place in their own heritage. The Somali Bantu have little history or experience with written language or working within bureaucratic systems.

In the United States, support from resettlement agencies for issues such as these, lasts for a period of four to eight months (Office of Refugee Resettlement, 2010). After this point, self-sufficiency is expected and resources must be obtained by individual families without government assistance. This is certainly a phenomenal task for any person to accomplish, especially a foreign-born person with little or no English skills or experience with a written language. The guidelines for the refugee resettlement program were created 30 years ago, under very different economic conditions and for very
different refugee populations. University-prepared Iraqi refugees entering the US today, for instance, have had contact with American culture and many speak English. The length of resettlement program assistance is conceivably less for such a family than for the Somali Bantu family who has no English skills.

As refugees try to understand and navigate new systems, both they and health care providers are challenged in communicating and formulating treatment plans for this population. Without an interpreter, history taking and communication with the refugee client is impossible, creating barriers in client understanding of health information and plans for treatment. Polypharmacy (the use of multiple prescription medications) and co-morbidities (multiple diseases) in the elderly also create challenges for safe medication use and chronic disease management. The Agency for Healthcare Research and Quality (2010) reports that there are multiple factors that impact health outcomes in the elderly; such as co-morbidity, patients’ beliefs, values and preferences, social support, multiple sites and settings of care, as well as economic and social policies. These issues in tandem with being a pre-literate society, having limited English proficiency (LEP), poor health literacy, cultural beliefs, low-income, and the biological effects of aging, place the Somali Bantu elderly at a disadvantage for learning how to manage their health care needs and navigate the health care system.

Adjusting to a New Country

The study of how migrating cultures adjust to each other was first discussed by Plato, followed over a millennia by the inquiry of anthropologists, psychologists and sociologists (Rudmin, 2003). However, each discipline has defined the adjustment of migrating societies based on disciplinary specific research models and perspectives. Due to variances in the definition of this process and the intent of this paper, I will describe
the experiences of the Somali Bantu elderly as it relates to health care in Boise, Idaho. I will refer to this process as adjustment. The following is a contextual reference for acculturation, adaptation, and assimilation to give the reader insight into the process of adjustment the refugee must traverse when entering a new country and culture. My intent is to give a frame of reference for this process rather than focus on the end result. The goal of this is to offer a new perspective, and call for the beginning of a new way of seeing, understanding, and responding to the health care needs of diverse refugee groups.

Anthropologists Redfield, Linton, and Herskovits (1936, pp. 149-152) posited that acculturation was a phenomenon that resulted from continuous, first-hand contact between two different cultures. Changes in original cultural patterns might occur in either or both groups as a result of these encounters (Rudmin, 2003).

According to McElroy and Townsend (2009), acculturation is a stage of cultural movement towards assimilation. Health care in UN camps was provided to refugees by waiting in lines, starting at the break of dawn. From these encounters with UN medical staff, the Somali Bantu became accustomed to pills in bags, shots, stethoscopes, and examinations. This began the acculturative process from traditional herbal remedies and “bone setters” (medicine men who were trained to align and reset broken bones in their villages) to Westernized health care filled with unknown medications, technologies, and processes. From the standpoint of medical anthropology, “acculturation involves continuous and intense contact between two previously autonomous populations…and one or both systems are extensively changed by this contact,” whereas “assimilation occurs when one group becomes fully integrated into a dominant society” (McElroy & Townsend, 2009, p. 315).
Nurses, anthropologists, psychologists, and sociologists all suggest varying definitions and theories on how migrating cultures adjust to their new environments and host societies. I would offer that when groups truly assimilate into a dominant culture and assume the cultural norms of that society completely, there are benefits and losses in the transaction. While the Somali Bantu elderly will benefit from knowing how to navigate a new system for health care, traditional knowledge of healing remedies may be lost as a part of the group’s cultural heritage. Maintaining fundamental religious beliefs, such as Allah’s power to heal and intercede on behalf of the ill, is an important aspect of culture that should not be lost to assimilation.

Karimollahi, Abedi, and Yousefi (2008) speak to the need for health care providers to be sensitive to socio-cultural diversity and to include the spiritual needs of ethnic populations in their care planning. A vast array of literature exists on the topic of cultural competency and culturally appropriate and sensitive health care. Plawecki (2000) suggests that clinicians must understand that older refugees expect providers to be respectful of their cultural beliefs and customs. In 2001, the US Department of Health and Human Services’ Office of Minority Health published the National Standards for Culturally and Linguistically Appropriate Services in Health Care (2001). In this report, health care organizations and their staff were encouraged to respond with sensitivity and cultural awareness to the needs and preferences of ethnically diverse groups, thereby improving access to care, quality care, and health outcomes for the patient.

For the purpose of this paper, I will focus on describing the elderly refugee’s experience of adjustment as they navigate the health care systems of Boise, Idaho versus trying to determine and measure the degree to which they’ve made acculturative changes towards potential or eventual assimilation into American culture. Even for those refugees
who have been in Boise for four to seven years, such as the Somali Bantu, adjustment to American health care continues to take place. Health care providers and health care systems alike are affected in this process. We are learning how to communicate more effectively and practice more effective medicine through interpreters, adjusting treatment plans and education based on individual health literacy, and collaborating on cultural best practices with other providers sponsoring such events as the Idaho Conference on Refugees 2010 (Idaho Office for Refugees | Home, n.d.).

**Health Status**

The Office of Global Health Affairs reports substantial health burdens in the Somali Bantu population due to their pre-migration status, migratory experience, prolonged internment in refugee camps, and the resettlement process itself (Background on Potential Health Problems for Somali Bantu, n.d.). OGHA points out the potential for long-term psychological and physical consequences of these experiences. The Global Health Report (Refugee Reports, 2004) lists the following health issues for the Somali Bantu: (a) malnutrition, (b) infectious diseases (dengue fever, hepatitis A, B, C, and D), (c) HIV/AIDS, (d) malaria, (e) measles, (f) shigellosis, (g) syphilis, (h) trachoma, (i) tuberculosis, (j) typhoid, (k) parasitic diseases (giardia, leishmaniasis, pinworm), (l) oral health care, and (m) mental health.

**Barriers to Health**

While conducting 18 months of research with the Somali Bantu community, it became apparent to me that this ethnic group presented greater health challenges than the average American population due to historical factors, pre-literacy, and language interpretation needs. Coming from a rural environment and developing countries, they had no exposure to Western technologies or systems and little understanding of the
English language or time. Vulnerable populations are described as those susceptible to, and at risk for, health problems. Aday (2001) states vulnerable populations are at risk for poor physical, mental, and social health. Aday points to influencing factors for vulnerability, which include social status, economic conditions, gender, age, and educational level. The Somali Bantu community has been susceptible to all these factors during their pre and post-migratory period to this country.

Background

There has been a forced exodus from Somalia, Africa due to social and religious persecution. With only the clothes on their backs, they walked for days to reach the refugee camps in Kenya having endured torture, famine, the loss of their homes, and in many cases, the loss of family members. The Center for Applied Linguistics (CAL, 2003) states that the Somali Bantu tribes of Eastern Africa include over 300 groups, each with a distinct dialect. Somalis who are indigenous to the country of Somalia are taller in stature, have straighter hair, narrower nose bridges, and lighter skin than the Bantu, who were brought to Somalia from Tanzania and Mozambique as slaves. The Somali Bantu are distinguished from, and separated socially from, the native Somalis based on their physical characteristics. The Somali government barred the Bantu from education and political involvement, lending to high illiteracy rates and social isolation.

Escape from Persecution and Slavery

Originally, the Somali Bantu were nomadic tribesmen who organized themselves into clans and kinship associations. As slaves, they became farmers for the Portuguese in the 15th century, the Sultan of Oman in the 1800s, and the Italians between 1935 and 1940 (Van Lehman & Eno, 2003). Because of their history, culture, linguistic differences, and physical appearance, they have been marginalized and persecuted. The Bantu fled to
the Juba River Valley where they farmed and lived in villages. Marauding military regimes took what little the Bantu had and then tortured, raped, and killed village members. The Somali Bantu sought refuge by fleeing across the border to Kenya in the early 1990’s (Figure 1), where there were four refugee camps established by the United Nations that held over 160,000 refugees at the height of resettlement (Cultural Orientation Resource Center, 2008). The people then awaited resettlement to host countries around the world; a fifty year old Bantu woman who I interviewed stated she had been in the Kakuma camp for 14 years before coming to Boise. Europe, Australia, Canada, and the United States have partnered in resettlement efforts. As exemplified above, some refugees have waited for a decade in austere conditions, enduring nightly raids and bandit attacks before arriving in their new countries (Van Lehman and Eno, 2003).

![Figure 1.1 Eastern Africa](image)

**Figure 1.1 Eastern Africa**

**Entering America**

Refugees enter the US under the provisions of the 1980 Refugee Act, which sets limits by geographical regions of the world, on how many refugees will be accepted. When a refugee’s application is approved by the US Citizenship and Immigration
Services, the International Organization for Migration and the US Department of State coordinate his or her travel to the United States. The refugee must reimburse air travel expenses to the government through incremental payments once the individual has gained employment (Patterson, 2006).

Working with the Idaho Office of Refugee Resettlement, agencies such as the Agency for New Americans, World Relief, and the International Rescue Committee welcome new refugees as they arrive at the Boise airport. These organizations also assist with job search, housing, basic needs support, English classes, transportation, health referrals, translation services, and case management for 90-180 days based on the family’s financial resources and needs (Cultural Orientation Resource Center, 2008). The goal of these federally-assisted programs is to help refugees become economically self-sufficient as soon as possible. However, this produces a dilemma for the Somali Bantu who have a long history of cultural barriers that have prevented them from participating in organized social systems. In effect, the Bantu have experienced systemic social forces that ‘teach’ them that an individual not only is not, but cannot be one’s own advocate, and virtually all Bantu refugees in Boise have been unable to achieve autonomy in the prescribed eight-month period. At least in part due to this unfamiliarity with American systems, the resettlement program’s expectation of autonomy, and the Somali Bantus’ learned dependency additional time and assistance is perhaps needed to complete a successful adjustment process.

Refugee Resettlement Volunteer and Nurse

I first became involved with the Somali Bantu Community in 2003 as a volunteer with the Agency for New Americans (ANA). Upon the arrival of refugees in Boise, volunteers are involved to assist ANA case managers with transportation, shopping,
learning appliances and technologies in their apartments, and teaching English for the refugees. I drove younger women to work as housekeepers for hotels and taught English to an elderly Somali Bantu woman and her teenage daughter on their living room floor. In the process, I too learned a great deal. I became aware of pre-literacy in the community, language barriers, cultural traditions, and the Muslim faith.

In 2007, I began working with Somali Bantu refugees as a public health nurse and experienced with them issues and problems related to interpreters, communication issues, missed appointments by the refugees, and transportation problems. Through these experiences, I became committed to searching for improved health outcomes by reducing barriers to care for this ethnic community. In 2009, I collaborated with a local hospital to produce educational media for refugees surrounding newborn care and immunizations.

As a graduate student, I selected the Somali Bantu community as my population of interest for research. The Boise State University Nursing Department, which had received a grant from the Office of Minority Health, approached me to join research efforts and conduct a community and cultural assessment on the Somali Bantu in Boise, utilizing Giger and Davidhizar’s Transcultural Assessment Model (2008) (Appendix A). This was an ideal starting point to continue learning about the beliefs, environment, culture, and health care experiences of the refugee community as a whole. From this study, I was able to then focus on the elderly of this community to determine what issues they might have in relation to American health care in Boise, Idaho.

Elderly Refugees and Health

According to the New York Times article Invisible Immigrants (Brown, 2009, August 31), the elderly make up America’s fastest growing immigrant group. The number of foreign-born people over 65 has increased from 2.7 million to 4.3 million
since 1990. Their numbers are predicted to swell to 16 million by 2050. The 2007 census data shows 16% of immigrant seniors living below the poverty line, compared to 12% native-born elderly. This data has a positive correlation to health related quality of life (HRQOL) and health disparities based on the Centers for Disease Control and Prevention’s (CDC) weekly report on morbidity and mortality (Centers for Disease Control and Prevention, 2003). The report concluded that low income (annual household income < $15,000) adults 45-64 years of age have a lower position on the HRQOL than all other adults. It states “Unemployment, inability to work, and activity limitations partially explain these HRQOL disparities in this age-income group” (CDC, 2003, p. 1). While I have found no qualitative or quantitative research specific to the elderly Somali Bantu as it relates to their adjustment to American culture, health disparities, or their experience of health care since arriving in the US, it is perhaps safe to apply the above statistics to them, and even project that other factors identified above may actually exacerbate these issues for them.

**Statement of the Problem and Population Addressed**

Potential problems associated with addressing health disparities of this population are the inherent cultural differences of the Somali Bantu community and how they interface with American health care, as these factors have the potential to negatively affect the Somali Bantu elderly health outcomes and health care access. At the same time, health care providers who work with this population need to understand the cultural relevance of their communications and interventions on the health outcomes of the Somali Bantu elderly, providing sufficient time for interpretation and health education. Thus the health care system itself, and its providers, should be adapting to the influx of refugees and creating new ways of doing things for ethnic populations in their current and
future approaches to the provision of care. This describes a process of adjustment – where both sides adjust to the other and their new situation – rather than assimilation where only one side is expected to change to suit the existing situation.

A systemic issue of health disparities for elderly members of the Somali Bantu community can be said to exist because of language barriers, resettlement policies, age and adjustment capabilities, and health care access - a complex mix of factors belonging to the Bantu, immigration policies, and the receiving health care system and its members. While many starting points exist for researching and addressing this system, this thesis adopts a socio-technical focus with the idea that any sustainable interventions will require an understanding of differences in beliefs, values, and the rationality and functions of Somali Bantu people and the health care system in Boise, Idaho.

An example of this in the Somali Bantu elderly community is the continued lack of English skills despite numerous classes they attended during the eight months of federal program support. The classes are still available at the English Learning Center in Boise, but it is difficult to get a ride to the Center when family members are working or looking for work. Lack of social contact has limited the acquisition of language skills through the process of cultural immersion (a situation that doesn’t exist for school age children, who experience immersion in American school systems, during an eight-hour school day). While age, and the belief that they can acquire these new skills, are factors in the elderly refugee’s ability to learn English, understanding the cultural history of the Somali Bantu being banned from education, helps a health care provider develop empathy and creativity in providing education and treatments when opportunities for this are scarce. By studying the Somali Bantu elderly experiences of health care from their perspective, health care providers can better understand cultural dimensions of care,
improve communication and outcomes, and assist elderly refugees in their navigation through the health care system.

Locally, nationally, and internationally, health care providers are searching for meaningful ways to provide health services for ethnic populations. The Somali Bantu elderly present complex challenges in health care due to their limited exposure to United States (US) culture, language barriers, poor health literacy, and low income. A subset of the Somali Bantu are the elderly who are further marginalized by lack of work and no English training in refugee camps or here in the US. Currently, there is limited data regarding Somali Bantu elderly refugees and their health issues thus the need for further research to define the needs and barriers to health care for this population.

**Qualitative Inquiry**

Because this research is aimed at identifying and describing factors involved in the adjustment of elderly Somali Bantu refugees, it must make use of research methods that allow me to learn their experiences. Qualitative research methods can help us understand the emic, or insiders view, of the people- in the case of this study, the elderly Somali Bantu. Spiers (2000) differentiates between *emic* and *etic*, stating that the *emic* perspective is a description of the phenomena as understood by the person who experiences it (study participant/patient). Whereas *etic* is the perspective of someone outside the experience (researcher/ health care provider). Narrative storytelling by key informants and direct observation of members of the community in various settings, informs me of the Somali Bantu elderly encounters and experiences with the health care system. Ethnographic research is a type of qualitative research well-suited to the discovery of factors leading to understanding the emic knowledge, values, and ways of a people (Schensul, Schensul, & LeCompte, 1999). Within this, narrative data provided by
the informants, and observation of their activities across various ‘natural’ settings, provides for a wide array of data with which one can develop an understanding for the elderly Somali Bantus’ role in their adjustment process and the overall operation of the socio-technical systems (for example, Medicare, insurance, and health care) in which they interact.

**Significance to Nursing**

America is often called a melting pot of cultures, with a long history of immigration from foreign lands and diverse people who seek refuge from persecution. Nursing and the health care system are now faced with a new wave of “freedom seekers” who present special health care needs and communication challenges. As health care providers, we need to not only understand who they are, but also their belief systems and where they come from, to help them adjust to the situations they are experiencing and, in turn, help to adjust the health care system for the better.

**Vulnerable Population Theory (Aday, 2001)** states that factors for poor health are increased by the diminished availability and distribution of community resources. Social characteristics (age, gender, and race and ethnicity) of vulnerable groups, social ties with the community, economic status, and housing are associated with social status (prestige and power), social support, and the ethnic community’s productive potential (income earning). Aday (2001) explores the ethical, conceptual, and political influences of the community (macro level) and the individual’s perspective (micro level) and “their interrelationships in illuminating the concept of vulnerability (p. 2). Understanding the factors that influence vulnerability is significant to nursing for the provision culturally competent care and advocating for appropriate economic and health policy changes for these populations.
To meet these challenges, we must first understand the experience of the elderly refugee from their own unique history, culture, and environment versus care based on the prior assumptions of nurses and other providers, and what is considered “appropriate care” within the American health care system. While numerous studies exist, investigating the health care providers’ perspective of working with this population, a gap in knowledge remains as to the elderly Somali Bantu client’s beliefs and perspectives on American health care and how they navigate within this unknown system. The significance of this gap is demonstrated by the elderly Somali Bantus’ missed medical appointments (nearly 50% in the Boise area), misunderstanding prescriptions and their use, lacking full immunization coverage, and poor outcomes in medical management of chronic conditions such as diabetes or hypertension. Poor English language skills, minimal health literacy, the biological effects of aging, cultural beliefs and practices, and low socio-economic status are all associated with how an elderly Somali Bantu refugee experiences and adjusts to health care in Boise, Idaho.

The significance to Nursing is to better understand the Somali Bantu culture’s history, beliefs, language barriers, health literacy, and the health care needs of its elderly so that some adjustment by the receiving system can be accomplished by nurses at the point-of-service of health care. Nurses can influence the health care system and the ethnic elderly by providing culturally sensitive care and effective health education techniques and programs.

Health disparities exist in this population based on reports from the Agency for Healthcare Research and Quality (2010), the Centers for Disease Control and Prevention (CDC, 2003), and the IOM Home - Institute of Medicine (n.d.). Exploring the elderly members of the Somali Bantu and whether there is lack of access to medical services and
listening to their personal experiences with the health care system can provide insight for potential improvements in communication and the delivery of health services for this community, thereby working to decrease health disparities and increase their health-related quality of life.
CHAPTER 2: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Review and Critique of Literature

The literature related to the specific health of the Somali Bantu is sparse. The literature review is therefore focused on broader health and cultural issues, including health disparities, health literacy, language acquisition, the history of the Somali Bantu, refugee health, biological changes related to aging, and a review of various aspects of cultural adjustment known as assimilation, acculturation, or adaptation of migrating populations and their host countries. Finally, an explanation of the conceptual framework used in the study is included.

A literature review was performed utilizing scholarly database search engines to explore the extent of knowledge and research involving the health care experience of the elderly Somali Bantu refugee population and for those health care providers who administer health services for them. In this literature review, it was found that the majority of studies produced since the 1990s focus on the health care provider’s view (etic). There has been limited investigation into the Somali Bantu experience of American health care, particularly the elderly.

Health Disparities

Eliminating health disparities among Americans is a primary goal of Healthy People 2010: Understanding and Improving Health. Race and ethnicity are associated with these gaps in overall health, health literacy, and access to health care. Death rates for heart disease are 40% higher for African Americans than for Caucasians; 30% higher
for all cancers; prostate cancer more than double; and higher rates of breast cancer for African American women despite similar rates in mammography screening. “Inequalities in income and education underlie many health disparities in the United States. In general, population groups that suffer the worst health status are also those that have the highest poverty rates and the least education” (Healthy People 2010 Online Documents, n.d., p.12).

Springer, Black, Martz, Deckys, and Soelberg (2010) cite communication barriers linked to language and culture as contributors to health disparities among Somali Bantu refugees. Limited English proficiency, poor health literacy, and cultural beliefs affect their interactions with health care providers in the way they (1) share information with providers through interpreters; (2) understanding of health information and treatment instructions and; (3) participate in shared decision making in their health care. The Somali Bantu elderly are at increased risk for errors in medication self-administration, missed medical appointments, misunderstanding medical information, or inability to adhere to treatment plans due to language barriers and poor health literacy.

**Health Literacy**

“Health literacy is the degree to which people have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (Parker, Ratzan & Lurie, 2003, p. 147). According to Singleton and Krause (2009), culture and language set the stage for the acquisition and application of health literacy skills. The authors report that nurses are in a key position to facilitate interconnections between patient culture, language, and health literacy in order to improve health outcomes for culturally diverse populations. An example would be an elderly refugee with hypertension who is unable to communicate with health care
providers, navigate the health care system, and participate in self-management of his or her disease due to a poor understanding of medical terms, anatomy, keeping appointments, and filling out insurance claims and health history forms. Day (2009) gives examples of how to promote health literacy through storytelling. She states that “the real health literacy issue is not the lack of information, but rather the ability of the healthcare consumer to access and process the information” (p. 1). Related to accessing and processing information, she suggests that storytelling is man’s oldest form of teaching and motivating change.

Language Acquisition

Humans develop language through their capacity to perceive, produce, and use words to understand their world and communicate with each other. Language may be vocal or manual as in American Sign Language. Its alphabet, syntax, and phonetics form the capacities one must master to effectively communicate. The ability to expand one’s vocabulary and incorporate the pronunciation of new words is related to speech repetition (Bloom, Hood, & Lichtbown, 1974).

Critical Period Hypothesis (Penfield & Roberts, 1959) proposes that language acquisition mainly occurs up to puberty if adequate environmental stimuli are received. It is believed that if language development is attempted after this period, full command of language, including its grammatical systems, will not be achieved (Young-Scholten, 2002). Studies show that older learners of a second language rarely achieve the native-like fluency that younger learners obtain. Singleton and Lengyel (1995) state that when learning a second language, younger is better. He does point out, however, that five percent of adult bilinguals master a second language even when they begin learning as
older adults. This information may prove useful when designing English Language Learning (ELL) programs for elderly refugees such as the Somali Bantu.

**Biological Changes Related to Aging**

According to the Federal Interagency Forum on Aging Related Statistics (AgingStats.Gov, n.d.), older adults are more likely to suffer from co-morbidities (multiple diseases), take more medications (polypharmacy), undergo more medical procedures, and use more health care than any other age group. Gijsen et al. (2001) state that the elderly with more than one chronic disease have worse overall functional status and self-rated health, use more health care, and die earlier than those with a single disease.

Healthy People 2010 (n.d.) describes 42% of people over 65 as having functional limitations that inhibit the Activities of Daily Living (ADL), such as walking, bathing, dressing, getting in/out of chairs, or using the toilet. Women have higher levels of functional limitations than men and physical functioning was not strongly related to race in the Health Indicators (Healthy People 2010, n.d., pp. 32-33). Loss of vision and hearing, along with oral health problems, are often associated with aging. One-half of older men and over one-third of older women reported hearing impairments. This appears to increase with age, as those >85 showed 62% hearing loss. Impaired vision affects 17% of the elderly; while Medicare does not cover services such as eye or hearing exams, glasses, hearing aids, or dental care. 23% of those 65-74 years, and 32% for people >85, reported no teeth (edentulism). There was an association between low socioeconomic status and edentulism, with 39% reporting no natural teeth (Healthy People 2010, n.d., p. 28).
According to Rogers and Langa (2010), ophthalmologic abnormalities such as diminished vision, ocular changes, and cataracts may affect cognitive decline in the aged. The authors cite an Australian study of 2,087 older adults over a two year period. Their data suggest that vision was associated with memory decline and attribute this to the under-diagnosis and under-treatment of visual problems in the elderly due to cognitive decline.

Somali Bantu History

Forced Migration

Imagine fleeing on foot across southeast African terrain with only the clothes on your back and the horrors of political persecution, torture, and the death of loved ones emblazoned in your mind. As a consequence of generations of such experiences in their native regions of Africa, in 1999, the US designated the Somali Bantu as “persecuted.” Since then, eight to twelve thousand refugees have obtained permission to resettle to various communities across the United States (Ethnomed, 2007). The Idaho Office of Refugees states that Boise, Idaho is one of hundreds of cities and 49 states that have resettlement programs (Idaho Office for Refugees, 2008).

Resettlement Agencies

Non-government organizations such as the International Rescue Committee have used anthropometric (the measurement of physical and cultural development) surveys to produce information we have regarding health beliefs and practices of this population. Partnerships developed within communities, such as the Somali Health Care Initiative in Minnesota, have conducted community-based participatory research to understand the needs of this group and to improve overall access to health care (Wellshare, n.d.).
The Agency for New Americans, as well as other resettlement agencies such as the International Rescue Committee, and World Relief work with the Idaho Office for Refugee Resettlement to assist with housing, English skills, employment, education, and adjustment needs. In 2006, 608 refugees arrived in Idaho from 18 different countries, speaking 22 different languages (Idaho Office of Refugees, 2008). Work of various community groups have gathered some information regarding the culture and health care needs of this vulnerable portion of our population, yet available research has focused on the economics and cultural competence of health care workers providing care for the Somali Bantu rather than members of the Somali Bantu community itself.

**Culture**

Government and resettlement agencies have numerous resources regarding the history, culture, beliefs, and challenges of the Somali Bantu population. The Center for Applied Linguistics (CAL, 2003) provides a publication for providers and others assisting Somali Bantu refugees in their new communities called, *The Somali Bantu: Their History and Culture* (Van Lehman & Eno, 2003), which gives a basic introduction to the people, history, and culture of this population. Kemp and Rasbridge (2001) discuss the history of Somalia and the political turmoil and civil wars it has endured. Clan-based militias have displaced 50% of the population, and hundreds of thousands have died. Islamic practice shapes many aspects of Somali Bantu culture, dictating times for daily prayer, fasting, and end-of-life rituals such as burial.

According to Cassanelli (1995), the term “Bantu” is associated with slave origins and low status by Somali-born natives. The Bantu were long-time residents of farming villages along the Juba River Valley in Southern Somalia. Civil war eroded supplemental sources of food and employment (state farms) and those who remained in their villages
were repeatedly terrorized by successive waves of armed militias. Thus began the exodus of thousands of Somali Bantu refugees to UN camps across the border in Kenya.

The United Nations High Commissioner for Refugees (n.d.) provides statistical data on health within the refugee camps of Dadaab and Kakuma, Kenya, where the Somali Bantu lived for 10-14 years before entering the US. The program report provides data on access to health care, mortality rates, maternal and newborn health, malnutrition, water and sanitation standards, sexual and gender-based violence, and HIV prevalence. The UNHCR partners with non-government organizations (NGO) to provide food, water, shelter, medical care, and screening for refugee resettlement to host countries such as the US.

**Refugee Health**

**Elderly Refugee Health**

As indicated above, sources such as the Global Health Report, Office of Minority Health, CDC, Ethnomed, and independent accounts from health care providers (Grady, 2009, March 29) have offered an expansive overview of Somali Bantu health care issues through refugee health screening projects and quantitative surveys. From these, we know that most of the Somali Bantu refugees suffer from malnutrition, infectious and parasitic diseases, chronic diseases, and mental health issues. Gorospe (2006) looked at the demographic growth of elderly legal immigrants (refugees), health care coverage, and policy changes that might be needed. He points to the influences of poor diet, fast-paced American life, and health literacy on elderly refugee health and their acculturation process.

The New York Times article *Invisible Immigrants* (Brown, 2009, August 31) offered insights into the lives of transplanted refugee elders and the isolation they
experience while the younger members of their community “jet off” to make a living in American society. Limited research studies could be found specific to the elderly Somali Bantu population and their perspectives of health or their experience of American health care. Information from these sources makes the strong suggestion that elderly refugees face the greatest difficulties in adjusting to health care in America.

**Access to Health Care for Refugees**

The National Healthcare Disparities Report (2007) notes recent immigrants (refugees being a subset of this group) are a high-risk population for health disparities due to limited English proficiency, lack of medical insurance, low income, and diminished health literacy. In four of the eight core report measures of access to health care, African Americans (African refugees being a part of this category) had significantly worse access to care than Caucasians, and African Americans were 25% more likely than Caucasians to have communication problems with their health care providers. The 2007 report did not provide a breakdown of data into subgroups such as the Somali Bantu refugees, so one cannot be certain how accurately it portrays this ethnic group. Gaps in the literature suggest that we need to further define if these problems are due to socio-economic status, prejudicial attitudes of providers, lack of cultural sensitivity on the part of the health care system, personal beliefs held by recipients of health care, or a systemic amalgam of these and other factors.

For example, Adair, Nwarneri, and Barnes (1999) conducted an interpreted, written survey of Somali patients seen at a primary care clinic over a seven month period. The objective was to identify barriers to health care access perceived by a group of refugees from Somalia and by the doctors and nurses caring for them. The central finding of this study was that health care providers, while being seemingly familiar with
the demographics of this population, were inaccurate in predicting how the Somalis’
values and beliefs affected their approach to and use of care. Interpreters were found to
be a critical component in providing good communication between provider and patient,
but even when providers are able to efficiently translate via interpreters, there remained a
“disconnect” between what providers thought they knew about this ethnic population and
how the client felt about health care access, service delivery, and outcomes.

Grady, a reporter from The New York Times (2009, March 29), interviewed a
Minneapolis doctor to determine what effect the refugees had on the local medical center.
Interpretation and resources needed to care for the special needs of the population were
significant due to language differences, interpretation time, and transportation needed to
get to appointments.

Aamodt (1982) states that nursing researchers have used ethnographic methods in
the past to study poorly known groups, especially those whose literacy and linguistic
skills are more diverse. Indeed, more work needs to be done in the arena of transcultural
or refugee health to better understand the emic view of this culturally diverse people.
Schensul et al. (1999) indicate that ethnographic research is appropriate when the goal is
to “explore the factors associated with the problem in order to understand and address
them or to identify them when they are not known” (p. 29).

Policy Issues

Agency for Healthcare Research and Quality (2010) reports that by 2011, 77
million baby boomers will begin to turn 65 and the number of Medicare beneficiaries will
increase to 20.6 % of the population. By the year 2030, one in four people over the age
of 65 will be from a racial or ethnic minority population. Caring for the elderly involves
complexities in clinical care that are difficult to coordinate at the health system level due
to fragmented financing and management systems. Efficacious care for the elderly, therefore, will require new models of coordination between acute, chronic, preventive, rehabilitative, and long-term care services.

Moua, Guerra, Moore, and Valdiserri (2002) state that one of the greatest issues facing refugees is the general lack of health insurance coverage. The rate of uninsured status is two and a half times higher than for native-born Americans. This is attributable to the “intimidating nature of our health care system, made worse by language and cultural differences…” (p. 190). Refugees and their children make up 25% of all people living in poverty; 50% higher than that of native-born individuals.

Locally and nationally, host cities and resettlement agencies are questioning the financial systems and practices of the federal Office of Refugees and Resettlement. The Refugee Resettlement Act of 1980 provided 36 months of financial support for newly arriving refugee families. Today it only covers eight months of support; woefully short of meeting the needs of populations such as the Somali Bantu (Nadeau, 2007). Lewiston, Maine is a host community for refugee resettlement. In a joint meeting between federal refugee agencies, the congressional delegation and city officials, federal refugee funding and programming issues were discussed. The recommendations stemming from this meeting included sustained English Language Learner (ELL) programs, job training, and a national labor strategy for limited/non-English speakers.

In the Idaho Statesman (April 11, 2010), Jan Reeves, director of the Idaho Office for Refugees, stated that the resettlement agencies in the area (such as Agency for New Americans, International Rescue Committee, and World Relief) work with Legal Aid and other support organizations to “cobble together” a safety net to prevent refugee homelessness. There is a new project on the horizon called the Refugee Resource
Community Plan in Boise, Idaho, which will focus on housing, jobs, and cultural integration (p. A6).

**Acculturation, Adaptation, Adjustment, and Assimilation**

Andrews and Boyle (2007) state that the processes of assimilation and acculturation can be defined by the changes individuals and cultural groups make to adapt to their new environment over time. They point out that numerous factors influence whether a refugee will maintain traditional health beliefs and practices. Some of these include length of time in host country, age of the individual, ability to speak English, economic status, educational status, and health status of family members. Due to documented discrimination and poverty, access to health care has been compromised and risk for health problems is increased.

Abraido, Armbrister, Florez, and Aguirre (2006) claim that “changes in values, belief systems, and worldviews have remained unexplored in public health research on acculturation and health outcomes” (p. 1344). The authors’ state acculturation in relation to health behaviors is also dependent on gender and age. Alba and Nee (1997) equate assimilation with social processes that incorporate ethnic minorities into the mainstream of American life. Acculturation is noted as the refugee’s adoption of “cultural patterns” of the host society such as dress, language, emotional expressions, and personal values and typically occurs prior to full assimilation.

Barron, Hunter, Mayo, and Willoughby (2004) use an acculturation model from Choi (2001) to show how the engagement process and cultural exchange between groups modifies the beliefs, norms, and values of the non-dominant group, resulting in social, economic, and political transformation. They point out that the process of acculturation is stressful and may hinder the refugee’s “ability to hear, understand, and process
information, interfering with the client's adherence to medical management” (p. 332).

Assimilation of ethnic groups is cited as a process of blending or fitting into the total community

Berry (1997) discusses the concepts of acculturation, adaptation, and assimilation as they relate to immigration issues and the differences between these concepts. The phenomenon of acculturation, for example, involves changes in cultural patterns and behaviors as a result of first-hand contact with another culture. Both groups change as a result of this contact, usually one (the refugee) more than the other (health care providers). Environmental demands create changes known as adaptation (refugees adapt to new food sources and grocery shopping). Assimilation is defined as the individual’s desire to maintain his or her cultural identity while seeking interaction with the “dominant” culture (American). The stresses of assimilation can be reduced, according to Berry (1997), through the protective benefits of maintaining cultural traits and the social support of the community.

Hieronymi (2005) describes assimilation as becoming members of the host country; that newcomers are welcomed to participate in the community, and the new community becomes their “own.” Key dimensions to assimilation are to adopt basic cultural components of the host society, particularly the language. Adopting fundamental political values of the new country is a step towards “naturalization” and becoming a citizen. Refugees are willing to give up certain aspects of their identity linking them to their country of origin and are “willing to seek and accept a new identity in their country of asylum” (p. 140).

McElroy and Townsend (2009) talk about acculturation as a continuous and intense contact between two separate cultural groups; one or both systems being
extensively changed by the contact. Assimilation is a long-term process, accomplished more easily by individuals than by whole groups. It occurs when the non-dominant group (refugee) becomes fully integrated into the dominant society. The authors purport that changes in health occur following contact with the dominant group in four major areas: demography, epidemiology, nutrition, and health care. These subsystems are connected synergistically; changes in one affecting changes in the others. For instance, health care by shamans or herbalists may be ineffective during an epidemic, leading people to try medicines or vaccines offered by American health care systems (for example, flu shots and antivirals).

Piedra and Engstrom (2009) define assimilation as a “process by which immigrants and their children integrate into society” (p. 272). Those who arrive in the US with little education, poor literacy, and little or no exposure to complex social institutions and technology typically adjust more slowly than those with education and skills. The receptivity of the host country and its policies towards refugee resettlement have a powerful impact on the support and resources available to help refugees maintain control over their lives during the assimilation process in a new land.

According to Price and Cortis (2000), “assimilation assumes that the out-group will change and adapt to the cultural practices of the dominant or in-group” (p. 239). They see this as an ethnocentric attitude, which can lead to stereotyping and ascribing certain characteristics to the out-group. The British, too, have been a host country for refugees and their policies reflected an expectation that the “incomers” would become a part of British culture and assume the characteristics of native English. When the ethnic English and policy makers realized that the “incomers” wouldn’t readily give up their beliefs, values, and practices, a “multicultural” viewpoint emerged (Gerrish, Husband, &
Mackenzie, 1996). Acculturation is a process that affects the behavior of migrant groups through daily interaction and “living within the social context of a particular geographical, political and socio-economic environment” (Price & Cortis, 2000, p. 238).

Siatkowski (2007) discusses acculturation in the Hispanic culture using assessment and measurement of language abilities, length of residency in the US, age at entry, socio-economic status, educational level, values, beliefs, and practices. The article did not relate these factors to illness or health and notes this as a limitation to the study.

No data was found on the acculturation, adjustment, or assimilation process of elderly Somali Bantu refugees, particularly as it relates to health care, indicating the need for further studies in this area.

**Conceptual and Theoretical Framework**

Theoretical frameworks used for this study included the community assessment model of Anderson and McFarlane (2000) and Giger and Davidhizar’s (2008) model for cultural assessment. Community Based Participatory Research methods were used for data collection; the research provides for a holistic and personal perspective on the experience of the Somali Bantu elderly in American health care, which, in turn, afforded the identification of areas for point-of-service improvement and nursing intervention.

The Community as Partner nursing framework assessed eight community sub-systems of the elder Somali Bantu: (a) the physical environment; (b) economics; (c) education; (d) safety and transportation; (e) politics and government; (f) health and social services; (g) communication; (h) and recreation. Giger and Davidhizar’s (2008) model recognizes the cultural uniqueness of ethnic populations and focuses its assessment around (a) communication; (b) space; (c) social organization; (d) time; (e) environmental control; and (f) biological variations.
Community Based Participatory Research (CBPR) is based on the principles of collaboration, equitability, and community partnership. Researchers work side by side with community members to define community concerns, implement research, disseminate findings and apply them. The Somali Bantu community, in this case, became a part of the research team and I became engaged in the activities of their community, such as religious celebrations (Ramadan), gardening, and immunization clinics.

Summary of Literature

The areas of focus for this literature review included the Somali Bantu history, background, cultural beliefs, and variations in the conceptual terms: acculturation, adaptation, adjustment, assimilation; and added adjustment issues the elderly face during resettlement. Potential barriers to health care access due to income, poor health literacy, and language skills for the Somali Bantu elderly community were also reviewed. The Somali Bantu refugees have endured a long and difficult journey from their homeland in Africa, yet they are resilient and maintain their motivation to adjust to the new ways of American society. Living conditions were crowded and sometimes hazardous in the UN camps, contributing to malnutrition and poor health of this population. Access to health care was limited during this period as well. There was no access to education for the middle aged and elderly refugee in the UN camps; most of the English Language Learning classes would be provided once they had arrived in their host communities.

Resettlement agencies work to provide housing, medical care, financial assistance, job placement services, English and cultural orientation classes, and transportation for a eight to twelve month time frame per out-dated refugee resettlement policies. The Somali Bantu elderly are a particularly vulnerable subset of this refugee
population due to the extended adjustment period needed for English language learning, improving health literacy, and adjusting to a vastly different culture. One that requires you to fill out medical and insurance forms, schedule appointments, arrange transportation, and arrive on time.

Health disparities are linked to this population and with limited research available regarding health care of the ethnic elderly, the gap in health related quality of life may be widened. The literature confirms the prevalence of co-morbidities, trauma, and the biological effects of aging, yet provides little evidence of how these factors influence the adjustment of the elderly refugee to health care systems or their health outcomes.

The literature provided a wide array of examples on acculturation, adaptation, adjustment, and assimilation. While the definitions may vary based on the discipline (nursing, anthropology, or sociology) investigating this phenomenon, there appears to be a continuum, or process, by which migrating populations adjust to their new homes, culture, or environment. How the host culture adapts to its new arrivals, as seen in health care, can determine how well this process transpires for the non-English speaking refugee who has no prior knowledge of this system.

Refugee health is dependent on complex, inter-related factors associated with cultural, environmental, socio-economic, and political conditions. Elderly refugees are a subset of this population, with increased vulnerability due to delayed English language acquisition, poor health literacy, biological changes related to aging and co-morbidities. There is limited data available regarding the effects if these factors on the health of specific ethnic groups such as the elderly Somali Bantu.

Somali Bantu face numerous barriers when trying to access health care. Linguistic challenges include poor English proficiency, health literacy, and writing (Somali Bantu
have no written language and have not learned these skills). Four to seven years post-
migration, the majority of elderly members of the Somali Bantu community are still
unable to communicate without an interpreter and fill out medical forms. Low income,
lack of health insurance, transportation, unfamiliarity with the health care system, and
health literacy issues are noted as the most prominent barriers for the majority of the
community, especially the elderly.

**Statement of the Purpose**

The purpose of this research study is to explore the perceptions and health care
experiences of the elderly Somali Bantu population in Boise, Idaho, using qualitative
descriptive methods, ethnographic narratives, and community-based participatory
research (CBPR) methods. Giger and Davidhizar’s cultural assessment (2008) and
Anderson and McFarland’s Community as Partner assessment (2000) were used as a
conceptual frameworks for the primary assessment and evaluation of the Somali Bantu
community with a special focus on the elderly, giving insight into the experiences,
beliefs, education, economics, health, and environment of this group. From this research,
gaps in health care can be identified, the refugee’s cultural needs and understanding
improved, health education techniques can be developed that are ethnically-based, and
barriers to health care access minimized.

**Research Question**

What is the experience of the elderly Somali Bantu refugees of Boise, Idaho as it
relates to their adjustment to new health care system regimens such as prescriptions,
doctors’ appointments, insurance forms, adherence to treatments, immunizations, and
patient-provider communications?
Conceptual and Operational Definitions

Definitions of key concepts associated with the research problem include:

- **Acculturation**: a multidimensional concept involving the interaction between two cultures and the process of change that occurs as a result of the interaction. Through the process of acculturation, an individual learns to adapt by integrating some of the beliefs and values of the new culture, while maintaining some of the beliefs and values of the original culture (Siatkowski, 2007, p. 322).

- **Adaptation**: changes that take place in individuals or groups in response to environmental demands (Berry, 1997, p. 13).

- **Adjustment**: the process of modifying one’s behavior in changed circumstances or an altered environment in order to fulfill psychological, physiological, and social needs (Merriam-Webster’s Medical Dictionary, 2007, p. 2).

- **Assimilation**: those ways in which individuals and cultural groups adapt and change over time (Andrews & Boyle, 2007, p. 277).

- **Community-based Participatory Research**: is research that is conducted as an equal partnership between traditionally trained "experts" and members of a community (Community Health Scholars Program, 2006).

- **Culture**: the values, beliefs, norms, and practices of a particular group that are learned and shared and that guide thinking, decisions, and actions in a patterned way (Leininger, 1991, p. 55).

- **Emic**: a view that originates within and prioritizes the cultural or folk view (Garbarino, 1983, p. 82).

- **Etic**: pertains to the view of the outsider, the scientific observer. It is an analytic view that is reproducible by another trained observer (Garbarino, 1983, p. 102).
• **Health** - includes four domains of well-being: physical, mental, social, and spiritual (World Health Organization, 1998).

• **Health care** - is the provision of services that helps individuals achieve an optimal state of well-being, in any setting or stage in the human life cycle (Indian Health Service, n.d.).

• **Health disparities** - a difference in which disadvantaged social groups (such as the poor, racial/ethnic minorities, women, or other groups who have persistently experienced social disadvantage or discrimination), systematically experience worse health or greater health risks than more advantaged social groups (Braveman, 2006, p.180).

• **Health literacy** - the degree to which people have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (Parker et al., 2003, p. 147).
Assumptions

Assumptions for this research include:

- The accurate reflection of what was occurring during the formal interviews and group interview while working through an interpreter.
- It is assumed that all study participants felt no coercion or pressure to participate.
- The demographic data and health statistics reported for elderly groups in general are assumed to be applicable to the Bantu elderly.
- The health care experiences and adjustment of the Somali Bantu elderly in Boise may be reflective of similar experiences of the Somali Bantu elderly in other US communities.

Approaches to Data Collection

Collecting meaningful data that reflects disparities in the Somali Bantu community is needed to ensure that programs and health education efforts are targeted, specific, and culturally relevant. Qualitative and especially ethnographic research allows the researcher to approach the study population with an open mind; to learn from the study participants what their emic or “lived” experience has been. Through the qualitative interview process, I was able to observe social behavior, the environment, and could participate in social interactions with those being studied. Qualitative studies that involve participants as partners in the research for planning and conduction of the study are known as participatory research (Burns & Grove, 2005).
CHAPTER 3: METHODOLOGY

Design

Research Question

The goal of thesis is to answer the research question: What is the experience of the elderly Somali Bantu refugees of Boise, Idaho as it relates to their adjustment to new health care system regimens such as prescriptions, doctors’ appointments, insurance forms, adherence to treatments, immunizations, and patient-provider communications?

Qualitative Descriptive Inquiry

Naturalistic research seems most appropriate for this type of study when trying to define and understand the experience of the elderly Somali Bantu in Boise, Idaho as it relates to their adjustment to new health care system regimens such as prescriptions, doctors’ appointments, insurance forms, adherence to treatments, immunizations, and patient-provider communications.

Data collection took place in an uncontrived and uncontrolled environment: the elderly Somali Bantu’s residence. This allowed for a natural atmosphere in which the elderly could freely share their experiences. Interpreters were an integral part of participant-researcher communication during the interview process, data collection, and analysis.
Setting, Population, and Data Collection Techniques

Data collection techniques included a literature review of scholarly data bases, in-depth interviews, a focus group interview, and observations of the community. The data collection tool (questionnaire) for the primary community assessment and the elderly focus group was developed using the conceptual frameworks of Community as Partner (Anderson & McFarland, 2000) and Giger and Davidhizar’s (2008) cultural assessment.

With the assistance of Somali Bantu interpreters, 1 to 1.5 hour long interviews were conducted by two researchers for the primary community assessment and elderly focus group. Participants discussed their experience of American health care in a setting that was non-threatening and safe (usually the interviewee’s apartment). Researchers performed observations of the living environment, interactions between family and community members, communication patterns, and resources in the surrounding community using a guide developed from the conceptual framework.

The elderly Somali Bantu experiences at doctors’ offices, with prescriptions and taking medications, understanding treatments, use of interpreters, appointments, going to emergency rooms, and completing insurance forms were all investigated. A tape recorder and field notes were used in order to ensure that subsequent data analysis could be conducted on the full contents of what was said. Preliminary, open-ended questions were formulated with the assistance of the Somali Bantu advisory group to minimize researcher bias. Field notes were taken unobtrusively during interviews and observations.

Community-based Participatory Research

In conjunction with the Boise State University Nursing Department and research grant from the Office of Minority Health, this research was embarked upon using Community Based Participatory Research (CBPR) as a model for conducting qualitative
research as it pertains to the “lived” or emic experience of the Somali Bantu community in relation to health care. CBPR is defined by the Community Health Scholars Program (2006) as “A collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community and has the aim of combining knowledge with action and achieving social change…” (Hartwig, Calleson, & Williams, 2006, p. 1). The model encourages trust-building through community participation and the identification of community problems and solutions. Conducting research with active and critical cooperation and participation of the community ensures the cultural appropriateness of the research questions (Appendix B), supports the accuracy of data obtained through member checking, and makes use of interviews and focus groups to identify and propose sustainable solutions.

Methods

Methods utilized in this study included a larger study focused on a primary community and cultural assessment, literature review, observations, in-depth interviews \((n = 8)\), and an additional elderly focus group interview \((n = 6)\).

Getting to Know Each Other

In July 2008, the Boise State University research team met for the first time with the Somali Bantu leaders and members of the community; approximately 30 attended, with both men and women represented. Approximately 20% of this group was over 50 years of age. The initial meeting was facilitated by known volunteers from the Agency for New Americans resettlement agency who have worked with the community since their arrival in Boise. A community advisory board was established with the leadership of the two local groups: The Somali Bantu Community Association has more elderly
members than the Zigua community. The Zigua constitute a smaller group of Somali Bantu, with a younger demographic and history of being more proactive in their new surroundings. In contrast, the main group of Somali Bantu is older and appears to be comfortable keeping historical ethnic and cultural practices of their culture.

The Somali Bantu community advisory board was formed and met several times with the research team to review the appropriateness of interview questions as they were being developed and provide feedback as to the research team’s understanding of the data obtained. Members of the advisory board included community leaders (two), interpreters (two), and interested male (two elderly) and female members of the community. They acted as cultural consultants during questionnaire development, letting the research team know if questions made sense and if researcher interpretations and analysis of the interview data were accurate.

**Establishing Trust with the Somali Bantu Community**

Trust, within the research study, was earned through numerous meetings with the community association leaders and key community members to inform them of the research process and its purpose. An advisory board from the Somali Bantu communities assisted the researchers in questionnaire development, which was a factor in developing trust and understanding prior to entering into the community (field). Development of trust occurred over an extended period of time in the Somali Bantu community, but not without some cultural and contextual misunderstandings in the process. Through interpreted discussion between the advisory group and the research team, misunderstandings were identified, intent and apologies were offered, and friendly resolutions were obtained. An example of this occurred in the initial phases of research, when the research team was getting to know the Somali Bantu community. We had
approached only one of two groups within the Bantu community in Boise when we presented our collaborative research proposal, not knowing that a second group existed. This created unintentional hard feelings with the Zigua community, who we then met with to offer our apologies. The president very graciously accepted our apology and from that point forward, we were able to garner trust through fair distribution of research team time and resources to both Somali Bantu communities.

Primary Community Assessment Group

Fourteen community members were selected for in-depth interviews for the original study and community assessment. All participants were recruited by the community interpreters based on criteria indicated below and their willingness to participate. Interpreters from this community are well trusted by its members, as few outside of the community who have fluency in the Af-Maay and Kizigua dialects. They are the most knowledgeable regarding medical terminology, anatomy, and translation of their language into English vocabulary. Efforts were made during all communications to express the voluntary nature of the study and to avoid any coercion of study participants. The sample included young (18+ years of age) and old (50+ years of age), and male and female members of the Somali Bantu and the Zigua communities, who had experienced health care recently. Eight of the 14 participants selected for in-depth interviews were elderly (50+ years of age). Only the eight elderly interviewed were used in this research.

Tool Development for Interviews

Open-ended questions, utilizing Giger and Davidhizar’s cultural assessment model (2008) were developed for the community assessment’s in-depth interviews and then checked by the Somali Bantu community advisory board for cross-cultural understanding and accuracy. Oral consent was given by each participant through the
attending interpreter (Appendices D/E). The interview sessions were conducted by two BSU researchers and an interpreter and lasted one to one-and-a half hours. Audio-recordings of interviews were made with permission of the study participant.

**Elderly Focus Group**

As an extension to the primary research project for this thesis, a subset of the primary study group was selected by the interpreter based on interest and availability to participate in an elderly focus group. A two-hour interview was conducted by myself, utilizing a different set of questions (Appendix C), to elicit open-ended storytelling of their experiences with health care since arriving in Boise. Six ($n = 6$) elderly Somali Bantu members (four females and two males) attended the focus group with the interpreter: a younger Bantu man who knew English entered after the interview had started. Efforts were made to express the voluntary nature of the study and to avoid any coercion of study participants. The interview was audio-taped with the permission of the participants for future translation. Observations and field noting were also utilized for data gathering.

A limiting factor within this study was discovered during the interview process. We found that the responses of women- and especially older women- were reserved and perhaps limited when compared with those of all men in the one-on-one interviews. Related to cultural unfamiliarity with individual autonomy noted above, as a society, the Bantu collectively make decisions. This means they typically engage in long discussions as a group before reaching consensus. This is also a paternalistic society (male hierarchy) and the male is the decision maker for the family. The tribal chief ultimately has the final say in the community’s decision and he is sought for counsel and guidance by its members. It is unknown if the limited response of the older women is related to
gendered values, but it was observed in the focus group that after the male had spoken the women freely engaged in dialogue and side conversations. The collective nature of the focus group engaged the elderly women on a deeper level than had the in-depth community assessment interviews.

Because of the collective nature of the culture, the focus group interview with four female and two male elders, I hoped to obtain a deeper level of understanding of their experience and to allow them to tell their stories in the context of their familiar cultural practice and unencumbered by a structured interview process. The result was a collection of ethnographic narratives of the Somali Bantu elders’ experience of American health care. The group was very open in sharing their experiences and the women went on to dominate the conversation after the males gave their stories. It was a lively interview, filled with overlapping conversations, children playing, and visitors entering and leaving.

**Data Rigor**

In qualitative research, scientific rigor is ensured during data collection through measures to support dependability, confirmability, transferability, and credibility (Guba & Lincoln, 1989). In this study, confidence in the systemic accuracy of data, or credibility, was established by member checking, asking the advisory board if the interview questions were culturally congruent and if the collected data was accurate and interpreted in a manner that maintained the emic values and orientations of the informants. An audit trail was maintained over the 18 month project that included demographics such as age, interview location, interview date, interpreter present, and researchers present. Interview transcripts and audiotapes were collected by the researcher and stored in the Boise State University’s nursing department for security. All were
interpreted interviews in Af-Maay and the Kizigua language of the Somali Bantu, with notes taken by an assistant researcher during the interview process. Accuracy of the interpretation was verified by providing another interpreter in the community, who was familiar with the Af-Maay and Kizigua dialects, with the recording and an anonymous interview transcript so the interpreter could access the accuracy of interpreted dialogue. Both interpreters utilized for this process confirmed close to word-for-word accuracy in the audio-taped interviews they heard.

Results of the community assessment data analysis were shared with the Somali Bantu community advisory board to authenticate researcher understanding and interpretation of data and that the community’s perspective was accurately represented.

**Credibility**

Credibility is needed to guarantee that the reality of the research participant is the same as what the researcher discovers and perceives, especially when cultural variances are present in the research environment. Credibility of the data was reinforced through prolonged engagement with research participants over a span of 18 months. Engagement with the community included informal meetings (planning), formal interviews, and an elderly focus group interview. The Somali Bantu community advisory board meetings offered the research team insight into participant responses and to confirm researcher understanding. Data analysis for the community assessment involved six research team members and a research assistant who collectively analyzed data.

Member checking and peer debriefings were components of researcher assessment and evaluation of what the community assessment team researchers had seen and heard in the field. Member checks involved participants in the research in providing feedback on our interpretations of what we were seeing and hearing. We became the
“learners” as we were engaged in the ethnic surroundings of the Bantu. Over time, a reciprocal awareness and understanding seemed to transpire between community and research team. The elderly focus group data analysis was conducted by me, utilizing my ethnography professor and classmates as a peer debriefing team each week during the study.

**Confirmability**

Member checking also played a role in establishing confirmability. Confirmability assures that data, interpretations, and research outcomes are rooted in the context of the study population and not from the researcher’s imagination (Guba and Lincoln, 1989). Analysis methods were developed through inductive analysis of data and development of sub-themes, and themes which captured major patterns in the data. Thus, the raw products (field notes, transcribed interviews, observations, and audio-tapes) and the processes I used to compress them are auditable through the figures, tables, and appendices of this study.

**Transferability**

Guba and Lincoln (1989) refer to transferability in terms of the way “thick descriptions” of field events relay or transfer information from one study group to another due to similarities between groups in background, culture, environment, or experience. Transferability was obtained from in-depth interviews and the rich experiences reported by participants through their narratives. By providing an extensive and careful description of the time, place, and context in which the elderly Somali Bantu experience health care, other researchers may be able to apply the findings of my research to their own scholarly inquiries. By presenting a thorough data collection and
analysis, I can facilitate transferable judgments on the part of other researchers that may be applied to their own study population if findings are found to be transferable.

Protection of Human Subjects and Ethical Considerations

According to the US Office of Research Integrity (ORI), refugee populations are defined as an at risk research population due to linguistic barriers, issues of health literacy, poverty, prejudice, violence and trauma, health care access, and the challenges of resettlement in a foreign country (Steneck, 2004). Understanding the Somali Bantu experience of health care and involving their community in the discussion will assist healthcare providers in the provision of culturally sensitive and appropriate care.

Steps were taken, through interpreters, to ensure the informed consent of these individuals during the community assessment and the elderly focus group interview. Because the Bantu do not have a written language and many of these refugees do not read or write English, the consent form was interpreted and spoken to them in their native language. All files and data were coded and kept in a locked file to protect confidentiality of research participants. Names, ages, and genders used in this report are pseudonyms and do not identify actual participants. Approval for this project was obtained October 2008 from the Institutional Review Board (IRB) of Boise State University.

Data Analysis

According to Lincoln and Guba (1985), naturalistic inquiry provides rich, descriptive data from study participants in their natural environment. This helps the researcher understand the participants’ personal, or emic, experiences. For 18 months, I learned about the elderly Somali Bantus’ challenges in adjusting to American culture while preserving parts of their ethnic heritage through a scholarly review of the literature,
in-depth interviews, and observations. Descriptive content analysis of the in-depth community assessment interviews with the elderly and my elderly focus group interview was used to inductively discover emerging themes (re-surfacing conceptual similarities in the data) related to their experience of health care in Boise, Idaho. Field and Morse (1985) suggest an innovative approach to data coding utilizing colored highlighters to denote major emerging themes or categories during analysis. I utilized this system during my analysis of the primary community assessment data and the elderly focus group transcripts.

Primary Community Assessment Group Analysis

Analysis of the observations and interviews was done with a minimum of four research team members. Analysis sessions involved review of interview and observation data for similarities and themes, utilizing negative case analysis to ensure ontological authenticity (Guba & Lincoln, 1989). A final list of themes was compared to information gleaned from the literature review. Formal interviews were noted by a scribe and tape recorded, but not transcribed, due to the unavailability of reliable transcription services in the Kizigua and Af Maay languages used by informants. Data from the observations and interviews that specifically related to the elderly was used in combination with thematic data collected from the elderly focus group (Appendix F/G).

Elderly Focus Group Analysis

In the analysis of elderly focus group observations and the focus group interview data, I listened to the audio-taped interview many times for reoccurring themes. Each participant’s carefully transcribed quotes were grouped into similar categories from which the themes began to surface.
Development of Themes

Using data from all sources, the following themes emerged: (a) Biological Changes Related to Aging (pink); (b) Culture (orange); (c) Socio-economic Status (green); and, (d) Literacy (yellow). The inter-connections between these themes were identified with string on a visual wall display I constructed to aid data analysis. Sub-categories were developed and transcribed excerpts were attached to support the elderly emic experience of health care in Boise, Idaho as seen in Figure 3.1.

![Data Analysis Wall Display](image.jpg)

**Figure 3.1  Data Analysis Wall Display**

Data from all sources were analyzed for common traits and behaviors within families, between interpreters and clients, and with health care providers during communication and interactions. Information about on-verbal nuances, body language, and gestures from field notes were also identified and coded in terms of their potential relation to what was being said or performed at the time.
Methodologic triangulation (Giacomini & Cook, 2000) was applied in the analysis of data by looking for conceptual overlap and relatedness across data collected through literature review, interviews, member checking, debriefing, and observation. Triangulation adds to the reliability of qualitative research by grounding one’s findings on two or more theories, data sources, investigators, or analysis methods (Burns & Grove, 2005).

By combining a qualitative descriptive research design, the theoretical frameworks of Community as Partner (Community Health Scholars Program, 2006), Giger and Davidhizar’s (2008) model for cultural assessment, and CBPR research methods for data collection, the research provides for a holistic and personal perspective on the experience of the Somali Bantu elderly regarding health care in Boise, which, in turn, afforded the identification of areas for point-of-service improvement and nursing intervention.

Unknown Health Care Needs

The Somali Bantu refugees, particularly the elderly, have numerous health care risks (infectious and parasitic diseases, chronic disease, and mental health issues) that exist in parallel with illiteracy, language and cultural barriers, age, socioeconomic conditions, and resettlement. The Somali Bantu refugee community has come to Boise, Idaho in search of a new home and freedom from persecution. With this new life, new challenges emerge as these new immigrants adjust into a foreign country and culture. Some of these challenges include access to culturally appropriate health care, communication barriers, and the identification of health care needs. We don’t yet know what health care needs might exist at this point for the Somali Bantu elderly due to gaps in current research with this ethnic group – gaps this research may help to close.
CHAPTER 4: RESULTS

Description of Participants

Naturalistic inquiry provided a comfortable and safe environment for elderly members of the Somali Bantu community in Boise, Idaho in their own homes and apartments. Participants for this study are a purposive sample of the elderly Somali Bantu community, selected by community interpreters based on their interest and availability to participate. For the primary community assessment group, there were eight elderly study participants; four were men ($n = 4$) and four were women ($n = 4$). The sample size for the elderly focus group was six; four were women and two were men. They are self-identified as elderly (50+ years of age) and are a subset of the larger Somali Bantu community of approximately 246 men, women, and children. They have lived in the Boise area for four to seven years, most residing with six to eight extended family members in one to two bedroom apartments. The majority of elderly Somali Bantu do not speak English and rely on interpreters to communicate. Men and women are included in the study and all members participated voluntarily. Study participants were given pseudonyms to protect their anonymity; these names were taken from the Somali Bantu cultural profile (Van Lehman & Eno, 2003). Observations of this community were conducted during the interview process, in and around their apartment complexes, during community events, and in my work with them as a volunteer and health care provider.

I have worked with this refugee population since 2003, when I volunteered as an English tutor with the Agency for New Americans. I have worked with the Somali Bantu
as a public health nurse since 2007, providing immunizations for adults and children upon entry into the country. As a researcher, I have engaged with them in participatory research for 18 months, conducting a primary community assessment utilizing Anderson and McFarlane’s Community as Partner (2000) and Giger and Davidhizar’s theoretical framework (2008). An ethnographic study was then conducted, utilizing a subgroup of the original community assessment. Six elderly members of the Somali Bantu community participated in this focus group, which would further investigate the experiences of the group as they related to health care in Boise.

Data analysis procedures for this study were selected to fit with methods used for data collection: in-depth interviews, observations of the community, literature review, and an elderly focus group interview. During the community assessment phase of the research, at least four members of the research team met to review the interview field notes. Analysis of this data resulted in the development of themes from which an initial list of health issues, beliefs, and practices were identified with this population.

Analysis of data was then conducted to look for common experiences and potential barriers to their adjustment to health care in Boise, utilizing the emerging themes of (a) biological changes related to aging; (b) culture; (c) socio-economic status; and, (d) literacy (Figure 3.1). From the data analysis of primary community assessment group and elderly focus group interviews, the literature review, and my observations, these four themes appeared to have the most significant influence on how the elderly Bantu refugee accessed and utilized health care in Boise. The interviews and elderly focus group field notes were reviewed, transcribed, and analyzed to identify emic accounts of the participants. They shared their stories of health care in Boise, Idaho and what the new health care system was like for them as elderly members of this ethnic
community. I developed a visual display of how these factors were inter-connected and influenced the elderly refugees’ task of accessing health care and understanding its mechanisms of care (Figure 3.1). The interview excerpts were then used for thematic development of those factors that appeared to be most influential in the process of adjustment for elderly Somali Bantu as it relates to health care in Boise, Idaho. Table 4.1 describes main themes and subthemes with quotes – the findings section will focus on the main themes.
Table 4.1  Thematic Analysis of Interview Data

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
<th>Key Words</th>
<th>Participant's Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological Changes</td>
<td>Disease history</td>
<td>Sickness, high blood pressure, diabetes</td>
<td>“Brought sickness from camps: high blood pressure, diabetes” (8/6/09, 60+, male)</td>
</tr>
<tr>
<td>Related to Aging</td>
<td>(co-morbidities)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biological Changes</td>
<td>Polypharmacy</td>
<td>Multiple medicines, problems telling time, reading</td>
<td>“Some old people take many medicines. Some people can’t tell time, can’t read, so have problems with medicine” (6/5/09, 60+, male)</td>
</tr>
<tr>
<td>Related to Aging</td>
<td>Memory/Language Learning</td>
<td>English learning</td>
<td>“They (the elderly) go to English classes, they try, they do their best, but still they don’t understand” (I, 11/24/09)</td>
</tr>
<tr>
<td>Biological Changes</td>
<td>Mobility/Transportation</td>
<td>Doctor’s appointment, cars, transportation, dependency</td>
<td>“It is hard to get to doctor, I have no car. Sometimes my son, sometimes the neighbor, sometimes they’re at work” (H, 60+, 11/24/09)</td>
</tr>
<tr>
<td>Related to Aging</td>
<td>Health care access</td>
<td>Villages, no power, no hospital</td>
<td>“People live in villages. No power, can’t build hospital” (5/29/09, 60+, female)</td>
</tr>
<tr>
<td>Culture</td>
<td>Muslim faith</td>
<td>Prayer, sickness</td>
<td>“if they’re not helped (by American medicine) we pray for them” (8/6/09, 60+, male)</td>
</tr>
<tr>
<td>Culture</td>
<td>Traditional healing</td>
<td>Drumming, oils, burning, fruit and leaves</td>
<td>“At home used drumming, oil body, fruit and leaves for sick person” (8/6/09, 60+, male)</td>
</tr>
<tr>
<td>Culture</td>
<td>Political oppression</td>
<td>Education, opposition</td>
<td>“Government (Somali) prevented education. We end up- no education” (8/6/09, 60+, male)</td>
</tr>
<tr>
<td>Literacy</td>
<td>Use of interpreters</td>
<td>Importance of interpreters, medical visits</td>
<td>“Interpreter helps us to understand when we go to the doctor. They are important part of the visit” (8/6/09, 60+, male)</td>
</tr>
<tr>
<td>Literacy</td>
<td>Wellness before education</td>
<td>Illness precludes learning</td>
<td>“So when you’re sick, you’ll be thinking of your medication, not you’re education” (H, 60+, 11/24/09)</td>
</tr>
<tr>
<td>Socioeconomic Status</td>
<td>Poverty</td>
<td>No Medicare for those under 65 years of age</td>
<td>“Only one person working, those who are not 65 do not have Medicaid” (8/6/09, 60+, male)</td>
</tr>
<tr>
<td>Socioeconomic Status</td>
<td>Health care access</td>
<td>Medicare</td>
<td>“Thanks to the United States government for Medicaid” (8/6/09, 60+, male)</td>
</tr>
<tr>
<td>Socioeconomic Status</td>
<td>Medical (cost)</td>
<td>Insurance, Medicare, uninsured</td>
<td>“2-3 thousand dollar bill from hospital (50+, female household member). Can’t pay. Was sick 3 days ago and didn’t go to doctor because of hospital bill” (8/6/09, 60+, male)</td>
</tr>
</tbody>
</table>
Results and Findings of Research

Biological Changes Related to Aging

The life expectancy in Somalia is only 49.6 due to a long running civil war, famine, widespread disease, and little or no access to health care. Therefore, old age is considered to be 50+ years of age in this community (Somali Bantu Research Group, 2009). The majority of the Somali Bantu elderly are female due to males being killed during the Somalian civil war. This was apparent during the research as the majority of elder community members are female.

Of the elderly Somali Bantu I interviewed in the Boise community, the informants appeared to have good mobility, hearing, sight, and memory compared to others of the same age in the general population that I’ve worked with as a health care provider. They responded appropriately (orientation to time and level of consciousness) to interpreted interview questions and engaged in lively discussion during the interview process and interventions such as the Medication Safety and First Aid/CPR classes I provided.

Healthy People 2010 (n.d.), describes 42% of people over 65 as having functional limitations that inhibit the Activities of Daily Living (ADL), such as walking, bathing, dressing, getting in/out of chairs, or using the toilet. The degree to which functional limitations affect the Somali Bantu elderly population in Boise is unknown and requires further baseline data collection.

Memory/Language Learning Related to Aging

Learning English and health literacy may be affected by age and memory, but they do not prevent the elderly Somali Bantu from learning over time. The elderly must remember instructions for multiple medications after the doctor’s appointment has ended and without the interpreter present to review the instructions on the prescription bottle or
push-pack, medication errors may occur. Rahma, a 60+ year old female, shares through the interpreter:

I go to the English class for five years, and still I don’t remember, I don’t understand. If I don’t have my interpreter when I go to see the doctor, then I won’t understand. Sometimes I still forget when I have so many medicines and I don’t know what they’re for...I don’t remember always.

Singleton and Lengyel (1995) states that when learning a second language, that younger is better. He does point out, however, that five percent of adult learners master a second language even when they begin learning as older adults. The author does not address, however, whether this five percent were literate in their own, or primary, language. Having no prior knowledge of an alphabet from which to build words and sentences, learning a new language in written form holds challenges for the elderly refugee. I’ve observed in my immunization practice that holding a pen seems foreign to the Somali Bantu elderly. Initialing or making an “X” for their signature on an immunization document requires time, thought, and focused, fine motor effort of the hand.

Difficulty learning a new language and their continued dependence on interpreters impedes the elderly Somali Bantu in their adjustment to health care processes and creates a barrier to self-empowerment in their new community. Extended resources for language learning are needed as are health literacy classes that are geared towards pre-literate populations and the ways they learn. The majority of elderly participants reported chronic diseases such as diabetes and hypertension, but since symptoms of these conditions are often covert, elderly Bantu patients who have not yet come to understand health care treatments and how their bodies work are sometimes skeptical of doctors’ orders. This leads to decreased effectiveness of health care, even when it is available.
Disease History

Chronic illness is common in the elderly, yet the experience of the elderly Somali Bantu is rooted in their history and they have no knowledge of things such as blood pressure measurements, how the heart works, or how to adhere to dietary changes. Native-born Americans receive blood pressure measurements as a normal part of their health care. Pictures of anatomy, relatively frequent access to medical care, and even “pop-medicine” television shows experienced in childhood, orient Americans to how the body works, giving some a frame of reference for how blood pressure affects the body and how its treatments work. Hypertension is reported in this population during their stay in the refugee camps. There is no data prior to that period to assess whether there are genetic implications within this population. There appears to be a prevalence of disease in this community based on oral histories of the study participants. Further data collection is indicated to determine these baselines.

According to the Federal Interagency Forum on Aging Related Statistics (AgingStats.Gov, n.d.), older adults are more likely to suffer from co-morbidities (multiple diseases), take more medications (polypharmacy), undergo more medical procedures, and use more health care than any other age group. This creates a complex environment for the health care provider as they try to coordinate care and manage multiple diseases and potential medication interactions.

Mustaf, a 60+ year old male, stated “The doctor said I was having high blood pressure and gave me medicine. I go to the pharmacy and the doctor there tells me how to take this medicine. I don’t know, I don’t feel my blood pressure when is high. How do I know I have it? Maybe sometimes I get headaches. I have to trust this doctor and his instrument.

Trust is a vital component of adjusting to a new environment. The history of persecution and torture the Bantu have endured would seem to influence their interactions with the
host society, yet my interactions with them have proven to be open and trusting from my perspective. Some struggle, however, with the care received from health care providers.

The president of the Zigua community in Boise voiced disbelief of medical advice when he had gone to a doctor who had talked to him for a few minutes, did no physical exam, gave him no medications, and then charged him $300. He asks “What kind of medicine, what kind of doctor is this?” However, from the data collected, elderly participants felt they were treated well while on Medicare and that their health care needs were met.

**Polypharmacy**

Medication safety was identified as a concern during an interview with an elderly Bantu woman who did not understand the concept of dose and the dispensing of drugs in push-packs; consequently, she had taken all of the contained medication at once and had become very ill. She had then gone off of her medications entirely, in fear that she would become severely ill if she restarted them and didn’t understand that she could go back to the doctor to discuss this. This, in part, might also be related to her unfamiliarity with the autonomy expected of her by her health care provider. She may be hesitant, or language barriers preclude her from contacting the doctor to discuss the problem.

Polypharmacy complicates the elderly’s ability the effectively manage multiple medications, their timing, and the monitoring of their side effects. The various routes of administering medications can also be confusing. One elderly, diabetic man reported giving an orange his injection of morning insulin as he had been shown to do in his training, and then he ate the orange thinking that its sugary properties had been averted. According to Springer et al. (2010), the Somali Bantu elderly are at increased risk for errors in medication self-administration, missed medical appointments, misunderstanding
medical information, or inability to adhere to treatment plans due to language barriers and poor health literacy.

**Mobility and Transportation**

Since doctor’s offices are generally not within walking distance of the community apartments, even for the most agile, it is not surprising that interviewees reported mobility issues in walking to the store or pharmacy and had limited access to transportation. This is one example of how the effects of age, language, culture, and socio-economic factors intersect in the refugee’s life. Shaalo, a 50+ year old man, stated he needed his son to take him to his doctor, but this was sometimes hard to do because of his son’s work schedule. Speaking to the appointment desk at the doctor’s office was also a problem without his son there to assist him due to his language barrier. I observed that the majority of the elderly do not drive, bus schedules are hard to navigate due to their inability to read or tell time, and taxis are cost prohibitive.

The New York Times (Grady, 2009, March 29) interview with a physician from a Minneapolis medical center cited transportation as a major barrier for the Somali Bantu community, particularly the elderly, who relied on family members for language interpretation and a ride to their doctor’s appointment. One of the interpreters shared with me that during his travels to Boston (another resettlement city for Somali Bantu refugees) that there is a community bus that goes to each apartment where the refugees live and picks them up and takes them back home from their doctor’s appointments. “This seems to work very well,” he says.
Culture

The effects of culture on the Somali Bantu elderly experience of American health care cannot be underestimated. Unfamiliar American medical treatments baffle the Somali Bantu elderly as they learn to accept the “new” health care that America has to offer without proficient English language skills and health literacy to help interpret what they’ve been told is “wrong with them.”

Muslim Faith

They have left behind traditional healing remedies such as plant bark and roots that are not readily available on this continent, yet the Somali Bantu Muslim faith continues to provide a link for topics related to sickness and health.

When asked what she thought caused sickness, Nuuria, a 50+ year old female replied, “I don’t know, it’s about God maybe.” Hussein, a 60+ year old male says, “God can bring anything.” Allah plays an integral part in the daily activities of the Somali Bantu and the health of individuals is prayed upon, ultimately being left in the hands of the “higher power.”

As I have interviewed this group as a researcher and assisted them as a volunteer and nurse, I see a community that holds steady to a set of values embedded in their Muslim faith (daily prayer time, fasting during Ramadan, and the belief that Allah takes care of all things). These beliefs and practices are interwoven with the new ways of accessing medical care; the elderly of this community are unopposed to learning its complex mechanisms of entry (Medicare applications, insurance forms, scheduling interpreters, making and keeping appointments, filling prescriptions, and referral systems for medical tests and specialists).

Extended Families

Somali Bantu families include multiple generations and kin relationships (cousins, nieces, and nephews) living under the same roof, usually in a two or three bedroom
apartment. As in their homeland, the village tries to take care of all its members, sometimes in ways that conflict with the desires of Western medicine. Amina, a 50+ year old female, shares that, “Older Somali Bantu are cared for by daughters and granddaughters traditionally, if one becomes ill, we will all take care of that person. Nursing homes are something we don’t know.”

During one of the interviews, I noticed an elderly woman sitting in a reclining yard chair. She was positioned along the wall of the living room and did not engage in answering the interview questions. When I asked if she was feeling alright, the younger woman replied, “Yes, she’s just old; we will take care of her.” As a collectivist society, the community takes care of each other as a whole. This was observed around the apartment complex as the majority of the families were multi-generational, assisting each other with the care of children, the disabled, and the aged.

African cultures are collective while American culture is focused on individualism. Andrews and Boyle (2007) define collectivism as “the need to maintain group harmony above the partisan interest of subgroups and individuals” (p. 302). Children in these societies are raised to be interdependent and to care for others in their family and community. Members of collectivist cultures are expected to subjugate individual needs for the needs of the family.

Traditional Healing

For the Somali Bantu, traditional remedies such as roots, tree bark, and “bone-setters” were the only treatments available in the Juba River Valley of Africa. While encamped at Kakuma, refugees would stand in a line all day to receive care (typically, a bag of pills) from the UN medical staff. According to the UN High Commissioner for Refugees (UNHCR) (n.d.), the number of refugees per health care facility in the Kakuma
camp in Kenya was 17,519 with a utilization rate of 1.7 new consultations per person, per year. Kakuma has five health care facilities (the standard is nine facilities per camp). Aid agencies such as Red Cross, CARE Canada, National Council of Churches of Kenya, and International Rescue Committee partner with UNHCR to provide primary health care for the refugees and the local community inhabitants (UNHCR, n.d.).

Medical resources and equipment were scarce and native plants did not grow in the camp due to the lack of water for planting. A formulary of 30–40 drugs is on hand to treat primary diseases of the residents (malaria and diarrheal diseases such as cholera). Numerous study participants stated American medications work better than the pills given to them in the UN camp. Traditional herbal remedies cannot be used here in the US, as North American plants do not resemble those used in Africa; therefore, an acceptance of new, American ways of health care has been observed. While health care in America is expensive, those who are fortunate enough to be covered by Medicare expressed gratitude and faith that the health care systems in Boise would provide the best care.

The elderly members of the community that I spoke to appreciated the knowledge of their health care provider. They trusted providers with their health issues and felt they were treated with respect. Medical technology was viewed as a positive and progressive tool for care even though they may not understand its application (such as the blood pressure cuff), while traditional Islamic cultural practices for death and burial are strongly adhered to, sometimes leading to uncomfortable experiences for the Bantu.
End of Life and Traditions

An example of how health care provider knowledge and sensitivity to these customs could have provided culturally sensitive care was described by Arbow, a 60+ year old grandmother.

My daughter’s baby was born too soon, but the doctors did not keep the body to give to us. They took the body and burned it. This is not good. This is not the way we treat our dead. (She went on to explain the burial ritual.) First you have to wash the body, then find someplace to bury after a few days. You wrap the body in a white cloth and face them towards Mecca. People pray for them and people come over to your house.

Karimollahi et al. (2008) discuss the fundamental beliefs of Islam and their relationship to health, illness, and dying. Muslims submit to the will of Allah (God) and receive illness and death as a part of life and a test from Allah. The authors stress the importance of health care provider awareness and sensitivity to cultural values and preferences when developing care plans and the inclusion of family in end-of-life decisions. It’s important for health care and its practitioners to also adjust to the influx of refugees and a global client population and to allow for the core beliefs of every ethnic group to be accommodated in the holistic provision of care.

Socio-economic Status

The majority of Somali Bantu in this community are considered to have a low socio-economic status and have been significantly impacted by the economic down-turn of 2009-2010. Those who are 65+ years old have access to Medicare for their medical needs, but those who are younger do not always have access to health insurance and, as with other Americans, access to health insurance appears to be a strong influence on whether an individual will go to a doctor when necessary.
Poverty and Health Related Quality of Life

The 2007 census data shows 16% of immigrant seniors living below the poverty line, compared to 12% native-born elderly. This data has a positive correlation to health related quality of life (HRQOL) and health disparities based on the Centers for Disease Control and Prevention’s (CDC) weekly report on morbidity and mortality. The report concluded that low income (annual household income < $15,000) adults 45-64 years of age have a lower position on the HRQOL than all other adults (CDC, 2003).

Health Care Access

Unshirey, a 60+ year old male, states ‘If they have Medicaid, they go to the doctor and pharmacy and get pills. The problem is most don’t have Medicaid so they don’t go to the doctor.’ The majority of those working, who are 64 years or younger, have no medical insurance due to low-wage jobs, or are unemployed. When asked if the Somali Bantu had a hard time getting medical help when sick, Halema, a female under 65, explained “Yes, only one person working. Now have a $3,000 bill from hospital because no Medicaid. I was sick three days ago and didn’t go to the doctor.” The fear of large medical bills prevents them from seeking care until they feel very ill. Poor understanding and management of chronic disease for those under 65 leads to increased usage of costly emergency department visits. Gaps in language, health literacy education, and affordable urgent care for acute illness are contributors and barriers to access of appropriate health care.

The majority of refugees I serve as a public health nurse are eligible for free immunizations through the Vaccines for Children program (children 18 and under) or during the eight months of medical coverage allowed for under the federally funded refugee program. In an audit of 695 black African refugee charts at the health
department, I discovered that 46% of those refugees were not fully immunized. Unless covered by Medicare or Medicaid programs, this population would not have access to health care and immunizations.

**Literacy**

It is estimated by the International Organization for Migration (IOM) (2002) that 5% of the Somali Bantu population is formally educated. Illiteracy rates are believed to be 76% or more in this sub-population of Somali culture. In the UN camps, children were allowed in school, but not the elderly. I am unsure of the grade level obtained by children in the UN camps, younger male members of the Somali Bantu community in Boise have elementary school skill levels in reading and writing based on my observations of their email communications, their community association website, and completing health forms. Of the 14 elderly I interviewed in both research projects named here, all would be considered pre-literate or illiterate.

It has been four to seven years since most members of this community arrived on American soil and most of this community continue to struggle with learning the English language. Fatuma, a 60+ year old woman, voices with frustration, “I try and try to learn the English in those classes. I go for awhile, but I don’t remember when I get home and no one to talk to. Maybe I’m too old.”

While the young learn English through immersion in school, the elderly are often isolated from this language-building interaction. Even middle-aged and younger adults in the Somali Bantu community have a hard time reading and writing English. This becomes vividly apparent when filling out insurance forms and health screening questionnaires.
Relying on Community Interpreters and Family

The elderly rely heavily on the community interpreters or their children to help bridge the communication gap; there are multiple accounts of how doctor’s visits are unproblematic when their interpreter is present. Mberwa, a 60+ year old man explains, “I go to clinic, experience with doctor is good now. They know I’m a refugee, I’m with an interpreter.” This produces a heavy burden for a handful of interpreters who try to serve the members of their community and older family members. More people desiring the support of interpreters, than available interpreters, produces a problem of access to health care and access to assistance in developing health literacy so that they can help themselves more readily. The cost of interpretation ($20-30/hr.) is only covered for the first 8-12 months from arrival and therefore is not a sustainable solution for the elderly who need interpretation. The interpreters now provide this service to their community out of collective obligation.

Health Literacy

The impact of literacy and the lack of English skills have a huge effect on the elderly refugee’s ability to understand health information, maintain appointment schedules, and adhere to medical treatment regimens (taking medications as prescribed). Mwanamku, a 50+ year old woman stated “I did not know the way this medicine should be taken (a rectal suppository) I was not supposed to be take this one by my mouth.”

Despite instructions from health care providers and pharmacists, narrative stories by the elderly Bantu describe that medication errors in dose, route, or timing are often made. Schyve (2007) states that the Joint Commission reports low health literacy, cultural barriers, and limited English skills are the “triple threat” to effective health
communication between patients and providers. Limited data is available surrounding the examination of culture and language as determinants of health literacy.

A large majority of the elderly Somali Bantu in this Boise community are still reliant on the interpreters in their community to help them understand the nature of new therapies and medications they receive from medical providers. Self-administration errors, forgetting or misunderstanding the directions interpreted to them at the doctor’s office, and missing follow-up appointments have been observed during the course of this study and in my interactions with the Somali Bantu elderly as a public health nurse.

Desire and Motivation to Adjust to New Ways

As a volunteer and nurse, I have observed and experienced the Somali Bantu community as being a trusting group. They are eager to learn. I have noticed that some will agree to treatment despite not having a full understanding of its context or intended goal. When interpreters are present, they relay the information to the client based on their level of understanding of the disease, body part and its function, and finding a word in their language that “fits.” Given the dependent role this population was placed in for years within the UN camps, these may be behaviors of learned compliance towards the system of institutionalized health care.

However, I’ve observed as a nurse and volunteer that this community is very willing to receive new information regarding immunizations, health recommendations and education, and new ways of doing things (taking medications from “push-packs” and showing up for appointments on time). During a mobile flu immunization campaign at an apartment complex where the Somali Bantu community lives, there was a large turn-out by the community to receive shots.
As an instructor, I’ve also learned that through hands-on demonstration, language barriers to learning health information can be overcome to some degree. During an interpreter-assisted First Aid/CPR class taught to the community, the elderly participants of the class were able to demonstrate back the learned skill through repetitive demonstration and practice. Younger members of the class were seen to be more than willing to pitch in and assist the elders if they were doing something incorrectly. Through demonstration and storytelling, educational information was relayed to the young adults and older students, and a new skill was learned for its health and safety application in the workplace and in their community. Van Lehman and Eno (2003) state that important aspects of Somali Bantu culture are passed down from one generation to the other through storytelling, singing, and oral recounting of their history.

Complex Issues with No Simple Solutions

The biological changes related to aging in the Somali Bantu have associations rooted in Africa with their history of forced migration, limited health care access in UN camps, malnutrition, trauma, and parasitic diseases. Political and ethnic persecution have marginalized them as a group and forced them to the fringes where education and economic self-sufficiency are difficult to accomplish. Chronic illness has accompanied them on their journey to their new homeland and health care providers must overcome language barriers and cultural variances when providing care through interpreters. Polypharmacy compounds the potential for medication side effects and language skills again influence the elderly refugee’s ability to adhere to treatment regimens and instructions for multiple prescriptions.

Cultural beliefs are deeply enmeshed in the fabric of the Somali Bantu community. The elderly have been the oral historians and educators for their villages in
Africa and now are relegated to the isolation of apartments while their families struggle to make a living in America. Fundamental Islamic beliefs and practices for prayer, fasting, marriage, and caring for the sick and dead are central to daily life in the Bantu family and the collective nature of the society makes it crucial for health care providers to include family members in decision making.

Socio-economic conditions affect not only the aging Somali Bantu refugee but also the health related quality of life for other aging Americans who live at poverty level. Health disparities exist in association with low-income status and ethnic populations, compounding the gaps in access to care and preventive health programs such as immunizations and health screenings (for example, mammograms and prostate cancer screening). Low-wage jobs held by those 50 to 64 years of age don’t offer medical coverage and this group is left with no access to care: the emergency department is the last resort for the severely ill. Most will not go to the doctor due to lack of insurance and the fear of un-payable medical bills – a problem the Somali Bantu share with many Americans, and a problem that shows how needs of the Somali Bantu are not unique.

Literacy and understanding the English language is the cornerstone to all interactions, communications, and potential progress in American society. Current refugee resettlement policies fall woefully short of the real needs of pre-literate societies who come to the US.
CHAPTER 5: DISCUSSION AND CONCLUSIONS

Interpretation of Results and Findings

The process of refugee resettlement is a complex and often daunting task for newly arriving refugee communities. The complexity of this task is compounded for the elderly Somali Bantu refugee as they face biological changes related to aging, cultural adjustment, and barriers related to socio-economic status and literacy issues. Utilization of community and cultural assessment frameworks and qualitative, descriptive research methods provided rich, emic narratives for this study, describing the elderly Somali Bantus’ experience of health care in Boise, Idaho. Previous research surrounding the Somali Bantu elderly and their adjustment to health care systems, based on their experience, is limited and does not address the depth or breadth of issues they face, or how the network of factors described above has systemic influence on their health.

Detailed description and understanding of the factors influencing the elderly Somali Bantus’ experience of health care is necessary if educational and health care systems and providers are to provide culturally appropriate care, avoid misunderstandings in provider-client communications, engage in health education, reduce health disparities, and improve chronic disease management and patient care outcomes. The four influencing factors of: (a) biological changes related to aging; (b) culture; (c) socio-economic status; and (d) literacy will be discussed and their relationship to how the Somali Bantu elderly adjust to American health care.
Biological Changes Related to Aging

Aging brings about many functional changes in life: diminished mobility and cognitive function, chronic disease, sensory deficits, and losses in independence and loved ones (Healthy People 2010, n.d.). For the elderly Somali Bantu, these are compounded by language barriers and unfamiliarity with a new host society that appears only marginally ready to help them learn how to help themselves. Comorbidity and the use of multiple prescriptions present disease management challenges for the health care provider when trying to obtain an accurate history through an interpreter and the subsequent development of patient education and treatment programs. Factors that positively influence the elderly refugee’s adjustment to health care are family and community support and medical insurance for those 65 and over through Medicare. Factors that negatively influence this adjustment are sensory losses, decline in cognitive function (memory) and mobility, socio-economic status, and the ability to learn a new language.

I have attended the Idaho Conference on Refugees twice in the past two years. The Idaho Office of Refugees has sponsored this event, which brings together health care providers, refugees, resettlement agencies, case workers, teachers, mental health specialists, and others in the community to discuss to needs of refugees. Health care providers who have been to Africa and understand the history of the Somali Bantu and the struggles of the refugee are collaborating with others in the community to build relationships that support the refugee community. Monthly meetings now occur at one of the regional medical centers in Boise to discuss care for this vulnerable population. There has been recent anecdotal information regarding a Mayor’s task force for refugee resettlement in Boise.
Culture

While varying degrees of adjustment occur in this elderly population, full adjustment of the elderly Somali Bantu has not occurred in the past four to seven years following resettlement to Boise. As a public health nurse, I am able to interact with a wide variety of refugees from various countries. Providing immunizations for their children, I see them at intervals of two, four, six, and 12-15 months, and I can observe the degree of adjustment they’ve made to office procedures and their progress in language acquisition. The degree of adjustment and language acquisition is much faster for an educated Iraqi or Bosnian refugee than for the Somali Bantu. This is not caused by lack of intelligence or capacity to learn language on the part of the Bantu but is understandable in terms of their inexperience with written language and relative isolation that comes with it, history of oppression, forced migration, poverty, access to education, and unfamiliarity with how bureaucracies and institutionalized systems work.

The participants of this study voice trust in their health care providers and the quality of care they receive. Vast differences remain between dominant American culture and the ways of this historically agrarian, Muslim community. The elderly have adjusted in many ways to the new way of health care in Boise. They have learned to keep appointments, fill out forms, renew prescriptions, and coordinate transportation and interpreters. They’ve learned the name of diseases, tests, and the instruments and process that American doctors use. Factors having positive influence on the Bantus’ cultural adjustment to health care include their willingness to learn new systems and ways of living, their trust in the host country, and maintaining their spiritual beliefs and practices, which bolsters the unity of their community and in turn, enhances factors that influence their healing.
Negative influences can be lack of understanding of refugees and their culture by the host community and health care providers who may feel they’re taxing the system (in particular, visits to the Emergency Department of a hospital). They may have the attitude that the refugee should quickly adjust and know how the system works. Providers are pressed by busy schedules and 15 minute visits that limit full engagement with the patient, especially if interpretation is needed. The health care system itself provides little opportunity for effective patient health education in relation to pre-literate populations.

Primarily, I see a need to advocate for refugees as a nurse so that politicians and program administrators are informed as to the enduring issues this population faces and to collaborate with community partners to create sustainable solutions for the future. It is also important to educate the community about refugees, fostering an environment of acceptance to their cultural differences, while assisting them with a smooth adjustment process.

Cultural sensitivity training for health care staff is often rare in lieu of other mandatory trainings such as blood borne pathogens, CPR, HIPPA, etc. One size does not fit all in regard to ethnic populations and how health care providers work with them. The cultural characteristics and beliefs of an Iranian Muslim, for instance, will not be the same as for a Somali Bantu Muslim. They may follow the same tenants of Islam yet maintain very diverse ethnic customs. I have found it important as a public health nurse to learn about each refugee population that I serve so that I provide culturally sensitive and appropriate care.

**Socio-economic Status**

The Somali Bantu community arrived in the US with few, if any, material possessions. They rely on low-wage jobs with no medical insurance coverage, affecting
their ability to access health care. Some have learned to adjust by waiting until they are very ill and then go to the emergency department for care. For the 50 year old Bantu refugee – or any other resident or citizen in America - eligibility for Medicare is not an option until 65 years of age or disability, indicating a need for refugee resettlement policy and systemic changes in medical coverage and access. Health disparities, access to health care, and health-related quality of life are related to socio-economic status and poverty. Local coalitions involving the Department of Labor, resettlement agencies, refugee community associations, local businesses, and agencies such as The Momentum Group, with the Common Ground programs, can work together to develop sustainable job training and skills-building programs within the community.

Positive influencing factors that facilitate the elderly Somali Bantu’s adjustment to American systems such as health care are community advocates, job skill training, and social and political policies that support refugee resettlement and medical coverage. Negative factors include language barriers, poor economic climate, and job availability with benefits such as medical insurance.

**Literacy**

Literacy is a cornerstone of refugee resettlement and adjustment to a new host society and its systems. Its acquisition is a major hurdle for the Somali Bantu elderly because they have never known a written language, which assists individuals in transferring knowledge to learn a new language. Critical Period Hypothesis (Lenneberg, 1967) states that the ‘ideal’ window of time to learn language are the first few years of life. The critical period hypothesis asserts this is why children are able to learn several languages at once when immersed in a linguistically rich environment while learning a second language is often a tremendous struggle for older people. For the elderly Somali
Bantu refugee, mastery of the English language may be an unfair expectation for adjustment within a specified and limited time frame predicated by policy.

Positive factors that influence language acquisition that I’ve observed are the elderly refugees’ motivation to learn, assistance from younger members of the Bantu community as interpreters for health care appointments, and the availability of the English Learning Center and The Momentum Group (2010) in Boise to assist with skill development through hands-on application of learning. Negative influences include biological capability for new language acquisition, age at the time of resettlement, social isolation, and pre-literate history and prior segregation from educational opportunities for this population.

I don’t believe anyone is too old to learn, however, I do see a need for on-going English Language Learning and language assistance programs that immerse the older members of the Somali Bantu community in American culture and language beyond the eight months currently provided by resettlement policy. Based on my observations teaching First Aid/CPR and Medication Safety classes, experiential learning for this age is the key to applying what they’ve learned to everyday situations.

I would propose interactive, participatory learning, such as competence-based programs that utilize hands-on application of curriculum to assist older adult students in the English acquisition process. While research points to the probability that aging doesn’t prohibit acquisition of a second language, support systems and extended English Language Learner (ELL) classes are indicated for this population in order to gain useable skills. Af Maay and Kizigua dialects have been passed down orally without a written alphabet. Therefore, learning a new language without the foundation of an alphabet and learned sentence structure (syntax) will take appreciably longer. Health education
materials need to utilize ethnically appropriate pictures and storytelling to show relationship to their world.

**The Elderly Somali Bantu in Boise: The Journey Continues**

From their time of arrival in Boise four to seven years ago, the elderly Somali Bantu have faced many challenges in their adjustment to the new ways of American culture. As they set foot on American soil, they would begin to learn the rules, expectations, and tasks of becoming a new resident with the assistance of resettlement agencies. The 50-64 year old Somali Bantu who were not disabled would need to find employment, a difficult task if they did not have English skills. They would also need to learn the technology of their new home (light switches, microwaves, and phones) while managing finances, shopping, driving, and learning how bills are paid (and what happens when they’re not).

They would need to adjust to medical screening and immunization schedules and work with agency case workers to make appointments and arrange for transportation and interpreters. They would need to fill out Medicare forms and manage their own disease with little knowledge of insurance systems, health information, or the side effects of multiple medications (polypharmacy). This would all need to be accomplished within an eight to twelve month time frame while refugee resettlement program benefits still covered them.

Given the numerous and complex nature of tasks the elderly Somali Bantu have needed to adjust to, the status of English language acquisition for this group is still minimal and reliance on interpreters is strong. Medical coverage is an issue for those 50 – 64 years of age and even those refugees who are 65+ voice their concern; without
English language skills, they will be unable to maintain their Medicare benefits unless they can pass their naturalization exam (obtain US citizenship).

As a public health nurse and educator, I notice that the Somali Bantu population continues to struggle with time issues and keeping appointments. Health care providers have voiced frustration with this behavior as it affects their clinic schedules. While some providers are sensitive to the barriers of transportation, literacy, socio-economic status, and culture, it remains a challenge for other health care providers. Some health care systems have adjusted themselves to the needs of this vulnerable population by providing interpreter services, conducting home visits, and developing culturally appropriate care guidelines and educational materials.

The journey of adjustment has not ended for the elderly Somali Bantu considering its complex nature and multi-factorial influences. Continued research and collaboration of community members, agencies, and policy makers needs to occur in order to build the refugee’s self-sufficiency, job and literacy skills, health access and health education, and a mutual understanding of diverse cultures in our community.

**Limitations**

Issel (2004) states that there are limitations to qualitative methods that include the time and resources to carry out the study, accessibility to key informants, and being overwhelmed with data “analysis paralysis.” Recall and observational bias may be present if thorough field notes and audiotapes are not maintained, and scheduling logistics can be a challenge when working with a culture that is polychronic (time is limitless, the concept of appointments is unfamiliar) and researchers who are monochronic (Western concept that time is limited, therefore, we must manage and stay on time). Some of the interpreting challenges presented during the research process
included the availability of interpreters (some held two or more jobs, leading to sporadic availability for the research), scheduling and keeping appointments, and knowing whether or not the interpretation was transmitted accurately or in the same context or frame of reference as the researcher intended.

The aforementioned potential limits were addressed through collaboration with members of the Somali Bantu Research Group at Boise State University’s nursing department so that resources such as research staff, time, administrative support, and funds for interpretation could be shared through an Office of Minority Health grant. Accessibility to key informants in the Somali Bantu community was established through connections with volunteers of the Agency for New Americans who had been working with the community for several years and had an interest in promoting the research project. “Analysis paralysis” was prevented through periodic analysis meetings with the research group to review and conceptualize from available data and analyses accomplished to date.

Distrust is a potential limitation to gaining study participants; many members of the Somali Bantu community have been isolated and marginalized by their environments and many potential participants could be understandably wary of participation in an institution-based research study. To increase this trust, prolonged engagement with this community was a commitment of the BSU research team. Utilization of a community-based participatory approach to research provided involvement of the Somali Bantu community and its leaders to inform and guide the research process in their community. A Somali Bantu advisory group was formed to meet with BSU researchers to create culturally relevant research questions for the formal interviews and to review data collected for researcher understanding and interpretation. Trust was established over
time, multiple engagements through meetings in the Somali Bantu community, and on the BSU campus, clarification of misunderstandings, respect for cultural differences, and patience.

Availability of Somali Bantu interpreters and lack of research funds to conduct the study were also limiting (interpreter fees are typically $20 to 30 per hour). The number of formal interviews completed and the hours of paid interpretation provided were factors of financial limitations and interpreter and researcher time availability. Transportation challenges and work schedules for the Somali Bantu were also complicating factors.

Implications for Nursing Practice, Policy, Theory Development & Education

Implications for nursing practice involving the elderly Somali Bantu can be defined at a number of levels of care. Cultural sensitivity and awareness of this elderly population (where they’ve come from, what they’ve endured, and the challenges they now face) are important skills for nurses and other health care providers to obtain when providing culturally appropriate care. Understanding the emic perspective of the elderly Somali Bantu enables and informs me as a health care provider on how to approach care and health education for vulnerable, ethnic populations. Through 18 months of research engagement, three years of professional interaction as a public health nurse, and my involvement as a volunteer, I can also offer insight and knowledge of the Somali Bantu culture and help others avoid the cultural mis-steps I made along the way.

Fragmented care can be avoided, as well as unnecessary trips to the Emergency Department, if designation of primary care providers and medical homes is established when the refugee first arrives under the refugee resettlement program coverage. Coordination between local medical providers and health care systems can smooth the
refugee’s transition between his or her initial entrance health screening and the subsequent assignment of a medical home for chronic disease management and primary care for acute illness. The implications for public health would be to provide as many on-site (at the patient’s residence or a common site where many patients can assemble easily) programs as possible (such as immunization campaigns) to alleviate transportation barriers and to develop patient education on medications from the Somali Bantu’s perspective, utilizing storytelling (Day, 2009) and pictures to relay health information.

The level of client literacy is important to assess when working with refugee populations, but it is sometimes difficult to determine to what extent one’s comments are understood. The elderly Somali Bantu refugee (and other cultures I have worked with) will readily nod their head in agreement even if they don’t understand or agree; this is done out of politeness or respect. Miscommunications may occur due to language barriers, limited health literacy, and variances in cultural contexts. This uncovers a need for further education surrounding medication safety and an understanding by the Somali Bantu elderly of what conditions are being treated. Health education instruction, using visual media and storytelling, could be utilized by nurses and other health care providers at the point-of-service and in educational workshops to minimize language barriers and improve the elderly refugee’s understanding of health information.

American health care is a complex system with many components to understand. Health care providers who are aware of the complex nature of refugee health and the time it takes for the elderly refugee to adjust to health care systems will be able to better assist in this process and improve health care outcomes for the Somali Bantu elderly at the same time. As a health care professional, I observe that the health care system anticipates that all recipients of care will fit into the mold of typical case studies and treatment
protocols. When faced with cultural extremes (from dominant American societal norms), illiteracy, lack of health insurance coverage, and complex case management, many providers are hard-pressed to find treatment plans that are culturally congruent. This thesis provides a look at factors in which we can better tune our communications, improve health education materials and programs, and collaborate with others in the community to effect policy change and delivery of care.

Vulnerable populations are complex to study due to the many influencing factors they face. For instance, socio-economic conditions are associated with health disparities, gaps in health-related-quality-of-life, and health care access. When you add the components of aging, illiteracy, and culture, vulnerability is compounded for the elderly Somali Bantu.

Challenges presented to nurses working with vulnerable populations, such as the elderly Somali Bantu, include setting aside enough time for visits when interpretation and allowance for extra questions and filling out forms is needed. Understanding their cultural differences, religious beliefs, and hurdles they face (such as transportation) can assist the nurse in providing culturally sensitive and congruent care. A real focus needs to occur in how we develop treatment plans, establish health care coverage and access through policy change, utilizing health education strategies for those with no prior English skills, and in growing community partnerships and collaborations.

Helping the elderly Somali Bantu navigate through the health care system, providing extended English language learning and cultural orientation classes specific to this ethnic group and others with a have high percentages of illiteracy or pre-literacy, developing interactive health education programs, and advocating for policies and programs that support adjustment to these new systems is essential for positive health
outcomes in this population. Refugee resettlement program policies designed for other
groups with substantially different characteristics should be revised to reflect the current
economic environment, job training programs implemented, and education of the
American public as to the history and plight of our newest citizens.

Recommendations for Further Research

To more fully understand the complex nature of adjustment as it relates to elderly
Somali Bantu resettlement, further research is needed. Based on the findings of this
thesis, I recommend further investigation as to the current health status of the elderly
Somali Bantu community, utilizing health provider chart audits. Health fairs provided
near Somali Bantu apartment complexes could offer health assessments that screen for
hypertension, diabetes, depression, and other chronic conditions; baseline data that is
needed to further assess the health status of this population. Further inquiry is also
needed to determine the best methods for teaching English, job skills, and health literacy
topics to ethnic groups who are illiterate or pre-literate and who include many elderly
members.

Investigation of successful community programs for refugees in other
resettlement cities could give insight into transportation solutions, extended English
language learning programs, health system collaborations to provide timely access for
medical needs, and culturally appropriate health education programs utilizing
storytelling, evidence-based teaching methods, and proven techniques such as sheltered
instruction. Developing educational materials for ethnic populations, especially the pre-
literate, needs to be explored and its outcomes evaluated.


Summary

America is a land of immigrants who have come to its shores in search of a better life. The Somali Bantu refugees have had a long and arduous journey to their new homeland and have been received with good intent by its host country. Based on the findings and conclusions of this thesis, however, the US does not have adequate policies and programs to meet the needs of some of its newest arrivals – the Somali Bantu. The elderly are a subset of this population, accompanied by multiple health concerns, poor language skills, and very little knowledge of health literacy and the American health care system. Collaborations between resettlement agencies, government organizations, health care providers, and the community-at-large are necessary to develop sustainable programs for elderly refugees.

In this study, I have worked towards answering the research question: What is the experience of the elderly Somali Bantu refugees of Boise, Idaho as it relates to their adjustment to new health care system regimens such as prescriptions, doctors’ appointments, completing insurance forms, adherence to treatments, receiving immunizations, and participating in patient-provider communications? This question has been answered using a naturalistic, descriptive study with the elderly Somali Bantu refugees in Boise, Idaho. Based on the findings from this study, suggested recommendations for practice, policy, and continued research were made. Limitations of the study were the small sample size, location of research, the constraints of culture and language that required the involvement of interpreters and a community advisory board.
However, working within these limitations, the analysis, findings, recommendations, and conclusions are presented as credible and trustworthy.

The results found within the literature review, participant’s stories, observations, my research and volunteer experiences, and professional interactions with the Somali Bantu elderly have answered the research question and offered insight into their world as they view it. The Somali Bantu elderly share many of the same problems as native-born, low-income, aging Americans; yet they do not have the benefit of literacy or familiarity with health systems to fully navigate by their own accord.

Collaboration between federal, state, and local agencies is required to update refugee resettlement policies that provide the support needed for the elderly to obtain sufficient English skills, cultural orientation, and health care access. Resettlement agencies, business, non-profits such as The Momentum Group, and the Department of Labor can form coalitions that work towards development of job skills and sustainable work solutions. Health care and educational institutions can contribute by partnering with the Somali Bantu community to further assess their health care needs and develop culturally appropriate health care programs. Together, communities like Boise can bridge the health care gap, reduce health disparities, and aid in the elderly Somali Bantu refugee’s adjustment to their new American life.
REFERENCES


http://www.somalianinfo.com/information-on-somalia.html


APPENDIX A

Nursing Assessment
Giger and Davidhizar’s Transcultural Assessment Model (2008, p. 8)
APPENDIX B

Community Assessment Interview Outline
Community Assessment Interview Outline  
Health only for Somali-Bantu Community

I will be asking you questions about the Somali-Bantu community in general. So when you answer the questions, please consider all of the Somali-Bantu people, not just yourself or your family.

<table>
<thead>
<tr>
<th>General Health</th>
<th>Prevention</th>
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<tbody>
<tr>
<td>• What things made the SB ill in Africa? In the camps? Here in the US?</td>
<td>• What do you do here in the US to stay healthy? Rituals?</td>
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<table>
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<tr>
<th>Risky Behaviors</th>
<th>Traditional Medicine</th>
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<tbody>
<tr>
<td>• Are any of the following behaviors common in your community?</td>
<td>• Do the SB regularly use any traditional healing practices since coming to the US? Why or why not?</td>
</tr>
<tr>
<td>• Smoke or chew tobacco</td>
<td>• When you go to an American doctor, do you tell them about your traditional healing practices? Why or why not?</td>
</tr>
<tr>
<td>• Use drugs like marijuana or cocaine</td>
<td>• What do you believe causes you to become sick?</td>
</tr>
<tr>
<td>• Sex with people more than one person</td>
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<tr>
<th>Genetic/hereditary disorders</th>
<th>Coping with Illness/Triage</th>
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<tbody>
<tr>
<td>• Have you noticed some illnesses that are common in more than one generation of a single family? (Provide baldness example)</td>
<td>• How do you decide if someone is just a little sick or sick enough to go to the doctor or hospital?</td>
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<tr>
<th>Death and Dying</th>
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<tbody>
<tr>
<td>• What rituals do the SB do when someone has died?</td>
<td>• What do you do when someone who is ill does not seem to get better after going to the doctor?</td>
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<tr>
<td>• Has your community shared this with any medical provider?</td>
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<td>• Do the bad dreams make a person sick?</td>
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<td>• If you were looking for a mate would you look for someone who was skinny or larger?</td>
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<tr>
<td>• Have your choices changed since you have come to the US?</td>
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APPENDIX C

Focus Group Interview Questions
Focus Group Interview Questions

1) Can you tell me a story about your experiences with American doctors and the health care in Boise, ID?

2) Do you have a doctor that you see for your health problems?

3) Has it been hard to adjust to American health care? What has made it easier for you?

4) Is it hard to see the doctor when you need to?

5) Is it hard to get to the doctor (transportation)?

6) Because of language differences, is it difficult to understand the doctor’s advice or treatment? Can we improve this?

7) Are there any other stories you would like to share with me? Are there any questions I can answer for you?
APPENDIX D

Consent To Be A Research Participant - Community
CONSENT TO BE A RESEARCH PARTICIPANT

ORAL CONSENT

Somali Bantu Community Assessment
Boise State University

This consent script will be read to the participants.

Pam Springer, RN; Cathy Deckys, RN, Kim Martz, RN; Mikal Black, RN; and Terri Soelberg, are doing a project called “Improving Health Care for Refugees”.

The reason for this project is to improve the bonds between the Boise State Nursing Department and the Somali-Bantu refugee groups. The project will help us to understand you and other members of the Somali-Bantu refugee groups.

The purpose of this study is to: Better understand the ways of the Somali-Bantu people especially related to health beliefs and practices.

You are being asked to join this study because you are of the Somali-Bantu refugee group or you have direct knowledge of this population and you are over the age of 18. You are not required to join this study, it is voluntary.

If you agree to be in this study, these will occur:

1. You will take part in an interview with the researcher and a helper at a time and place that is handy to you.
2. You will answer questions about how the Somali-Bantu refugee population lives.
3. The interview should take about 1 to 1.5 hours.
4. The interview will be tape recorded (audiotaped).
5. Some of the things you say may be shown in papers and presentations. No one will know who said the words.
6. Notes will be taken during the interview.
7. Your answers will not be shared with anyone except the researchers.
8. You may be asked to attend one group meeting where the results of the project will be talked about. You will be asked if the results are right. This meeting should take 2-2.5 hours and will be held at a time that works for most people.

There may be some risks to being in this study, but we think they are very small.
- Some of the questions may make you feel bad.

If a question makes you feel bad:
- You do not have to answer a question if you do not want to.
- We will skip any questions you want to skip.
- You may stop at any time.
There will be no direct gain to you. But by taking part in this project, you will help us better understand the Somali-Bantu people.

There are no costs to you for to take part in this study other than your time.

You will not be paid to take part in this study. Joining the study is voluntary.

If you have any questions or concerns about this study, please call, Pam Springer, at (208) 436-3600. If you do not wish to do this, you may call the Institutional Review Board, which is concerned with the protection of volunteers in research projects. You may reach the office between 8:00AM and 5:00 PM Monday through Friday by calling (208) 426-5401 or by writing: Institutional Review Board, Office of Research Compliance, Boise State University, 1910 University Drive, Boise, ID 83725-1138.

You will be given a copy of this consent form to keep.

**TAKING PART IN RESEARCH IS NEVER FORCED.** You are free to not take part in this study or to stop at any point. Your choice to take part in this study or not will have no sway on your present or future status with Boise State University.

*If you give your consent to take part in this study please say yes. If you do not wish to take part in the study please say no.*

  *Participant answered*  
  yes no

*You have said you would like to take part in the study.*

*If you give agree to be audiotaped in this study please say yes. If you do not wish to be audiotaped please say no.*

  *Participant answered*  
  yes no

*If you give agree to allow us to use your words in presentations and papers please say yes. If you do not wish us to use them please say no.*

  *Participant answered*  
  yes no

Signature of person obtaining consent Date

**THE BOISE STATE UNIVERSITY INSTITUTIONAL REVIEW BOARD HAS REVIEWED THIS PROJECT FOR THE PROTECTION OF HUMAN PARTICIPANTS IN RESEARCH**
APPENDIX E

Consent To Be A Research Participant – Elderly
CONSENT TO BE A RESEARCH PARTICIPANT

ORAL CONSENT
Elderly Somali Bantu Focus Group
Boise State University

This consent script will be read to the participants.

Cathy Deckys, RN, BSU Nursing Student
The reason for this project is to improve the bonds between the Boise State Nursing Department and the Somali-Bantu refugee groups. The project will help us to understand you and other members of the Somali-Bantu refugee groups.

The purpose of this study is to: Better understand the experience of the elderly Somali-Bantu community, especially as it relates to health care in Boise, Idaho.

You are being asked to join this study because you are of the Somali-Bantu refugee group or you have direct knowledge of this community and you are over the age of 50. You are not required to join this study, it is voluntary.

If you agree to be in this study, these will occur:

9. You will take part in an interview with the researcher and a helper at a time and place that is handy to you.
10. You will answer questions about how the Somali-Bantu refugee population lives.
11. The interview should take about 1 to 1.5 hours.
12. The interview will be tape recorded (audiotaped).
13. Some of the things you say may be shown in papers and presentations. No one will know who said the words.
14. Notes will be taken during the interview.
15. Your answers will not be shared with anyone except the researchers.
16. You may be asked to attend one group meeting where the results of the project will be talked about. You will be asked if the results are right. This meeting should take 2-2.5 hours and will be held at a time that works for most people.

There may be some risks to being in this study, but I think they are very small.

- Some of the questions may make you feel bad.

If a question makes you feel bad:

- You do not have to answer a question if you do not want to.
- We will skip any questions you want to skip.
- You may stop at any time.
There will be no direct gain to you. But by taking part in this project, you will help us better understand the Somali-Bantu people.

There are no costs to you for to take part in this study other than your time.

You will not be paid to take part in this study. Joining the study is voluntary.

If you have any questions or concerns about this study, please call, Pam Springer, at (208) 436-3600. If you do not wish to do this, you may call the Institutional Review Board, which is concerned with the protection of volunteers in research projects. You may reach the office between 8:00AM and 5:00 PM Monday through Friday by calling (208) 426-5401 or by writing: Institutional Review Board, Office of Research Compliance, Boise State University, 1910 University Drive, Boise, ID 83725-1138.

You will be given a copy of this consent form to keep.

**TAKing PART IN RESEARCH IS NEVER FORCED.** You are free to not take part in this study or to stop at any point. Your choice to take part in this study or not will have no sway on your present or future status with Boise State University.

*If you give your consent to take part in this study please say yes. If you do not wish to take part in this study please say no.*

*Participant answered yes no*

You have said you would like to take part in the study.

*If you give agree to be audiotaped in this study please say yes. If you do not wish to be audiotaped please say no.*

*Participant answered yes no*

*If you give agree to allow us to use your words in presentations and papers please say yes. If you do not wish us to use them please say no.*

*Participant answered yes no*

Signature of person obtaining consent Date

THE BOISE STATE UNIVERSITY INSTITUTIONAL REVIEW BOARD HAS REVIEWED THIS PROJECT FOR THE PROTECTION OF HUMAN PARTICIPANTS IN RESEARCH
APPENDIX F

Interview Field Notes
Appendix C
Community Assessment Interview Outline
Health only for Somali-Bantu Community

I will be asking you questions about the Somali-Bantu community in general. So when you answer the questions, please consider all of the Somali-Bantu people, not just yourself or your family.

<table>
<thead>
<tr>
<th>General Health</th>
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<tbody>
<tr>
<td>- What things made the SB ill in Africa? In the camps? Here in the US?</td>
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<table>
<thead>
<tr>
<th>Prevention</th>
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<table>
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<tr>
<th>Risky Behaviors</th>
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<tbody>
<tr>
<td>- Are any of the following behaviors common in your community? Smoke or chew tobacco Use drugs like marijuana or cocaine Sex with people more than one person</td>
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<tr>
<th>Traditional Medicine</th>
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<tbody>
<tr>
<td>- Do the SB regularly use any traditional healing practices since coming to the US? Why or why not?</td>
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<tr>
<td>- When you go to an American doctor, do you tell them about your traditional healing practices? Why or why not?</td>
</tr>
<tr>
<td>- What do you believe causes you to become sick?</td>
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<table>
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<tr>
<th>Genetic/hereditary disorders</th>
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<tbody>
<tr>
<td>- Have you noticed some illnesses that are common in more than one generation of a single family? (Provide baldness example)</td>
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</table>

<table>
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<tr>
<th>Coping with Illness/Triage</th>
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<tbody>
<tr>
<td>- How do you decide if someone is just a little sick or sick enough to go to the doctor or hospital?</td>
</tr>
<tr>
<td>- What do you do when someone who is ill does not seem to get better after going to the doctor?</td>
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</tbody>
</table>

10/13/09 O. Decker
Participant - Why are you here today?

I'm here for a health check-up.

Do you have any medical conditions?

Yes, I have high blood pressure.

What medications are you on?

I'm on blood pressure medication and an antidepressant.

Do you have any other medical issues?

No, that's about it.

Have you ever had cancer?

No, I've been cancer-free.

Do you have any other family members with cancer?

No, I don't have any family members with cancer.

Have you ever had surgery?

Yes, I've had several surgeries in the past.

What type of surgery?

Various procedures, including heart surgery.

Do you have any allergies to any medications?

No, I don't have any allergies.

When you're feeling unwell, who do you turn to first?

My doctor, of course.

What type of doctors do you see?

I see a primary care physician and a specialist as needed.

Do you prefer to see male or female doctors?

I don't have a preference, it depends on who's available.

Do you prefer to see doctors or nurses for routine care?

I prefer doctors for routine care.

How do you feel about your current health care provider?

I'm satisfied with my current provider.

Have you ever considered changing doctors?

No, I've been with my current doctor for a long time.

Do you have any concerns about your current health care provider?

No, I don't have any concerns.

What's the best thing about your current health care provider?

Their bedside manner is great.

What's the worst thing about your current health care provider?

Nothing, I'm completely satisfied.

Have you ever had difficulty communicating with your current health care provider?

No, I've always been able to communicate effectively.

What type of insurance do you have?

I have a health insurance policy.

Do you feel that you understand your health care plan?

Yes, I feel that I understand it well.

Have you ever had a difficult experience with your insurance company?

No, I've never had any problems.

How do you feel about your current health care plan?

I'm satisfied with it.

Do you have any other comments or questions about your health care experience?

Not really, everything is going well.
Appendix C
Community Assessment Interview Outline
Health only for Somali-Bantu Community

I will be asking you questions about the Somali-Bantu community in general. So when you answer the questions, please consider all of the Somali-Bantu people, not just yourself or your family.

General Health
- What things made the SB ill in Africa?
- In the camps? Here in the US?

Prevention
- What do you do to stay healthy? Rituals?

Risky Behaviors
- Are any of the following behaviors common in your community?
- Smoke or chew tobacco
- Use drugs like marijuana or cocaine
- Sex with people more than one person

Traditional Medicine
- Do the SB regularly use any traditional healing practices since coming to the US? Why or why not?
- When you go to an American doctor, do you tell them about your traditional healing practices? Why or why not?
- What do you believe causes you to become sick?

Genetic/hereditary disorders
- Have you noticed some illnesses that are common in more than one generation of a single family? (Provide baldness example)

Coping with Illness/Triage
- How do you decide if someone is just a little sick or sick enough to go to the doctor or hospital?
- What do you do when someone who is ill does not seem to get better after going to the doctor?

10/12/09 Transcription by C. Deckey
**Death and Dying**
- What rituals do the SB do when someone has died?
- Has your community shared this with any medical provider?

**Provider Interactions**
- Where do you go for medical help?
- Describe your experiences at the doctor’s office. What happens?
- Have you ever felt like a doctor did not understand what you were trying to tell them? Please describe.
- Has a medical provider ever told given you information you did not understand? Please describe.
- Do SB people have a hard time getting medical help when they are sick?

**Insurance**
- Do most SB have health insurance?
- If so, do you have trouble understanding and completing the forms? **No**. Take to Health Inspector.

**Medications**
- Are there any problems when you take the medications? **No**.
- When taking medications, do you generally understand what you are supposed to do? **Yes**.

**Mental Health**
- Do you or others have bad dreams or memories of things that happened in Somalia?
- Who do you talk to about these bad dreams? Any medical providers?
- Do the bad dreams make a person sick? **Yes**.

---

**Body Image**
- If you were looking for a mate would you look for someone who was skinny or larger?
- Have your choices changed since you have come to the US?

---

**Participant Question:** Have schools for children, everyone can learn. No end up no education. **Main job in Somalia was farming.** His clan came from Juba Valley. Gov prevented ed.
## Appendix C
### Community Assessment Interview Outline
#### Health only for Somali-Bantu Community

I will be asking you questions about the Somali-Bantu community in general. So when you answer the questions, please consider all of the Somali-Bantu people, not just yourself or your family.

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</table>

**Prevention**
- If I get sick, I...

**Risky Behaviors**
- Are any of the following behaviors common in your community?
  - Smoke or chew tobacco
  - Use drugs like marijuana or cocaine
  - Sex with people more than one person

**Traditional Medicine**
- Do the SB regularly use any traditional healing practices since coming to the US? Why or why not?
- When you go to an American doctor, do you tell them about your traditional healing practices? Why or why not?
- What do you believe causes you to become sick?

**Genetic/hereditary disorders**
- Have you noticed some illnesses that are common in more than one generation of a single family? (Provide baldness example)

**Coping with Illness/Triage**
- How do you decide if someone is just a little sick or sick enough to go to the doctor or hospital?
- What do you do when someone who is ill does not seem to get better after going to the doctor?

---

**Getting sick depends on the person.**

**Being clean — you will not get sick.**

**Go to the Dr. Rituals — like, but not here in America. Here you go to the hosp.**

She doesn’t know.

Yes, there is. In Africa there are STD concerns explained. Yes, infect himself & his wife. Not here in America. Go to the hosp. If sick. Doesn’t know about roots here. Yes, sick 2 weeks ago. Then she’s talking. Thanks to Us. Gets American Big Change. (meds)

Person not moving, a lot of sickness. Person looks different, not peeing, not stooling. Wait.
**Death and Dying**
- What rituals do the SB do when someone has died?
- Has your community shared this with any medical provider?

**Provider Interactions**
- Where do you go for medical help?
- Describe your experiences at the doctor’s office. What happens?
- Have you ever felt like a doctor did not understand what you were trying to tell them? Please describe.
- Has a medical provider ever told/given you information you did not understand? Please describe.
- Do SB people have a hard time getting medical help when they are sick? No

**Insurance**
- Do most SB have health insurance?
- If so, do you have trouble understanding and completing the forms? No

**Medications**
- Are there any problems when you take the medications?
- When taking medications, do you generally understand what you are supposed to do? Yes

**Mental Health**
- Do you or others have bad dreams or memories of things that happened in Somalia? No
- Who do you talk to about these bad dreams? Any medical providers?
- Do the bad dreams make a person sick? Yes - Sometimes

**Body Image**
- If you were looking for a mate would you look for someone who was skinny or larger? No
- Have your choices changed since you have come to the US? No

---

**Additional Notes**
- Have to bury that person. Pray for him.
- Come home, have people over.
- Depends. Need 24 hr. Yes, they understand once we have an interpreter.
- First thing, on Welfare, then go to the Hosp. She has a regular Dr. He does understand. Interpreter helps w/ this.
- Yes, medication (didn't understand route)
- Don't know.
- Dr. explains everything. Has only one need. Back pain. Can't stand up sometimes.
- She shares memories w/ daughter/grandchild. She'll start crying herself, remembering. When she has dreams, she says "Everyone come here." and tells them about it.
- Ask permission for marriage. Go see my father for permission to marry.
APPENDIX G

Elderly Focus Group Transcripts
Elderly Focus Group Transcripts

Transcription: Elderly Somali Bantu Focus Group Interview
Audio-taped 11/24/09
Cathy Deckys (CD)

Coding:

**BIOLOGICAL CHANGES RELATED TO AGING**

**CULTURE**

**LITERACY**

**SOCIO-ECONOMIC STATUS**

01 CD: Can you tell me about your experiences (woman sneezes) bless you, stories, your experiences with doctors and health care in Boise, ID? (Interpreter translates to the group) A woman starts to speak then an elderly man speaks first. (another woman coughing)

02 H: The first thing when you go is to his doctor, is the person, the nurse checks his weight, she measures him, everything. Then you go into the room, the nurse asks you what the problem is, do you have back pain, heart, whatever you have. After she explains, she records it and makes a chart. So then she measure the high blood pressure and puts it on the record. Then she measures your ears and calls the doctor. Again when the doctor comes in, then she asks some questions she asks. When the doctor examines you then, he asks you if there are any problems as he examines you. Is that medication help you that he prescribed and he will get that medication for you from the pharmacy. (A woman starts to talk, then another woman and the interpreter between themselves)

03 Interpreter (I): So…

04 CD: Is her experience different?

05 I: Yes, they give her different medication, the medication is working for her. That she’s happy

06 Female A: America good. America good.

07 CD: How is it different from Kakuma.. a…I know in Somalia there weren’t doctors.

08 H: **Big difference, there was no appointment at all.** (knock on the door, someone enters, discussion ensues) **No doctors.**

09 CD: **No doctors?**
11 I: Yep.

12 CD: Are appointments good or bad?

13 H: His wife was, she just got a lot of sickness in Kakuma and took her to the ER and she could not see the doctor till tomorrow at 8:00.

14 CD: Hmmm…So she had to wait till the next morning when the doctor came in?

14 I: Yes, she called him and the doctors weren’t there. (group discussion)

15 Young male (speaks English for himself) Hard to hear with multiple discussion occurring. We have to call him to come, this is the difference. The way they make, the way they treat the people over there (Kakuma) and here a little bit different. But here, when you go to the hospital (many discussions, can’t hear)

16 CD: and who are you?

17 D-----: (more discussion between group members)

18 H: They have diabetes, high blood pressure. But here they have medication.

19 CD: How about for the women, ahh, having children?

20 H: (long monologue)

21 CD: Can I hear from the women? How is it here now for the women having babies?

22 Female B: There in Africa you may wait. Here, the doctor says when you are going to have the baby. Here after the due date, the doctor says you have to have surgery (laughter, discussion).

23 Female C: Back in Africa, in Kenya, the babies died because of lack of vitamins. Here people have a lot of different vitamins, nutrition. (discussion)

24 D: I was working there in the clinic, they have seen a lot of things there. Here they give what is called epiduris. When they keep the woman epiduris, she still feels pain, but here, when they give the epiduris she may not know she has the baby. The difference of delivery from there and here.

25 CD: So the one here is better?

26 Female D: (discussion)

27 I: After two weeks the surgery coming out (stitches) Just some kind of
28 D: Also there’s a difference of the surgery there and here. There when they give you surgery, you have to take like two weeks you drink like porridge, something, like soup. But here, you can eat within two days or a day. You ready to go on, but there, no. You don’t lift over 5 lbs. or children, but my sister, she had surgery, now she’s complaining (discussion, child crying)

29 I: No shots, no vaccine

30 D: The children died of malnutrition, not a lot for them to eat.

31 CD: What’s it like to be older in America when you need to get health care? (discussion)

32 H: Here in America, especially the medical side, it’s great for the people if they have Medicaid. For some it’s very expensive.

33 CD: So if you have government insurance, you’re ok?

34 I: Except for her, she takes it from her pocket (she under 65), (Discussion)

35 Female B: Ha (yes)

36 I: That’s why she can’t go all the time to the doctor. Even when she’s sick, she goes to get the over the counter medicine. She goes to the hospital and has six prescriptions. But now she has a bill of $25,000 and can’t pay this.

37 CD: So is she just waiting to be 65 so she can get Medicare?

38 Female B: Yep. (discussion)

39 H: In Africa, there was high blood pressure; if you go they will treat you. You have to wait two or three weeks for an appointment. Some people might die. When the blood’s high the person might collapse.

40 CD: So it was easier to get medicine for those conditions? (Yes) Is that because there is so much of it? (Yes)

41 H: Here if you don’t have an appointment (with the doctor), you have to go to the emergency room.

42 CD: What’s good about American health care?

43 H: The difference here, the good thing here, you can go to the ER. When you leave there and go home, that’s when you wait for the bad news. It’s a lot of money. (Discussion)
CD: So what I hear you saying about American health care that’s bad is how much it costs. (I: Yes, expensive) And what else?

Female D: Here they give you three days, if you don’t deliver, they start you. After the due date (phone)

CD: Why don’t they wait?

I: Here what they’s saying is, if the baby is there, it’s time to take it. (Discussion)

H: So here, they have more knowledge about the person.

CD: Does everyone here see, have a doctor who they see for health care?

Group: Ha (I: Yep).

CD: Do you go to that doctor every time?

I: Yea.

CD: Do you feel like they know you?

Group: Ha (yes)

I: This lady, he comes to her house.

CD: (gasp), he does? (Female B’s head nods yes) Oh…good doctor. Oh, that’s unusual. Who is that doctor? (Discussion)

CD: Saint Al’s? (discussion) Owyhee clinic, yea. Saint Al’s, yea, yea, a lady doctor? I know who you’re talking about, ok. That’s wonderful.

CD: So is that good for them to come to your house?

Female B: Ha (yes)

CD: And how do you understand each other?

I: Interpreter.

CD: So your health care, from what I know this year, depends on these guys (the interpreters) who help you with the translation, yea? (Heads nod)

CD: Is the English getting easier after these years? (discussion, laughter)

I: Yes, with the interpreters.
Female A: I still don’t speak it at all.

CD: Do you have hope that you’ll learn English at all?

Group: Ha (yes), for citizenship

CD: Does everyone want to have citizenship? (discussion)

H: Yes, to keep our Medicare. To take care of my high blood pressure.

CD: How can it be easier for you to learn English?

H: For a person like him (older male), he may not get it faster. He may learn a few words from his son.

CD: And for the children, they hear it (English) all day long

CD: Are the older people able to get out and immerse themselves in the language?

H: They take class, they try they best, but still it’s too much.

CD: So is there anyone from the agency who can help them study? (discussion)

D: The agency will help you for about one year. When eight months is over, they take care of you one and a half then they release you and say you’re independent.

I: They tried the classes, they did their best.

CD: Well, it needs to be longer. I mean, I can’t imagine going to your country and learning your language in five years, that would be so hard for me. (discussion)

H: So when you’re sick, you’ll be thinking of your medication, not you’re education.

Female C: America is good. (discussion)

CD: Has it been hard to adjust to American health care? (discussion)

H: Not with the right interpreter. One time when I went to the hospital, they got a Somali interpreter. The interpreter told the doctor I had leg pain when I had said my foot was hurting. Sometimes, we take the children to talk for us.

CD: Is that a different role for the parents to have the children speak for them?

I: Yes.

CD: In your culture, the older people are respected. Is that right?
86 Group: Ha

87 CD: And this is the same since coming to America?

88 I: Yes

89 CD: Does all of the community take care of the older people when they get too sick to take care of themselves?

90 Group: Ha (discussion)

91 CD: Is it hard to get to the doctor? (transportation)

92 H: Yes, I have no car.

93 CD: How do you get to the doctor if you don’t have a car?

94 H: Sometimes, my grandson, sometimes, a neighbor. Sometimes they’re at work.

95 H: Sometimes, they can’t get to their appointment. They call a taxi and the taxi doesn’t come. (discussion)

96 Female D: She don’t have the transportation.

97 D: Let me explain. When she tries to get a taxi, she tries to explain where she needs to go and they don’t understand. The interpreters can’t take them, because the agency won’t pay.

98 I: In Boston, they have their own transportation. A van comes to pick the people up at the apartments and take them to their appointments. They go by all the peoples places, then when you’re done, they come to pick you up.

99 D: Appointment reminders are good. You have an appointment, they call you. Doctor says if you miss three appointments, we can’t take you anymore.

100 CD: Would anyone like to tell me any other stories? (discussion, coughing)

101 H: Suppose you go to the doctor’s office, he prescribes you medication, you go and get it, you have Medicare. When you go to the pharmacy, Medicare doesn’t cover that medication, then you have to go back to the doctor to get a different medication.

102 CD: So the Medicaid program only covers certain medications and if the doctor knew they didn’t cover the medication, they could do something different.

103 I: Yea. (discussion)
104 CD: Ok, I would like to thank you for telling me your stories today.

105 Group: Ha (yes)

106 CD: Can you tell me how to say thank you in Af-Maay?

107 I: Asanta shani (sp?)

108 CD: Asanta shani!