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Somali Immigrant Women and the American Health Care System: Discordant Beliefs, Divergent Expectations, and Silent Worries

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Abstract

The civil war in Somalia resulted in massive resettlement of Somali refugees. The largest diaspora of Somali refugees in the United States currently reside in Minnesota. Partnering with three community organizations in 2007–8, we implemented the Community Connections and Collaboration Project to address health disparities that Somali refugees experienced. Specifically, we examined factors that influenced Somali women's health experiences. Utilizing a socio-ecological perspective and a social action research design, we conducted six community-based focus groups with 57 Somali women and interviewed 11 key informants including Somali healthcare professionals. Inductively coding, sorting and reducing data into categories, we analyzed each category for specific patterns. The categorical findings on healthcare experiences are reported here. We found that Somali women's health beliefs related closely to situational factors and contrasted sharply with the biological model that drives Western medicine. These discordant health beliefs resulted in divergent expectations regarding treatment and healthcare interactions. Experiencing unmet expectations, Somali women and their healthcare providers reported multiple frustrations which often diminished perceived quality of health care. Moreover, silent worries about mental health and reproductive decision making surfaced. To provide high quality, transcultural health care, providers must encourage patients to voice their own health explanations, expectations, and worries.

Keywords

USA; immigrant health; women's health; health disparities; cultural competence; health care interactions; community-based social action research; mental health

Introduction

Relocation from one country to another requires extensive adjustment and can result in family and social disruption as well as altered health (Lum & Vanderaa, 2009). Re-location is more difficult and health consequences greater when associated with civil conflict and homeland violence (Berman, Girón, & Marroquin, 2006; Berry, 2005; Miller & Rasco, 2004; Palmer &

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Ward, 2007). However, despite these enormous difficulties, immigrant health status and needs are poorly understood (Kandula, Kersey, & Lurie, 2004). Furthermore, research on immigrant health reveals contradictory evidence and complex relationships (Cunningham, Ruben, & Narayan, 2008). For instance, although many research studies demonstrate that foreign-born persons generally experience better physical health than native-born persons (Walker & Barnett, 2007), this healthy immigrant phenomenon does not pertain to all immigrant groups nor does the health advantage that some groups experience always persist. The Minnesota Department of Health (MDH, 2005) identified significant health disparities between some immigrant groups and other Minnesotans. To seek deeper insights about why such disparities might exist, a community-based social action research study was conducted to explore the health experiences of Somalia-born women who re-located to Minnesota. Escaping violence in their war-torn country, most Somali women entered the United States as refugees. This article details findings about healthcare interactions that some Somali women experience when seeking health care.

Background on Immigrant Health

Citing evidence from a comprehensive review on immigrant health, Cunningham et al. (2008) concluded that immigrants' health differs from that of non-immigrant populations in the United States. Some immigrant groups experience better health outcomes in terms of mortality (Singh & Hiatt, 2006), heart disease (Jasso, Douglas, Rosenzweig, & Smith, 2004), obesity (Antecol & Bedard, 2006), and some cancers (John, Phipps, Davis,& Koo, 2005) than those of native-born Americans. Healthy lifestyles, careful pre-immigration screening, and extensive social support seem to contribute to better outcomes. However, researchers have also noted that many immigrants experience gradually deteriorating health (Fennelly, 2007; John et al., 2005; Kandula et al., 2004). Similarly, immigrant health declines with length of residence in Canada (McDonald & Kennedy, 2004). In the United States poverty, acculturation stress, environmental risks, lifestyle changes, and health care access apparently contribute to declining health for some immigrants (Fennelly).

An information gap on immigrant health disparities currently exists. Health care organizations and government agencies often fail to collect explicit data on ethnicity (Cunningham et al., 2008; Kandula et al., 2004; MDH, 2005). As a result, immigrant health outcomes are frequently reported in general rather than specific terms. Collated data which can hamper efforts to address disparities often mask important distinctions in health outcomes for specific groups. Because immigrating populations are becoming more heterogeneous, explicit data on ethnicity is increasingly important for healthcare organizations (MDH). In addition, some immigrant groups are understudied. For example, Cunningham et al. reported in their systematic review that relative to proportions of United States foreign-born populations, research studies over-represented Latin-American and European immigrants and under-represented Asian and African immigrants. Since African immigration is expanding in the United States (Carroll et al., 2007b), this disparity has special significance. Lacking information about specific ethnic groups, the health care system cannot tailor services to address unique health needs and therefore, health care services may not provide culturally appropriate care. Lack of access to culturally competent health care is one of the most significant barriers to reducing health disparities for minority populations (Betancourt & Green, 2007; Cooper, Hill, & Powe, 2002; Smedley, Stith, & Nelson, 2003).

Foreign-born residents of color often experience barriers similar to those of racial minorities in the United States (Lauderdale, Wen, Jacobs, & Kandula, 2006; Lillie-Blanton & Hudman, 2001; Lum & Vanderaa, 2009). In one analysis, investigators reported significant interactive effects of race/ethnicity and immigration status on physical and mental health status, health services utilization, and health insurance coverage (Lum & Vandera). Additionally, some

researchers describe a “double jeopardy” phenomenon that exists for immigrants of color. In a large-scale survey conducted in California, researchers reported that foreign-born persons of color reported more incidents of discriminatory practices by health care professionals than United States-born persons of color (Lauderdale et al.). Discriminatory practices may harm people’s health and result in health disparities (Smedley et al.).

Studying immigrant women’s health care experiences is particularly important since women play a key role in advancing their family’s health as well as their own; entire communities in the United States can benefit from deeper understandings about immigrant women’s healthcare experiences. Additionally, women emigrating to the United States are increasing in number and diversity (Carroll et al., 2007b; Zhou, 2002).

Since African immigration is relatively new, very few studies have been conducted on African immigrant groups (Carroll et al., 2007b; Lum & Vanderaa, 2009). A few, contextually-based studies offer valuable insights on Somali women’s unique health needs and perspectives (Carroll et al., 2007a; Finnström & Söderhamn, 2006; Straus, McEwen, & Hussein, 2009; Uvall, Mohammed, & Dodge, 2009). Learning more about the Somali women who have settled into Minnesota will provide evidence-based ideas for culturally competent care and culturally specific programs.

Background on Somali Immigration

Located in East Africa, Somalia has been ravaged by a clan-based civil war that began in 1978 and exploded in the late 1990s when rebels from the United Somali Congress ousted former dictator Siyad Barre (Griffiths, 2002). Somalia’s persistent internal and intra-clan conflicts have weakened efforts to reconstruct a formal government infrastructure. As a result, many Somali refugees migrated to Kenya and Ethiopia where large refugee camps are located. Several countries including the United States provided refugee sponsorships to relocate families. Currently, the largest Somali Diaspora in the United States resides in Minnesota (MDH, 2003) and is estimated at 25,000 (Minnesota State Demographic Center, 2004). However, unofficial estimates suggest that 75,000 Somali refugees have settled in Minnesota (DeShaw, 2006). Moreover, the Somali community continues to expand since civil strife in Somalia continues and United States immigration policies support family reunification.

A recent report concluded that Somali refugees in Minnesota are among the least served by Minnesota’s health and social service systems (MDH, 2005). Three main contributing factors were identified. First, no health insurance and difficult payment systems often discourage immigrants from seeking needed health care. Second, the State of Minnesota is one of the least diverse states in the country with people of color representing only 13% of the state’s population compared to 32% nationally (Penny, 2006). Third, health care professionals whose ethnic backgrounds often differ from most of their immigrant patients are frequently unaware of communication barriers that make comprehension and adherence to medical treatments very difficult for immigrant groups (Betancourt & Green, 2007; MDH, 2005). Therefore, immigrants who develop chronic conditions such as diabetes and depression suffer higher rates of disease morbidity than non-immigrant populations (MDH, 2005).

Research Method

An ecological framework which depicts complex and intertwined personal, situational, and sociocultural factors influencing health guided this study (Ayala, Maty, Cravey, & Webb, 2005; Green & Kreuter, 2005). Teaming with one Somali-operated organization, a community center, and a health organization that works closely with the Somali community, we designed a community-based action research study. This method emerged from the perspectives of social

ecology theory and the social determinants of health model (Israel, Schultz, Parker, & Becker, 1998). Stringer (2007) suggests that action-based research methods seek insight into problems that people confront in everyday life. Data are collected from people most affected by the research phenomenon and from people in the sociopolitical arena that impact the phenomenon (Israel et al.). The research questions that guided this study included "What are the health concerns for Somali immigrant women and girls?" "What are the health experiences of Somali women as they manage their health?"

This study received ethical approval from the University of California Los Angeles IRB (Office for the Protection of Human Subjects), as well as St. Catherine University IRB in St. Paul, Minnesota.

Data Collection

Representatives from the community-based organizations recruited participants by posting flyers. Eight to13 Somali women participated in six focus groups for a total of 57 women. Participants' ages ranged from 18 to 80 years with a mean of 36.6 years. Their length of living in the United States ranged from 1 week to 20 years with an average residency of 7.16 years. Many participants reported living several years in refugee camps in East African countries prior to immigrating to the United States. Four focus groups were mixed ages; two were comprised of young women ages 18–25. A Somali and Euro-American researcher conducted two focus groups at each organization during June 2007–January 2008.

To systematically collect data, we applied the same interview template at each session (Krueger & Casey, 2000). We started with warm-up questions such as, "If you were to describe a healthy female, how would you describe her?" We then proceeded to ask transition and key questions such as "What are some of the health issues that Somali women experience?" and "What are the factors that influence Somali women's health?" We concluded with summarizing questions such as, "What is the most important issue that we have talked about today?" Although many of the participants spoke English, some women preferred speaking Somali, and the meaning of their spoken words was immediately deciphered by a Somali interpreter. Lively dialogue occurred at all sessions; occasionally, the interpreter reminded women to talk one at a time so all voices could be heard. Women were just as eager to speak with one another as with researchers. Focus group sessions were audio-recorded and transcribed.

Thirteen key informants were individually interviewed in 2008. Key informants included representatives from the MDH, local non-governmental refugee assistance organizations, and local health care organizations. Also included were two Somali nurses, a Somali language interpreter, an African-American physician, and Euro-American psychologist who all work with Somali women. We asked questions that pertained to health concerns, available services, service gaps, structural facilitators and barriers, and future initiatives. All key informants spoke fluent English; therefore interviews were conducted in English, audio-recorded, and transcribed.

Data Analysis

After importing research text into Atlas.ti data management system (Knowledge Workbench, 2006) and with the assistance of an Atlas.ti consultant, researchers first selected four transcripts with rich data to initiate coding and establish coding reliability. Each researcher conducted first level coding on these four transcripts by inductively and descriptively labeling groups of words (Robson, 2002). Comparing codes, we noted slight differences in level of abstraction and easily reached agreement. Second, we divided the remaining transcripts and separately completed first-level coding on assigned text. Codes that resulted from each researcher's first-level coding were compared and collated; the resulting 129 codes were considered detail codes.

Third, detail codes were reviewed and sorted into 24 cluster codes which were re-sorted into six higher level categories: health descriptions, concerns, facilitators, barriers, systems, and processes. The resulting coding hierarchy was revised slightly when reviewing all transcripts. Fourth, because descriptions of facilitators and barriers seemed to interact with other data categories, an additional layer of coding on facilitators and barriers was applied to all text. A data matrix that displayed data according to personal and structural barriers and personal and structural facilitators was constructed. Studying the data matrix, we noted that interactions between Somali women and the American healthcare system were frequently unsatisfying and unproductive. Narrations about healthcare interactions were then studied more closely. Hyvärinen (2008) claimed that expectations are embedded in almost every utterance and suggested that when speakers narrate, they are describing incidents of "changing, failing, or realized expectations" (p. 456). Studying narration for linguistic evidence of human expectations, Tannen (1993) found nine indicators. For example, statements that contained negative, repetitious, and tentative expressions often foreshadowed articulated expectations. We returned to the data to study expectation indicators and consequently uncovered discordant health beliefs and two divergent expectations. Two silent worries also surfaced.

Results

Discordant Health Beliefs

The biomedical model in Western medicine generally views illness as biologically-mediated and treatment as individually-focused. In contrast, the vast majority of participants in all focus groups viewed health holistically and within the context of their daily lives. Being engaged in productive activities; relating well to self, family and Allah [God]; and living in communities that "watch our children and avoid violence" were among the contextual descriptors of health.

Women in all groups also described their beliefs about illness. Occasionally, women illustrated ill health as symptoms such as pain, insomnia, and fatigue. However, for most Somali participants, illness had stronger roots in explanations such as spiritual dissonance, social disconnection, and sadness. For example, one woman noted, "It's [cause of illness] the lifestyle here. There's more stress. Depressions. Lack of sleep. We are isolated into our own world. All of that is deteriorating our health." In a different focus group, there was general agreement regarding the statement, "In Somalia, we were one nation and we knew each other. Here women are more isolated. We have depression." Additionally, participants in all groups mentioned and sometimes emphasized spiritual explanations for illness. For example, "Sometimes it [illness] is just part of Allah's destiny so I have to face it regardless of what happens." Another participant in a different focus group stated, "Even if we are very, very sick, we believe it's from Allah so we pray to Allah." Emphasizing that point, a different participant in the same group stated, "All the diseases I have, I tell only Allah. It's not for other persons, it's just between me and Allah."

Discordant health beliefs sometimes evolved into misunderstandings. For example, a key informant who was a Somali obstetrical nurse described instances when she queried Somali women about why they avoid prenatal check-ups. She stated, "They [pregnant Somali women] say, 'When I go to them [healthcare providers] and tell them I have back pain, they tell me to hop up on this bed and open your legs, but that's not where it's hurting.' It creates misunderstandings." A Somali focus group participant asserted, "When we go [to the clinic], doctor says you have this and this [conditions], gives you a prescription, tells you a bunch of steps and come back [to the doctor]. I think if I hadn't gone to the doctor, then I wouldn't have all this [condition]." Another participant insisted, "A lot of [Somali] people think that if they go to the doctor, it's what makes you sick so staying away from the doctor makes you pretty healthy." Everyone in that focus group agreed with the participant's statement. In a different focus group, a woman stated, "Somali women never go to the doctor, because we go and the

doctor believes we are crazy or psychotic, and we say that makes us more crazy so we don't go."

Suggesting that some Somali patients "speak in allegory," a healthcare provider narrated, "So when immigrant patients tell their [American] healthcare provider that they hurt all over, the clinician initiates all sorts of tests that have no relationship to what the patient is really experiencing." Explaining that healthcare providers in Somalia understood these allegories, this participant noted, "But here, we're just confused. It creates a disconnect that neither patients nor providers know how to bridge."

Divergent Expectations

Expectations about treatment—Accustomed to a Somali healthcare provider who listens to symptom explanations and immediately prescribes treatment, Somali women often expected similar immediacy from their American health care providers. In contrast, most American clinicians expect their patients to wait, sometimes for days, as they rely on the accuracy of laboratory-based diagnostic tools to determine disease conditions and treatments. For example, one participant narrated, "I don't understand why the doctor asks so many questions. The doctor should know the answer. He should know my diagnosis and tell me what's best." Another focus group participant asserted,

> They [health care providers] don't give me anything. The only time I go to them is when I'm sick. They tell me, drink water, eat food, take Nyquil. I don't have money for Nyquil. They are supposed to provide me with something. That's why I say they don't do anything for me.

A different participant claimed, "At home [in Somalia] when I am sick, I go to the doctor, I get a shot and I'm fine. Here they keep telling me, 'Come back' and they're not doing anything. I'm getting worse!" Narrating an incident when she brought her grandmother into the Emergency Department, a Somali nurse key informant explained,

> They [health care providers] put her on an x-ray table and then it's over. No medicine, no nothing. They tell her she can go. And, my grandma says, 'Okay, now what's next?' And I told her, 'No grandma, that's it.' She [became] mad and said, 'What do you mean, they put me on this table and they're not doing anything for me?' And then I had to argue with them [providers] as to the point of the x-ray when they're not going to do anything. And she has to have another doctor appointment, but what's the point of that, when she was there and could have had it the same day? She still had the pain.

Noting these frustrations over lack of immediate results, a physician key informant stated, "They [Somali patients] just go to the hospital and then expect that we're going to know exactly what's wrong with them and treat them."

Women in all focus groups described difficulty understanding the processes of screening, preventing, and managing chronic diseases. Accustomed to viewing illness as a symptom-based, treatable condition, many women expressed distress with pill-based treatment regimes. One focus group participant noted, "In our culture, we don't have prevention and screening. So when we [Somali people] get screening and hear we have high blood pressure or diabetes, it's difficult to understand."

Describing the "challenge of treating chronic diseases such as diabetes and hypertension" for people from "different cultural backgrounds," a physician key informant stated, "They [immigrants] believe that we [healthcare providers] are treating symptoms to cure as opposed to our understanding that we're treating symptoms because there is no [disease] cure. There's no sense of chronic disease." Similarly, a Somali interpreter key informant stated,

> Most Somali people have high cholesterol because we eat a lot of red meat. So what happens? The doctor tells the patient, 'You're fine but you have these three diseases.' Patients say, 'How am I fine? I can't be.' And I tell them, 'You are, in the doctor's eyes, if you take your pills and do your exercise, you are a healthy person. You can work, you have 10, 12, 20 years to go.' And patients say, "He [doctor] is not making me healthy. I have these diseases.' And they are not willing to take pills, and [then they] go to the ER [with] a stroke because we are not a culture of taking pills.

Somali women in most focus groups indicated that concern about symptoms rather than illness prompted them to make health appointments. In fact, symptoms often represented the illness, and therefore, women expected a cure for symptoms rather than an illness-explanation with chronic, pill-based treatment. Therefore, when symptoms dissipated, treatment was stopped. As a result, medications accumulated. A key informant who was a Somali public health nurse claimed that some of her patients produce "10, 20 pills, and I ask them, 'Do you take all these, do you know which is which, do you know how many times you take these?' They don't understand their pills." Another Somali provider explained, "They [Somali patients] go to the doctor who gives them new medications and they don't throw away the old ones."

Focus group participants in two different focus group described potentially dangerous medication usage. For example, one participant narrated,

> A lot of seniors live in the same building and share their problems. They say, 'What do you take?' And the person says, 'Oh I take a pink one [medication]. Come and see.' And the other says, 'Oh I take a pink one too. I have the same problem.' So, they compare with each other.

Another participant followed by stating that women sometimes even share their medications with one another.

Women in all focus groups described the American healthcare system as "complicated" and "difficult to understand." Participants in some focus groups noted, "fear of calling 911 because we cannot pay." A Somali key informant claimed, "Seventy-five percent of our people have bad credit because they don't have information about payment systems." Some women stated that they do not seek health care because, "Stress is going to the doctor and having a bill next week."

Several participants in three focus groups described difficulty understanding insurance applications and healthcare forms. One Somali participant described "going in and out of insurance because I don't understand the policies." Women described receiving healthcare forms in the Somali language, but since some cannot read, "It's [translation] not helpful." Waiting for application approvals was also difficult. One woman stated, "I asked for assistance for all my medications, but the office told me, 'It's a process. You have to wait until it goes through.'" In one focus group, participants indicated strong agreement with one woman's summary:

> In Somalia, everything was normal. The doctor lived in the village with us and we would see him whether we were sick or not. We didn't worry about whether it was covered. But here, medicine is not covered, and they do not tell you what the medicine is for. In Somalia, when we took medicine, we got healthy. All medicine was natural. We only took medicine one time a day. But here, it is many times a day and many, many pills.

Expectations about healthcare interactions—Accustomed to being known by their physician, Somali women expected to develop a personal relationship with their American healthcare providers. In contrast, the American healthcare system expects clinicians to manage

multiple patients simultaneously and use time efficiently. Somali women frequently expressed frustrations with brief appointments and rushed healthcare encounters. For example, one participant stated, “I feel when you go to the doctor’s office, they [doctors] are not really listening. We can’t talk to them for more than 15 minutes, and they can’t spend another minute with you or they won’t get paid.”

Describing typical healthcare encounters, a Somali nurse who also works as a language interpreter stated,

> The doctor doesn’t ever have enough time. He will say, ‘Okay tell me why you’re here today.’ [The patient] says, ‘This is what happened 10 years ago, I was walking and then I…’ And the doctor says, ‘I need to know why you’re here today!’ And for her to tell why she’s here today, she has to go back 10 years, but the doctor doesn’t have time. The doctor says, ‘Can she tell me one thing?’ And I would say, ‘I’m waiting!’ To say what the problem is, some people have to go back to how it started. For that, the doctor needs attention and time to listen to the whole story for him to get [the current problem] but I don’t think they have time or patience. So they look at me like someone who doesn’t know what she’s doing, but at the same time, I can’t pull all the information from the patient. So I say, ‘Be quick. He wants to know why you’re here now, now!’ and she’s saying, ‘I’m saying, wait, wait!’ It’s easier even when I’m dealing with someone young. But for elderly people, that’s not how they tell their story. When they [older women] come to the doctor and all he wants is information [about the problem] and he doesn’t even sit down. So he gets frustrated, and I get frustrated, and everybody’s frustrated, and she [the patient] says, ‘He doesn’t even have time, he didn’t even listen to what I said!’

As a result, many Somali women fail to trust their healthcare providers and instead feel as one focus group participant stated, “It [doctor visit] is a waste of time. What did I get last time? Nothing. What did I get before that? Nothing. And what am I going to get there this time?” In all focus groups women described unfulfilled expectations about healthcare interactions. Even a physician key informant noted, “We have to educate our providers so they don’t just think – oh, here’s another foreign person and, oh my gosh, now we’re going to spend an extra 20 minutes with the translator. Often you just want to focus on the problem and get out.”

Almost all participants in all focus groups viewed their health as part of life situations; health problems could not be compartmentalized into a single scenario to present to healthcare providers. Acknowledging the importance of developing a relationship with her Somali patients, a physician key informant suggested, “You have to respect where they [Somali patients] are, and it does take time to develop a relationship, and we are just not given a lot of time.”

The challenge of working across languages in the healthcare system was consistently and passionately described by all participants. For example, one focus group participant stated, “I don’t feel satisfied when I can’t understand my doctor.” Referring to an interpreter, a healthcare provider queried, “Who wants to tell their problems when there’s a third person in the room?” A Somali healthcare interpreter noted, “When I say ‘I have a headache’ in English, it’s like I have a headache, but in our language, it goes around and around and [providers] don’t get the point.” This highlights another aspect of cross-language relationships: a lack of words to express what is being experienced. A Somali healthcare interpreter stated, “In our culture, we used to call it [cancer] infection so we know it by the name infection. It [cancer] has no translation in Somali. [Also] we don’t have inflammation, so if you say [inflammation] to someone in Somali, it’s infection. They know what that is.”

Speaking clear fluent English, several young Somali women expressed frustration because the healthcare system required them to have a language interpreter. For example, one woman explained,

> They [healthcare providers] say, 'We have to delay until we have an interpreter.' And I say, 'I don't need an interpreter.' And they say, 'You have to have one.' If you're Somali, they [healthcare providers] don't listen. Even though you speak perfect English, they think you don't understand, you are dumb and they will not explain to you what is happening.

Speaking in fluent English, one focus group participant described an incident in the Emergency Department where she received care for seizures during her pregnancy and asserted that healthcare providers failed to explain that she was supposed to continue taking medications for her seizures which eventually led to hospitalization. The participant simply concluded, "They [healthcare providers] assume that if you wear different clothes that you cannot speak English, and they don't explain anything." A physician participant concurred and stated, "Sometimes we don't think that Somali women will understand [explanations] so we don't take the time to explain. I don't have any idea why we think that because you can't speak English, you are not intelligent, but that happens all the time." As a result, one key informant summarized "misunderstandings between well-intentioned doctors and well-intentioned patients [occur], distrust builds, relationships break" and health suffers.

Silent Worries

Sadness—Resulting from homeland war trauma, family separation, and forced migration, chronic sorrow was prevalent. However, most participants in all focus groups acknowledged inability to discuss sadness with their health care providers. For example, one participant stated, "Many African women don't feel comfortable telling their providers about their feelings. There's all that shame so it stays pent up for months, years." A Somali OB nurse stated, "Our people [suffer] from mental illness but there are so many layers to it. [Some believe] they may be cursed by someone. It's hard explaining that to physicians." A nurse practitioner who works very closely with Somali women claimed, "It's [Somali culture] not a culture that grew up understanding mental health issues, except for the diseased mental health issues. There was anxiety and depression, but there weren't any words for it." A Somali nurse stated, "Most of the people who came here had a lot of trauma before getting here. That doesn't go away. One lady lost everybody. Her husband and sons were killed in front of her, and she wonders, 'Why do I live? Why do I wake up every day?'"

Many key informants acknowledged the prevalence of paralyzing depression and described challenges in helping the Somali community. A physician describing her concern about depression in elderly Somali women noted,

> They're afraid to go out. They're used to farming work and now they're relegated to being inside a house. Very isolated. I had one elderly woman who was depressed, but we couldn't use the word depression. She said 'It would be a disgrace for me to admit to anyone that I was depressed.' So she wasn't open to any treatment. I think that's a huge issue, and I don't know how that's going to be addressed.

Acknowledging the silent suffering of many women, a Somali focus group participant stated, "If you're depressed, you can't be part of society, at least in the Somali community, because you are CRAZY. There's something wrong. You're not going to do things right, you're going to cause trouble." A health care provider described a young Somali woman who, accompanied by her husband, repeatedly returned to the clinic with somatic pains. After several health visits where the husband translated all messages, the physician finally arranged to see the woman by herself. The young patient admitted to being depressed, but according to the physician, "It

would be a total disgrace for him [husband] if his wife had that label because he's supposed to be head of the house and she's supposed to be happy with him." The couple agreed that she could take medication for her headaches; the physician prescribed an anti-depressant that also treated headaches. Commenting on sadness, a nurse practitioner stated, "They [Somali women] have a lot of mental health issues, which come from the huge disruption in their lives. They come to a society which works very differently from home."

Many key informants acknowledged a lack of culturally-appropriate mental health services. A nurse stated, "We don't have enough providers who are interested in doing the work." The magnitude of mental health problems, especially for elderly women, was aptly described by a clinical psychologist who stated, "It's not the life they want. They've lost everything. They're not going to learn the language. They're not going to retrain for a job. They don't see a future. They can't start over like a 20 year old who's been displaced."

Reproductive health—Two focus groups with young participants and four Somali key informants expressed concern about the silence that surrounded girls' reproductive decision making. Quietly raising this issue, a young Somali woman stated,

> Right now, there's a cultural clash between the older generation and the younger generation. People are going to be shocked when I say this, but in our community, young girls are sexually active. There is this idea, based on culture and religion, that young girls are not to have sex until they are married, which is safer with all these sexually transmitted diseases. But if you go to any high school, young Somali girls are sexually active, and they don't know how to protect themselves. This is a taboo subject in our culture. Our mothers will not sit down with us and say, 'Okay, don't have sex, but if you are, do this and this.' [Instead] they will say, 'Don't have sex' and there is nothing beyond that. The reality is, as much as our parents would love the idea that kids are doing the things they are supposed to, a lot of girls are having abortions. I don't know about cases of HIV. But that means if girls are not getting education from their mothers or the family, then we should have outside sources available. Culture and religion are not allowing us to talk about this. We can't talk about prevention especially with our own parents. It also has to do with puberty. When a girl reaches puberty, there are a lot of things that she doesn't know. So moms need to sit with their daughters, like a girl can get her period and not even know what that is. So, yeah, there's a lot that we need to talk about.

Echoing this concern during a key informant interview, a Somali nurse acknowledged uncertainty about opening discussion on reproductive health with her own puberty-age children and queried, "As girls get bigger, there's the issue of birth control and in my culture and religion, you can't have sex before marriage, but what are they doing? Is it right to teach them? I don't know what's right." A Somali interpreter stated, "We [Somali people] are not open. The doctor says, 'How are you going to make space between children?' and the mom [asks] me, 'Doesn't he want me to have children?' This is very hard. We see it's a blessing to have children. It's hard to understand my culture." Another participant stated, "You raise your daughter and hope a nice man marries her. That's all you hope. So to sit down and talk about sex, it's taboo. No one wants to talk about it. You don't know where to start." A Somali nurse acknowledged, "The number of abortion is high. They [young women] are not taking birth control but once it happens, they want to terminate. Our culture, our religion says it's wrong but at that moment, all she's thinking is, 'I don't want this baby.'"

Acknowledging silent suffering among women in her community, one participant summarized by saying, "We are a small community. Everybody knows everybody. If I say my problem, then other people will say, 'She has that problem' and they will look at me different. So I keep quiet about my problem until it's out of proportion."

Discussion

According to Altheide and Johnson (1997), human expectations are manifested in everyday life as people assign meaning to their experiences. For example, when confronted with illness symptoms, patients generally utilize past experiences, education, and culturally-bound health beliefs to construct an explanation about their illness experiences (Kleinman, 1980). These illness explanations arouse expectations which are then carried into healthcare encounters.

During analysis, we noted that Somali women narrated numerous instances of unrealized expectations. Somali women generally perceived health and illness as part of their larger, situated life experiences rather than individually experienced events; as a result, women expected their healthcare providers to view health holistically and contextually, when in reality American healthcare systems usually fragment health and prioritize physical over social and mental well-being. Additionally, many women expected to present their explanatory models to healthcare providers; however, these providers often work in healthcare systems that expect efficiency and do not structure adequate time for healthcare professionals to listen. Similar results were found in a Canadian study on immigrant women who claimed that healthcare providers made little attempt to accommodate cultural beliefs in their interactions with patients (Weerasinghe & Mitchell, 2007). Women viewed healthcare professionals as “insensitive” when health beliefs clashed (p. 317).

Similarly, Warfa et al. (2006) determined that immigrant patients often held one illness explanation while healthcare providers often provided another. This difference often impaired healthcare interactions and interfered with patient satisfaction. These researchers also noted that immigrant dissatisfaction with primary care often contributed to immigrant patients’ decisions to delay healthcare or seek care in Emergency Departments. Betancourt and Green (2007) similarly found that illness explanations often differed between immigrant patients and their healthcare providers. These differences interfered with treatment adherence and patient satisfaction. In our study some Somali patients’ expectations of symptom cures conflicted with healthcare providers’ expectations that patients would self-manage their medications to treat chronic disease conditions. Women often expressed dissatisfaction with medication-focused health care given their view of illness was situational rather than biological disruption.

In a study on Emergency Department use by Somali refugees in Minnesota, DeShaw (2006) found that Somali patients expect a specific diagnosis, medicine and a cure from their healthcare providers. Attending a clinic for screening and illness prevention was unfamiliar to Somali patients who were accustomed to only seeking healthcare when ill. Furthermore, Carroll et al. (2007a) studied Somali refugee women’s understanding of prevention services and found that while many women understood the need for vaccinations, most women did not understand cancer screening techniques. Cancer was not easily translated nor understood as a disease entity. Our study results revealed similar findings.

People’s social realities including expectations interact through language (Altheide & Johnson, 1997). Numerous research studies on various immigrant groups concluded that language differences challenge not only patients and their families but also healthcare providers (Flores, 2005; Flores, 2006; Gany et al., 2007; Jacobs, Agger-Gupta, Chan, Piotrowski, & Hardt, 2003; Jacobs, Shepard, Suaya, & Stone, 2004; Messias, McDowell, & Estrada, 2009). In these studies, language differences between patients and their providers created communication barriers that increased the risk for medical errors, treatment non-adherence, and poor health outcomes. Strauss, McEwen, and Hussein (2009) studied Somali healthcare workers’ perceptions of childbirth in the UK and concluded that for Somali women, language was the primary barrier to maternity services. Similarly, Somali women and healthcare providers in our study indicated that language differences interfered with effective health care.

According to many researchers, immigrants from conflict-affected areas such as Somalia experience an increased risk of post-traumatic stress and depression (Berman et al., 2006; Kokanovic, Dowrick, Butler, Herrman, & Gunn, 2008; Miller & Rasco, 2004). Specifically, Carroll (2004) studied Somali refugees in New York and identified three major mental problems: *murug* (sadness), *gini* (craziness from spirit possession), and *waali* (craziness from trauma). In our study, women briefly described depression but most mental health conditions were characterized by silence; two explanations could pertain. First, the social stigma that accompanies mental health conditions in many societies also occurs in the Somali community (Whittaker, Hardy, Lewis, & Buchan, 2005). Similarly, exploring ethnic disparities in mental health care, Nadeem, Lange, & Miranda (2009) studied 1,577 low-income depressed women in five groups which included Latina and black immigrants as well as U.S. blacks, whites, and Latinas; compared to United States-born white women, ethnic minority women were less likely to express a need for mental health care. This phenomenon was particularly striking for black immigrant women from Africa and the Caribbean. The authors reported that these women were more likely to stigmatize mental health concerns and less likely to perceive a need for mental health care.

Second, many immigrant women might consider mental distress as part of the larger immigration experience, and, therefore, cannot be avoided or treated. Often disconnected from family and social support, female immigrants in a Canadian study described the stress of adjusting gender roles, locating employment, managing family conflicts, encountering discrimination, and learning a language (Meadows, Thurston, & Melton, 2001). Health effects such as depression, headaches, rashes, and anorexia were linked to migration stress. Somali women in our study echoed stresses associated with relocation and cultural adjustment but suffered silently.

While some Somali mothers expressed confusion over ways to discuss sex and reproductive health with their adolescent children, some daughters expressed a need to discuss these topics with their mothers. This communication gap reportedly led to unsafe reproductive decisions which could harm adolescents' health. Othienol (2007) found that many Africans are uncomfortable discussing sex and reproductive health with their healthcare providers. Difficulty in resolving conflicting cultural perspectives on gender and reproductive health occurs among women from many immigrant groups (Bruce, 2007; Meadows et al., 2001).

The information in this study offers deeper understandings about many Somali women's healthcare encounters in Minnesota. However, immigrant women living in different areas may have different experiences to report given tremendous diversity exists within each immigrant group as well between immigrant groups.

Further research into Somali health beliefs would benefit healthcare providers and organizations. Moreover, a meta-analysis that examines common variables in interactions between immigrant patients and health care providers seems timely. Since many talents and strengths were evident among our participants, studies that investigate resilience factors could yield valuable information for programs to promote family strengths. Above all, developing intervention programs is imperative. Despite increasing need, very few intervention models for resolving language barriers have been investigated. Health literacy programs need to be developed and tested. Interventions that prevent and manage depression are particularly important for young women since some research indicates that second-generation immigrants have an increased risk for depression and are less likely to seek treatment (Heilemann, Kury, & Lee, 2005). Elderly immigrant groups would also benefit from intervention studies that promote mental health and social networking. In addition, implementation of women's and girls' reproductive health programs would be appropriate. Approaches such as participatory

action research that actively involve Somali women and girls in project development and investigation would be especially helpful.

Pertaining to practice, our findings indicate that healthcare providers need to become more aware of their own explanatory models and resulting expectations. Additionally, healthcare providers should analyze situations for unrealistic as well as divergent expectations. Querying patients about their illness explanations and care expectations, acknowledging expectation differences, and explaining how the American healthcare system operates could prevent unrealistic patient expectations. Healthcare providers could advocate for immigrant patients by clearly communicating patients' expectations to other healthcare providers. Initiating programs to facilitate healthcare system navigation for all immigrants could be beneficial. Healthcare providers could also provide a strong voice for healthcare system changes that allow for more time in patient-provider interactions.

When working across language, healthcare providers need to be particularly aware of non-verbal language and develop deliberate and consistent ways to demonstrate warmth and welcome. Even when healthcare systems have resources such as language interpreters and culture brokers available to assist immigrant families, providers should analyze each situation to determine how language impacts patients' healthcare experiences. Developing specific, cross-language evaluation tools that document patients' understanding of illness information and treatment instruction would be beneficial. Forms with diagramming methods such as body mapping would be particularly useful for limited-literacy patients.

Finally, suggesting that healthcare professionals need to expand beyond "medically-focused" and "problem-based" approaches, a pediatric healthcare provider claimed,

> [We need to] be more patient centered and probe for contextual understanding of patients and their needs. But in reality, in healthcare organizations, even in the pediatric world which is supposed to be family-centered, the medical model is still pervasive and medical models still tend to strip down the context to assumed common denominators. There's no time given, there's no reward for understanding and caring for somebody holistically and contextually.

The United States Department of Health and Human Service (USDHHS, 2000) aims to increase the quality and years of healthy life and eliminate health disparities. The World Health Organization (WHO, 2008) emphasizes strategies to address the social determinants of health. However, difficulties in working across difference, including discordant health beliefs and divergent expectations often result in unsatisfactory and unproductive relationships which could fuel disparities for some immigrant groups. Healthcare providers play a key role in uncovering health beliefs, assessing expectations, and eliminating divergence so that more productive, satisfying, and effective healthcare interactions result and WHO and USDHHS goals can be met.

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