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Caring for Somali Women: Implications for Clinician-Patient Communication

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Abstract

Objective—We sought to identify characteristics associated with favorable treatment in receipt of preventive healthcare services, from the perspective of resettled African refugee women.

Methods—Individual, in-depth interviews with 34 Somali women in Rochester, NY, USA. Questions explored positive and negative experiences with primary health care services, beliefs about respectful vs. disrespectful treatment, experiences of racism, prejudice or bias, and ideas about removing access barriers and improving health care services. Analysis was guided by grounded theory.

Results—Qualities associated with a favorable healthcare experience included effective verbal and nonverbal communication, feeling valued and understood, availability of female interpreters and clinicians and sensitivity to privacy for gynecologic concerns. Participants stated that adequate transportation, access to healthcare services and investment in community-based programs to improve health literacy about women's preventive health services were prerequisite to any respectful health care system.

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Conclusion—Effective communication, access to healthcare services with female interpreters and clinicians, and community programs to promote health literacy are themes associated with respectful and effective healthcare experiences among Somali women.

Practice Implications—Adequate interpreter services are essential. Patient-provider gender concordance is important to many Somali women, especially for gynecological concerns.

Keywords

cross-cultural communication; women's health care; preventive healthcare services; refugee

1. Introduction

Global patterns of migration and population shifts have increased ethnocultural diversity in the US, Canada, and Europe. As a result, health care professionals provide care for culturally diverse immigrant and refugee populations in a variety of settings. In the US, racial/ethnic minority Americans are projected to comprise 40 percent of the US population by 2035.(1) Currently, about 25 million refugees and immigrants comprise about 10% of the US population. These major demographic shifts send a clear message that health care policy and practices must address the needs of minority individuals and their communities.

Immigrants and refugees from Africa represent one of the fastest-growing groups resettling in the United States, Canada, and Europe.(2) In 1991, a civil war erupted in Somalia that led to mass forced migration and displacement; over a million Somalis fled to neighboring countries and another two million were displaced internally.(3;4) Between 1991 and 2000, over 100,000 Somalis arrived in the U.S. as refugees, asylum seekers or through family sponsorship.(4) Somali Bantus, a Somali ethnic minority group, began arriving in 2003 and are the largest single African group to be granted asylum in US history.(5)

Somalia is a clan-based society where political, economic, social welfare and physical safety are influenced by membership in the patrimonial clan family. Most of the early refugees belonged to this clan system.(6;7) Despite variations in ethnic or clan identification, nearly all Somalis are Muslim (>99%); gender-specific roles, responsibilities, and traditions are the norm. The healthcare system in pre-war Somalia consisted of Western-style hospitals and clinics, especially in urban areas, and also "traditional" or "cultural" doctors, more common in rural regions. Nearly all Somalis are familiar with Western medical concepts such as vaccination, rehydration, the use of antiobiotics, and infectious illnesses such as tuberculosis and malaria. Most Somalis are also familiar with traditional approaches to treating illness which may include prayer or religious ceremonies, invoking healing spirits, and/or use of herbs or other botanical medicinal products. (19)

As a result of the civil war, many Somalis lived in camps like Kakuma and Dadaab; such environments were often harsh, poorly rationed, and lacked resources and facilities to adequately address the health, educational, and nutritional needs of their populations. (34) Many refugees relied upon episodic, crisis-based healthcare. Thus, aside from childhood immunization programs, most Somali refugees have little prior experience with preventive health services (14).

While the Somali and the Somali Bantu both have a common country of origin, and both endured hardships in refugee camps as a result of the civil war, in other ways their life experiences have been very different. As descendants of former slaves captured in the early 19th century(8) the Somali Bantu were marginalized and never integrated or married into the customary Somali clan system. As a result they fell outside of the major clan lineage divisions and often experienced discrimination and deprivation of basic rights such as

education and political representation.(6;7) The Intergovernmental Organization for Migration (IOM) estimates that only about five percent of Somali Bantu refugees (mostly male) are proficient in English; literacy levels are also low for Maay Maay, the commonly spoken language for the Somali Bantu.(9)

Despite the large number of immigrants resettled in the United States, extensive evidence exists to document various forms of racial and ethnic disparities in providing preventive healthcare services in the US.(10;11) Though information is very limited for other immigrant and refugee groups in the US, prior work has shown that refugee women, specifically those from Somalia, receive fewer preventive services.(12;13) Because of insufficient resources, many refugees have relied upon episodic, crisis-based health care which may preclude women from participating in preventive health activities such as cervical cancer screening, thereby contributing to observed disparities.(14) Yet the pathways through which Somali women experience disparities in preventive health care services are complex and may include patient related factors such as cultural beliefs, subjectivity and variability in one's presentation of symptoms and preferences for treatment, language barriers, mistrust of the clinician, and stereotyping or bias about health care professionals. Clinician-related factors include language barriers, prejudice against minorities, clinical uncertainty when interacting with minority patients, and beliefs or stereotypes held by the provider about the behavior or health of patients with different cultural backgrounds.(15;16) System-related factors include structural/access barriers, geographic availability of health care facilities, time and productivity pressures on providers, and variation in managed care arrangements.(17;18)

The overall goal of this paper is to explore the range of both Bantu and other Somali women's experiences with communication about preventive health services in the US in order to understand the role communication plays in disparities in this population. We wanted to explore the range of experiences and remain alert to the possibility of distinctions among resettled Somali women generally rather than compare distinctions between Bantu and other Somali women per se. This study addressed the following question: From the prospective of Somali refugee women, what are characteristics and behaviors associated with favorable communication and treatment in receipt of preventive healthcare services?

2. Methods

We conducted in-depth interviews with a community-based sample of resettled Somali women. Eligible participants were female adults (>18 years old), born in Somalia, and currently living in Rochester, NY. Participant recruitment was by word of mouth, key informants and primary care provider referrals; recruitment then continued via the snowball technique. We included a broad range of Somali women, representing a variety of ages, ethnic/clan identification, duration spent in refugee camps, and duration of resettlement in the US. We had not initially planned to focus on distinctions between Somali Bantu versus other Somali women in this study; this was due to the fact that we had not anticipated access to this group of Somalis rather than our assumption that their views would be the same as other Somalis. The onset of our study coincided with the arrival and resettlement of many new Somali Bantu families in our area. Our key informants advised us to include these newly resettled Bantu women in the study also, so we invited them to participate to enrich data collection by incorporating a range of experiences. The study protocol was approved by the University of Rochester Research Subjects Review Board (Rochester, NY, USA). Snacks and a $10 grocery gift card were given as compensation to participants, as well as reimbursement for transportation when needed.

Individual interviews explored several key concepts; reported here are women's beliefs about what constitutes favorable health care. Some interview questions were based on prior work in the field; (19) others were developed based on emerging data, interviewers' input, and key informant feedback to maximize reliability, technical, and conceptual validity. Appendix A shows the interview template.

The individual interviews occurred at a time and place convenient to the participant, and were audiotaped and transcribed. Forty-five women were recruited to participate. Only one woman declined, citing time constraints and language difficulties. Of the remaining forty-four women, thirty-four were interviewed to achieve sufficient data saturation, which was determined through repetition of concepts and themes. The order of the interviews was established randomly.

Two professional and two lay interpreters (all Somali females) were used for non-English speaking participants and for any participant who preferred to speak their primary language. One of the professionally-trained interpreters (SO) reviewed audiotapes of all interviews conducted with lay translators to check accuracy of translation, and made written corrections, clarifications, and other notations for transcripts, which were integrated into the analysis.

2.1 Analysis

A multidisciplinary team analyzed data using grounded theory, a coding/editing method that extracts emerging themes from the data (20;21). Codes were systematically established from the data by three coders. The primary analysis team (JC, EV, KD, SO) met regularly to discuss coding issues and emerging categories and themes. Emerging categories and themes were then reviewed at a series of meetings with a secondary analysis team consisting of senior faculty with advanced qualitative research skills (RE, NC, KF). The purpose of this analysis phase was to identify and confirm the most salient themes; search for any discrepancies or disconfirming data; develop linkages between the present study and prior work in the field; and brainstorm about resolving persistent ambiguous or contradictory issues. At the final phase of analysis, a Somali women's focus group was conducted to check thematic validity and clarify questions and ambiguous concepts posed by the interim analysis of the completed individual interviews. The focus group was conducted in English, Somali and Maay Maay (a language commonly spoken by Somali Bantu). A professional female interpreter (SO), trilingual in English, Somali, and Maay Maay, translated the questions (and replies) for the focus group. Two other facilitators (JC and KD) were also present to monitor the group process, to ensure participants had equal opportunity to respond and state their views, and to track the pacing of the questions and topics covered. We audiotaped the focus group and the interpreter (SO) listened to it and made any corrections of omitted material into the transcripts. Despite clan and/or ethnic differences among participants, the focus group dynamics were animated, amiable, and respectful with all women actively contributing to the discussion. Throughout the data collection and analysis, six community Somalis, four females and two males served as key informants and/or interpreters. They assisted with participant recruitment, interview template design and revision, and they verified accuracy and validity of emerging themes.

3. Results

3.1 General characteristics of participants

A total of 34 Somali refugee women participated in the study. Fifteen (44%) were Bantu Somali women, and nineteen (56%) were other (non-Bantu) Somali women. Ages ranged from 18 to 53, with a median age of 27 years. Duration of residence in the US ranged from

two months to nine years. Twenty-three (68%) of participants required the assistance of an interpreter. Table 1 summarizes socio-demographic characteristics.

Compared to non-Bantu women, Bantu women were younger (median age 24 vs. 32), in the US for a shorter period of time (median one year vs. seven years), less likely to be employed outside the home, less likely to have had any formal education, and more often needed the assistance of a translator during the study interview. Both groups were equally likely to have children (93-94%), but more Bantu participants were married (73%) as compared to other Somali women (56%). Bantu women, on average, lived in refugee camps for a longer period of time – up to 10-12 years –as compared to other Somali women (on average, four to five years). The Bantu women primarily spoke Maay Maay; one also spoke Kezwa. Other (non-Bantu) women spoke Somali, Swahili, and Barawa.

In the following sections, we first discuss themes regarding the necessary foundation that participants stated had to be in place in order to have effective communication and receipt of services. Next we discuss themes about clinician characteristics, behaviors, and communication styles that were associated with a favorable and respectful healthcare experience. Examples of questions include “Do you think that Somali women in the US have problems getting the health care they might need?”, “Tell me what you think is respectful (considerate of your needs and wishes) treatment to you,” and “Do you think that doctors or nurses treat you differently because you are Somali? Please tell us about this and give some suggestions for how health care professionals can improve care of Somali women.”

3.2 Prerequisites/ foundation for favorable healthcare experiences

For these participants, important prerequisites to an effective healthcare experience were having easy, *understandable access to the healthcare system, continuity of care, and general principles of patient centered care*.

3.2.1 Easy access to the healthcare system (absence of structural barriers)— Most women (n=23, 68%) readily described concerns that they had either for themselves or their loved ones that they had either discussed or wanted to discuss with a healthcare practitioner. Although 17 (50%) of women initially stated that they had “no problems” in response to the question “Do you think that Somali women in the US have problems getting the health care they might need?”, these women later clarified that their responses (some gave more than one stipulation) depended on the availability of an interpreter (n=12), transportation being available (n=4), having insurance (n=2), or knowing how to get an appointment (n=4). The corresponding quotes in Table 2 highlight these issues.

3.2.2 Continuity of care—Participants discussed features of *continuity of care* in creating a satisfying experience more likely to engage them with the health care system for routine care. Several women mentioned that the use of reminder systems such as cards, calls or notices were helpful to keep appointments or follow up on preventive health issues given competing demands of work and family. Participants also valued the familiarity of a single primary health care clinician, as participant 030 in Table 2 illustrates.

3.2.3 Attributes of patient-centered communication—Participants described themes related to patient-centered communication. Such themes embody certain universal ideals of optimal interaction and communication in the healthcare experience: the role of *positive nonverbal communication and cues of the clinician’s personality*, the importance of *feeling valued and respected* as a person, and an *interest on the clinician’s part to understand the psychosocial context* of the participant.

Participants discussed several key nonverbal clinician qualities that allowed them to speak more comfortably, raise their concerns, or ask questions about diagnosis or treatment plans. Examples mentioned as important to a positive healthcare experience included the practitioner smiling and showing kindness, being available to talk, showing patience, and demonstrating interest and/or understanding about Somali culture or language (see Table 3, participant 020).

Feeling valued and respected as a person: Participants stated that the physical examination was a basic component to a good quality health care visit. The ritual associated with the physical examination and the importance of touch was illustrated by the complaint by some that if one was not examined properly, it was an indication of an uncaring clinician or incomplete health care visit. A theme related to a satisfying health care visit was receiving a medication that would cure the presenting problem or complaint. Many women stated that the best part about high quality health care in the US was that doctors had medicines to treat their complaints, and they had access to these pills, in contrast to their experiences in Somalia or whilst in the refugee camps. This view was especially common among more recently resettled Bantu women. For these women, access to health care was the top priority and they tended to discuss their gratitude for access to care rather than providing specific details about positive (or negative) cross-cultural health care experiences.

Five women shared examples of unpleasant health care experiences that represented disrespectful, incomplete or insensitive care. Themes associated with poor health care experiences included receiving depersonalized care, being rushed through the visit, being made to wait a long time (especially if others arrive later but are seen sooner), and demonstrations of impatience or visible frustration due to language barrier on the part of health care providers or staff. Table 3 provides examples of negative experiences expressed by two participants (030 and 017).

3.3 Clinician factors related to respectful treatment and favorable health care experience for Somali women

3.3.1 Availability of female clinician and female interpreter—A key theme, especially for the more recently resettled women, was that availability of interpreter services (preferably female) was the single most important priority for improving health care. Several women mentioned that a trusting relationship with an interpreter made it more likely they would express their deepest concerns rather than withholding information about their health. Participants felt that the importance of the healthcare clinician's gender was unique to Somali culture; they felt that they could communicate more effectively with female clinicians. Yet, some Somali women stated that this view might be changing as women acculturated (i.e., had a longer duration of residence, acquired English fluency, and/or became familiar with US customs) to life in the US. Of the women asked (n=29), eighteen women (62%) stated they felt more comfortable sharing private, personal issues if their provider was female. This preference was expressed by Bantu and non-Bantu women, older and younger women, and women were both newly resettled and those who had lived in the US for longer period of time. Among the participants who preferred a female clinician, these women felt strongly about it. For them, their decision to seek health care depended on whether or not the clinician was female, especially if a physical examination was necessary or the visit involved discussion of sensitive or private issues, usually gynecologic concerns. One participant stated that missing an appointment was preferred to many women over being examined by a male clinician. Participants 008 and 029 highlight this issue in Table 4. Of the 18 women, five stated that in an emergency, it would be acceptable to have a male doctor, but as a rule, felt more comfortable communicating with a female. Eleven participants (38%), however, did not have a preference, stating because of a doctor's unique

and important role, gender was not a consideration. The quote by participant 021 in Table 4 illustrates the challenges that several women expressed in their decision-making both trying to adhere to their preferences (whether personal, religious, or both) yet also recognizing certain conditions could modify these preferences.

3.3.2 Gynecologic concerns (circumcision) and need for privacy—The great majority of Somali women are circumcised (a procedure which involves removal of all or part of the clitoris, with or without the labia minora and majora).(22;23). Our participants expressed a variety of opinions about whether or not the practice should continue, about the nature and degree of appropriate circumcision techniques, and shared a range of emotional reactions about having undergone the procedure themselves. Although women's views about circumcision varied among these participants there was consensus that clinicians providing preventive care to them need to have a basic understanding of this practice. Respect for privacy and sensitivity to female circumcision was seen as paramount to a positive health care experience; several women expressed the need that certain health concerns be known only between the patient and her doctor. This desire for privacy extended to limiting involvement and access to medical records to other health care providers and staff. Participants stated that it was especially important that they were adequately prepared for the gynecologic exam by their providers, with a clear explanation of the procedure involved, the tests being done, and the rationale for the tests.

3.3.3 Need for Somali health care workers and health education programs—A key theme expressed by recently resettled Bantu women as well as other more well-established participants was their desire to improve their educational level overall and, more specifically, their health literacy about US preventive health care services. Several women stated they felt more comfortable learning from other knowledgeable Somalis, at times being hesitant to discuss questions with their doctor. A promising and potentially effective venue for improving health literacy raised by participants was to develop community-based health education programs for African women. Such programs should be designed and led by the women themselves based on local informal community networks and include the *presence of Somali health care workers to promote basic health education*, with consultations from health care professionals. Participant 008 in Table 5 describes this idea.

4. Discussion and Conclusion

4.1 Discussion

Our results suggest that addressing structural barriers to care and demonstrating basic skills in patient centered communication are the bedrock upon which culturally mediated issues can be addressed. Several salient features- availability of female clinicians, interpretation by females who are trusted, sensitivity to cultural practices such as circumcision, and promotion of health education through means supplemental to the clinician-patient relationship-were all identified (by both Bantu and other Somali participants) as culturally mediated issues for effective, respectful provision of preventive health services to Somalis. Overall, themes were quite similar between Bantu and other Somali participants, possibly due to the fact that despite some pertinent historical differences, the social roles occupied relative to each other were more distinct in Somalia than in the US.

Certain unique findings of our study address other possible dimensions of culturally appropriate respectful care. For example, gender concordance for optimal communication emerged as a necessary component especially for highly personal and sensitive issues relating to gynecologic issues and female circumcision. For the majority of women (both Bantu and other Somali), this view was strongly held and should be considered a priority for

improving access to preventive health services for Somali women. For example, our participants had diverse beliefs about and experiences with female circumcision; yet they uniformly wanted clinicians to understand that circumcision was common and recommended that clinicians respectfully inquire about it in medical history-taking when appropriate. Effective communication and language competency as cornerstones to culturally appropriate and respectful care is consistent with prior studies of other non-English speaking populations and theoretical frameworks of cultural competency.(24-27) Additionally, Beach et al. (2005) have shown that among other minority groups in the US, being treated with respect is significantly associated with adherence to treatment recommendations.(35) Gender concordance may be a prerequisite to respectful, effective communication, relationship-building, and trust, which in turn are associated with improved satisfaction with and use of healthcare services for these participants. Other work has also provided support for the role of partnerships among other minority groups and their clinicians to promote improved participation in decision-making, satisfaction, and improve health status. (36) Health care programs which explicitly address communication, trust, and relationship-building as components of cultural competency could be a promising way to improve preventive healthcare services for Somali refugee women.

For participants in this study, effective communication was grounded in having access to known female interpreters. Because gender roles and responsibilities are distinct in traditional Somali culture as compared to mainstream North American culture, cross-gender interactions can be more awkward and thus the presence of a female interpreter and a female clinician are more acceptable and appealing to many Somali women. High quality, culturally appropriate interpreter services might work to reduce disparities in preventive health care via several different mechanisms for Somali women by changing their health-seeking behavior, improving health education and counseling, building trusting relationships with their health care providers, and improving accuracy of medical history-taking, diagnosis and treatment. By definition, interpreters allow patients the opportunity to participate more effectively in decision-making in their care, and may result in less physician dominance with more patient centered communication behaviors in the visit, which studies have shown to be lacking in other minority groups (37).Interpreters may work to reduce disparities by functioning in an expanded role as cultural liaisons and advocates, assisting patients in navigating the health care system to ensure appropriate follow-up and adherence to treatment plans.(28) For example, participants in our study associated receipt of medications with a satisfying, high quality healthcare experience (often due to the contrast with lack of access to needed medications whilst in refugee camps). Such an expectation could pose a challenge if medications are sought or expected in situations where receiving a medication might not be appropriate; this issue can be addressed more thoroughly and explicitly with an interpreter. Adequate interpreter services are especially critical for those individuals with the least English, reading, or writing proficiency - and who therefore rely the most on interpersonal discussions - such as the Bantu women in our study.

Nonverbal dimensions of communication - such as showing kindness and patience – emerged as important in culturally competent care among our group of participants. Such nonverbal cues, when occurring with other patient centered communication behaviors such as showing interest in the person’s context, life experiences, cultural background (29;30) are likely to improve comfort and satisfaction with preventive health care services. Patient-centered communication can improve shared decision-making about appropriate screening, alleviate anxiety, and improve trust. (31;32) This is consistent with other studies showing that patients’ perceptions of the clinician of “knowing” the patient, recognizing and valuing their life experiences is important and may help to improve adherence, satisfaction and use of in primary care health services. (36).

As far as we know, this study is the first known report to include Bantu Somali women in addressing Somali women's preventive health concerns and views about favorable and respectful treatment in the US. All participants in this study were Somali and were diverse in terms of ethnic identification, (Bantu and other Somali women), languages spoken, and stages of acculturation in the US. As a result, themes suggest that in order to be culturally competent, clinicians must be flexible and accommodate to patients' needs that change across the spectrum of resettlement and acculturation. Recently resettled women (who tended to be Bantu) emphasized access and removal of structural barriers to high quality healthcare; more established Somalis (who tended to be non-Bantu) highlighted specific aspects of effective communication in the doctor-patient relationship and provided more details about respectful treatment in the medical visit. These results also support the idea that cultural competency operates at the individual, group practice, and institutional levels; (33); because of this multidimensionality, views about it, and each component's relative significance, vary from person to person and time to time.

Health care practices and systems can promote and support culturally appropriate, community-based health promotion programs for resettled refugees such as Somalis; appealing programs build on existing kinship and community structures to promote health literacy among all Somali women, but especially among Somali Bantu women who have the least amount of prior education (if any). Our participants, by making the link that community-based efforts would be an effective means to improve their health literacy about women's preventive healthcare services, indicated this as a means to improve access and use of health care services. Such community based programs have been implemented with some success in other immigrant and refugee groups. (38;39) Somali people have a legacy of remarkable resilience in the face of repetitive and varied hardships. It is imperative that healthcare professionals who work with this population understand and tap into their unique characteristics and survival strengths, build on positive health promoting habits and behaviors, and provide education about preventive health services. Education about preventive care, recognition of the need to seek care and early intervention are prerequisites for Somali refugee women to receive the quality and level of healthcare necessary to improve and maintain their overall well being.

Limitations—The interviews were conducted by health care professionals, which may have influenced the subjects' response to questions asking them to critique the health care system. To minimize this effect, the research team interviewed women with whom they had little or no direct patient contact and similar questions were asked in various formats and sections of the interview and crosschecked for consistency. Because familiar healthcare professionals well known to the community locally (AA, JC, NG, LK) were involved with the study, this may have increased ease of participants sharing information and opinions; alternatively, certain issues may have been avoided.

Social pacing in interactions (e.g., differences in "warm up time" needed for the interviews) may have negatively affected the comfort level of participants in answering personal questions. Some participants were difficult to engage in the interview process perhaps because of cultural differences with interview norms and expectations. Cultural beliefs on gender roles and norms regarding publicly revealing personal viewpoints (which could be viewed as criticism) may have impeded the discussion for both Bantu and other Somali participants. To decrease these situational influences on participant responses, the interviewers tried to maintain an open dialogue with the participants, avoiding direct questioning.

Language barriers must also be acknowledged in cross-cultural qualitative research of this nature. Initially, the project required the use of lay translators. The team was eventually able

to coordinate interviews with two professional Somali female translators, one of whom (SO) then listened to transcripts of the interviews done with lay translators to address the accuracy of the translation. Since the professional translator made an average of only nine lines of corrections per 394 lines of transcript for these interviews, the quality of lay translators in this study was high.

4.2 Conclusion

Themes in this study associated with favorable treatment in health care services for Somali women included logistical ease and familiarity accessing the health care system, interpreter services, development of trust and relationship-building, preference for female interpreters and female clinicians especially for gynecologic concerns, and Somali-organized community based health education programs to improve health literacy. Future work needs to evaluate and test these factors along with community-based programs for resettled African refugee groups to examine their effectiveness on improved satisfaction, access, and use of preventive health care services.

4.3 Practice implications

Results from this project point to several ways to improve health care services for Somali women (both Bantu and other Somali women). First, having an adequate interpreter, preferably female, is a high priority especially for gynecologic concerns. Other attributes associated with favorable and respectful care were clinician demonstrations of open-mindedness, patience, curiosity, interest, concern, non-judgmental inquisitiveness about Somali culture, and receiving medications. Examples of disrespectful treatment provided are those in which the person feels rushed (especially after having been made to wait), not receiving an adequate physical exam, and visible demonstrations of frustration or annoyance on the part of health care staff due to language barriers. An issue unique to Somali women expressed by our participants is the importance of gender concordance in facilitating open communication, especially due to gynecologic issues and concerns relating to female circumcision.

> “I confirm all patient/personal identifiers have been removed or disguised so the patient/person(s) described are not identifiable and cannot be identified through the details of the quotations.”

Appendix A

Interview Questions

1. Do you feel more comfortable having a medical visit with/communicating with a male or female doctor? Why or why not?
2. Describe a situation where you would feel comfortable having a medical visit with/communicating with a male doctor. (Explain)
3. Do you think that Somali women in the US have problems getting the health care they might need? (Explain)
4. Tell me what you think is respectful (good, kind, considerate of your needs and wishes) treatment to you.
5. Do you think that doctors or nurses might treat you differently because you are Somali?
6. Please tell me about this and give some suggestions for how people can communicate more respectfully towards you.

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Table 1

Summary of Participant Characteristics

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

	Somali		Bantu		Total	
	N	%	N	%	N	%
No	8	42.1%	11	73.3%	19	55.9%
Missing	0	0.0%	1	6.7%	1	2.9%
Total	19	100.0%	15	100.0%	34	100.0%

Table 2

3.2.1 Smooth experience accessing and using the healthcare system

035 [If I don't] have transportation I can't go to the hospital. That's the problem. And if I don't have anybody to make the appointment for me I can't do it [myself]. Translators are needed.

029 It's easy to get [tests done] once you have your doctor and the insurance and everything.

022 I got an appointment [with my doctor]. I'm looking for translator, but I don't [have] one.

003 When I came here, 3-4 weeks I was here and I get sick. I don't get [my] Medicaid card. If [I am] sick, I call someone that speaks [my] language and they'll call the doctor and make an appointment for me to go to the doctor.

3.2.2 Continuity of care

030 I used to go to [a former health center] but I didn't like that. Cause I didn't see the doctor. They made me see different doctors. I didn't like it that way you know. I like to have one doctor who I can see when I have an appointment. That's why I didn't like [the former health center]. I moved to here. It's good.

Table 3

3.2.3 Attributes of patient-centered communication
020 Many Somali women need to understand more. And [they need] attention. First, doctors should smile to the patient. [Then] talk to the patient slowly. [Then] talk slowly step by step. And then the patient can tell you everything.
030 But sometimes I feel that I'm a minority because of my culture. I thought maybe they were ignoring me or they don't want to treat me. Sometimes they leave you in a room for a long time. You stay there feeling pain you know. One day I was having a lot of pain so I had to go to emergency. I stayed all day long until I came home. I didn't see anybody. Nobody was coming to see me or to help me. They call everybody, but me and my sister. What's wrong with you? Why are they not calling us? Sometimes the emergency is a big problem for me. When I feel pain I go to the hospital and they take all day long. Maybe if I go in morning I can come home in evening without anybody seeing me.
017 [In the past], I had a doctor. A male doctor. I always told him I don't feel better with the medicine [but] he wasn't serious. [I] was talking, I [told] him and he listened, but [he] don't do anything. I was losing control because he didn't know how I was feeling.

Table 4

3.3.1 Availability of female clinician and female interpreter
008 There is one thing – a communication barrier. When you get a translator and the translator doesn't really get you the translation in details. Some of them just talk and talk and then when it comes to the translator, he can't put the words the [right] way…. [doctors] have to go deep inside with [Somali women] and know each other like women, when they come for their healthcare, they have to be given the chance. If they really want a translator, they should not be given a man. Give her a woman translator, so that she can be open to tell all the problems.
029 I was OK with [speaking with a male doctor about GYN issue], but most of the Somali women like women. Feel confident with a woman. You know you can discuss some stuff more with women than men. Because of the culture thing. Yeah, a lot of Somali women they don't discuss any health problem with men. They feel free to talk to another woman and discuss something like that with them. Most of them don't speak English so sometimes they get a translator who is a man. It's hard for them to explain their problem to another man. It's better to explain to your husband than another man.
021 Religion sometimes says it is good for you to have [a] female doctor if you are female, but because of circumstance, you have [a] little problem [adhering to this]. That issue [happens] all the time. If somebody is dying and if you don't have female and you say I don't want to see male, I want a female doctor, it' s out of religion. For us, our religion says, "If you have choice, prefer female. Is good for you." But in case of a critical condition, and they don't have female, don't say "I can't, I can't." I was pregnant. I needed help. When they [said] they [didn't] have a female doctor, I [said], "Anything, for me is OK". I'm more comfortable with a female doctor.

Table 5

3.3.3 Need for Somali health care workers and health education programs
008 [Somali women] need to be educated on why they should go to the doctor. Have a seminar and talk to them – a group of women together to say that we need you to do this and you should go through this to have immunization because of this and that. Some of them just stay home because they don't understand why they need to be thereWomen should talk to them. [Get them] together and tell them that we want to talk to about the importance of going to the hospital [or clinic], so they get to know why. When they get to know why, they can educate the other women so they know the importance of going to the [clinic] and that they should go. We can't just give them things to read because they can't. We can get the women together though, so they know the importance of these things.