GIVING YOUNG FEMALES A VOICE: PERSPECTIVES OF SOMALI BANTU REFUGEES PARTICIPATING IN A WELLNESS AND LEADERSHIP DEVELOPMENT PROGRAM

by

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ABSTRACT

Health effects of migration are determined by the conditions under which the migration occurred, the extent of integration into the host country, the social status of women in the host country and the health conditions in the host country. Women who are displaced as a result of a crisis such as war carry the responsibility to ensure their children obtain the bare necessities such as food, water, and shelter, typically with very little means of income.

Severe life-threatening trauma and a post-migration life with stressful events such as unemployment and lack of social contacts are important factors in the long-term health of traumatized refugees. Social supports have long been seen as a central component in the migration movement by informing people where to resettle and by shaping relations between homeland and host societies. Optimal health is predicted by the strength and characteristics of a refugee's social ties. The likelihood of a health program to succeed increases based on participants' involvement in the planning and development of the health program. Barriers for refugees to participate in health programs can include financial constraints, family events, language, lack of transportation and childcare.

The Somali Bantus are a minority group within Somalia, descendants of slaves brought to Somalia 200 years ago. Approximately 14,000 Somali refugees have entered the U.S. during a resettlement program. In 2004, Catholic Charities moved 184 Somali Bantus to Pittsburgh,

Pennsylvania. Healthy Girls Circle (HGC) based at Magee Womens Hospital in Pittsburgh, PA, was designed to empower Somali Bantu teen girls and young women by developing their leadership skills and increasing their knowledge of health and wellness.

A secondary data analysis of qualitative interview data was conducted to gain a deeper understanding of the perspectives of the Somali Bantu refugees participating in HGC. Motivational factors and barriers to participation were identified as social support, household responsibilities, as well as a desire to gain knowledge and skills regarding exercise, nutrition and job preparation. This research is significant to public health because of the recognition of taking a holistic approach in program development that addresses female Somali Bantu refugee health care needs and leadership development. In addition, it fills the gap in the literature by identifying motivations for young women to attend health programs.

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PREFACE

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1.0 INTRODUCTION

According to the United Nations High Commission for Refugees (UNHCR), (2005) a refugee is defined as "any person who [has] to a well-founded fear of being prosecuted for reasons of race, religion, or nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality" (http://www.unhcr.org/refworld/docid/43141f5d4.html). Somalia is a country that has been in upheaval since civil war broke out in 1991, which caused over 25% of the population to flee (Guerin, Diiriye, Roda, Corrigan, and Guerin, 2003) making these individuals refugees. The resettling of these refugees has required major adjustments and disruption in familial and social networks. Relocation poses increased difficulty and health consequences when civil and homeland violence occurs (Pavlish, Noor, and Brandt, 2010).

Refugees face a variety of challenges when adapting to a new country such as language barriers, discrimination, and less serious issues such as grocery shopping (Guerin et al., 2003). Many of these challenges some stemming from unemployment, separation from family, a lack of proficiency in English, and previously living in conflict regions compromise their health. Somali Bantu refugees, the majority of whom are women and children, continue to enter the United States from refugee camps in Kenya (Upvall, Mohammed, and Dodge, 2009). These women and children are struggling to learn a new way of life in the United States.

It is important that Somali women maintain good health because they tend to be the sole caretakers of each other and their children. Therefore, ensuring that they have resources available to them that will assist in living a healthy lifestyle is crucial. Examining refugee women's health and health care experiences is important since they have a vital role in advancing their health, the health of their families, and the health of their communities at large (Pavlish, Noor, and Brandt, 2010).

Although the Somali Bantu share common issues and barriers to health services with other refugee groups, they have a unique history, culture, religious beliefs, and experiences that influence their health. This has created a need for a heightened awareness amongst health care professionals in the United States to become familiar with the needs of this population, and incorporate into their practice, health care services that take the unique needs into consideration. For example, services provided by a health care professional that do not take into account the religious background of refugees may inadvertently violate their religions and will not be received well by this population (Comerasamy, Read, Francis, Cullins, and Gordon, 2003).

The aim of this study was to identify motivational factors and barriers to participation in health promotion and leadership programs, such as Healthy Girls Circle (HGC), a program based in Pittsburgh, Pennsylvania dedicated to working with Somali Bantu female refugees that teaches them about healthy lifestyles and leadership developments skills. The Principal Investigator (PI) collected qualitative data by way of interviews with the participants in HGC and analyzed the findings identifying motivational factors, knowledge and skills gained, as well as barriers to participation. The findings will assist other programs that focus on the health, well-being, and leadership development of female refugees to attract and encourage participation and identify the needs of this particular population.

This paper explores migration struggles in terms of health and gender, Somali Bantu resettlement, traumatic, stressful events, and their impacts on individuals and the role social support plays in addressing some of these negative impacts. Civil war often results in countless deaths and causes entire populations to relocate. Experiencing the deaths of loved ones and resettling in another country places an individual at increased risk of suffering from psychological and physical stress (Lie, 2002). Once relocated, social support has served as a positive reinforcement to benefit the well-being of refugees.

This paper discusses consumer participation in health programs, the benefits of involving participants to ensure successful programs, and barriers to participation. Consumers who assess, plan, and implement solutions for their health needs are more likely to increase knowledge, mastery, and control in health programs. Providing consumers with the opportunity to play a vital role in the planning and development in a health program will yield positive and successful results. Although, a health program coordinator and consumers can collaborate to identify and meet their needs, barriers exist that inhibit consumers to participate.

Several gaps exist in the research regarding the participation of Somali refugee women in health promotion and disease prevention programs. Optimal health for women is important in these communities because of their various roles and responsibilities in the family unit (Pavlish, Noor, and Brandt, 2010). Social and economic struggles faced by women due to relocation often result in negative health consequences. A clear understanding of the motivation that drives this population to seek medical care and participate in groups that can contribute to healthier lifestyles is essential in helping health care professionals better serve their diverse needs.

In addition, methods of data collection and analysis of this study will be discussed in detail. Results of the analysis of qualitative interviews will be discussed illustrated by comments from the participants. Comparison between the literature and the findings of this study will be explored, specifically looking at motivational factors, barriers, and knowledge gained through participation in health programs. Finally, this paper presents recommendations for working with Somali Bantu refugee women to ensure their health and leadership development needs are addressed and met.

2.0 BACKGROUND

In this chapter, an in-depth literature review examines different aspects of refugee migration, specifically in terms of health effects of resettlement, women and their unique position during a crisis such as displacement, and the civil war in Somalia, which lead to displacement of much of the population. In addition, the mental and physical effects of displacement and coping strategies will be explored to highlight the importance of making available health programs and resources to promote health and well-being among this vulnerable population. This chapter will conclude with a discussion of one of these programs, Healthy Girls Circle (HGC), a program that promotes healthy lifestyles and leadership development among Somali Bantu refugee teen girls and young women living in Pittsburgh, Pennsylvania.

2.1 REFUGEE MIGRATION

Migration is among the top contributing factors to population change and can be attributed in part to the increased number of wars around the world (Adanu and Johnson, 2009). Civil wars and conflicts often occur in areas where low income is prevalent and result in many deaths and the displacement of large numbers of people (Adanu and Johnson, 2009). Displacement means

finding a new location in which to reside and begin a new life. Displaced individuals oftentimes do not have any option but to leave their homes and migrate either to another part of their country or leave their country all together (Adanu and Johnson, 2009). Migration poses many threats to the well-being of those who are affected by war and are forced to leave their homes.

Persecution, harassment, discrimination, poverty and forced migration result in disruption of the social, cultural and economic connections with the host country and cause migrant stress (Iglesias, Robertson, Johansson, Engfeldt, and Sundquist, 2003). According to Pavlish, Noor, and Brandt (2010), chronic sorrow was prevalent as a result of homeland war and trauma, family separation, and forced migration.

Civil war and the breakdown of society result in a decrease in security, and more often than not, women are disproportionately affected because of norms about violence against women (Caprioli and Douglass, 2008). Vulnerability to a decrease in safety for women spreads beyond civil wars and can be found throughout the resettlement process. Professionals ought to increase their awareness of the stress that is a result of migration is important when working with these individuals in any setting, specifically, for the purpose of this paper, in a health care setting. Lacking information about specific ethnic groups and their history means that services cannot be tailored to address unique health needs and therefore, health care services may not be culturally appropriate (Pavlish, Noor, and Brandt, 2010). Foreign-born residents of color often share barriers to health care services similar to those of racial minorities in the U.S. (Pavlish, Noor, and Brandt, 2010).

2.1.1 Health and Migration

The resulting health effects of migration on women are determined by the conditions under which the migration occurred, the extent of integration into the host society, the social status of women in the host country and the prevailing health conditions in the host country (Adanu and Johnson, 2009). Armed conflicts cause a rapid deterioration in the health status of refugees and as a result of war, refugees are usually in a worse state of health than residents in the host country (Adanu and Johnson, 2009). Relocation is more difficult and health consequences greater when associated with civil conflict and homeland violence (Pavlish, Noor, and Brandt, 2010). Healthy lifestyles, careful pre-immigration screening, and extensive social support seem to contribute to better health outcomes (Pavlish, Noor, and Brandt, 2010).

The right to health can be viewed as a right to a variety of goods, services, and facilities along with conditions that are necessary to attain optimal health, including underlying determinants such as clean water, food supply, housing, and health education information (Musoba et al., 2009). Immigrants who develop chronic diseases such as diabetes and depression suffer higher rates of disease morbidity than non-immigrant populations (Pavlish, Noor, and Brandt, 2010). Being engaged in productive activities, healthy relationships with self, family, and Allah (God), living in a community that watches over the children and avoiding violence were all contextual factors that were predictors of good health (Pavlish, Noor, and Brandt, 2010).

Health-related problems stem from unemployment, separation from family, learning a new language, and previous experiences in conflict regions (Guerin, Diiriye, Corrigan, and Guerin, 2003). All these challenges impact the health and wellbeing of women and are aggravated by the various lifestyle changes that result from being a refugee (Guerin, Diiriye,

Corrigan, and Guerin, 2003). Since refugees are primarily women and children, it is important that women remain in good health because of the many responsibilities they take on, including taking care of their children (Guerin, Diiruye, Corrigan, and Guerin, 2003).

Once health care services become available, barriers continue to exist within the health care setting in regards to understanding the services needed and granted to women. For example, immigrant women have reported difficulty understanding the process of screening, preventing, and managing chronic diseases (Pavlish, Noor, and Brandt, 2010). Focus group participants in a study by Pavlish, Noor, and Brandt (2010) described potentially harmful medication usage, reported that sometimes they share medications among themselves. Improved survival rates and success in the treatment of their health can be attributed to improved literacy, decision-making abilities, reduced discrimination, and development of female independence (Aden, Omar, Omar, Hoberg, Perrson, and Wall, 1997). Somali women often perceive health and illness as part of their larger, situated life experiences rather than individually experienced events (Pavlish, Noor, and Brandt, 2010). As a result they expected their health care provider to view health holistically and contextually, when in reality American healthcare systems usually fragment health and prioritize physical over social and mental well being (Pavlish, Noor, and Brandt, 2010).

2.1.2 Women and Migration

In 2005, estimates from the UN (UN, 2006) show that women have been migrating at a rate similar to men for 40 years and have accounted for 50% of migrants (Adanu and Johnson, 2009). Women who are displaced as a result of a crisis such as war carry the responsibility to ensure their children obtain the bare necessities such as food, water, and shelter, typically with very

little means of income (Adanu and Johnson, 2009). This responsibility of the female to care for not only herself but also to take care of the children without the help of a male can be a heavy burden in the midst of migration and uncertainty.

Gender differences exist everywhere; however, in regards to experiences and responsibilities taken on as a result of fleeing their host country and migrating to a new location, men and women assume the responsibilities post migration that they had before. Andanu and Johnson (2009) found that accepted gender roles often mean that the woman is the sole caregiver to the children. According to gender ideals in Somali culture, the male is the breadwinner and head of the household. Women on the other hand are inside the household as the obedient wife (Hansen, 2008). Cleaning, washing, and cooking are seen as the roles of a woman and are seen as shameful activities for men to be associated with (Hansen, 2008). The added pressure of migrating and caring for their children, most of the time without the help of the father, leads to great difficulty and added stress for Somali women. During a crisis, such as displacement, women often fall vulnerable to violence and are unable to express their needs for themselves and children (Musoba, Byamukama, Mutambi, Aporomon, Luyombo, and Rostedt, 2009).

2.2 SOMALI BANTU RESETTLEMENT

The Somali Bantus, a minority group within Somalia, are descendants of slaves brought to Somalia 200 years ago during the African slave trade (Upvall, Mohammed, and Dodge, 2009). Located in East Africa, Somalia has been ravaged by a clan-based civil war that began in 1978 and erupted in the 1990s when rebels from the United Somali Congress ousted the former

dictator Siyad Barre (Griffiths, 2002). It can be said that the Bantus are Africans without a nation who became targets for attack when Somalia fragmented due to a civil war in 1991 (Conte, 2005). The Bantus fled the war by the thousands walking thousands, of miles to refugee camps in Kenya and Ethiopia, where refugee camps were located (Conte, 2005).

Worldwide there are over 400,000 Somali refugees recognized by the United Nations; Kenya, Yemen, and Ethiopia are among the countries with the highest number of these refugees (McCrone, Bhui, Craig, Mohamud, Warfa, Stansfeld, Thornicroft, and Curtis, 2005). The U.S. among other countries provided refugee sponsorships to relocate families (Pavlish, Noor, and Brandt, 2010). After the onset of the civil war in 1991, thousands of Somali refugees resettled in the U.S. (Johnson, Ali, and Shipp, 2009). The number of African-born immigrants to the U.S. increased 142% between 1990 and 2000 from 363,000 to 881,300 (Johnson, Ali, and Shipp, 2009).

2.3 TRAUMATIC AND STRESSFUL EVENTS

Traumatic events due to war, disasters, torture and mass violence lead to serious psychological consequences and mental disorders (Araya, Chotai, Komproe, and Jong, 2007). The consequences suffered by the Somali community greatly affected the most vulnerable in the society, which included women and children as the primary victims (Aden et al., 1997). U.S. Somali Bantu refugees, the majority of whom are women and children, are from refugee camps in Kenya (Upvall, Mohammed, and Dodge, 2009). Somali women who had been forced to leave their country due to war, some of whom then migrated to the U.S. as refugees, struggling to learn

a new way of life (Upvall, Mohammed, and Dodge, 2009). Poorly acculturated immigrants are vulnerable to environmental stress factors at work, at home and in the neighborhood (Iglesias et al., 2003). Compared with other African immigrants, Somalis have low rates of literacy and English fluency and lower socioeconomic status (SES) and are less likely to be insured or have a regular source of care (Johnson, Ali, and Shipp, 2009).

Mental Health Effects

The nature of and the degree of traumatic exposures experienced before flight put refugees in high risk group in terms of future mental and physical health problems (Lie, 2002). Refugees oftentimes faced stressful situations in the past and continue to experience daily stress as they cope with adjusting to a new way of living. Torture, discrimination and not feeling secure in everyday life were risk factors for poor health (Lie, 2002). Adverse psychiatric consequences of psychologically traumatic events have been reported in refugee populations, although the extent and implications of such mental health effects are unclear (Steel, Silove, Phan, and Bauman, 2002).

Severe life threatening trauma and a post-migration life with stressful events such as unemployment and lack of social contacts were seen as important factors in the multifactorial explanation of long-term health conditions of traumatized refugees in exile (Lie, 2002). War and ongoing conflicts in the country of origin that jeopardize family and friends back home put additional stress on the refugees in exile already forced into a passive position (Lie, 2002).

Coping and Treatment

Strategies that individuals utilize to cope with the stress and struggles of events are as diverse as a population itself. Coping is conceptualized as an individual's response to stressful or negative events; individuals may employ different coping strategies (Araya, Chotai, Komproe,

and Jong, 2007). Strategies to cope with stress can be internal or external to the individual (Halcon, Robertson, Monsen, and Claypatch, 2010). Internal coping resources include self-efficacy, mastery, self-esteem, personal beliefs about the external world, health and energy, and education. External coping resources consist of social support and the environment (Halcon, Robertson, Monsen, and Claypatch, 2010).

Mental health services may not be available or even acceptable for refugees because of the cultural differences of Western mental health approaches, language barriers, social stigma, insurance issues, fear, and isolation (Halcon, Robertson, Monsen, and Claypatch, 2010). Social support is believed to act as a buffer against adverse affects of stress and trauma and provide emotional and material nourishment by removing potential stressful factors from the environment (Araya, Chotai, Komproe, and Jong, 2007). Individuals' support systems may also help buffer the effects of life events upon their psychological state (Thoits, 1982).

Gender Differences

Men and women alike are at risk to be affected by severe consequences of armed conflicts and war and are both equally as vulnerable to dangerous situations. However, women are more likely to be exposed to abuse and rape and also carry the burden of caring for the family, whereas men are more exposed to combat and war (Araya, Chotai, Komproe, and Jong, 2007). In general, women are twice as likely to suffer from posttraumatic stress disorder than men as a result of trauma (Araya, Chotai, Komproe, and Jong, 2007). Across diverse settings that involve crisis, the health of women and girls, men and boys is affected differently (Musoba et al., 2009). A study conducted by Aden et al. (1997) found an increase in Somali female mortality after the age of 15.

2.4 SOCIAL SUPPORT

Civil wars often result in a breakdown of civil society, which results in a decrease in safety for those who reside in a community that has been affected by war (Caprioli and Douglass, 2008). The events that some refugees have experienced and the turmoil of moving from one country to another, places them at an increased vulnerability to mental health problems and may also have higher levels of physical health needs and different patterns of social needs than non-refugees (McCrone et al., 2005). Somali women tend to suffer from isolation because of the lack of social interactions they used to engage in and depend upon in Somaliland (Hansen, 2008). To a number of Somali women with children, Western life is not a joyful experience because of the restriction of experiences and social networks (Hansen, 2008). Family separation, dissolution of social networks following war and displacement, and the conditions of resettlement combine to undermine the possibility of community cohesion (McMichael and Manderson, 2002). Social support aims to enrich the quality of supportive interactions between individuals and members of their communities (Gottlieb, 1985).

2.4.1 What is Social Support?

Social support is the physical and emotional comfort provided by family, friends, co-workers, and acquaintances. Gottlieb (1985) suggests that social support can be divided into three categories and analyzed by the way in which support arises and strength of support. The first category of social support searches into the effective potency of social relationships and into the emotional provisions of social relationships. The second measure of social support encompasses

examination of the structure and supportive foundations of social networks and focuses on the individual's personal relationships with frequent interaction. The third category of social support is measured in the terms of social participation and involvement in formal and informal social life (Gottlieb, 1985). All three categories measure the content in which the social interaction occurs with self and others. Informal social networks operate to ensure that individuals have access to information, goods, and services; these ties are typically common among immigrant populations as a source of solidarity and support (McMichael and Manderson, 2004).

Social support serves as a resource for an individual to access and build relationships. Social capital also serves a similar purpose to build upon relationships, and increase access to goods and services. Social capital refers to various social factors that contribute, often subtly, to the well being of an individual (McMichael and Manderson, 2004). Social capital can be used to describe connections among people, loyalties, investments, and mutual obligations that develop among people and are strengthened so that new links can be developed (McMichael and Manderson, 2004). Participation and membership in family groups, social networks, or other social structures can benefit one's well-being and health and are also identified as having the capacity to reduce the negative effects of life events (McMichael and Manderson, 2004). For new immigrants, social capital can be resource of information, support networks, introductions, friendships, and possible material goods (McMichael and Manderson, 2004).

Social supports have long been seen as central in migration movement, informing where people choose to resettle and shaping relations between homeland and host societies (McMichael and Manderson, 2004). Women who experienced childhood trauma in the family, forced social isolation during displacement, and not married are correlated with lower perceived social support than men (Araya, Chotai, Komproe, and Jong, 2007). Studies of resettlement suggest that

migration creates reliance among immigrants greater than would have existed in their country of origin (McMichael and Manderson, 2004).

2.4.2 Health and Social Support

Health is not predicated on the availability of social relationships or on the social circles in which the individuals participate, but rather on the strength and characteristics of their social ties (Gottlieb, 1985). Individuals with a strong social support system should be better to cope with major life changes, in contrast to those with little social support, who may be vulnerable to undesirable coping outcomes during life changes (Thoits, 1982).

Women who lack a strong social network are at an increased risk of poor health (Iglesias et al., 2003). Eating and exercise habits typically change when refugees arrive in a new country, making diet and nutrition important health issues for refugees (Guerin, Diiriye, Corrigan, and Guerin, 2003). Somali women are often concerned about weight gain after arriving in a new country, especially a developed country, because of the increase in sedentary lifestyle, which contrasts with their lifestyle in Somalia (Guerin, Diiriye, Corrigan, and Guerin, 2003).

2.4.2.1 Reproductive Health and Cultural Norms

The reproductive health needs of women are often overlooked even in the most organized refugee camp (Adanu and Johnson, 2009). Aspects of the Somali culture affect the mortality of women such as familial responsibilities, traditions, and preventative practices (Aden et al., 1997). The number of children men and women have is a reflection of their status in society and adherence to religious teachings (Comerasamy et al., 2003). The more children they have, the

more likely they are to meet the expectations of their culture. Due to societal and religious teachings, high reproductive burden could be a possible explanation for excess female mortality and prolonged negative health effects of pregnancy such as anemia and undernourishment (Aden et al., 1997). The negative health effects of pregnancy have become a major concern of many Somali women who typically are not consumers in health care services, but are searching for options to decrease the amount of pregnancies.

Although Somali women are not regular users of family planning services, a study by Comerasamy et al., (2003) discussed the importance of contraception among Somali women, addressing two main concerns: women not wanting more children and a high prevalence of pregnancies with an average of five children. Information and the experiences of others using contraception influenced the acceptability and use for other women (Comerasamy et al., 2003). Among Somali women, experiences of other women and the act of talking about contraception are barriers. Contraception is not usually a topic for conversation with strangers and is discussed only among women within their communities (Comerasamy et al., 2003). Discussions about contraception among mothers and daughters are also rare. While some Somali mothers expressed confusion over how to talk to their daughters about sex and reproductive health, daughters felt a need to discuss these topics with their mother (Pavlish, Noor, and Brandt, 2010). This communication gap could potentially lead to unsafe reproductive decisions, which could harm adolescents' health, that otherwise could have been prevented with proper education.

2.5 CONSUMER PARTICIPATION IN PLANNING PROGRAMS

Consumer participation in planning health programs can happen individually or collectively, either at the individual level or at the community or group level (Lee, Thompson, and Amorin-Woods, 2009). Ideally, consumers assess their own health needs and problems, plan and implement solutions, create and maintain processes. International evidence suggests that when people are involved in health projects and services, there is greater likelihood of success, with improvements in psychosocial well-being, knowledge, mastery, coping and control (Lee, Thompson, and Amorin-Woods, 2009). Opportunities to learn more about health, to establish relationships between clients and service providers, greater dissemination of health information, greater use of community resources, and in some cases better future employment prospects for individuals are among some of the benefits of consumer involvement in participating in health programs (Lee, Thompson, and Amorin-Woods, 2009).

Although the benefits encompass multiple indicators of success, consumer involvement is not often utilized because of various reasons, including the challenge of working with culturally and linguistically diverse groups (Lee, Thompson, and Amorin-Woods, 2009). Increased cultural awareness among health care providers can impact the economic and social disadvantages affecting refugees. Factors such as understanding the complexities of a new healthcare system, distrust of government services, lack of awareness of services, and poor understanding of how to access regular health care can contribute to a greater burden of illness amongst refugee groups and to health inequalities (Lee, Thompson, and Amorin-Woods, 2009). Awareness of these critical factors among health care providers need to be set in place for consumer participation to be successful.

2.5.1 Barriers to Participation

Barriers for refugees to participate in health programs can include financial constraints, family events, lack of transportation and childcare, as well as not being comfortable speaking the host country's language. A study conducted by Guerin, Diiriye, Corrigan, and Guerin (2003) identified lack of transportation, cultural or religious reasons, and taking care of family/children as the most cited reasons for not attending programs. Cultural factors can also influence the ways that individuals and communities participate in health services and programs (Lee, Thompson, and Amorin-Woods, 2009). McMichael and Manderson (2004) found that gossip and fear of betrayal prevented women from sharing personal information with each other and establishing the level of intimacy that allows for the exchange of information, goods, and services. Group members might be criticized within their communities for talking about sensitive topics such as alcohol and other drug use and experiences within their community to service providers and public rather than dealing with drugs issues in a private matter (Lee, Thompson, and Amorin-Woods, 2009).

Financial and transportation constraints undermine women's ability to maintain social ties and a sense of community, leaving women feeling trapped in their homes without a reason to leave (McMichael and Manderson, 2004). They are lonely because they are not involved in activities and roles that offer special interaction, and parenting troubles emerge as children are drawn into a new cultural world (McMichael and Manderson, 2004).

Social events, religious gatherings, and celebrations play an important role in women's lives promoting interaction, shared time, a sense of well-being, and decreased loneliness. These gatherings support the continuance of Somali culture, community life, and hospitality

(McMichael and Manderson, 2004). These social interactions can relieve the sense of loneliness of a female Somali refugee (McMichael and Manderson, 2004). Another barrier to participation in health programs is the constant stream of marriages, engagement parties, women's gatherings, and religious events.

2.5.1.1 Language as a Barrier

Not speaking the language of the dominant culture or host country may involve separation and create long-term acculturation stress (Iglesias et al., 2003). Groups that confronted a cultural barrier, a new language, social devaluation and a lack of social support had increased morbidity (Iglesias et al., 2003). A woman who does not speak the language of the host country and lacks employment is less likely to benefit from the health system and learn about health services that are available (Adanu and Johnson, 2009).

Language barriers can inhibit communication of ideas as well as necessary information when speaking with a health care provider both in a formal and informal setting. In a study by Lee, Thompson, and Amorin-Woods (2009), good command of English was important for participants to communicate their ideas and opinions and so that staff could communicate information about the agency and its programs to women in the group. Some women felt their English was poor and were uncomfortable asking questions and sharing their ideas (Lee, Thompson, and Amorin-Woods, 2009). In a health care setting, language differences between patients and their providers created communication barriers that increased the risk of medical errors, non-adherence to treatment, and ultimately leading to poor health outcomes (Pavlish, Noor, and Brandt, 2010).

2.6 SOMALI BANTU RESETTLEMENT IN PITTSBURGH

Approximately 14,000 Somali refugees entered the U.S. during a resettlement program sponsored by the US government in 2003 (Upvall, Mohammed, and Dodge, 2009). In 2004, Catholic Charities began to move 184 Somali Bantus to the mid-size city (350,000) of Pittsburgh, PA over a period of 18 months (Conte, 2005). By 2005, 180 Somali refugees, almost 75% under the age of five, had arrived in Pittsburgh (Upvall, Mohammed, and Dodge, 2009). When these refugees arrived in Pittsburgh they were given a three-month rent-free apartment furnished with donated household supplies, furniture, clothes, and food. The expectation and mode of living in the U.S. by these refugees differed greatly from their previous 12 years in Kenyan refugee camps, after escaping clan warfare and then the Somali civil war in the early 1990s (Upvall, Mohammed, and Dodge, 2009).

2.7 HEALTHY GIRLS CIRCLE

In 2007, Magee Women International (MWI) received funding from the Jewish Women's Foundation to work with the Somali Bantu high school girls to hold 10 Healthy Girl/Healthy Families (HGHF) sessions. These sessions included topics ranging from nutrition to reproductive health. According to the feedback received via evaluations, the program provided the girls with a sense of empowerment, control, and freedom. Through the evaluations, planning for post-secondary school options was deemed important to the girls to learn more about. In 2009, MWI received funding from the FISA Foundation to hold 20 Healthy Girls Circle (HGC) sessions to

enhance the HGHF program and focus on wellness and post-secondary school options. A total of 17 females participated in HGC 2010.

Healthy Girls Circle (HGC) based at Magee Womens Hospital in Pittsburgh, Pennsylvania, was designed as an experiential learning process to empower Somali Bantu teen girls and young women by developing their leadership skills and increasing their knowledge of health and wellness. HGC provides an environment for girls and young women that is safe, supportive, and provides opportunities for personal, professional, and educational growth.

HGC 2010, with the support of the FISA Foundation and the Jewish Women's Foundation continued to work with an estimated 12 Somali high school girls and seven recent graduates, almost all of whom were born and raised in the refugee camps of Kenya. Most of these young women are the eldest or near eldest in their families and held multiple responsibilities compared to their American counterparts, including child care, looking for housing, health and public/social services for their family, food preparation and shopping, and general household management.

The overall objectives for HGC 2010 included: 1). Encouraging the girls to share health information with elder women; 2). Strengthening awareness and develop practical skills surrounding health care and self-care; and 3). Enhancing preparation for studies and careers. Many of the programmatic decisions were made and driven by the consensus of the participants. For example, in deciding which topics to focus on throughout the year, participants had the opportunity to give input about topics. Among their top choices were exercise, nutrition, and sexual health. The program met monthly at Magee Womens Hospital of UPMC.

The goals of the meetings were to introduce new topics and increase health knowledge and leadership skills of the participants. Strategies comprised use of guest speakers, videos, and

both interactive and hands-on activities. The topics covered included teaching strategies, exercise, healthy eating habits, hygiene, and personal and career development. In addition, participants were coached on how to share their knowledge with their peers and family members. By the end of each meeting, the participants had developed a comfort level of sharing the information with others.

3.0 METHODS

Research Design

This project was designed as a program improvement and evaluation using open-ended interviews to collect information on the perspectives of the participants in HGC. The interview questions used were developed by the PI and approved by the project coordinator of HGC. The answers gathered during the interviews were then used to conduct a secondary data analysis for this project.

Data Collection

Interviews were planned by the PI with participants of HGC to obtain comprehensive and qualitative feedback about the program. The interview questions (see Appendix A) focused on what the participants liked and disliked about the program, the participants' motivations for and barriers to attending the program, knowledge and skills gained, as well as any suggestions they had to improve the program. Participants were given a $5.00 gift card if they agreed to provide feedback about the program in an interview for evaluation purposes. Interviews were conducted before and after the scheduled HGC sessions. An interview with the Project Coordinator of Healthy Girls Circle was also planned to gain a perspective of her personal assessment of how the program has evolved since its inception, any modifications of the program, reasons for the modifications, and how the program dealt with culturally taboo topics. In addition, gauging the

level of comfort and behavioral changes that have been observed over time was also discussed with the project coordinator.

Research Analysis

A secondary data analysis was conducted after all the interviews were transcribed to gain a deeper understanding of the perspectives of the Somali Bantu refugees participating in HGC. Commonly recurring themes were identified including motivations, barriers, knowledge gained, and additional topics they wanted to learn in future sessions. This study submitted a protocol and received exempt ethical approval from the University of Pittsburgh's Institutional Review Board (IRB) in Pittsburgh, PA.

Interviews with the HGC participants were recorded and transcribed by the PI. Through systematic and line-by-line reading of each interview transcript, themes and sub-themes were identified in the data. Definitions of themes and sub-themes were established (see Appendix A) utilizing the language and words of the participants during the interviews. Additional in-depth interviews were planned with three to five participants to focus on the thoughts and perceptions of the girls and young women regarding health, the differences in their health before and after entering the United States, how their health differs from that of their elders, and any struggles they encounter when changing health behaviors. At the time of the grant renewal, the program did not receive additional funds and therefore, the second set of interviews did not take place.

4.0 RESULTS

The PI of this project conducted interviews with ten HGC participants and HGC'S Project Coordinator. Interviews with the participants ranged from eight to 15 minutes in length; they were recorded with the permission of the participants and transcribed. Interviews with both the Project Coordinator and the participants provided perspectives on successes, knowledge gained, motivational factors that contributed to their attendance, and the challenges that have been overcome in the process of conducting the various meetings and sessions.

4.1 PROJECT COORDINATOR INTERVIEW

The PI conducted an interview (see Appendix C) with HGC's Project Coordinator to gain a deeper understanding from someone who had worked with the participants since the inception of HGC in 2007. Development of the program and topics covered were determined by a needs assessment conducted by the project coordinator with the participants of HGC, involvement of the teen girls and young women, as well as evaluation forms completed at each meeting by the participants. Prioritization of topics was determined by posting paper on the walls of the room where the sessions took place, on sheets of paper posted on the walls asking that each individual write down the topics on which she wanted more information. This allowed the program to be

driven by the participants and provided them with a sense of ownership. The program prides itself on functioning by the utilization of the active role the participants play in decision-making and creating a program that is for them and by them. Sexual health was the topic chosen by the majority of the group on which to focus; however, after follow-up sessions, the participants expressed discomfort with the topic, so the program topics shifted to exercise, nutrition, and hygiene. The program prides itself on functioning by the utilization of the active role the participants play in decision-making and creating a program that is for them and by them.

According to the Project Coordinator of HGC, other challenges arose during the implementation of the program such as the language spoken in the sessions. Within the group, two dialects from Somalia were spoken among the participants as well as English. The variation in language oftentimes made it difficult for the participants to stay focused. Moreover, they would speak in their dialects when others were speaking, which distracted other participants. Frequently, many of the teen girls and young women had not seen one another since the last session so they would spend some of the time catching up rather than paying attention to the information being discussed. In order to maintain a sense of focus, English was established as the only language to be spoken during the meetings.

4.1.1 Motivational Factors

According to the Project Coordinator, motivation for participation varied across participants; however, many of the reasons were similar. The Project Coordinator cited the desire to get out of the house and have the opportunity to mingle with other Somali females in a safe setting as the primary motivation for the participants to attend HGC activities. The all-female setting is unique

and provided social support that allowed for open communication that is not typical when males are present.

Social Support and Safety

The social support experienced at HGC reinforced potential for achievement of educational, career and economic goals. Within the safe setting of the meetings, participants discussed developing and maintaining healthy relationships with their partners, and various contraceptive methods that typically were not utilized or viewed as an option. Willingness to work hard to achieve the "American Dream" was evident as the participants demonstrated their desire to learn a new language, attend secondary education, and prepare themselves for successful careers in various fields.

4.1.2 Knowledge and Skills Gained

According to the Project Coordinator, some of the observed attitude and behavior changes from the inception of the program to its end range from increased sense of self and increased comfort level using public transportation to awareness of the importance of taking care of one's health. Before participating in the program, having an active role in decision making and providing their opinion was a rare occurrence.

Exercise and Nutrition

Utilizing the strategy to actively involve the participants in the development of the program has benefits both for the amount of participation and dedication to the program as well as the healthier changes that have been observed. For instance, the program provided the

participants with pedometers in an effort to promote and increase physical activity. The girls and young women decided to create a competition among them to compare who walked the furthest.

Moreover, along with an increase in physical activity, selecting healthier food options has also increased. For example, on a recent ice skating trip, the teen girls and young women preferred water to soda and juice that were available. Following a session on healthy eating and nutrition, the teen girls and young women had the opportunity to apply what they learned by taking a trip to the Magee Womens Hospital cafeteria for lunch. To the pleasant surprise of the Project Coordinator, they selected foods they had learned were healthy and even tried new foods. This demonstrated their willingness to use what they had just learned and expand their palate to healthier food choices. These behaviors and attitudes have spread far beyond just the participants; family members within the households have also made healthier changes in their lives. Participants have shared in various sessions that their selection of foods bought at the grocery store has become healthier; preparation of meals has also changed. Other life choices aside from exercise and nutrition have continued to develop and change while attending HGC.

Leadership Development

Increasing leadership skills, encouraging personal and professional growth development, and providing awareness of healthier lifestyle options have been the main scope of the program. Along with the goals set forth, interest in higher education has also been expressed throughout the time that the teen girls and young women have attended. For a number of the participants, this interest in higher education became a reality when they began attending college. Some of the younger participants, who are engaged to be married, have made the decision to postpone

marriage until after high school graduation as some of them would like to take advantage of the college funding option through Pittsburgh Promise[1] and pursue a college degree.

From the perspective of the Program Coordinator, HGC has served not only as a conduit to promote healthy lifestyles and develop leadership skills, but has also been successful in implementing a project, working as a team, and identifying and learning about important health topics. The teen girls and young women have continued to fine tune and pursue personal educational and career goals, and have reflected on the meaning and importance of healthy lifestyles. They have also demonstrated through personal actions their willingness to play a leadership role in their community's health education and improvement.

4.1.3 Barriers to Attendance

The program faced challenges that were not language related; some related to fitting the program into and sometimes competing with the busy and complex lives of the participants. As per the Project Coordinator, the teen girls and young women have multiple responsibilities at home; the participants' priorities to maintain household duties and babysit their younger siblings often impeded their ability to attend various HGC meetings and activities. For some of the participants who lived in the same household, alternating weeks between the two of them was the only option for both to attend at least some of the sessions. This was an ongoing challenge throughout the

[1] The Pittsburgh Promise is essentially three promises in one. The following is promised to those who live in the City of Pittsburgh and attend Pittsburgh Public Schools: 1. Provide students with up to $40,000 as a scholarship to pursue higher education. 2. Reform urban public schools to prepare students for success in higher education, and 3. Develop urban neighborhoods so students live and go to school in a place that is conducive to learning.

program; however, even with the multitude of responsibilities at home, school, and within the community attending HGC was a priority in their busy lives.

4.2 PARTICIPANT INTERVIEWS

The PI conducted interviews (see Appendix A) with 10 of the teen girls and young women who participated in HGC. Qualitative interviews provided general information about the participants of HGC and their perspectives on the program. Since the inception of HGC activities in 2007, six of the ten participants have been attending meetings since the program commenced; two of the participants have been attending for two to three years, and two have been attending for less than a year (see Appendix D).

The target population for HGC is high school and college aged Somali refugee females. Six of the ten interviewees attend high school, two attend college, one did not finish school, and one is not in school (see Appendix D). All of the participants currently in high school plan to go to college. Their career aspirations included attending medical school to become either a doctor or a physician's assistant, becoming a teacher, social worker, or nurse (see Appendix D). The two students who are currently in college are studying accounting and nursing. The major themes that emerged from the interviews included motivational factors, knowledge/skills gained, and barriers preventing participants from attending HGC meetings.

4.2.1 Motivational Factors

Motivation is the driving force that helps us achieve goals. For the participants, reasons to attend HGC sessions varied; however, very similar responses were provided when asked why they attend HGC activities. Motivational factors to attend HGC can be broken into two categories: social support and safety, and intentions to help others.

Social Support and Safety

Social support from others and feeling safe to share information, thoughts, and ideas were among the main reasons to attend. Below are some responses to the interview question asking what their motivations were to attend HGC:

> I come here for learning about healthy, [sic] what should we do, what we should not do, and I like being around my friends. (Participant 4)
>
> I come because it's like really helpful for our healthy [sic] and other things you do yourself and with friends. You get to learn new things and I like this program a lot. (Participant 6)
>
> When I come here I feel safe, like, people like me, people just like me for who I am. (Participant 9)

Participant 10 shares a similar sentiment as voiced in her statement:

> It's a safe place where you can express yourself and get knowledge at the same time. These days it's very rare…I can be with my friends, cousins, and people that I like. It's a place that you can express yourself and get very good education.

The participants enjoy visiting with their friends whom they do not see very often, and this time allows them to build upon their relationships. When asked about her favorite aspect of HGC Participant 6 stated:

> The most things that I enjoyed was meeting my friends. I don't get to see them for two months, three months so whenever we have this program we get to see each other like every two weeks, every three weeks.

With an all-female group, some of the interviewees felt that they could share information they otherwise would not be able to in the presence of their male counterparts. Participant 7 stated: "It's a fun program and it's all females so we can say whatever we want to say without worrying if boys are there." In addition to feeling motivated to attend HGC because of the social support and safety net to express themselves, the participants also enjoyed learning new things to help others.

Intentions to Help Others

Some of the participants expressed how helpful the HGC meetings were in providing new information that helped not only them, but also their families. Knowledge about diet and exercise helped these girls and their families to start eating better and increase physical activity in order to manage the diabetes that is prevalent among their family members. Participant 1 stated:

> An example is like our parents don't speak English, so they don't really know how to take their medications, they don't really know what to do, they just do what they feel like. So we learned a lot of things about that and to help them take the right amount and care for them…the most I enjoyed is this year 'cause it was a lot of things that it can help family and friends so I enjoyed that.

Another interview question asked about how the girls planned to utilize the information and knowledge gained in HGC in different aspects of their lives and within their communities. Below are some of the participants' responses:

> Well, I was able to tell my friend that she was kind of getting overweight and she needed to start eating healthy and she very much agreed with me and I was able to provide information she needed to take the first steps to improving her health. (Participant 10)

> I will, like, tell them [community members] like, what to do, and what they should be eating and the steps and they should be exercising more 'cause they just

> say, I'm a parent, I will just sit at home and watch my child, but maybe you can take a walk to the park with your child. That would be good rather than sitting in a house. (Participant 1)

Social support and safety were the most reported motivational factors followed by intending to help others with the information they had received. Some of the most enjoyable aspects of the program were the application of the knowledge for their family and friends.

4.2.2 Knowledge and Skills Gained

Various topics were discussed during the HGC meetings. Some of the most memorable and useful topics reported by the participants were exercise, nutrition, sexual health, and job preparation. Not only was an increase of knowledge reported but also an increase in utilization of the acquired knowledge. Participant 10 reports: "I am able to take better care of my body and my spirit and my self-esteem by coming to this place because it is very powerful." Overall, the participants found the various topics they learned about to be useful and pertinent to them and their lives.

Nutrition and Exercise

Participants were asked if their knowledge about the importance of nutrition and exercise had increased since participating in HGC; all of the teen girls and young women reported that their knowledge had increased in some way. Some started making healthier food choices, and others increased physical activity. When asked if her knowledge had increased since attending HGC, Participant 9 stated:

> For the nutrition I used to, like, eat fried chicken a lot and then when I came here they told me it wasn't good for me and I to tell [sic] my folks that maybe fried chicken is not good food, things, good food for us to eat, maybe we need to change the way we eat and they understand it and we are changed the way we are

> eating. And with the exercising, I used to exercise but not every day, but now I came here they tell me that maybe it is good to exercise every day if you have the time and I am trying and it helps me with everything. I don't feel tired anymore. I used to, when I was sleeping and I would get up, I would be sleepy and sick and my body would hurt but now I sleep well, I eat good food, I eat good breakfast, good dinner, and I wake up in the morning, like, oh my god, I don't even feel like I slept. I don't know why. It helps me with a lot. When I come here the nutrition and the exercise helps me a lot.

Participants were also asked in what ways the knowledge gained in the meetings had led to an increase or change skills since participating in HGC:

> I think that I am doing the right things, eat right, sleep right, eat healthy food. Not junk food. I don't eat candy anymore. I don't. I mean, I love them but I don't eat them anymore. (Participant 9)

> Yes, about eating. I have to choose when I go to the store, I have to look what they have, like vitamin percentage, all that kind, and I have to check and also I eat a lot of fruits and vegetables. (Participant 6)

Participant 1 also gave a similar response about her knowledge gained, stating:

> My knowledge increased in exercise. 'Cause before I used to stay home and do nothing in the summer time, just sleep and hang out all the house [sic]. But this time, I went out myself to get a job and it has given me a lot of the exercise I need. I would just go to the store and buy whatever I need and eating it, like too much candy, nothing. But now I stopped it. I decided to drink tea instead of too much food and maybe drink water and like exercise more.

Exercise and nutrition were popular topics about which the participants felt they learned new things and translated their knowledge into action.

Sexual Health

Sexual health was the first topic that was discussed in HGC because the participants identified this topic as the most important to them. In later sessions, some of the participants reported through pre- and post-tests that sexual health was a very sensitive subject and they did

not feel comfortable talking about it with their elders. However, some participants thought this topic was very important to learn about, as Participant 6 stated:

> Well, I enjoyed the new things we learn, like I didn't know STD would affect, like, that much, like, the different kinds of STDs, and I knew about HIV but I didn't know, like, how you could get HIV and knew a few of them but not a lot of them.

Others already were aware of different sexually transmitted diseases (STDs), but they learned how to prevent them, like Participant 7:

> Like I realized I a lot of stuff and not only did I know a lot of stuff from it [sic]. I also know people how to prevent STDs and how to stay healthy and not do anything that could hurt them.

The level of knowledge about sexual health varied from participant to participant; however, the information taught in the sexual health session of HGC provided enough information for everyone to learn something new.

Leadership Development/Job Preparation

Many of the participants thought the information they were learning in HGC was going to help them and others not only in regards to their lives today, but also help them in the future. Participant 1 stated: "It's helpful and it teaches us a lot of different things that we didn't know and things that can help us in the future or right now." Some of the participants were better qualified for employment positions for which they applied because of training they received in HGC. For example, Participant 5 reported:

> I enjoy the most the CPR class because I had to take it for a job that I applied for. Now they tell me I have to get a CPR class…but I just get the CPR right here.

An interview question asked about the ways they learned new information. Most reported it was through auditory methods, but one participant was enthused to learn new material in any form because she knew she would learn something valuable:

> Yeah, because you writing, I learn more. You talking, I learn more. When I look I learn more. When I'm doing, I learn more. Anyways, I learn more, even the doctors ask me the same question I learn more. (Participant 9)

4.2.3 Barriers to Attendance

Although the teen girls and young women enjoyed participating in HGC, barriers existed that prevented them from attending various sessions (see Appendix B). These barriers included household responsibilities, babysitting, attending family events, weddings and funerals. Below are some responses from the participants when asked what some of the reasons were that prevented them from attending HGC sessions:

> If I didn't come, maybe busy with my children or something is going on with my family that whenever I miss that for. I missed a couple times, I didn't come. (Participant 5)

> Well, it was because of work, going to school, I mean I had a class at the time I came here, the time like Saturday we had a program that I used to take and so I had to meet with some of my classmates every Saturday and I also had to work. There was two, three Saturdays that I had to be at work to six o'clock in the morning. (Participant 6)

Participants 8 and 9 also experienced similar barriers to attendance:

> Sometimes parents are going somewhere so you have to take care of the kids so yeah, if you a lot of you guys are coming here, someone has got to stay home. (Participant 8)

> There are a lot of stuff I need to take care of at home, a WIC appointment on Saturday, maybe I have an appointment on Saturday, dentist, family funeral, someone passed away, there are a lot of reasons that you may not come. I always have to have a reason and if I don't have a reason I have to come here. I have to. Sometimes there is no way, you can't make it, maybe you need to do laundry, or some laundry mats may close at noon on Saturday. There are a lot of reasons why you can't come. It's not because you don't want to. (Participant 9)

Interviews concluded by asking the participants if they had anything important to add that was not discussed during the interview. Many did not have anything to add. This was not the case for Participant 3, who said: “I just want to say thank you to the project coordinator and you for helping us to stay healthy and to tell us the right things that will help us in our futures.” One of the participants was thrilled about the program and thought very highly of the impact it had on teen girls and young women, stating:

> I think that Healthy Girls Circle should never be…never go away because it really helps teens understand what they are going through and I think that Healthy Girls Circle should be an everlasting program. (Participant 10)

5.0 DISCUSSION

Refugees face an array of challenges when adapting to a new country: separation from family and friends, unemployment, a lack of proficiency in English, and having lived previously in conflict regions. The challenges they encounter as a result of migration compromise their health, that of their families, and of the overall community. As studies have shown, women are characteristically sole caretakers of children in times of relocation.

The participants in this study expressed their key role in babysitting and looking after either their children or their younger siblings. In fact, this vital responsibility to the family unit to prevented the teen girls and young women from attending HGC. This barrier inhibiting attendance to healthy programs aligns with barriers cited in the literature. The stress of caregiving can take a toll on the participants who often discussed how they would take turns with their siblings (depending on their age) about who would attend HGC and who would stay home and take care of the children. Those participants who had children would discuss arrangements that would need to be made with their mothers or sisters so they could attend. For one participant, she felt very lucky to have a husband who would take care of the children while she attended since men typically do not serve that role. Other barriers identified both in this study and in the literature include school and work responsibilities as well as various cultural and

family events. The participants in HGC have a variety of responsibilities that include attending school, serving as a translator for their families, babysitting, and working.

Family events are an example of the importance of social support within this unique and close-knit Somali Bantu community. Participation in family groups and social networks can benefit the health and well-being and have the potential to reduce negative health effects of life events (McMichael & Manderson, 2004). Participating in this program provided them with an opportunity to see their friends, build trust within the group, and build their social support. Involvement in this program also allowed the females to feel safe to discuss topics they would not typically discuss because of the presence of males and the taboo nature of some of the topics.

Reproductive health, specifically sexually health and contraception, is considered to be a taboo topic among Somali women so people do not talk about such sensitive and private matters. Somali mothers feel perplexed about the manner in which to talk to their daughters about sex, and reproductive health; however, daughters felt a need to discuss these topics with their mother (Pavlish, Noor, and Brandt, 2010). In this study conducted with participants of HGC, sexual health rated highest when the teens and young women voted for their preference of topics to cover in HGC, but still they decided against pursuing it in later sessions. The communication gap that exists between mothers and daughters could potentially lead to unsafe reproductive decisions. Through education received in programs such as HGC, the teens and young women are able to make comprehensive and informative decisions regarding their health.

Some research cites the importance of involving consumers/participants in health program planning because of the greater likelihood of program success. The participants in this study were aware of their everyday realities and needs to live a healthier life. This heightened awareness of their needs aided the decision-making process for topics to be covered. The

Program Coordinator requested that each participant write down her top three choices on butcher paper hung around the room for topics to be covered. Although sexual health was the top voted topic to be covered, evaluations following that particular session revealed a discomfort among the participants to discuss this topic with their elders. The focus of HGC switched to less sensitive topics including exercise and nutrition. Since the participants did not feel comfortable talking with their elders about topics surrounding sexual health, one of the goals of HGC set forth was not accomplished; however, many of the teens and young women in the study changed their lifestyle by eating healthier and increasing physical activity.

The information learned at HGC translated to changes in their homes and among family members and friends, who also chose healthier options when grocery shopping, preparing healthy meal choices, and exercising. In essence, by allowing the participants to actively participate in the program planning process, success was evident to the participants and spread throughout their families and community. Sexual health, due to its taboo nature in this community, was the exception to the success of the program despite the desire of the participants to learn about; however, the desire was not translated to levels of comfort to teach others.

Although the participants did not feel comfortable speaking to their elders about sexual health, they were still very interested to learn more about the topic for personal reasons. For example, the Project Coordinator was approached by one of the participants who was getting married inquiring about what to expect the first night with her husband. The participant shared with the Project Coordinator that the men take the role in explaining everything to the women and they are to remain in solitude with one another for several days in hopes to become pregnant. According to some of the participants, the familial and cultural pressure to have the first child within the first year of marriage is high, leaving some anxious about getting married because of

their plans to attend college. This oftentimes places them in a struggle between their culture and the lives they live and opportunities available in the U.S.

Overall, the participants enjoyed all the aspects of HGC and would not change anything about the program. In a study conducted by Guerin et al. (2004), Somali women participating in exercise sessions enjoyed the sessions and 75% reported “nothing” when asked what they liked least about their memberships. Exercising in an all-women’s facility was important to the women so they feel culturally “safe,” not only for themselves, but for the integrity of the community (Guerin, Diiriye, Corrigan, and Guerin, 2003). In the same study, facilities required a place for the women to dress appropriately for exercise without fear of men coming into the center and or looking into the center. The participants of HGC also expressed their feelings of safety to share their thoughts and ideas without fear of males being present. Although HGC is not designed as a gym membership, it is evident both in the literature and in this study the importance of creating a culturally safe space.

6.0 CONCLUSION

Somalia is a country that has been in upheaval since a civil war broke out in 1991, causing much of its population to flee and migrate to the United States. Migration following homeland violence and war results in a myriad of difficulties and negative health consequences. Refugees face a variety of challenges when adapting to a new country, many of which compromising their mental and physical health. Some of these challenges stem from unemployment, separation from family, a lack of proficiency in English, and living previously in conflict regions. The resettling of these refugees has required major adjustments and disruption in familial and social networks.

Somali Bantu refugees, the majority of whom are women and children, continue to enter the U.S. from refugee camps in Kenya and struggle to learn a new way of life. Optimal health for women is important because of the many responsibilities they bear as the sole caretaker for their children. Examining immigrant women's health experiences is important since women play a vital role in advancing their own needs for maintaining good health, as well as addressing the health care needs of their families.

The likelihood of psychological and physical stress manifesting in the lives of refugees who have lost loved ones due to war and resettling in another country is quite high; however, social support has served as a positive reinforcement to benefit one's well-being. Mental health services may not feasible for refugees to access because of the cultural disconnect, language

barriers, social stigmas, financial constraints, and fear. Social support is known to act as a buffer against adverse effects of stress and trauma. Health programs are great avenues to increase the opportunities for populations such as refugees to build upon their social ties.

Consumer participation in health programs has shown to benefit participants who are involved in the planning process as well as the overall programmatic goal achievements. Consumers who assess their own health needs, and plan and implement solutions are more likely to increase knowledge, mastery, and control in health programs. Although a health program coordinator and consumers can collaborate to identify and meet the needs, barriers exist that inhibit consumer participation.

In conducting this study, motivational factors that contributed to interest in participating in program sessions included social support, and helping others. A desire to gain knowledge and skills regarding exercise, nutrition and job preparation were also identified. Barriers to attending the HGC sessions involved such things as familial, work, and school responsibilities. All were identified and further explored. This study fills the gap in current research by exploring motivational factors for young refugee women to attend health programs, allowing for future programs to limit barriers for prospective participants.

Limitations

As with every study, this one has limitations. Language posed some challenges, including the lack of translators to clarify any words or statements that needed interpretation for the participants. This was evident during interviewing when questions had to be repeated in multiple ways. The need to ask questions to clarify what was being asked could also be attributed to the level of technical use of language rather than the use of layman terms.

In addition to language, the small sample size was a limitation to this study. The study is specific to the Somali Bantu refugee population residing in Pittsburgh, Pennsylvania, and therefore, information about the perspectives and lives of the participants in HGC cannot be generalized to other refugee populations. The length of the interviews was short in duration and some did not provide in-depth information about the lives and experiences of the participants. Moreover, interviews were conducted before and after already scheduled HGC sessions therefore, some of the answers may have been rushed and not completely thought through. Finally, social desirability may have played a role in the answers provided to the PI of this study. Participants may have highlighted only positive experiences and behavior changes in efforts to give the interviewer answers they thought she wanted to hear.

Recommendations

Recommendations from this experience and the research conducted can help to develop or enhance existing programs working with female refugee populations in order to improve programmatic objectives as well as better understand the needs of the participants. They include:

- Allowing time in the beginning of each session for socialization among participants so they are not distracted during a session and can focus on the information being provided.
- Incorporating parents/mothers in some of the programs in order to gain some of the same knowledge and insight learned by the young women participants. This would enhance the content of the information and possibly provide a setting to implement healthier lifestyles in the home.
- Involving non-English speaking mothers or other female elders.

- Having translators hired to ensure everyone is receiving all the correct information and allow for the elders to inquire further about the material covered. Working towards providing quality interpretation services would vastly improve trust and outcomes.
- Educating those working with and treating this population regarding the social and economic impact of resettling.
- Early intervention and treatment with a multidisciplinary approach, as well as the rise in awareness and education about risk factors are warranted.
- Incorporating sensitive topics such as sexual health when planning for a health program should be incorporated in the later sessions of the curriculum. Beginning with more subtle topics such as exercise and nutrition may increase the likelihood of program goals to be accomplished.
- Incorporating a session in the leadership component in the program that focuses on résumé and Curriculum Vitae (CV) building in order to teach young women about the importance of displaying a high level of professionalism when applying for jobs and education beyond high school.
- Measuring outcomes to evaluate the success of the program such as changes in nutrition and physical activity as well as the delay of marriage and pregnancy.
- Developing approaches to address health approaches that are both culturally and religiously sensitive to those who are involved with these groups such as: healthcare providers, sponsors, educators, policy makers, and other professionals.
- Providing health care to refugees to ensure they receive the necessary care they need to be healthy.

Reaching out to the Somali Bantu female refugees and taking a holistic approach in addressing their health care and leadership needs is important for them and their families. The importance of their role in their health and the health of other around them, was evident when working with the participants in HGC, who took the knowledge and skills they gained to their families in hopes to better their lives by eating healthier and exercising more. Developing appropriate programs and increasing education among refugee women can ultimately play an integral and important part in creating a healthier society for all.

APPENDIX A

PROGRAM EVALUATION INTERVIEW QUESTIONS

Introductory Script: Hello. Thank you for taking the time to help us understand your perspective and thoughts about your participation in the Healthy Girls Circle. The purpose of this interview is to help us improve the program. Your answers will remain confidential. If you don't feel like answering any of these questions, please feel free to let me know.

1. Are you a student?
    a. What school do you attend?
    b. If in high school:
        i. What grade are you in?
        ii. What are your plans after graduation?
    c. If in secondary education:
        i. What is your major?
2. When did you start attending HGC activities?
3. What aspects of HGC have you enjoyed *most* since being involved with this program?
4. What aspects of HGC have you enjoyed *least* since being involved with this program?
5. Do you think the various presenters provided information in a clear and concise way that helped you understand the information?
    a. If not, do you have any suggestions to improve the delivery of new information?
6. We discussed various topics thus far in the program, such as teaching strategies, public speaking, nutrition, exercise, and sexual health. From these topics:

a. Has your knowledge increased?
    i. If so, how?
    ii. If not, do you have any suggestions that may have helped increase your knowledge?
b. Have your skills increased?
    i. If so, how?
    ii. If not, do you have any suggestion that may have helped increase your skills?

7. How do you plan to use your experiences and skills?
8. How has participation in HGC helped in any areas of your life?
9. How do plan to use your experiences and skills learned in HGC in your community?
10. How have your teaching sessions with your elders gone?
    a. If you have not conducted a teaching session, why not?
11. What are some of your motivations to attend HGC?
12. What some reasons that prevented you from attending HGC sessions?
13. How do you think we could improve the program?
14. Would you recommend HGC or a program similar to HGC to someone else?
15. Are there any other comments about anything that we discussed, or anything that we have not had a chance to talk about that you think it is important to add?

Conclusion: Thank you for participating in this component of the evaluation for Healthy Girls Circle. Please contact Ebony Hughes or Stefanie Vigil if you have any questions.

APPENDIX B

TABLE 1. IDENTIFIED THEMES AND SUB-THEMES

Theme	Sub-Themes	Definition
1. Motivational Factors		Reasons to attend HGC without a monetary incentive.
	1.1 Social Support	Participant enjoys seeing her friends.
	1.2 Safety	Participant feels comfortable sharing thoughts, feelings, and ideas with others and without the presence of males.
	1.3 Helping Others	Participant takes what she learns at HGC and teaches family and friends.
2. Knowledge/Skills Gained		Knowledge and skills acquired at HGC
	2.1 Nutrition	Participant learns about healthy food choices and applies knowledge by eating healthier.
	2.2 Exercise	Participant learns new exercises and the importance of physical activity. Participant applies knowledge by increasing activity.
	2.3 Sexual Health	Participant learns about STD'S, HIV, and how to prevent them.
	2.4 Leadership Development/ Job Relevancy	Participant learns topics that are applicable to prospective jobs.
3. Barriers from Participating		Barriers that prevented participants from attending a HGC meeting/session.
	3.1 Babysitting	Participant needed to take care of children or younger siblings.
	3.2 Family Events	Participant needed to attend weddings, funerals, or other cultural events.
	3.3 School/Work	Participants school/work schedule conflicted with HGC meetings.

APPENDIX C

INTERVIEW QUESTIONS - PROJECT COORDINATOR HEALTHY GIRLS CIRCLE

1. How long have you been apart of the Healthy Girls Circle (HGC)?
2. What were some of the ways you prepare to share information with the participants of HGC?
    a. How are the topics prioritized?
3. Have there been any modifications to the HGC curriculum since you started the program?
4. What are some of the challenges you have faced in the program?
    a. How have you overcome them?
    b. Are there still some that you are still working on?
5. Have the behaviors or attitudes of the participants in HGC changed since the beginning of the program?
    a. What are some of the changes you have seen?
    b. What are some changes you hope to see in the future?
6. Are there culturally taboo topics that have been discussed in the program?
    a. What are they?
    b. How did you discuss them to ensure comfort in the audience?
7. Are there any participants that you think could assist me further in discussing their perspectives of health?

APPENDIX D

TABLE 2. SAMPLE DEMOGRAPHICS FOR QUALITATIVE INTERVIEWS

Characteristics (N=10)	N (%)
Gender:	
Female	10 (100%)
Education:	
High School	6 (60%)
College	2 (20%)
Not In School	2 (20%)
Plans Following High School:	
Attend College	6 (60%)
Enrolled in College	2 (20%)
N/A (Participant not enrolled in High School)	2 (20%)
Desired Major in College:	
Accounting	1 (10%)
Medicine (Doctor, Physician Assistant, Nurse, etc.)	3 (30%)
Education	1 (10%)
Social Work	1 (10%)
Undecided	4 (40%)
Duration Attending Healthy Girls Circle:	
0 - 1 Year	2 (20%)
1 -2 Years	0 (0%)
2 -3 Years	2 (20%)
3 -4 Years	6 (60%)

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