

Understanding the health beliefs and practices of East African refugees

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Abstract

Objectives: This study explores East African refugees perceptions, ideas and beliefs about health and health care, as well as the ways in which health information is shared within their communities. **Methods:** This study consisted of two focus groups with a total of 15 participants, including East African community leaders and health professionals. **Results:** East African refugees in the US have strong cultural, religious and traditional health practices that shape their health behavior and influence their interactions with Western health care systems. **Conclusions:** Health care providers who understand refugees beliefs about health may achieve more compliance with refugee patients.

Keywords

East African refugees, health beliefs, health behavior, health education

Introduction and Background

In 2010 73,293 refugees resettled in the United States.¹ These refugees have often fled war and may have experienced war trauma or torture prior to or during flight and may have spent years in refugee camps where they face severe conditions including sexual violence, limited access to clean drinking water and adequate nutrition, disease and continued violence.² Consequently, refugees frequently arrive in the United States with physical or mental health symptoms.²

Despite the pressing need for health care, many barriers prevent refugees from accessing health care after arriving in the United States, including cultural differences, lengthy resettlement and acculturation periods, and lack of access to transportation, health insurance, or interpreters.^{3,4} While some refugees connect with health care services quickly, others may not find appropriate health care, potentially exacerbating symptoms or illnesses.²

In addition to barriers faced by refugees, some health care providers may not be aware of some of the culturally grounded health care practices and beliefs of refugees, making accessing health care more difficult.^{3,5} For example, in a qualitative study of

Hmong health beliefs, Johnson⁶ found that differences in medical terms, difficulty with translation or interpretation and misunderstanding of the Western biomedical system led to negative health care experiences and mistrust and fear of Western medicine. Some research has found, however, that refugees may be more compliant with treatment if it is adapted to fit their beliefs about health and health care.⁷ Refugees integration into Western health care clinics may be facilitated by adapting treatment to incorporate their health beliefs.

There are a growing number of health promotion efforts targeting immigrants and refugees such as encouraging cervical cancer screening among Asian American women.^{8,9} Researchers and public health professionals reporting on efforts to promote healthy behaviors among immigrant and refugee communities identify the importance of lay health workers. For instance Fang and colleagues found that including community members and community lay health workers in the design of cervical cancer screening education helped to identify and address barriers to health care and enhanced participation.⁸ Lam and colleagues found that while media campaigns helped to inform Vietnamese women about the importance of Pap tests, lay health workers were essential to encouraging women to actually receive the tests.⁹

East African Refugees

This study focuses specifically on East African refugees in Minneapolis, Minnesota. Like all refugees, refugees from East Africa, including Somalia, Ethiopia and Eritrea, have distinct experiences related to their socio-cultural history and distinct culturally grounded health beliefs. Somalia has lacked a central government for more than 20 years and as factions fight for power, Somali refugees have fled chaos, violence, torture and trauma.¹⁰ Oromos have been struggling for an Oromo homeland within Ethiopia for decades and have experienced brutal suppression at the hands of the Ethiopian government.¹¹ As a result of these conflicts, Oromos and Somalis have experienced high levels of war trauma including torture, rape and sexual violence, imprisonment, and physical violence.¹²

East African refugees arrive in the United States with culturally grounded beliefs about health, disease prevention, treatment for illness, and health care practices. These culturally grounded beliefs can be preventive. For example, in a study of 30 Somali refugees in New Zealand regarding mental health treatment Guerin and colleagues found that including readings from the Koran and enhancing family relationships increased treatment adherence.¹³ Carroll and colleagues found that spirituality and traditional health care practices were an integral part of Somali womens health care beliefs and values.¹⁴ Conversely, Guerin and colleagues found that Somali patients belief that mental illness only includes severe and untreatable diseases, limited the efficacy of mental health treatment at health clinics.¹³

Some scholars, community social service agencies, community medical clinics and others have described projects to address cultural barriers to accessing health care of East African immigrants and refugees. Palinkas and colleagues describe a program in San Diego that worked with East African refugees to improve confidence, comprehension and compliance with prevention practices.¹⁵ The authors emphasize the importance of community-provider relationships and blending refugee and Western explanatory models of disease and health in increasing refugee integration with Western health care. Likewise,

in a study of 34 African refugees in Australia, Sheikh-Mohammed et al. found that newly arrived refugees form strong connections with ethnic communities, which can provide an important milieu for the delivery of health education.⁴

While these studies of East African refugees give us some insights into their culturally grounded health beliefs about preventative health and health care practices, there is still a paucity of information regarding culturally grounded health care beliefs among East African refugees in the United States. This current study helps to fill this gap by exploring East African health care beliefs and practices that both encourage prevention and help in coping with illnesses among refugees in the United States, and exploring how East African refugees share health care information.

Methods

This study collected data using two focus groups with health care professionals that serve East African immigrants and East African community leaders in the spring of 2011 in Minneapolis. Focus groups can be a valuable strategy for collecting data in exploratory research studies, such as this study.¹⁶ The focus groups were part of a larger community based participatory research project exploring the social determinants of health and health disparities among East African immigrant communities. This research was approved by the University of Minnesota's Institutional Review Board.

Focus group participants were selected with the assistance of the projects community leadership group, which included community leadership within the Oromo, Eritrean, Ethiopian and Somali communities. This study purposively sampled key informants who were either health care providers serving predominantly East African refugees and immigrants or community leaders from within the East African communities. While this is not representative of the community as a whole, these participants were selected because of their unique familiarity with both Western health care systems and their respective ethnic communities, allowing them to provide perspectives not otherwise found in the larger community.

The focus group participants were recruited first by an email from the research coordinator and then a follow-up phone call. The first focus group had eight participants, all of whom were of East African descent. It consisted of six men and two women, and four health care professionals and four community leaders. The second focus group had seven participants, three who were of East African descent, two from other locales within Sub-Saharan Africa, and two of European descent. In the second group there were three women and four men, and all were health care professionals.

The two focus groups were conducted in a local community center and were conducted in English. All focus groups were co-facilitated by one member of the research team and one community member. Community members were trained in focus group facilitation by university faculty members. Using a structured interview guide with built-in probes, the participants were to discuss the following topics: aspects of the East African culture that encourage prevention of illnesses and promote health, aspects of East African culture that help people cope with an illness, associations within the East African community that address health and well-being, and how members of the East African community share information. The focus group lasted approximately 90 minutes. The focus groups were recorded and transcribed by a member of the research team. This is an

exploratory study and, following recommendations by Carlsen and Glenton, the authors chose to focus on obtaining thick description from a smaller number of participants and focus groups; this was also more manageable to community partners and allowed the study to be conducted within time and budget limitations.¹⁷

The written transcripts from the two focus groups were coded by two researchers using a thematic analysis technique. The data for each focus group were first coded using open-coding to develop a list of codes for each of three topics, prevention of illness, coping with illness and communication about health or health education. The focus groups were then reanalyzed using the code list. A single entry could have multiple codes, with codes assigned to text depending on separateness from other meaning. Like codes were then combined and themes were developed within three categories. Overarching themes and subthemes are presented in Table 1 below.

Table 1: Themes and Sub-themes

Prevention of Illness	Coping with Illness	Communication and Information Sharing
Cultural practices as both prevention and cure	Religion as coping	Orally and at social gatherings
Social gathering and social support as prevention	Social support as coping	Vouching
Traditional medicine as prevention	Traditional health practices as coping	

Results

Prevention of Illness

Traditional cultural practices from back home including religion and food both prevent illness and may cause illness. Participants reported that traditional practices from back home in Somalia, Ethiopia, and Eritrea both prevent as well as contribute to the development of illnesses in the US after resettlement. Christian and Islamic prohibitions against unhealthy or risky behavior including smoking, drinking, drug use and risky sexual practices reduce or prevent illnesses like substance abuse, high blood pressure, hypertension and diabetes. Respondents discussed the relationship between physical and mental well-being. Religious practices in Islam encourage reduction of anxiety and stress, which increases good health. One participant said: One way to prevent physical illness is to mentally be healthy. One of the ways I see in the East African community is with spiritual beliefs. When people can put their problems and their stress in the hands of a higher power, a lot of times that relieves a lot of the anxiety and stress on their physical selves. So in the case of a Muslim culture, *insha Allah*, its in Gods hands.

Prior to resettlement many East Africans walked long distances rather than driving, making walking an integral part of daily life. Many East Africans continue to walk in the

US, leading to increased health and well-being. Similarly, lack of refrigeration in East Africa encourages consumption of fresh foods without preservatives, a practice that is continued after resettlement. One participant said: Its more homemade food and its more organic made in home and no chemicals, or preservatives, thats one thing.

While some health practices like avoiding tobacco, drugs and alcohol or eating fresh foods are a continuation of religious and cultural practices from back home, some refugees change their behavior or lifestyles after acculturation leading to decrease in health and well-being. Participants pointed out that acculturation can lead to increases in consumption of fast food or foods high in sugar and fat. Driving or taking public transportation rather than walking can lead to increased rates of obesity and heart disease. Another participant pointed out that because East Africans dont have to read food labels to determine ingredients back home, they are not prepared to do so once in the US. Lack of education about unhealthy ingredients in processed, packaged and canned foods can lead to health complications. This participant said: We are disadvantaged because we dont look at the labels, what is contained, what chemicals affect our lives here so even if the culture is very preventative, but maybe in here, because of the lifestyle difference, and the chemical use, maybe we lost all that preventative method I think lack of education might stop our culture being preventative...

One participant talked about the complexity of assimilation into mainstream American culture. On one hand, lack of assimilation means some cultural practices like eating fresh food, walking regularly and keeping strong religious codes continue, preventing illness. Conversely, failing to assimilate into mainstream America could potentially prevent some education, sharing of health resources and access to health care.

Social gathering and social support prevent many illnesses, particularly mental health symptoms, and provide a space for education. The importance of social gatherings emerged as an extremely significant factor in both prevention of illness and healing from or coping with illness. Participants identified social gatherings like weddings, sporting events, religious services, funerals, coffee shops and malls as sites of social and familial support where people gather together and share news, ideas, and information.

Participants report that socializing in groups helps with depression and mental health symptoms. One person said: People are always together, nobody is alone. People are always talking together. So in terms of mental health and issues like that people will not leave you alone. So thats helpful I think. Another participant said:

And the other one is social gathering. This is a gathering where they talk to one another. Thats why theres not even a word for depression in our language, even I dont know it for Amharic too because we dont have, doesnt exist, as far as mental health issues, depression, and all those things because they gather together and they socialize and do many things. The events which we have in our community thats one way we bring people together. Thats the main thing which I see that encourages prevention and promote health.

Coping with Illness

Participants were asked to describe aspects of their traditional culture that helped people in their community to cope with illness and disease. Three main themes emerged: 1) religion, including religious practices and religious leaders, assists with both recovery from illness and prevention of illness, 2) social support from family, friends and neighbors within the community helps with both recovery and prevention of illness, and 3) traditional medicines and practices are still used to cope with illness.

Religion, both Christianity and Islam, provide illness coping strategies for East Africans. Religious activities like speaking with the imam, reading the Koran and going to prayers help reduce anxiety and stress and help to cope with illness. Participants talked about the importance of placing their health in Gods hands, reporting that God determines the course of disease and health, which allows the person who is sick to cope with illness by trusting in God. One participant described it this way: in our culture, the religious beliefs, we have a God. I may die, or I may not die, it depends on the hands of God. Its not in the hands of the disease. That mentality, that helps us to cope with the disease.

Social support is an essential part of recovery from illness. Participants described the ways in which friends, family and neighbors provide food and financial and social support when someone is ill. Visiting people who are sick is common, frequently with food. Visiting is thought to raise spirits and help with coping by letting the person know he or she is not alone. One participant said: getting support from family members is also another way to cope. Also people coming to see that person and praying for them, is another way that we cope.

Traditional health practices. Participants were asked about traditional health practices and medications from home that may still be used after resettlement. While many East Africans continue to use certain types of food or herbal medications to both treat and prevent illness, there appeared to be growing concern among some participants about the efficacy of herbal medications. In particular, participants who were also trained as medical professionals in the United States were concerned about appropriate dosage of herbal medications. Participants discussed the lack of scientific evidence for traditional medicine, but also stated that they knew people who had been able to cure illness like cancer and liver disease through traditional medicines.

Food is also an essential part of treating illness. Participants described types of foods that are used to treat or prevent illnesses such as tape worm, sore throats, and measles. These foods and medications are used after resettlement, as well.

One participant reported that being able to use traditional medication provides a psychological or placebo effect because it is a treatment that is trusted and culturally relevant. Traditional medicine might make people feel better simply from the act of taking it.

Prayer is also used to treat illness. Mental illness is believed to be cured through religious leaders like imams or priests. Religious leaders pray for those who are ill.

One participant noted that traditional medicines are often the only thing available to East Africans because of the cost of Western medicine in East Africa. This participant said: Traditional medicines are the only thing available to many Africans. Medicine costs

money. If we all depended on medications and modern practices, most people would die. We have to encourage some traditional practices, because many places in Somalia there are no doctors, no clinics, no hospitals.

Participants discussed the lack of education about screening practices in the United States. Participants seemed willing to use Western medicine to screen for illnesses, but because rates of some illness like colon or breast cancer appear low in the East African community, people are less likely to screen. People with illnesses aren't telling their friends and family that they have those illnesses, so others are less likely to attend screenings. One participant said Unfortunately those with illnesses in the community are not coming forward. They are not telling their friends, their neighbors that I have this. They hide it. So they are lowering the actual incidence of this illness.

Participants also reported potentially feeling more comfortable with East African medical providers. One participant said: If they have the same kind of traditional or care provider, from Somalia, or Africa, they can feel more relaxed and they can trust more, and they can share more about what they hide.

Sharing Health Information

Participants were asked about best practices for sharing health information, educating about healthy practices including screening for diseases and preventive care. Two themes emerged from these responses: 1) communication and education about prevention and treatment happens orally at social gatherings and 2) East Africans are more likely to comply with treatment or prevention strategies if another East African vouches for the health care practice.

Communication and education about prevention and treatment happens orally at social gatherings. Respondents explained that East Africans are a traditionally oral culture and that most important information is spread verbally through friends, family members and neighbors. Frequently, important information is shared at both formal and informal gatherings including weddings and funerals and at mosques, churches and coffee shops. Information is also shared at both formal and informal social gatherings. Information is best shared through community and religious leaders and elders and many informal networks exist for sharing information. For example, many East Africans play soccer and frequently health information comes through informal networks of soccer teams.

Other oral forms of media may also be effective, including television and radio; however print media like flyers, newspaper ads or brochures are not as effective. One participant pointed out that youth may be acculturating to American forms of media faster than adults. To reach youth it may be more helpful to use social networking sites.

East Africans are more likely to comply with treatment or prevention strategies if another East African vouches for the health care practice. A significant theme is that many East Africans may be more likely to comply with treatment or access preventive health care resources if other East Africans vouch for them. If someone has to have a Western medical procedure he or she will ask family or friends who have had the procedure prior to treatment. One participant who is also a medical professional said that he has some patients who have regular preventive health care or specific treatments who can vouch for the practices and treatments to new patients. One participant stressed the

importance of having an East African messenger to spread information about health care practices: One of the issues is you are the messenger and you can talk as much as you want, but it needs to be another neighbor, another friend, or another person who has done this.

Decisions to proceed with health care are made after speaking with family and friends. One participant who works at a medical clinic said: with the oral tradition, we see this a lot in the clinic. If someone has had a good result from a medicine and treatment, the whole community finds out about it. We don't even need to advertise. All of the medicines, they have heard about it through their community. I think that oral tradition, if that it worked for you, then I have faith it'll work for me.

One participant described how information is spread in the East African community through a "pyramid" approach. East Africans who speak English will read newspapers and online news sources and then give this information to friends and family who may not speak English.

Discussion

The findings from this study demonstrate that East African refugees living in the United States have strong traditional practices to prevent and cope with physical and mental health symptoms. These traditional practices include religion, social support, food, and traditional medicine. These findings build on the findings of Carroll and colleagues that religion and traditional health care practices are an important part of Somali health beliefs.¹⁴ Likewise, the findings from this study that some traditional health beliefs and practices regarding physical and mental health can actually lead to negative health or mental health outcomes are similar to Guerin and colleagues findings.¹³

Not surprisingly, both resettlement in the United States and the acculturation process have a variety of impacts on refugees health behaviors. Some cultural practices are continued after resettlement such as walking long distances, eating fresh foods and continuing religious practices. However, for some East Africans acculturation diminishes healthy practices, leading to increased disease. Some refugees are not prepared to make healthy food choices when faced with an abundance of processed and packaged foods. Other people may find themselves walking less frequently and shorter distances, and may not be replacing this behavior with other forms of physical exercise.

Data from this study indicate that East African refugees have strong social networks and frequently gather in groups for social events such as weddings, funerals, religious services and sporting events. In fact, social gathering and social support were key parts of almost every aspect of health behaviors discussed by the participants. Social gathering and social support in the form of company, food and monetary support prevent illness and assist with quick recovery from illness. Social support is an essential part of mitigating mental health symptoms like depression. Social gatherings are also a primary venue for sharing health information and encouraging healthy behaviors.

East African refugees in this study report having strong social networks and prefer to communicate health education orally. Similar to Sheikh-Mohammed et al.s findings in Australia, this study shows that oral communications and social gatherings are key venues for sharing health information.⁴ Further, oral information is preferred for sharing health

information even if it is not in person. Radio and television were also included as important means of sharing information.

A key and also unexpected factor discovered in these findings is that community-member vouching is an essential part of encouraging East African refugees to access health care, adhere to prevention and treatment recommendations and encouraging healthy behaviors. Newly arriving refugees may not know about Western medical practices and prevention and treatment recommendations made by Western doctors are not always followed. The medical professionals in this study reported that they often need to encourage their East African patients to follow treatment recommendations through having a successfully treated patient vouch for the practice in question. Respondents report that having someone from the same ethnic background recommend a form of treatment or a healthy behavior makes them more likely to comply. Respondents felt their patients were more likely to follow through with treatment if a fellow community member had successfully used the treatment in the past and could report favorably. Similarly, health education information such as information about specific diseases like diabetes and heart disease or recommended screening practices for breast and prostate cancer is best delivered from within the community. Many East Africans are more willing to adopt a practice if they learn about it from someone within their own community.

Conclusion

This study revealed a variety of health beliefs, ideas, perceptions and practices that are essential knowledge for health care practitioners serving East African communities. Many of the study participants described the ways in which their diet, lifestyle and daily routine were healthier in Africa. Transitioning to cultures in which there is frequent consumption of processed or high fat and sugar foods and less opportunity for daily exercise can significantly affect health. While African refugees believe in eating fresh fruits and vegetables and other illness-preventing foods and in regular exercise, their opportunities for this may be limited by resettlement. Health care professionals can provide support in returning to traditional health practices that prevent illness and support good health.

Health care providers should be aware of the continued use of and prevalence of traditional herbs and medicines to treat illness in the East African community. Increased communication with patients about alternative medicines may lead to more effective care. Additionally, research has indicated that showing a willingness to incorporate traditional medical practices into treatment may lead to better compliance.¹

Finally, participants in this study clearly endorsed a preference for oral communication of health information and education, as well as a necessity for hearing about health information from people within their own community and culture. East Africans may be more likely to access Western health care if another community member vouches for the clinic, the doctor, the treatment or the procedure in question. Public health professionals with this knowledge can tailor health education messages to address oral preference. Clinics that have worked successfully with refugee patients in the past can capitalize on the process of vouching for good health care to spread knowledge about healthy practices.

Implications for Future Practice and Research

The findings from this study have implications both for current practice and for future research. Public health professionals and educators can enhance health promotion efforts by adapting them to fit the cultural practices of refugee communities. Data from this study is being used by action committees in the East African community to develop health education materials about exercise and diet that are culturally relevant. Materials will be disseminated at social gatherings and through religious institutions. This study suggests that refugees may be more likely to participate in healthy behaviors if another person from the same ethnic background vouches for the behavior. Medical professionals from refugee communities are in a unique position to provide this education and encouragement to their communities because of their training in medicine and their standing in their communities. Health educators and promoters who are not from refugee communities could partner with medical professionals from ethnic communities to provide culturally grounded health education and promotion of healthy behaviors.

This study was exploratory in nature and was limited by its size and scope. However, the findings have implications for future research. Further exploration of the importance of vouching for treatments or health behaviors may give suggestions for ways to adapt health education strategies to be more culturally relevant.

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