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ORIGINAL PAPER

Cultural Health Assets of Somali and Oromo Refugees and Immigrants in Minnesota: Findings from a Community-Based Participatory Research Project

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Abstract: This community-based participatory research study sought to identify the cultural health assets of the Somali and Oromo communities in one Minnesota neighborhood that could be mobilized to develop culturally appropriate health interventions. Community asset mappers conducted 76 interviews with Somali and Oromo refugees in in Minnesota regarding the cultural assets of their community. A community-university data analysis team coded data for major themes. Key cultural health assets of the Somali and Oromo refugee communities revealed in this study include religion and religious beliefs, religious and cultural practices, a strong culture of sharing, interconnectedness, the prominence of oral traditions, traditional healthy eating and healthy lifestyles, traditional foods and medicine, and a strong cultural value placed on health. These cultural health assets can be used as building blocks for culturally relevant health interventions.

Key words: Emigrants and immigrants; refugees; cultural health assets; asset-based community development; health disparities; community-based participatory research; Africa, Eastern; culture; health promotion.

Minnesota has become one of the top states for refugee settlement in the United States, and the Minneapolis/Saint Paul metropolitan area is a hub for East Africa refugees. Minnesota now has more Somali residents than any other state, with the American Community Survey (ACS) data documenting that about 32,000 of the 90,000 Somalis living in the United States live in Minnesota,[1] though this likely substantially undercounts the population of Somalis in Minnesota. Minnesota also has one of the largest settlements of Oromo in the United States, who are the majority of the roughly 13,000 Ethiopians the ACS documents as living in Minnesota (also likely an undercount).[1] Like other refugees, Somali and Oromo refugees can experience a

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number of structural, cultural, and other barriers that limit their ability to engage in lifestyle behaviors that promote health[2] and to access appropriate health care services.[3–6] These barriers can include language barriers, low levels of literacy, lack of culturally appropriate health care providers, limited access to health information, inadequate financial resources, lack of transportation, and extreme environmental changes, among others. While data are still limited, there is growing evidence that East African refugees experience disparities in access to health care[7–8] and health status.[9–10] In Minnesota, the Minnesota Department of Health indicated that Somalis were among the groups in the state receiving the least health services.[11]

Despite some understanding of the health disparities and the barriers to health prevention and health care programs that East Africans face,[12–13] as well as the development of some promising practices,[14–15] the body of knowledge upon which to build community-based, culturally relevant interventions remains limited. While a focus on barriers is necessary for understanding the nature of disparities, an important way to build culturally relevant interventions is first to understand the cultural assets of immigrant and refugee communities.[16] The goal of this qualitative, exploratory study was to understand cultural health assets in the East African community in Minneapolis/Saint Paul that can be used to promote health and reduce disparities. We used a community-based participatory research (CBPR) approach to develop a partnership with a large community organization that serves the East African communities.

Conceptual framework. This study took an assets mapping approach, modified from the Asset-Based Community Development (ABCD) framework developed by Kretzman and McKnight,[17] to determine the cultural health assets. Assets models emphasize the positive ability and capacity of communities to identify relevant issues, develop appropriate solutions evolving from their community's strengths, and implement such solutions in a culturally appropriate and sustainable way. These differ from the more prominent deficit models, which focus primarily on health problems or needs of local communities that require professional interventions.[16] Such deficit models often lead to a focus on the failure of individuals or local communities to avoid diseases, rather than on the development of healthier individuals and communities.[16] While understanding that the health problems communities face are important, and indeed critical for documenting health disparities, consequences of a deficit analysis can be countered using asset-based approaches for assessment and interventions. The World Health Organization (WHO) recently recognized that asset-based approaches to health promotion are critical for supporting overall population health and reducing health disparities.[18] Health assets approaches have been used for developing a variety of health promotion activities, such as reducing television viewing,[19] reducing tobacco use,[20] and promoting adolescent health.[21]

Asset mapping is a central component of studies using the ABCD framework, and involves community members identifying the assets that exist within their own community. In the ABCD model, assets can typically include individual, associational, institutional, physical, and financial assets.[17] While asset mapping was designed for use in community development and is often used for neighborhood or place-based organizations, it is a research method that is compatible with the CBPR approach to research.[22] In this study, the CBPR partnership chose a particular type of asset, cultural health

assets, because the community of interest was a very specific cultural group. Cultural health assets are the assets related to the distinct ways that members of a culture live, including traditional and religious practices, that influence health.

Methods

This project used a CBPR approach to engage the East African immigrant community, employing the ABCD framework. The core project team consisted of staff from the Brian Coyle Center, a large community center that serves East African immigrants and refugees, and faculty from the School of Social Work at the University of Minnesota. As described by Israel and colleagues,[23] the team worked together as a CBPR partnership throughout the study. In addition, a community leadership collaborative, consisting of elders, community leaders and health care providers from the Somali and Oromo communities were involved in all stages of the project. This article reports the findings of the asset mapping part of the project, which was a qualitative study using individual health asset interviews with community members.

Participants. A sample of 49 Somalis and 27 Oromo participated in this study between December 2010 and March 2011. Nineteen (25%) participants were between ages 18–24, thirty-three participants (43%) were between ages 25–64, and 24 participants (32%) were over age 65. Fifty-eight percent of our sample was female. They were recruited through the distribution of flyers in the Cedar-Riverside neighborhood of Minneapolis in Somali and Oromo, which asked potential participants to call a direct line at the Brian Coyle Center if they were interested in participating, as well as through community networks and word of mouth. In addition, a community forum introducing the research project to the community in Somali and Oromo was attended by approximately 70 community members. (See below for more on the personnel working on the project, including those who spoke Somali and/or Oromo.) This enabled us to reach potential participants who were general community members, not only professionals or bilingual community members, which was a priority of the community leadership collaborative. Inclusion criteria for selecting the sample were people who were age 18 or older and born in East Africa and of Somali or Oromo descent. We used quota sampling to ensure variation on age and gender. The research process and all data collection methods were approved by the University of Minnesota Institutional Review Board and the community leadership collaborative.

Measures. A twelve-question semi-structured interview guide was developed by the community-university project team based on the ABCD model, with input from the community leadership collaborative. The interviews focused on cultural health assets and health practices of Somalis and Oromo, and included questions about such as, "Which parts of the Somali/Oromo culture encourage prevention of illnesses and promote health?" and, "Which traditions of the Somali/Oromo community are most appreciated among Somali/Oromo people living in the Cedar Riverside Neighborhood? What is important about each?" The interview guide was translated into Somali and Oromo, and was field-tested with eight community members.

Data collection. Five community members were hired as community asset mappers. These asset mappers were active residents of the community, and were both native

speakers of Somali or Oromo languages and fluent in English. As this was a CBPR project, asset mappers were trained not only in interviewing and data collection (as might be typical for a research project employing bilingual interviewers) but also in research methods, the ABCD model, diversity, research ethics, informed consent, data management and data analysis. Partners at the Brian Coyle Center and members of the leadership collaborative also participated in this training.

When community members called the Brian Coyle Center indicating interest in the study, the staff arranged the interviews with the asset mappers. Interviews were conducted at a location of the participant's convenience, either in their own home or in public confidential spaces, and consent was obtained before beginning the interview. The interviews were conducted in English, Somali or Oromo, and lasted approximately 45–60 minutes. The asset mappers recorded responses during their interviews and transferred written notes to a computer file within 24 hours. Interviews conducted in Somali or Oromo were then translated by the asset mappers back into English.

Data analysis. The individual interview data were coded to identify cultural health assets that could be used to develop culturally relevant interventions. The data were coded for themes by a multilingual research team consisting of two asset mappers, two staff from the Brian Coyle Center, and two university researchers. Three of the coding team (50%) were East African immigrants. The project team first held several long meetings in which they used open coding to code for themes and sub-themes, and then developed conceptual categories.[24] The data were then recoded using this coding scheme separately by two of the asset mappers. Finally, the team reconciled the coding of themes, sub-themes, and categories. Through reconciliation, eight central themes emerged related to cultural health assets.

After completing the analysis of the data, the CBPR partnership formed action teams led by community members to begin to develop community approaches to health promotion that build on the assets identified through this interview process.

Results

Eight cultural health assets common to both Somali and Oromo communities emerged from the interview data. These are described below.

Religion and religious beliefs. One of the most common themes that emerged from the data was the importance of religious beliefs as a cultural health asset. Participants discussed how religion was central to all aspects of their lives. Almost all of the Somali refugees in Minnesota are Muslim, and the participants described how Islam instructs them on all facets of life, including social interactions, family relationships, learning, working, and caring for others. A common statement from a Somali participant was, "[Islam] teaches them the way of life and how to live." Similarly, while the Oromo in Minnesota come from diverse religious backgrounds, the participants strongly asserted that religious beliefs were core to Oromo people regardless of their personal religion. A typical statement from an Oromo participant was, "Oromos are people of strong faith." Participants said that they learned new information while at religious institutions or from religious leaders. Religion was described as a source of pride for both Somali and Oromo communities.

Religious and cultural practices. Another key asset among participants was the specific religious and cultural practices that order their daily lives. The cultural health asset is similar to religion and religious beliefs, but varies in that it focuses on how beliefs influence their daily living. This was described distinctly by a number of participants. Many participants mentioned that Islam forbids the use of mind-altering substances, such as tobacco or alcohol, requires halal food, requires hygiene, and forbids premarital sex. Participants said they believed that these practices are a cultural health asset as they lead to improved health among their community. A number specifically mentioned how these practices are important for preventative health. In addition, many participants from both communities spoke of how their religion promotes hard work, exercise, and healthy eating, and how their religious practices help them cope with stress.

Culture of sharing. A predominant asset emerging from the data was the culture of sharing in all aspects of their lives. As a Somali participant said, "We share always." As one Oromo participant said, "Food is shared. It's part of our culture to share food." Sharing food is common to celebrate life's joys, as well as to comfort the sick and grieving. However, sharing food is not just for major life events or times of crisis; it is an integral part of the daily life of East African people. Women share ingredients and prepare food together, which can be a time for also sharing news and information about each other's lives. Participants also indicated that many types of resources are shared, including sharing money with people who are in a financial crisis, food with people who are poor, information, materials, employment or educational opportunities, and sharing passages from the Quran.

Interconnectedness and social gathering. A related cultural asset was the interconnected nature of their community. Respondents frequently discussed how people within their communities visit each other often, share information and live near each other. As one participant said, "In Cedar we are proud of being close to each other." Many Oromo spoke specifically about how they were a "united" community. People in both communities viewed socializing and visiting each other often as a cultural health asset which helps people prevent as well as cope with an illness, particularly mental illness.

Prominence of oral traditions. Oral traditions were described as an important cultural asset. Participants characterized their communities as being oral societies that greatly valued sharing information via word of mouth. Many discussed learning new information from lectures or talks given by religious leaders, or from listening to culturally specific radio or television. In addition, various other oral traditions were discussed as being common, such as telling stories, singing songs, or sharing proverbs.

Traditional healthy eating and healthy lifestyles. Another key theme was the traditional practices of healthy eating and leading a healthy lifestyle in Africa before migrating to the United States. While religious traditions promote healthy eating and healthy lifestyles, participants also discussed environmental factors that led to these traditional practices. Participants described how their traditional diets in Africa were very healthy, with fresh organic food and vegetables. There were few fatty or sugary foods and few preservatives available. In addition, participants discussed how people led active rather than sedentary lives in Eastern Africa, doing manual labor working in the fields or with animals, as well as walking frequently.

Traditional foods and medicines. Participants discussed specific traditional foods and medicines as cultural health assets, though the particular foods and medicines discussed were quite different in the two cultures. Many Somali participants discussed foods and spices that they used to prevent or treat illnesses, particularly black seeds, black pepper, honey, and garlic. Traditional medicine was usually discussed as complementary to what they termed "modern medicine," not as an alternative to it. Traditional medicines were frequently used in combination with reading the Quran and praying. Oromo participants also mentioned traditional foods, most commonly spicy soup which is used to both prevent and treat illnesses.

Valuing health. A final asset that emerged from the data was the strong value placed on health. Participants described the value of health as a religious belief. As a Somali participant indicated, "Religion encourages people to stay healthy." Participants discussed the virtues of exercise and eating healthy foods in the context of "valuing their health" as well as following religious teachings.

Discussion

The study represents the initial part of an ongoing community-based participatory research project that has an overarching goal of mobilizing Somali and Oromo cultural health assets to serve as the building blocks for developing culturally appropriate community interventions to reduce health disparities. The findings from this study indicate that Somalis and Oromo refugees living in Minnesota are maintaining much of their unique culture, and interventions that are based squarely on their culture might be more relevant.

Many of the cultural assets identified in our study relate to religion and religious practices. For the participants, religion was a key aspect of their lives. It influenced daily routines, such as work hours, food preparation and exercise. Likewise, religious institutions were the glue of the communities. The Somali and Oromo communities are conscious about the health and behavioral benefits of their religious practice and are proud of their religious and cultural traditions. This strong cultural asset of religious beliefs, practices and religious institutions are a potential key building block for developing health interventions. Our findings suggest that good health practices endorsed by religious institutions and promoted through religious organizations and teachings are likely to be accepted by community members.

In addition, the interconnectedness and culture of sharing were described as integral to Somali and Oromo cultures. The sharing of food and resources represented more than just sharing of material goods or information, but from our findings this practice of sharing represented social connectedness. The sharing of health information flows through these same social networks. This cultural asset is a key building block for promoting health and distributing health information. Health interventions related to health information or health promotion can build upon these cultural assets, and the development of health messages that can be easily and accurately passed through word of mouth. Training of key community members to serve as health informants is another possible asset based intervention based on this finding.

Another key set of assets that emerged related to oral traditions. In this culture with

strong oral traditions, proverbs, metaphors and stories that promote healthy living are abundant. The ability to integrate these into health promotion messages can help health practitioners working with East African communities.

Finally, there were assets identified related to the importance of traditional healthy foods and traditional medicines. Our findings showed that Somali and Oromo communities understand these foods and medicines as complementary rather than incompatible with western medicine. Our participants indicated that health was strongly desired and valued within their culture. As such, interventions focused on the health advantages of traditional healthy foods and medicines, which are often much more healthy than western food, may be culturally relevant and successful.

This study has several limitations, noteworthy being the small convenience sample from one urban area. We tried to mitigate this limitation through recruiting broadly through the neighborhood using multiple networks and by using quota sampling to ensure diversity in age and gender. Nonetheless, we recognize that these findings cannot be generalized and further study is needed. In addition, the use of note-takers instead of voice recorders was also a limitation, but this was deemed necessary as the local community was hesitant to allow tape recordings and this was a decision we made as a CBPR partnership team. We attempted to counter this limitation by providing in depth training on note taking and instructions to the asset mappers to take down quotations verbatim and by doing quality control checks of the data.

While earlier studies have focused on the health disparities of East African immigrants and barriers East Africans face in regards to health,[4,6–13,25] our study focused on uncovering cultural health assets of Somalis and Oromo. In addition, our study employed a CBPR approach, in which community members were involved in all parts of the project, from designing the research questions to data collection to data analysis. Our findings show that East African immigrants maintain much of their unique cultures after immigration, and this culture contains many health assets on which interventions can be based. In particular, our findings show that key cultural health assets of these communities relate to religion and religious practices, interconnectedness and the culture of sharing, traditional healthy foods and healthy medicines, oral traditions and a strong value based on health. Health interventions that build on these cultural health assets are more likely to be successful.

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References

1. U.S. Census Bureau. American Community Survey: 2008–2010 [Minnesota/United States]. Washington, DC: U.S. Census Bureau, 2011.
2. Devlin J, Dhalac D, Suldan A, et al. Determinants of physical activity among Somali women living in Maine. J Immigr Minor Health. 2012 Apr;14(2):300–6. http://dx.doi.org/10.1007/s10903-011-9469-2 PMid:21479887

3. Carroll J, Epstein R, Fiscella K, et al. Caring for Somali women: implications for clinician–patient communication. Patient Educ Couns. 2007 Jun;66(3)337–45. Epub 2007 Mar 6.
http://dx.doi.org/10.1016/j.pec.2007.01.008
PMid:17337152 PMCid:PMC3298771
4. Sheikh-Mohammed M, MacIntyre CR, Wood NJ, et al. Barriers to access to health care for newly resettled sub-Saharan refugees in Australia. Med J Aust. 2006 Dec 4–8;185(11–12):594–7.
PMid:17181498
5. U.S. Department of Health and Human Services. Office of Refugee Resettlement Annual Report to Congress—FY 2006. Washington, DC: U.S. Department of Health and Human Services, 2006.
6. Guerin PB, Elmi FH, Corrigan C. Body composition and cardiorespiratory fitness among refugee Somali women living in New Zealand. J Immig Minor Health. 2007 Jul;9(3):191–6.
http://dx.doi.org/10.1007/s10903-006-9030-x
PMid:17252194
7. Morrison T, Wieland M, Cha S, et al. Disparities in preventive health services among Somali immigrants and refugees. J Immig Minor Health. 2012 Dec;14(6);968–74.
http://dx.doi.org/10.1007/s10903-012-9632-4
PMid:22585311
8. Samuel PS, Pringle JP, James NW, et al. Breast, cervical, and colorectal cancer screening rates amongst female Cambodian, Somali, and Vietnamese immigrants in the USA. Int J Equity Health. 2009 Aug 14;8:30.
http://dx.doi.org/10.1186/1475-9276-8-30
PMid:19682356 PMCid:PMC2731767
9. Kinzie JD, Riley C, McFarland B, et al. High prevalence rates of diabetes and hypertension among refugee psychiatric patients. J Nerv Ment Dis. 2008 Feb;196(2): 108–12.
http://dx.doi.org/10.1097/NMD.0b013e318162aa51
PMid:18277218
10. Boise L, Tuepker A, Gipson T, et al. African refugee and immigrant health needs: report from a community-based house meeting project. Prog Community Health Partnersh. 2013 Winter;7(4):369–78.
http://dx.doi.org/10.1353/cpr.2013.0054
http://dx.doi.org/10.1353/cpr.2013.0045
PMid:24375177
11. Minnesota Department of Health. Immigrant health: a call to action. Minneapolis, MN: Minnesota Department of Health, Minnesota Department of Health and Human Services, 2005. Available at: http://www.health.state.mn.us/divs/idepc/refugee/topics/immhealthrpt.pdf.
12. Bhui K, Dinos S. Health beliefs and culture: essential considerations for outcome measurement. Dis Manag Health Out. 2008 Jun;16(6):411–9.
http://dx.doi.org/10.2165/0115677-200816060-00006
13. Pavlish C, Noor S, Brandt J. Somali immigrant women and the American health care system: discordant beliefs, divergent expectations and silent worries. Soc Sci Med. 2010 Jul;71(2):353–61. Epub 2010 Apr 29.
http://dx.doi.org/10.1016/j.socscimed.2010.04.010
PMid:20494500 PMCid:PMC2893335

14. DeStephano C, Flynn P, Brost B. Somali prenatal education video use in a United States obstetric clinic: a formative evaluation of acceptability. Patient Educ Couns. 2010 Oct;81(1):137–41. Epub 2010 Jan 13.
http://dx.doi.org/10.1016/j.pec.2009.12.003
PMid:20071131
15. Palinkas LA, Pickwell SM, Brandstein K, et al. The journey to wellness: stages of refugee health promotion and disease prevention. J Immigr Health. 2003 Jan;5(1):19–28.
http://dx.doi.org/10.1023/A:1021048112073
PMid:14512755
16. Morgan A, Ziglio E. Revitalizing the evidence base for public health: an assets model. Promot Educ. 2007;Suppl 2:17–22.
PMid:17685075
17. Kretzmann JP, McKnight JL. Building communities from the inside out: a path toward finding and mobilizing a community's assets. Chicago, IL: Institute for Policy Research, Northwestern University, 1993.
PMid:19426016
18. Harrison D, Ziglio E, Levin L, et al. Assets for health and development: developing a conceptual framework. Venice, London: European Office for Investment for Health and Development, World Health Organization, 2004.
19. Baker IR, Dennison BA, Boyer PS, et al. An asset-based community initiative to reduce television viewing in New York State. Prev Med. 2007 May;44(5):437–41. Epub 2007 Jan 17.
http://dx.doi.org/10.1016/j.ypmed.2006.11.013
PMid:17207848 PMCid:PMC1997300
20. Struthers R, Hodge FS, Geishirt-Cantrell B, et al. Community mapping: a tool in the fight against cigarette smoking on American Indian Reservations. Policy Polit Nurs Pract. 2003 Nov;4(4):295–302.
http://dx.doi.org/10.1177/1527154403258314
21. Amsden J, VanWynsberghe R. Community mapping as a research tool with youth. Action Research. 2005 Dec;3(4):357–81.
http://dx.doi.org/10.1177/1476750305058487
22. Lightfoot E, McCleary J, Lum T. Asset mapping as a research tool for community-based participatory research in social work. Social Work Res. 2014 Apr;38(1):59–64.
http://dx.doi.org/10.1093/swr/svu001
23. Israel B, Eng E, Schulz A, et al. Methods in community-based participatory research for health. San Francisco, CA: Jossey-Bass, 2005.
24. Miles MB, Huberman AM. Qualitative data analysis: an expanded sourcebook, (2nd ed). Thousand Oaks, CA: Sage Publications, 1994.
25. Rothe E, Holt C, Kuhn C, et al. Barriers to outdoor physical activity in wintertime among Somali youth. J Immigr Minor Health. 2010 Oct:12(5):726–36. Epub 2009 Sep 2.
http://dx.doi.org/10.1007/s10903-009-9287-y
PMid:19728092