Understand barriers to reproductive health care among Somali women in Columbus, Ohio

Engagement Impact Grant

Executive Summary

Somali immigrants in the US have low levels of preventative health care utilization. Particularly for women, lack of utilization of reproductive health services has negative impacts for women directly, and for their children, families and the community as a whole. Despite this, relatively little research has been carried out among African immigrants either on a national level or in Columbus, so the specific barriers to utilization of reproductive healthcare faced by Somali women in Franklin County have not been well characterized. The proposed project will be carried out by a team comprised of academics, policy-makers and individuals from community organizations serving Somali immigrants in Columbus. Through qualitative research with Somali women, we will comprehensively assess barriers to reproductive healthcare utilization including challenges related to culture, language, education, logistics, medical literacy, discrimination and other barriers. These findings will be used to develop potential programmatic interventions to increase Somali women's access to reproductive healthcare. We will then bring these proposed interventions back to the Somali population and other community partners for their input on feasibility and acceptability. The development of evidence-based, culturally-acceptable programs to increase Somali women's use of reproductive healthcare will lead to reduced risk of adverse reproductive health outcomes.

A. Concept

Background and summary

Since 1991, the east African country of Somalia has been devastated by a civil war that dismantled the central government and forced many Somalis to relocate to refugee camps in neighboring Kenya, Yemen, Djibouti and Ethiopia. Over the past 20 years, the Somali diaspora has increased exponentially as displaced Somalis have found permanent refuge in various countries throughout Europe and North America, including the United States (US). Thousands of Somalis relocated to the US between 2001 and 2010, with the majority of Somalis settling in Minnesota, California, Georgia, Washington DC, and Ohio. In 2013, more than 45,000 Somali immigrants were living in Columbus, Ohio, making it the 2nd largest settlement site in the US. The Somali population in Columbus is expected to grow by 200 people per month for the next four years.[1]

The well-being of the sizable and growing population of Somali immigrants is an important responsibility for providers and policy makers in the health and social sectors. Somali immigrants can face racial and ethnic discrimination, language barriers, religious intolerance, a lack of housing and educational services, and poor access to health care. Community-based research among Somali immigrants is essential to document these adverse experiences, in order to develop evidence-based programs and interventions to reduce inequities and improve the health and social well-being.

Somalis in the US, particularly Somali women, appear to have low levels of preventative health care utilization.[2] However, relatively little research has been carried out among African immigrants either on a national level or in Columbus,[3] so the specific barriers to healthcare utilization faced by Somali immigrants in Franklin County have not been well characterized. While considerable data suggests that individuals who experience violence and subsequent relocation often develop physical and mental health morbidities,[4] the extent of these conditions among Somalis in Columbus has not been described. In

[1] Somali Community Association of Ohio. (2014). <http://www.somaliohio.org/>
[2] Fiscella et al, 2003
[3] Cunningham et al. (2008). "Health of Foreign born people in the United States: A review". Health and Place; 14:623-636.
[4] Berman et al. (2006). A narrative study of refugee women who have experienced violence in the context of war. Canadian Journal of Research in Nursing; 38:32-53.

addition, prior research indicates that foreign-born residents of color often report higher levels of discrimination from health care professionals than US-born people of color,[5] but whether perceived or real discrimination is limiting utilization of health care services by Somali immigrants in Columbus is also unknown.

Significance of the Challenge

Low utilization of health services can have lifelong consequences. Particularly for women, lack of *reproductive* health services negatively impacts women directly, but also affects their children, families and the community as a whole. Our team has broad expertise in reproductive health research. As a result the proposed project focuses on understanding barriers to reproductive health care for Somali immigrant women in Columbus.

In Franklin County, infant mortality rates are consistently higher than both the Ohio and US rates since 1995, and the rates are much higher for non-Hispanic Blacks than for non-Hispanic Whites.[6] Birth outcome data specific to Somali immigrants in Columbus or the US overall are not available. However, a large study comparing birth outcomes of post-immigration, Somali-born women and native-born women in six receiving countries (Australia, Belgium, Canada, Finland, Norway and Sweden), reported higher rates of caesarean sections and stillbirths among the Somali-born women.[7]

Lack of awareness, prevention and treatment for sexually transmitted infections (STIs) such as HIV, chlamydia, gonorrhea, syphilis, and human papillomavirus (HPV), can also have severe reproductive consequences: discomfort, pain, pelvic inflammatory disease, infertility, damage to other organs including the kidney, heart, and brain, and (in the case of HIV and AIDS) death. STIs during pregnancy increase risk of miscarriage, stillbirth, premature rupture of membranes, preterm labor, infection of amniotic fluid, and congenital health problems for children.[8] HPV, which causes cervical cancer, is also more prevalent in women who are ethnic minorities, poor, and with lower education. HPV vaccination rates are lowest in the same population groups.[9] Somali women who immigrated to the US within the past ten years are less likely to be screened for HPV and cervical cancer than any other population group,[10] potentially due to barriers to access to screening services and the lack of culturally competent interventions targeting Somali women for screening.[11] Somali women's likelihood of attaining cervical cancer screening also depends on their education level, knowledge about cervical cancer, concerns about embarrassment and pain, preference for a female health provider, and their husbands' approval of cervical cancer screening.[12]

Many Somali women also have reduced reproductive health due to female genital mutilation/circumcision (FGM/C), including chronic pelvic infections, chronic or repeated vaginitis, repeated urinary infections, prolonged micturition (desire to urinate) and dysuria (painful urination).[13] Enhanced provision of culturally-competent, comprehensive, accessible health care for this very vulnerable subpopulation of Somali women is essential.

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[5] Lauderdale et al. (2006). Immigrant perceptions of discrimination in health care. Medical Care; 44:914-920.

[6] Office of Assessment and Surveillance, Columbus Public Health

[7] Small, R. et al. (2008). Somali women and their pregnancy outcomes postmigration: data from six receiving countries. BJOG: An International Journal of Obstetrics & Gynaecology, 115(13): 1630-1640. Doi: 10.1111/j.1471-0528.2008.01942.x

[8] Centers for Disease Control & Prevention: STDs & Pregnancy Factsheet. (2014)

[9] Brewer, N. T., & Fazekas, K. I. (2007). Predictors of HPV vaccine acceptability: A theory-informed, systematic review. Preventive Medicine, 45(2-3), 107–114. doi:10.1016/j.ypmed.2007.05.013

[10] Swan J, Breen N, Coates RJ, Rimer BK, Lee NC. (2003). Progress in cancer screening practices in the United States: results from the 2000 National Health Interview Survey. Cancer, 97(6):1528-40.

[11] Kahn, J. A., Lan, D., & Kahn, R. S. (2007). Sociodemographic factors associated with high-risk human papillomavirus infection. Obstetrics & Gynecology, 110(1), 87–95.

[12] Lyimo, F. S, Beran, T, N. (2012). Demographic, knowledge, attitudinal, and accessibility factors associated with uptake of cervical cancer screening among women in a rural district of Tanzania: Three policy implications. BMC Public Health, 12(22).

[13] Abdulcadira, J, Margairazb, C, Boulvaina, M, Irio, O. (2011). Care of women with female genital mutilation/ cutting. Swiss Med Wkly, 140:w13137.

Barriers to improved care

Several potential barriers may hinder access to reproductive health services by Somali women. Sexual health may be excluded from public discourse within traditional Somali communities. Parents may decline to teach their children about sex.[14] Somali women are expected to abstain from sex until marriage, and sexual promiscuity is highly stigmatized. Findings from a study of Somali women in Omaha, Nebraska, demonstrated that many women believed that carrying a condom suggested "loose morals," that women should not experience sexual pleasure, and that AIDS is a punishment from God for sexually-promiscuous individuals.[15]

Beyond cultural influences, accessibility to reproductive health services may be limited by barriers to the delivery of health care services. Distrust of biomedical solutions to treat disease and a preference for more holistic therapies may lead some women away from seeking treatment. The presence of a male clinician or language interpreter during health care encounters may also limit women's openness to discuss sexual health or seek treatment for signs and symptoms of disease.[14]

Lack of cultural competency among providers may further limit effective communication between clinicians and Somali women during health care interactions. Frustration may be bidirectional, resulting from with differing expectations about care, discordant beliefs about health, and the providers' structural inability to provide extensive, individualized attention. Somali women in Hartford, Connecticut, reported barriers to care that included language barriers, passive acceptance of incorrect care, cultural discordance in family planning services, and patient-provider gender discordance.[16]

An excellent example of disagreement between providers and Somali women involves childbirth by Caesarean section. Caesarean deliveries are viewed unfavorably by some Somali women, who fear that the procedure could result in death or disability.[17] However the rate Caesarean births is relatively high among Somali immigrant women, often because of FGM/C. Vaginal birth among women with FGM/C may be accompanied by prolonged labor, incontinence, obstetric fistula, or other adverse obstetric outcomes. As a result of these factors, obstetricians may favor Caesarean deliveries. While a recommendation for Caesarean delivery for some women may be well-grounded in medical literature, this evidence may not be properly communicated with members of the Somali community,[18] and this miscommunication leads to further distrust of the US healthcare system.

A further example of disagreement cited by Somali women surrounds the use of family planning services. For some families, the greater number of children within a family, the more the family is blessed by God. Having many children, particularly boys, is a status symbol; a women's worth may be so entwined with her fertility that if she cannot become pregnant, her husband will divorce her and remarry. In light of these beliefs, some Somali women find that modern birth control methods are not acceptable.[19] Providers who do not understand or adjust their approaches to these cultural norms, or do not individually assess their patients' beliefs around these topics, may fail to connect with their Somali patients.

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[14] Pavlish et al. (2013). Somali Immigrant Women and the American Health Care System: Discordant Beliefs, Divergent Expectations, and Silent Worries. Soc Sci Med; 71(2): 353-361.

[15] Feresu, S., Smith, L. (2013). "Knowledge, attitudes, and beliefs about HIV/AIDS of Sudanese and Bantu Somali immigrant women living in Omaha, Nebraska". Journal of Preventative Medicine; 3(1): 84-98.

[16] Gurnah, K, Khoshnood, K, Bradley, E, Yuan, C. (2011). Lost in Translation: Reproductive Health Care Experiences of Somali Bantu Women in Hartford, Connecticut. Journal of Midwifery & Women's Health, 56 (4): 340-346. Doi:

[17] Maithri, A, Borg, R, Frederick, J, Vragovic, O, Saia, K, Raj, A. Somali immigrant women's perceptions of cesarean delivery and patient–provider communication surrounding female circumcision and childbirth in the USA
International Journal of Gynecology & Obstetrics, 115(3): 227-230.

[18] Abdulcadira, J, Margairazb, C, Boulvaina, M, Irio, O. (2011). Care of women with female genital mutilation/ cutting. Swiss Med Wkly, 140:w13137.

[19] Deyo, Nancy S., "Cultural Traditions and the Reproductive Health of Somali Refugees Immigrants" (2012). Master Thesis.

In summary, data from other regions suggests that Somali women may have reduced utilization of preventative healthcare services due to of a range of barriers. Exploring the specific challenges to utilization of reproductive health care among Somali women in Columbus will permit development of culturally-competent, evidence-based programs to increase their access to appropriate care, which will lead to reduced risk of adverse reproductive health outcomes.

Potential for Transformational Change

The specific health concerns and barriers to health care utilization among Somali immigrants in Columbus has never been systematically examined. Almost no reliable reports document the current health status of this rapidly growing population. Little research (all in other regions) has developed and evaluated potential interventions to overcome low utilization of reproductive healthcare services.

Research activities leveraged and advanced though engagement

For the proposed research, together with our community partners, we will directly solicit Somali women in Columbus to identify locally-relevant barriers to utilization of reproductive health care, and to develop potential interventions to overcome those barriers. Proposed programs will be culturally respectful, acceptable, feasible and sustainable, and will address specific issues raised by Somali women in this community.

We will engage Somali women for each step of research and program development, including needs assessment and program design. Our research team consists of Somali community leaders (including the President of the Center for Somali Women's Advancement), health and policy experts in Columbus and Franklin County (including staff from the Columbus City Community Relations Commission, the Columbus Public Health Department, and Ohio's 3rd Congressional District), and academics with expertise in conducting reproductive health research (including faculty in the College of Public Health and the College of Medicine). This comprehensive team is both directly and indirectly connected to many Somali community organizations within Columbus, which will improve community members' trust and willingness to participate in our efforts. In particular, we have Somali women involved at all levels of the project: leadership from professional Somali women (including Katra Mohammed and Hibo Noor), collaboration within the research team with a Somali research assistant and a Somali focus group facilitator, and engagement with the many Somali women who will be study participants. The engagement of several Columbus policy-makers on our team also increases the feasibility of intervention programs developed during this research in response to our research findings.

Mutually beneficial and reciprocal partnerships

This program will succeed via the strength of our network of collaborators across disciplines and sectors, including local government and colleges of Ohio State University. Specifically, we will be working with Khadra Mohamed, President of the Center for Somali Women's Advancement; Karen Castro in Congresswoman Joyce Beatty's office of Ohio's 3rd Congressional District; Dr. Mysheika Roberts, Assistant Health Commissioner and Medical Director of Columbus Public Health for the City of Columbus; and Abdikhayr Soofe, the African Outreach and New American Initiative Coordinator for the City of Columbus's Community Relations Commission. We have Ohio State University cross-college collaboration, with Principle Investigator Dr. Alison Norris in the College of Public Health and Dr. Abigail Turner in the College of Medicine. We will also involve students throughout this project: as research assistants, for doctoral research, and in partnership with student organizations at Ohio State University, including the Somali Student Association and Students for Community Cultural Awareness, who are currently concentrating their efforts on the Somali population in Columbus.

Partnerships within this network will be mutually beneficial. Somali community partners will be provided both key data and a more powerful platform from which to create programmatic improvements that benefit the Somali population. These partners will assist the research team in establishing trust in the local Somali community, increasing their willingness to participate in the study. By providing

encouragement to the project and facilitating access to community members, the office of Congresswomen Beatty will champion the rights of local women and address both the immigration and health concerns of her constituents. Through this research and the programs developed as a result of it, Ohio State University will establish a positive presence within the Somali community. The work will be shared beyond Columbus via publication in academic journals. We expect that this program can foster academic growth through research experience among OSU students, and will become the dissertation for a collaborating PhD student.

Beyond the benefit to our outreach and engagement partners, this research could significantly impact the local Somali population as well as other immigrant communities, both in Columbus and beyond. Currently, few interventions have incorporated this level interdisciplinary collaboration and community support to address the concerns of a marginalized immigrant population. Furthermore, few studies of Somali immigrants have provided evidence-based and community-generated approaches to overcome barriers to sexual and reproductive health. Our innovative approach could benefit the Somali community in Columbus and elsewhere by providing a template process for future interventions that address barriers to health among other immigrant groups.

B. Growth Plan

The timeline of this 2-year project is separated into two phases. Phase 1 is a formative, comprehensive assessment of barriers to reproductive healthcare utilization, including exploration of challenges related to culture, language, education, logistics (e.g. hours of operation or transportation), medical literacy, discrimination, and other barriers. Phase 1 results will be used for Phase 2, in which we will draft several potential programmatic interventions to overcome barriers directly elucidated by Somali women. During Phase 2 we will assess feasibility of the potential programmatic interventions resulting from the Phase 1 findings, by returning to the Somali community for their input. The outcomes of Phase 1 include identification of barriers (as described above) to seeking services for reproductive health needs including prenatal care, births, STI care, and cervical cancer. The primary outcome for Phase 2 will be the development of programs to address the barriers described in Phase I, *and* a formal assessment of the feasibility and acceptability of those potential programs among the target population, Somali women. Following each stage, findings will be shared through publication in peer-reviewed journals, as well as through community dissemination meetings. Key activities and dates are detailed in the table below.

	Key Activities	**Date**	**Success**
Phase1	Meeting with all partners and Somali community organization leaders to define research goals	April 2014	Research goals defined
	Train staff, develop study documents, hire translators	May-June 2014	Somali community members and OSU students form a research team
	Recruit participants & other key community informants through: English and Somali flyers distributed by community partners, as well as in Somali grocers & restaurants, Columbus Public Health Farmers Market (targets Somali population), immigration offices, other locations	July-Aug 2014	Interest generated among individuals and groups from the Somali immigrant community
	Begin focus group discussions and in-depth qualitative interviews (40-50 women in 8-10 person focus groups, 10 key informant interviews)	Aug-Oct 2014	Qualitative data collected
	Analysis of data (transcription into English, coding using Atlas.ti data management system)	Nov-Dec 2014	Qualitative data analyzed and findings shared with partners and via community meeting.
s	Use of preliminary data to develop feasible	Jan-April	Interventions designed with

	Key Activities	Date	Success
	programmatic interventions, in collaboration with community partners, to overcome access barriers	2015	partner collaboration
	Recruit participants (see recruitment methods above), in addition to healthcare providers and medical translators as key informants	April-June 2015	Interest generated among individuals and groups from the Somali immigrant community
	Gather data on feasibility of intervention through focus group discussions and in-depth qualitative interviews	July-Sep 2015	Qualitative data collected
	Analysis of data (see analysis methods above)	Oct-Dec 2015	Qualitative data analyzed and findings shared with partners and via community meeting.
	Create finalized intervention strategies based on community input & begin dissemination to community partners	Jan-March 2016	Interventions ready for implementation by or with partner organizations

C. Team Description

Team Members and Roles

Alison Norris, MD, PhD, Assistant Professor, Division of Epidemiology, College of Public Health, Ohio State University. Dr. Norris has expertise using innovative methods to obtain high quality data about sensitive and stigmatized topics in sexual and reproductive health, particularly with women from east Africa. She will lead the team and provide oversight to data collection, management, analysis and dissemination.

Abigail Norris Turner, PhD, Assistant Professor, Division of Infectious Diseases, College of Medicine, Ohio State University. Dr. Turner is an expert in the behavioral and clinical factors associated with sexually transmitted infections, and has several collaborative projects with Columbus Public Health. She will provide oversight to data collection, management, analysis and dissemination.

Khadra Mohamed, MSW, President & CEO, Center for Somali Women's Advancement. Ms. Mohamed is deeply committed to improving the well-being of Somali women, and has been eager for a partnership such as this one, reaching from the community and into the academy.

Karen Castro, District Aide in Congresswoman Joyce Beatty's office, 3rd Congressional District of Ohio. Ms. Castro is Congresswoman Beatty's designated aide for immigrant issues. She will share her knowledge with the team and advise about how best to research the specific challenges to good health of women in Columbus's Somali community.

Mysheika Roberts, **MD, MPH** Assistant Health Commissioner and Medical Director of Columbus Public Health, City of Columbus. As a practicing clinician providing health care to low-income residents of Columbus, Dr. Roberts has unique insight about barriers and for opportunities to improve reproductive health care access. During Dr. Roberts' tenure, Columbus Public Health has developed several programs dedicated to health outreach in the Somali population. Dr. Roberts will guide the formulation of the research questions and advise on the development of interventions.

Abdikhayr Soofe, African Outreach and New American Initiative Coordinator, Community Relations Commission Staff, City of Columbus. Mr. Soofe works closely with the Somali immigrants via his programs for new American community members. He will insure the cultural competency of all members of the team, and will guide the formulation of the research questions and advise on the development of interventions.

Barbara Brandt, President of Barbara K. Brandt, Inc Philanthropic Consulting Services. Ms. Brandt is passionate about the health of vulnerable women. She will facilitate communications and collaborations, as she has experience working with all of this project's partners.

Jessica Londeree, MPH, doctoral student, Division of Epidemiology, College of Public Health, Ohio State University. Ms. Londeree is studying the Somali language as a first-year doctoral student in epidemiology at OSU. She will be instrumental in managing the multi-dimensional social and academic aspects of this project.