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**Providing Culturally Appropriate Physical Therapy to Somali Refugees in
Minnesota.**

By

Jessica J. Scholl

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Arts in Organizational Leadership

**St. Catherine University
St. Paul, Minnesota**

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Master of Arts in Organizational Leadership

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TABLE OF CONTENTS

	Page
Abstract	4
Introduction	5
Purpose of the Research	6
Conceptual Context	7
Research Question	25
Methods	26
Results	30
Discussion	43
Recommendations	54
Limitations	58
Conclusion	59
References	60
Appendices	
Appendix A Focus group consent form	65
Appendix B Interview consent form	67
Appendix C Focus group questions	69
Appendix D Interview questions	70

Abstract

Minnesota is home to the largest community of Somali refugees in the United States (Pavlish, Noor, and Brandt, 2010, p. 353). The Somali community has unique healthcare needs that current Western medicine is not meeting adequately. The Somali living in Minnesota are at risk for increased rates of obesity, diabetes, and other chronic conditions due to the change in lifestyle, eating habits, and stress caused by moving to the United States. The purpose of this research is to identify the healthcare needs, preferences, and practices of the Somali refugee community in Minnesota to better inform and guide physical therapy clinicians in providing effective, culturally appropriate healthcare. Data was collected from focus groups of Somali refugees currently living in Minnesota and interviews of select healthcare practitioners who have had significant experience working with patients who are Somali. Results highlight the difference in accessing healthcare in Somalia versus the United States, the lack of cultural reciprocity between healthcare providers and the Somali refugee community, and additional structural and internal barriers that exist for Somali refugees in receiving adequate healthcare. Recommendations include suggestions for physical therapy education, clinical practice, and the professional association which guides the practice of physical therapy.

Introduction

For as long as I can remember, I have had the desire to help people. I have sought to be a helper in every aspect of my life; when I was young I wanted to be a helpful daughter, sister, student, and friend. Now that I am an adult I help as a wife, step-mother and in my professional life as a teacher and physical therapist assistant. Not unlike most students entering healthcare, wanting to help people is how I chose the field of physical therapy for my profession.

In 2011 I had a career and life-changing opportunity to facilitate and lead a service learning immersion course for physical therapy students in Minneapolis and St. Paul. It was during that experience that I began to realize that simply *helping* may not be the best way to meet the healthcare needs of my increasingly diverse community, in particular the Somali community in the Cedar Riverside neighborhood of Minneapolis. *Serving* may be more effective. According to Rachel Naomi Remen (n.d.);

Helping, fixing, and serving represent three different ways of seeing life. When you help, you see life as weak. When you fix, you see life as broken. When you serve, you see life as whole. Fixing and helping may be the work of the ego, and service the work of the soul.

It occurred to me that by trying to help people and patients in my community, I was putting myself in a position of power over them and not creating a relationship or recognizing the value in what they bring to the healthcare team. In physical therapy, clinicians say the patient is a valued member of the healthcare team. If this is true, then we will value their input and choice about the care they receive, focusing on their assets and not simply their deficits; serving rather than helping.

Somali refugees have high rates of obesity and other chronic health conditions (Dharod, Croom, & Sady, 2013, p. 47). Physical therapy can play a role in promoting health, wellness, and disease prevention but current professional marketing efforts such as translating professional websites into Somali have failed to reach and positively impact the health of many Somali immigrants and refugees. On a consistent basis I have grappled with how to best serve and not simply try to help the Somali community who are struggling with various health issues. How can I learn about and focus on the assets of their community? How is their view of health and healthcare different than my own? How can I bridge the gap between the well-meaning clinicians who want to help and the patients who may not feel respected or valued as a member of the team? How can I balance productivity and financial demands in healthcare with my ethical responsibility to provide altruistic and culturally appropriate care?

Purpose of the Research

The purpose of this research project is to describe how physical therapy clinicians can modify the care they provide for the Somali refugee community in Minnesota to better meet their unique healthcare needs. The current culture of physical therapy resembles most of healthcare in the United States. It is described as Western Medicine or the Biomedical Model and it is guided by evidence based care grounded in scientific fact and research. Care is often delivered in a hospital or clinic setting. Visits with a physical therapist (PT) or physical therapist assistant (PTA) are scheduled by appointment. The environment is professional but at times, sterile. Reimbursement for services is determined by accurate documentation, evidence of efficacy, and by following guidelines for best practice. This works well for the majority of physical therapy

clinicians who are native to the United States, white, and familiar with Western medicine practices and norms. As the population grows and diversifies however; it may not meet the needs of all individuals accessing physical therapy services.

The mistake that I have often made in my work is that I treat patients the way *I* would like to be treated as a patient. I have come to realize that this may not be effective; perhaps physical therapy clinicians need to treat patients the way that *they* would like to be treated in order to meet their needs and achieve positive outcomes. Beatson (2013) writes that immigrant and refugee patients would benefit greatly from providers learning about their cultural practices and incorporating them into the treatment whenever possible. It is equally as important for clinicians to be able to articulate the culture of Western medicine. “Cultural reciprocity” occurs when a provider can talk about their views on healthcare, listen to their patient’s opinions and healthcare needs, and collaboratively develop a treatment plan acceptable to both (p. 145).

Conceptual Context

In order to clearly identify and inform the goals of this research, it is critical to review the existing literature and define concepts and put them into the context of this research. I will begin with a discussion of the literature on immigrant and refugee health which will lead into a discussion of specific health behaviors, unique health education needs and communication with the Somali community. I will then discuss the practice of physical therapy, describe clinicians who provide services and analyze the American Physical Therapy Association (APTA) Core Values that guide the profession and should influence care for the Somali community.

Immigrant and Refugee Health

Immigrants and refugees make up approximately 13% of the population in the United States and between 2000 and 2011, their numbers increased at a faster rate (29.8%) than native born individuals (8.3%) (Mirza et al., 2014, p.733). In Minnesota the rate of population growth for immigrants and refugees is higher than the national average. According to a report from Minnesota Compass, *Immigration in Minnesota: 5 things you should know* (2013) since 1990 the national population of non-native born individuals has doubled. The total population of Minnesotans not born in the U.S. however, has tripled. Hill, Hunt, and Hyrkas (2012) report Somali refugees are the third largest refugee group in the United States overall due to the political unrest and inhumane conditions in Somalia (p. 72). Nation-wide, Somali and other East Africans comprise 4% of the immigrant and refugee population. In Minnesota, the number of immigrants and refugees born in East Africa is 20% (as cited in 2014 Health Equity of Care Report).

Minnesota is considered one of the healthiest states in the country overall, but actually has one of the largest gaps in access to healthcare among racial and ethnic groups. Immigrants in Minnesota experience more health disparities compared to other Minnesotans. This is due in part to the stark inequity in housing, education and income levels. Poor access to health care, stress, pressure to assimilate to a new way of life, new foods, and different forms of transportation can all contribute to why significant health disparities exist between some immigrant groups and native Minnesotans (Pavlish et al., 2010, p. 353-54).

Non-citizens living in the United States received approximately 2.5% less Medicaid coverage, and are 8.5% more likely to be uninsured than U.S. citizens

(Navuluri et al., 2014, p. 5). Refugee immigrants have a higher rate of chronic pain and disease than non-refugee immigrants but have less access to care (p. 5). They may also experience additional challenges assimilating to a new culture if violence or war was present in their home country. Refugees are ten times more likely than the general population to experience post-traumatic stress disorder secondary to the rape, killing, torture, famine, destruction, and violent crimes against their families that they might have experienced (Piwowarczyk, Bishop, Yusuf, Mudymba, and Raj, 2014, p. 209).

There is a tendency for researchers and healthcare practitioners to discuss and group immigrants and refugees into one large category. This practice is ineffective in meeting the unique needs of immigrants and refugees because it may not address disparities that are unique to a particular group (Pavlish et al., 2010, p. 354). Mirza et al. (2014) also speak to the dangers of grouping various ethnic foreign born groups together, that doing so potentially ignores a group's specific needs (p. 733). "Beliefs about health are culturally constructed and affect people's decisions regarding treatment" (Wallin and Ahlstrom, 2010, p. 357) which suggests that each different cultural group will tend to have unique approaches to their health. Information regarding the demographics and statistics of immigrants and refugees as a whole is provided with the intention that specific recommendations from this research focused on the Somali community may be transferable to many different communities and patient groups.

The research that currently exists on immigrant and refugee health may not be helpful in addressing disparities because the identified barriers to accessing health care often come from the providers, not the patients. There can be a significant difference

between what providers identify and address as barriers and what immigrants and refugees themselves identify (Clarkson, Penney, Bettmann, and Lecy, 2013, p. 3).

There are several reasons why disparities in accessing health care exist among ethnic groups. Lower socioeconomic status is common for immigrants and refugees which may have a negative impact on health. The healthcare system in the U.S. is complex and difficult to navigate. Many immigrants and refugees struggle with not feeling accepted or valued by their health care providers which may decrease the likelihood they would schedule initial or follow up medical visits. Additionally, differences were documented in how much information is provided by physicians to their patients based solely on the patient's ethnicity; immigrants and refugees often don't receive adequate information about preventative care (Basanez et al., 2013, p.37 – 40 & Hill et al., 2012, p. 80).

Ninety five percent of refugees surveyed by Navuluri et al. (2014) indicated their healthcare clinicians provide culturally appropriate care. This statistic, however, may be misleading. The authors of this study describe two levels of barriers in accessing healthcare in the U.S. for refugees - structural and internal. They describe structural barriers as insurance, transportation, and navigating the healthcare system. Internal barriers are specific to an individual. The authors suggest that refugees don't focus on the internal barriers or recognize that they are not being met until the structural barriers are eliminated (p. 8). Current efforts in healthcare tend to be focused strictly on eliminating structural barriers and clinicians may not be prepared or trained to address the internal barriers. If true, this could explain why disparities in healthcare still exist for refugees in Minnesota.

Somali Healthcare Needs and Preferences

Somalia, a country located in the Horn of Africa, has lacked a central government for many years. As a result of the political unrest and violence, Somali refugees have fled their home country. Many of the refugees have been victims of physical, sexual, and emotional trauma and violence. The Somali that come to the United States have their own health beliefs, practices, preferences and needs (Simmelink, Lightfoot, Dube, Blevins, & Lum, 2013, p. 155-156). Despite being home to the largest Somali refugee community in the nation, Minnesota has not done an adequate job of caring for their health needs. Somali refugees are some of the least appropriately served by the current health system in Minnesota (Pavlish et al., 2010, p. 354).

A study by Wissink, Jones-Webb, Dubois, Krinke, and Ibrahim (2005) reported that a barrier experienced in particular by Somali women, is healthcare clinicians' lack of cultural competence or sensitivity (as cited in Hill et al., 2012, p. 73). For example, even though prenatal care is available in the United States many Somali women still hold on to their traditional practices which has led to increased infant mortality and health problems for the mothers. Somali women are "nine times more likely to deliver at or beyond 42 weeks," which increases the risk of complications during and after the delivery (Hill et al., 2012, p. 73). In Somalia, prenatal care was not part of healthcare and it was rare to seek the care of a provider during a pregnancy unless the mother was feeling extremely ill (Hill et al., 2012, p. 73).

A marked difference in the beliefs of the Somali community versus Western medicine is that illness is not often viewed as biologically caused. Instead the cause of illness is viewed in more holistic terms. Illness may be spiritually caused or because of feeling

isolated from their environment (Pavlish et al., 2010, p. 355, 358). One Somali woman commented during a focus group conducted by Hill et al. (2012) that “I think that in American culture you put a lot of trust in science. In the Somali culture, we put our trust in Allah” (p. 75). In Somalia some healthcare providers are trained in medical schools while others are “folk healers” but still very influential in the healthcare system. Treatments provided by these healers either focus on spiritual/human causes or “natural” causes (Tiilikainen & Koehn, 2011, p. 522).

The majority of the Somali population (99.8%) is Sunni Muslim and religion plays a large part in their culture and healthcare practices. The Quran can influence and guide health behavior of Somali people and many believe it is God who determines one’s health outcomes (Clarkson et al., 2013, p. 5). Many Somali believe that religion can both cause and cure disease and reading from the Quran can be healing (Simmelink et al., 2013, p. 156-157). According to participants in a focus group conducted by Pathy, Mills, Gazeley, Ridgley, and Kiran (2011) “Ramadan is the most important month of our year” (p. 47). Many Muslims honor Ramadan by fasting. Most do not eat, drink, exercise or take oral medication during daylight hours during Ramadan (p. 44). This may be an important consideration when treating patients who are Somali. Even those that don’t fast during Ramadan for various reasons must make it up at another time. Family members fast for those who are unable to fast due to mental illness (p. 49).

There are at least two separate cultural groups of Somali refugees; the Somali and the Somali Bantu. Many of Somali Bantu were enslaved by the Somali in Somalia. They were not given access to education or the opportunity to participate in the political system. Most of the Bantu are illiterate in Somali and English. The Bantu are seen by

many Somali as significantly different and are often persecuted (Parve & Kaul, 2011, p. 49 – 53). This may be an important distinction when treating Somali patients especially when interpreters are used. A Somali Bantu patient may not trust a Somali interpreter or vice versa because of the tension and history of violence between the two groups (Parve & Kaul, 2011, p. 49).

Somali patients may be more likely to miss a healthcare appointment if they have other obligations (Parve and Kaul, 2011, p. 53). This is more common with women as they are the primary care-takers and often put the needs of their family ahead of their own. As a result, at times they may miss scheduled appointments. Carroll et al. (2007) support this finding stating that “gender-specific roles, responsibilities, and traditions are the norm” in Somali culture (p. 338). If Somali women do attempt to cancel an appointment over the phone, many clinics now have automated systems to guide callers that they find confusing.

Somali immigrants, women in particular, expect and value learning new things about health and healthcare (Hill et al., 2012, p. 78). Many Somali can speak English but can't read English. Parve and Kaul (2011) point out that interpreters are not often provided for healthcare appointments. This is important when thinking about providing patients with written instructions and information about their condition or when consent forms are not orally presented to the patient (p. 53).

One significant difference is in the expectations that the Somali have about their healthcare. In Somalia healthcare was hierarchal and patients expected to receive immediate benefit or relief if they sought treatment (Pavlish et al., 2010, p. 356). Western medicine is focused on accurate diagnosis and it is common to visit a provider

and not have any treatment or relief of symptoms. This cultural mismatch may be problematic if a Somali patient was seeking initial treatment for low back pain, for example, and the physical therapist performs tests, measures and explains how their body mechanics were contributing to their pain sending them home with nothing but a picture of how to do a stretch of their hamstring muscles. These tests and interventions don't produce immediate results and because of this, the Somali patient may not be compliant with the stretches or return for a follow up visit. Although trust is an important part of the relationship between patient and provider for Somali, so is getting what they expected from the visit (Hill et al., 2012, p. 78).

Personal Observation and Experience

Trust and relationship building are important in the Somali culture. My experience with the Somali community in the Cedar Riverside community of Minneapolis has highlighted the importance of relationship building. I was cautioned by a trusted colleague that the community is leery of people outside the community, especially academicians coming in to help or study the community. If I wanted to learn about their culture I would need to initially just be present. My goal was to start a walking club with women in the community because I had heard that there was a significant prevalence of obesity and diabetes. For the first several months of our walking club, no one showed up to walk. We gathered at a mosque and talked. I became friends with a Somali woman who was very well known and active in the community and soon after we began walking together; more women joined.

My experience mirrors what Simmelink et al. (2013) describe as an effective method for educating the Somali community. They report that health information is best

delivered in one of two ways. One way is to have a community member vouch for the message, the treatment, or the provider. This is what happened for me. Even though I was not providing health care, it took the community elder and activist supporting my walking group to get others involved. She was also sharing information about our group orally at social or family gatherings.

Another goal was to educate community members about the benefits of physical therapy. When I brought this idea to the Minnesota chapter of the American Physical Therapy Association, the Board of Directors recognized an opportunity to promote our services to a group of people that we have not served well in the past. The initial thought was to translate the chapter webpage into Somali, as the internet is a primary source of information for physical therapy clinicians. I quickly realized my mistake when a Somali friend laughed at my idea; informing me that many Somali elders do not own nor know how to use computers and if they do, would most certainly not be searching on our webpage for information about their musculoskeletal pain. It was an embarrassing but effective lesson.

The difficult lesson I learned about the difference in cultural preferences and practices is quite common according to Pavlish et al. (2013). Most healthcare providers are completely unaware of the barriers that exist for the Somali community (p. 354). If we are unaware, we assume that our way of delivering healthcare and providing education is sufficient to meet their needs. It is critical for clinicians to learn about their patient's unique experiences and practices (Hill et al., 2012, p. 73).

Health Education

Educating patients on their diagnosis, the cause, treatment, and prevention are critical aspects of patient care, regardless of the discipline and involves active engagement from both the patient and provider. Physical therapy is no exception. When treating refugees, Beatson (2013) suggests that clinicians allow for more time to be spent on educating patients than with non-refugees. He advocates for clinicians talking about their own practices and treatment styles but stresses the need to learn about the patient's individual practices (p. 145). Chandry and Beasley (2012) support this concept that clinicians become familiar with the cultural and language background of their patients. For example, Pathy et al. (2011) found that most Somali patients want their healthcare providers to know more about Ramadan specifically, and be more respectful of their practices (p. 50).

For many immigrants and refugees, English is not the primary language. U.S. census data shows that 18% of the population speaks a language other than English in the home (as cited in Chandry & Beasley, 2012, p. 24). Misunderstandings may occur between patient and provider which can negatively impact patient health outcomes (p. 24). In a study by Filippi et al. (2014) literacy was rated by Somali refugees as the biggest barrier to health and healthcare. Many cultures, Somali included, have a tradition of oral storytelling and communication versus the Western practice of expressing their identities in a written form (Nichollas, 2009, p. 642). In physical therapy, clinicians include patient education as a key component of a plan of care. Additionally, most patients are discharged with written instructions on self-managing their symptoms. If communication

and literacy are barriers that are not addressed, the effectiveness of a treatment and the patient's overall health will suffer.

Healthcare providers may have the desire to provide appropriate health education and care but are often uncertain on how to accomplish this in a culturally sensitive manner. Morrison, Wieland, Cha, Rahman and Chaudhry (2012) acknowledge that clinicians do often lack information about various cultural groups' practices (p. 967). When clinicians are assessing a patient's health they should consider their patient's spiritual beliefs and how those impact their life (Pathy, et al., 2011). Having different cultural practices and beliefs does not need to worsen disparities if the differences are acknowledged by the provider and patient preferences are incorporated into the plan of care (Hill et al., 2012, p. 79). It is important to remember though, that disparities exist for reasons that involve the patient, the provider and the system (Carroll et al., 2007, p. 338).

Patient Compliance

Merriam Webster defines compliance as “the act or process of doing what you have been asked or ordered to do” (<http://www.merriam-webster.com/dictionary/compliance>). Use of this term can imply a hierarchical relationship between patient and healthcare provider. A more appropriate term may be adherence or concordance which is described as “the patient as the decision maker in the process and denotes patients – prescribers agreement and harmony” (Vermeire et al, 2001 as cited in Jin, Sklar, Oh, & Li, 2008, p. 270). Since compliance is the term most commonly used in the literature and in practice, however, it will be the term used throughout this paper.

In order for patients to achieve their physical therapy goals, there needs to be compliance with the plan of care that has been created. It is frustrating for physical therapy clinicians when there is little or no follow-through on prescribed exercises that are to be done at home. There are many factors, however, that directly impact patient compliance. A comprehensive qualitative review of the literature by Jin et al., (2008) categorized these factors into several categories. Demographic factors include the patient's age, ethnicity, gender, education and marital status. Psychological factors such as beliefs and motivations regarding the intervention, the patient-provider relationship, health literacy and the patient's knowledge about their condition also play a role. There are therapy-related factors that include how treatments are administered, the complexity of the treatment and the duration of the treatment. Social and economic factors impact compliance which includes the amount of time the patient may need away from work or family, the cost of the treatment, their income and social support. Finally, healthcare system factors such as the time it takes to get in to see a provider also impact compliance (p. 272-281).

Wang, Briskie, Hu, Majewski, and Inglehart (2010) report that patient compliance, including keeping scheduled appointments and following through on prescribed treatments improves from 71% to 94% when care is designed to meet individual needs (as cited in Basanez, Blanco, Collazo, Berger & Crano, 2013, p.38). It is important to acknowledge and address the *many* factors, though, that may impact patients' compliance with prescribed interventions. It is critical that both the patient and provider share their ideas and views on health to collaboratively develop the plan of care. Unfortunately time constraints due to clinic productivity requirements may not allow for

the extra time needed to communicate about differing healthcare views, preferences, and practices. It is common that the plan of care that is acceptable and appropriate to the provider supersedes that of the patient. Compliance may then suffer.

Most Somali are Muslim and Pathy et al. (2011) strongly advocate that communication needs to significantly improve between the healthcare community and the Muslim community to increase compliance (p. 43). A unique consideration for Muslims is their healthcare practice during the time of Ramadan. For most Muslims, the spiritual benefits of Ramadan far outweigh any pain or discomfort they may be experiencing thus they tend to not seek medical care or follow suggestions made by providers (Pathy et al., 2011). Additionally, many Muslims believe that regardless of their efforts to prevent illness and disease, God determines their health outcomes (Hill et al., 2012, p. 76). It would be appropriate for healthcare providers to ask patients if they want to share any of their religious practices or beliefs so the provider can be better informed about possible health behavior (p. 47-51).

Patients need to feel satisfied with the provider and the interaction to be compliant with treatment. If the provider spends adequate time with the patient and explains treatments well, compliance improves (Basanez et al., 2013, p. 38, 43). If there is a lack of patient understanding due to communication issues, which may be the case with immigrants and refugees, compliance may not occur and outcomes will suffer (Chaudry and Beasley, 2012, p. 24). In a study of Somali patients, participants report not being understood by their provider which Crano, 2012, Heider, 1958, and Tormala, 2008 identify as a reason why patients with diverse ethnic backgrounds do not trust their

provider or follow through with prescribed treatment (as cited in Basanez et al., 2013, p. 39).

Due to war, famine, and experiences in refugee camps many Somali refugees have a history of focusing on their immediate safety and health. This practice may present a challenge in the United States where the current focus of healthcare is on prevention. This focus, coupled with language barriers and literacy issues, can create compliance issues. One may assume that Somali refugees may be more compliant with interventions if interpreters are used during treatment sessions to facilitate communication (Morrison et al., 2012, p. 967-971).

Physical therapy clinicians believe they can be the “money savers” of the healthcare system by focusing on preventative care and keeping patients out of emergency departments as well as decreasing the number of costly hospital admittances (Barnett, 2011, p.8). If physical therapy practitioners are not effectively communicating with their immigrant and refugee patients the treatments and interactions may not be effective and not save money for the system.

Several authors describe the importance that nonverbal communication from the clinician can play on patient compliance. In order to maintain a sense of dignity if they are not feeling respected, patients with a different ethnic background from the provider will simply ignore the instructions and do what they know is comfortable to them (Basanez et al., 2013, p. 40). If Somali patients feel disrespected or stereotyped, they may not ask questions to clarify what the provider is saying (Hill et al., 2012, p. 79). If patients do feel valued and their preferences and practices are respected and integrated into the plan of care, compliance improves (Basanez et al., 2013, p. 42).

Physical Therapy and Altruism as a Core Value

Physical therapy is delivered by a physical therapist or a physical therapist assistant under the direction and supervision of a physical therapist. Currently, PTs earn a clinical doctorate upon graduation and PTAs graduate with an associate of applied science degree. For the purpose of this paper, physical therapist practice is inclusive of all care provided by a PT and PTA. Physical therapy clinicians refer to both PTs and PTAs.

The American Physical Therapy Association (APTA) is the professional organization which represents PTs, PTAs and students. The vision statement of the APTA adopted in 2013 is “Transform society by optimizing movement to improve the human experience” (retrieved from www.apta.org/Vision/). Membership in the APTA is optional and not required to maintain a license to practice physical therapy. The APTA has listed and defined seven Core Values that are essential for clinicians to exhibit to maintain professionalism in practice. These Core Values are accountability, altruism, compassion/caring, excellence, integrity, professional duty and social responsibility (retrieved from <http://www.apta.org/CoreDocuments/>). When thinking about the professional and ethical obligation to meet the healthcare needs of our diverse community, altruism appeared to be the most appropriate value in creating a framework to address the disparities that exist for the Somali community in Minnesota. This decision was supported by a study of students in the dental health field. Carreon, Davidson, Andersen and Nakazono (2011) found that dental students with attitudes and practices of altruism were better prepared to meet the needs of underserved communities and a diverse population (p. 58, 67).

According to the APTA, “altruism is the primary regard for or devotion to the interest of patients/clients, thus assuming the fiduciary responsibility of placing the needs of the patient/client ahead of the physical therapist's self-interest” (retrieved from <http://www.ptcas.org/Professionalism/>). Also included in the definition of altruism are sample behaviors of a clinician practicing altruistically:

1. Placing patient's/client's needs above the needs of the physical therapist.
2. Providing pro bono services.
3. Providing physical therapy services to underserved and underrepresented populations.
4. Providing patient/client services that go beyond expected standards of practice.
5. Completing patient/client care and professional responsibility prior to personal needs.

Dr. Nancy Watts published a seminal article in 1971 in which she describes the practice of physical therapy using a theoretical model which analyzes interventions or treatments using three dimensions of care; the process dimension, the purpose dimension, and the locale dimension. She cites sociologist Talcott Parsons (1951) describing the purpose dimension of the care provided by physical therapy clinicians as having an expressive function and an instrumental function. Instrumental functions of physical therapy “are acts which have as their purpose the practical solution of problems of getting the patient well again, or preserving his health” (as cited in Watts, 1971, p. 29) and this is where physical therapy can have its uniqueness. Examples include increasing strength or improving a patient's ability to walk without an assistive device.

Excelling at the provision of instrumental functions of healthcare is not enough to meet all of the patient's needs. The expressive function of care is also required. Watts (1971) describes these as "acts designed to contribute to the flow of satisfactions for the patient" (p. 29). This function could include taking extra time to answer all of a patient's questions to decrease anxiety about their impairment or offering a blanket during an intervention to protect their modesty and keep them warm. These behaviors may also be thought of as good bed-side manner. It is through these functions that a clinician can make their care truly patient centered, treating the patient as a person not just a diagnosis. In order to live into the APTA Core Values (<http://www.apta.org/CoreDocuments/>) of physical therapy and to practice altruistically, clinicians should excel in both functions of care.

Altruism is a common value for many healthcare professionals. Burks and Kobus (2012) describe altruism in healthcare as going above and beyond what is considered normal in daily practice (p. 318). Hem, Halvorsen, & Nortvedt (2014) describe another term that may fit with the intent of altruistic practice. They describe a "mature carer" as a middle ground between selfish behavior and true altruism which by definition calls the clinician to essentially ignore or put aside their own needs (p. 794). Reflection is critical to be a mature carer. The provider should self-reflect on their values, their patient's values and practices, and how they provide care. This allows for a reciprocal relationship to develop and for the minimization of a power differential between patient and provider. According to Pettersen (2012) "A carer is not an instrument for others to exploit, just as the caree is not of lesser worth for her dependency and vulnerability" (as cited in Hem et al., 2014, p. 789). These are not new concepts; according to Aristotelian ethics it is

important to “emphasize the importance of tailoring one’s judgment to the individual person” (Hem et al., 2014, p. 799). Despite the best intentions, healthcare provider’s efforts often fall short in meeting individual patient’s needs.

Burks and Kobus (2012) describe a common phenomenon in healthcare; that clinicians tend to talk about their patients in non-human terms or as objects. They refer to this as “othering” which was described by Boutin-Foster, Foster and Konopasek (2008) as the opposite of “other-directedness” (as cited in Burks et al., 2012, p. 318-319). In physical therapy, clinicians are encouraged to use patient first language to avoid this phenomenon. It is more altruistic to say “*the patient who has suffered a stroke*” versus “*the stroke patient.*” By using patient first language clinicians are better able to see the patient as an individual with unique needs and preferences, not as a diagnosis void of humanness. Unfortunately the financial and productivity pressures and burdens that clinicians experience may cause a decrease in quality patient centered care (Sethia, 2013, p. 344). In the field of nursing the pressures of current practice on nurses is resulting in less individualized care. Patients are not feeling as if they are a part of their healthcare team. Their needs are not understood, valued or attended to (Hem et al., 2014, p. 795). The result is patients feeling powerless or experiencing feelings of humiliation. If this power differential is not addressed it can lead to further disparity and injustice in healthcare (p. 800).

Dotson, Dave, Cazier, and Spaulding (2014) have noted a recent trend in nursing that many nurses who value altruism are leaving the field (p. 111). Similar to physical therapy clinicians, nurses are feeling the pressure to meet productivity standards and the authors note that there may be disconnection between the employee’s (nurses) values and

the values of the employer (p. 112). Medical interventions often take precedence over caring for patient's individual needs and preferences (Hem et al, 2014, p. 795) and altruistic tendencies may fade the longer clinicians are in practice due to the demands of the job. Altruism "may be fundamentally incompatible with the culture of medicine and the current financial drivers of healthcare" (Burks and Kobus, 2012, p. 322).

PTs and PTAs are expected to be productive. Not all facilities dictate specific productivity guidelines but clinician schedules are often full with back to back appointments. Productivity is determined by the number of billable units that are delivered. What is not often billable are such activities as taking extra time to explain a diagnosis or treatment or to ask in-depth questions about a patient's living arrangements or other contextual factors which influence their overall health.

The Somali refugee population in Minnesota is the largest in the country and the Somali people have their own unique healthcare needs, preferences, and practices which are not being met by the current healthcare system and methods of care delivery. Despite the increasing financial and productivity demands placed on physical therapy clinicians, we are called by our own Core Values to place the needs of our Somali patients above our own. It is our professional obligation to learn about our patients preferences and modify care in order to truly "transform society" as articulated by our Vision.

Research Question

This study investigated the following question: How could physical therapy clinicians modify care for Somali refugees to better meet their unique healthcare needs?

Methods

Subjects

It was critical to the success of the research to recruit and engage focus group participants who were willing to share their experience of health and healthcare with the researcher, someone they had never met. To accomplish this it was important to have a trusted Somali community member spread the word about the research and assist in recruiting participants. Information is often passed through the Somali community in a “pyramid approach” with a “messenger” informing and encouraging other community members to become involved (Simmelink et al., 2013, p. 159). This process began with the Director of Health Equity and Language Access of a major health system in Minnesota who shared the name and contact information of a local Somali interpreter. Meeting face to face with the interpreter to discuss the intended outcomes of the research led to an introduction to a Somali staff member at the African Immigrants Community Services (AICS) center in Minneapolis, MN.

Purposive sampling was used to recruit Somali refugees living in Minnesota who are students in the English language classes at AICS. All participants had been in the U.S. five years or less (other than an AICS staff member who also participated in the focus groups) and were able to provide insights on accessing healthcare in the U.S. as a new refugee. The only inclusion criterion for participation was exposure to or experience with the healthcare system in the U.S. This experience may or may not have included utilizing physical therapy services.

Prior to the focus groups, three meetings with AICS staff occurred to explain the purpose of the research, review the consent form and interview questions, and solicit their

assistance in recruiting focus group participants. The AICS staff recruited 12 Somali refugees to participate in two focus groups. The first focus group consisted of seven males whose time in the United States ranged from 14 months to 20 years (including the staff member who also provided interpretative services). The second group was six women who had lived in the U.S. between 12 months and four years.

A Somali interpreter was hired to translate the consent form into Somali. Once the document was translated, the AICS staff verbally read the consent form to potential participants prior to consenting to participate in the focus group. This was done without the researcher present to allow for an environment where potential participants felt free to ask questions or voice concerns. Somali community members are more trusting and willing to participate in an activity if another community member “vouches” for the practice or activity (Simmelink et al., 2013, p. 159). The staff at AICS served in this role.

In addition to the focus groups, semi-structured interviews of healthcare providers were used to triangulate the data. Two nurses were recruited through professional contacts and previous work experience with the researcher. Nurse A, a native-born Minnesotan is on faculty in a local nursing program and is the Director of a local drop-in center serving primarily East Africans. Nurse B was born in Somalia and currently serves as the Chief Operating Officer of a local federally qualified health center (FQHC) serving the East African community in Minneapolis, MN. Both have significant experience working with the Somali community.

Research Design

Qualitative research methods and a phenomenological framework were used to gather data on the Somali refugees’ experience with healthcare in the United States as

this allowed the researcher to “generate a better understanding of phenomena from the concrete particulars within the data” (Hanson, Balmer, Giardino, 2011, p. 379). Focus groups were used to collect data from Somali refugees to facilitate dialogue among participants which led to a better understanding of the factors that influence the health behavior of the Somali community (Krueger and Casey, 2009). The semi-structured interviews of healthcare professionals allowed for conversation between interviewer and interviewee that was free-flowing and closely resembled a conversation between a patient and provider. The interviewees were able to provide additional information outside of the structured questions that was relevant to the research (Nicholls, 2009, p. 640).

Data Collection Procedures

Institutional IRB approval was obtained prior to the focus groups and interviews. After participants provided written consent to participate in the focus group and be audio-recorded, they were informed that in order to protect their confidentiality they were not required to give their full name and were given the option to use a pseudonym. All participants were asked to keep participation in and the discussion during the focus groups confidential. Participants were given the contact information of the researcher for any follow up questions or concerns.

The focus groups were separated by gender and conducted in a conference room at AICS immediately following their English language class. To improve the trustworthiness of the data, it was important to conduct the research in a setting familiar to participants (Hanson, et al., 2011, p. 378). A male staff member served as interpreter for the male focus group and a female Somali interpreter was hired by the researcher to interpret for the female group. Somali tea and sambusas were served to each group as a

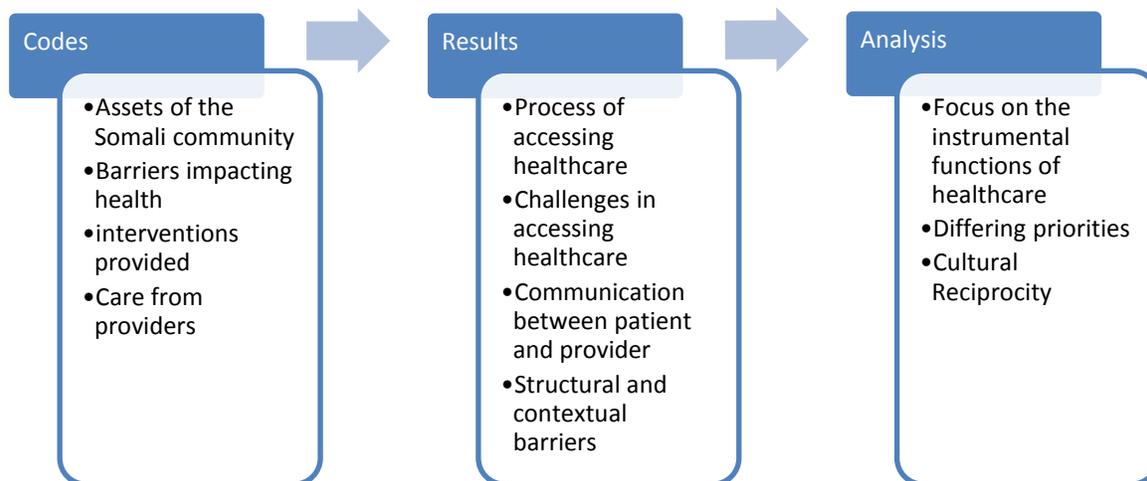
sign of hospitality and the researcher was dressed modestly with arms and legs covered as a sign of cultural respect. Prior to participants signing the consent form, everyone was allowed to ask any final questions. Participants were reminded that the conversation would be audiotaped and at any time, they could ask for the recording to be stopped. Each participant was given a \$10 Target gift card as a thank you for participation.

Prior to the interviews, participants were emailed the consent form and interview questions and allowed to ask any questions before agreeing to the interview. Due to time constraints and a medical issue, Nurse A was not able to meet face to face and instead recorded and emailed her response to the questions as an mp4. Nurse B was interviewed in her place of employment and the interview was audiotaped to ensure accuracy.

Data Analysis

Audacity audio editor was downloaded to the researcher's password protected computer and used to record the focus groups and interviews (<http://sourceforge.net/projects/audacity/>). Focus groups and individual interviews were transcribed verbatim. Field notes were taken during the focus groups and interview and memos were written immediately after each. The transcribed data, field notes, and memos were housed on the same password protected computer.

The data was reviewed by the researcher several times prior to analysis which occurred in three phases. The first step was to code the data which was based on key words used by participants or phrases that appeared several different times from both the focus groups and interviews. The coded data was then organized into four results or main ideas. The final step was to interpret the results and identify possible relationships between the main ideas (Hanson et al., 2011, p. 379).



A bias of the researcher prior to this study was an opinion that physical therapy clinicians do not adequately meet the healthcare needs of society other than white middle to upper class patients. In order to minimize the impact of this bias, the focus group and interview questions were reviewed with a trusted colleague versed in qualitative research and the research advisor prior to submitting an IRB application. Additionally, triangulating the data from Somali immigrants and healthcare providers who treat Somali immigrants provides multiple perspectives.

Results

Each focus group participant had an opportunity to respond to all of the questions posed (Appendix C). Questions focused on what participants liked and disliked about the healthcare system in the United States. They were also asked to describe how they treated illness and pain before (in Somalia) and after coming to the United States. Finally, each participant was invited to share if their health has improved or gotten worse since immigrating to the U.S.

The questions posed during the interviews of two healthcare providers focused more on their experience working with and treating the Somali refugee community. They

were asked to share strategies that were effective or not effective in meeting the healthcare needs of this community. They were also asked to share any advice or insights they might have for clinicians who are working with Somali refugees. Results from the interviews and the focus groups can be summarized and categorized into four main content areas: the process of accessing care in Somalia and in the United States, challenges in accessing care and achieving good health, breakdowns in communication between healthcare providers and the Somali refugee community, and barriers that exist for Somali refugees in receiving adequate healthcare.

Process of Accessing Healthcare

The results of the focus groups and interviews revealed that there are many differences and a few similarities between the Somali refugees' experiences in seeking and accessing healthcare in the United States versus in Somalia. Regardless of being in Africa or the U.S., most Somalis' initial action when seeking medical attention is to go to a clinic or hospital. *"If you live in a village [in Somalia] you've got a nurse, if you live in big city maybe you get the doctor"* (focus group (FG) B, participant (p) 2). If the injury or illness is serious enough, it is common to go directly to a hospital or emergency room. *"No matter what, we are going to go right away to hospital to treat pain"* (FG A, p. 1); *"if we feel pain in the home, we will go to the hospital right away"* (FG A, p. 2). The men reported that most hospitals in Somalia are government run. There is private pay care available but it is extremely expensive and even those individuals that can afford private healthcare usually access government services first and only pursue private care if they are not satisfied with the government services.

According to the focus group participants, this may be where the similarities end. The men described that in Somalia when they seek the care of a doctor or nurse, they go to the clinic, take a number, and wait for their turn to see the provider. *“You come in the morning, you take a number and the doctor never leave until they finish the whole, call the numbers. He’s going to finish”* (FG B, p. 4). The consensus of both of women and men though, was they preferred healthcare in the United State over healthcare in Somalia. Many participants mentioned that providers in the U.S. have more education and more access to advanced medical technology, *“doctors [here] have knowledge and technology”* (FG B, p. 4).

Some of the women shared stories of how lack of resources and technology in Africa led to the loss of a baby during the delivery process. *“I had a pregnancy in Africa; when I wanted to deliver the baby his head, outside, nobody come push out....and the baby dies”* (FG A, p. 3). Another woman shared a story of her pregnancy during time in a refugee camp.

“I had a baby in Africa, my second boy; it was in the refugee centers. There was a lady who was in charge but she wasn’t there at the time. We are circumcised. They baby head was almost there and they couldn’t open because of the circumcision. After that the baby go up. And after the umbilical come first before the baby. I believe if I was here, the baby would be born” (FG A, p. 4).

These stories prompted another participant to smile and say that now they are in the U.S. *“I would like to have a baby every year”* because the healthcare is so good, *“mothers get help, babies get help”* (FG A, p. 2).

Challenges to Accessing Healthcare

Despite the initial overwhelmingly positive response to healthcare in the U.S., there was discussion about aspects of healthcare that remains challenging for Somali refugees. According to one male participant, they “*don’t know anything about how healthcare works in the U.S.*” (FG B, p. 6) and navigating the system has been challenging. He spoke about a time, fairly recently when transportation was provided for him bringing him to and from appointments. He described how much he appreciated the transportation and how it helped him get the healthcare he needed.

The consensus amongst the men was that the two biggest areas of concern regarding healthcare are dental care and prescription medication. “*Most of the community, 99% are Medical Assistance and their insurance don’t cover a lot of dental work so that’s the big issue.....state run programs and government run programs are not good in the dental*” (FG B, p. 7). Almost all male participants commented on prescription medications. “*Prescriptions, they always, say doctors prescribe generic instead of brand names and when you push them ‘this medicine is not good, I need better medicine’ they say that’s the limit their insurance covers and their insurance can’t cover the expensive medicine*” (FG B, p. 1). One participant explained he had to “*go back three times to get the right prescription*” (FG B, p.3) and another stated “*I can’t get the right prescription.....they charge your insurance card and send you a cheap prescription*” (FG B, p. 6).

One of the major challenges Nurse B encounters in her facility is they are a federally qualified health center and are limited in what services they can provide and for which they can bill. She describes that other than referring out for services such as

physical therapy, the clinicians are limited to just prescribing medications. *“35% of our diagnoses are musculoskeletal in this clinic. We’re prescribing narcotics and muscle relaxers and people are not having a lot of success with that...because I think it’s a structural issue and I don’t think medications get at that level”* (personal communication, Oct. 1, 2015). They would like to provide on-site physical therapy and other complementary therapies but they are unable to bill for those services. She often refers her patients to physical therapy and the response is generally positive. *“They love physical therapy. That is one thing they go through with, with all the referrals we make”* (personal communication, Oct. 1, 2015). The Somali community served by her clinic has excellent compliance when referred to physical therapy, especially when it included aquatic therapy.

Nurse B went on to comment how she thinks the system of healthcare in the United States is flawed and not appropriately serving the Somali community. She claims that the medications being prescribed are not the answer in meeting the health needs of Somali refugees in Minnesota especially since such a high percentage of their issues are musculoskeletal. She reports her patients experience very little success with medication alone, *“muscle relaxers might give you relief so you can sleep but it’s not going to give you better quality of life”* (personal communication Oct. 1, 2015). She believes that physical therapy should be a part of primary care. It is currently categorized as a specialty referral but she advocates that it needs to be an *“essential part of our primary care system”* (personal communication, October 1, 2015).

Communication Breakdown

Despite a few concerns, in general, both the Somali men and women expressed praise and gratitude for the healthcare system in the United States at the beginning of each focus group. As the conversations progressed however, participants began to share stories that point to how the healthcare system is not serving them well. When asked what he doesn't like about healthcare in the U.S. one man's response was, "*you waste your whole day and they don't ever do anything for you, you just get sent back home*" (FG B, p. 2). He shared a story of going to the hospital emergency room and then having to wait four hours to be seen. When he came out, he realized his car was towed because it was in a two hour parking spot. That added to his frustration with the experience.

He was not alone in his frustration with wait time. Another man shared a similar story of a several hour wait in the emergency room with his son who had injured his leg. After three hours, they left without being seen and the man treated his son at home with ice and massage. One participant expressed his frustration with delays in finding out laboratory results. He shared that when he needs lab work he is told to go home and the results will be mailed to him. He claims at times he never receives anything or there is a long wait period to receive the information. He wants to know his results in a timelier manner. Several participants shouldered the responsibility for this, blaming themselves because they don't understand the healthcare system and don't speak English fluently. They recognize if they need to schedule an interpreter to help them understand it will increase the wait time even further.

These findings clearly align with what Nurse B reported when asked about preferences of the Somali community. She acknowledged that they usually want some

sort of an “*instant fix*” or answer for the condition they come in with (personal communication, Oct. 1, 2015). Nurse A had a similar response, that in Africa, they often had a personal relationship with their doctor or nurse and results from their care and interventions were usually immediate.

“There is a lot of disconnect with relationship building being that a lot of people felt very connected to their doctor back at home and the doctor knew their family and could tell them an estimated diagnosis or problem almost immediately, where here they have lots of tests and based on the test they might suggest another test and they may never get a clear answer. Or, you go to the pharmacist and they give you all these multiple medications and they’re not sure what they’re for and so people don’t take them or they share them or they go to another doctor and get more medication, so they’re on multiple medications for one issue. An example is people might be taking a lot of blood pressure medications and they are passing out” (personal communication Sept. 8, 2015).

This idea of an instant fix suggests that the only intervention that would satisfy this population is medication but both the male and female focus group participants enthusiastically stated that they are very likely to follow orders or recommendations in addition to prescription medication. They value exercise in particular, as an important part of health and treatment for various conditions. *“They are really comfortable with walking, than a gym because of again, they [the women] feel if they have a full hijab, getting on the treadmill can be safety hazard...they really prefer walking or women only physical activities are very popular”* (Nurse B, personal communication, Oct. 1, 2015).

Both of the nurses I interviewed agreed that communication, perceptions, and previous experiences can negatively affect healthcare experience for the Somali community. *“A lot of the people that we see feel like they are not part of the decision making process in the healthcare system here in the U.S.”* (Nurse A, personal communication, Sept. 8, 2015). When asked what advice they would give to a healthcare provider to improve quality of care, focus group participants responded *“when Somali community go there, treat well, good prescription [medication and other] and limit the waiting time”* (FG B, p. 5). *“Make sure they understand the pain you are complaining”* (FG B, p.1).

Nurse A commented on the perceived disconnect between the Somali Muslim faith and healthcare practices in the U.S. Women usually prefer women providers. Many women are afraid to seek the care of a doctor or other provider because they are circumcised and afraid they will be judged. There is a substantial stigma with mental health issues in the Somali community and many are hesitant to discuss or address these issues. Many of her Somali patients also don't understand why other remedies more traditional to their culture such as the use of prayer or black seed, which is used to treat many conditions such as asthma, impaired vision, or kidney stones are not prescribed. Her advice to clinicians is to be flexible enough to change protocols and programming based on the needs and desires of the community (personal communication, Sept. 8, 2015).

Nurse B brought up an important point when considering how to best meet the healthcare needs of the Somali community.

“I think that it’s not really unique in terms of they are not the only people that are, have these issues. The preference around faith, being a Muslim patient, I think is just a preference for gender; not having physical contact with opposite provider...for the more conservative women” (personal communication, Oct. 1, 2015).

Many of their preferences and practices apply to several different cultural groups. She cautions there is not one way to approach a Somali patient. Just like native born Minnesotans, they are very diverse. Some are conservative, others are not. They all have varying levels of exposure to Western medicine. Her advice is applicable to all patient interactions; *“be kind, be open, and ask a lot of questions”* (personal communication, Oct. 1, 2015)

Additional suggestions provided by both healthcare providers included a warning to not play the role of the expert telling Somali patients what to do. Start an appointment with a conversation, welcoming them in, possibly offering tea as a sign of hospitality. It is critical to build trust with patients in order to facilitate their story telling of what brings them in to see you. When first meeting a Somali patient, ask their name, do they have family? Are the family members living in Minnesota with you? Ask about their stressors and how they came to Minnesota. Did they experience trauma or were they part of the famine?

Additional advice included never assuming Somali patients understand what we are telling them. Nurse A suggests wearing culturally appropriate clothing when treating a Somali patient which includes having one’s arms and legs covered. Learn a few Somali words and avoid medical jargon. Allow time to really listen to and hear their story. She

stated that as a healthcare provider, we can “*go on the journey of health together*” with our Somali patients versus serving as the hierarchical expert (personal communication Sept. 8, 2015).

Community is very important in the Somali culture and Nurse A spoke to many of their cultural strengths; “*people are very much leaders and very much advocates for themselves*”, she also described community members as “*engaged and active in their decision making*” (personal communication, Sept. 8, 2015). A strategy she suggests is to have people from the Somali community involved in outreach efforts, “*have people in the community involved...use bilingual cultural liaisons*” (personal communication, Sept. 8, 2015). This can help build relationships between providers and the community. It is also important to recognize that group decision making is important in their culture, especially regarding healthcare issues. In general the Somali community wants to be informed as much as possible, but according to Nurse A, “*if it [diagnosis or plan of care] doesn't look the way they think it should they will let us know*” (personal communication, Sept. 8, 2015).

Another important consideration is many Somali patients have lower socioeconomic status and are affected by the social determinants of health (education, neighborhood safety, community context). Nurse B pointed out that professionals in the healthcare field are often middle class and their values tend to be different. “*We read, we write, we think health is the number one thing to focus on*” (personal communication, Oct. 1, 2015). This may not be the case for patients; they have many other things in the hierarchy of needs to focus on and healthcare clinicians need to be sensitive to this.

Structural and Contextual Barriers

Several barriers exist for the Somali community in accessing healthcare and maintaining health. These barriers can range from contextual factors affecting health such as housing and transportation, to communication issues that result in a delay of care. According to Nurse B, chronic pain and illness is very common for the Somali patients her clinic serves and for the community in general (personal communication Oct. 1, 2015). This was confirmed by the Somali men in the focus group. Of the seven participants, four stated that their health has gotten worse since coming to the United States.

One participant complained of chronic knee pain that developed after a few months in the U.S. He reported back in Africa he never experienced pain in his knees. His physician in the U.S. informed him that there was no lubrication left in his knees, or that it was essentially “*bone on bone*”. He was also told that he needed surgery but “*insurance would not cover the expensive procedure.*” When asked why he thought the pain developed his response was that “*it just happened, maybe the cold weather. Big issue since I come here*” (FG B, p. 2). Several focus group participants, men and women talked about how they walk for exercise in the U.S. but in Africa they would walk all the time. They may still walk quite a bit in the summertime if they live in a safe neighborhood with good accessibility to walking paths, but not in the winter.

Another participant shared that he has lost an unhealthy amount of weight since moving here. “*[I was] healthier in Africa than here, lost a lot of weight in America, became unhealthy, have gas, cannot eat the food in here. Something to do with the food in America*” (FG B, p.3) He is scheduled soon to have his third endoscopy. Upon moving

to the U.S. one participant became and has remained “*pre-diabetic, pre-hypertensive, before I used to be healthy*” (FG B, p. 7). This statement prompted another participant to speak up and share “*he [p. 7] is on the border, I crossed the border. I’m diabetic; I have high blood pressure, high cholesterol. So many things but I’m going to maintain [my health]*” (FG B, p. 5). “*Cholesterol and diabetic are problems in Somali community*” (FG B, p. 7). The one participant who reported his health improved upon moving to the U.S. had arrived in the country with hepatitis and was eventually cured with medication.

The women did not report or discuss any chronic illnesses but spoke about the challenges of the changing seasons in Minnesota. They believe that each season brings a new illness or “flu” and this was just not the case in Africa. “*In Africa we don’t have like this flu*” (FG A, p. 1) “*every morning my kid has this flu*” (FG A, p. 5).

Communication with providers and navigating the healthcare system is often a challenge for Somali refugees. According to one woman in the focus group, “*we don’t speak English and it is sometimes hard to find an interpreter. We just need extra help*” (FG A, p.4). According to Nurse B, providers often see female patients who describe general aches and pains but are unable to describe the causes. “*A lot of the women have had several childbirths so the muscles are weak and now with obesity, not being active in daily life that it’s really affecting their quality of life*” (personal communication, Oct. 1, 2015). Even for those that speak English, navigating the healthcare system and billing can be confusing. “*They send me a bill and I don’t understand,*” (FG B, p. 1) referring to confusion about what insurance covers and what is his responsibility.

In Western medicine, clinicians value prevention and medical screening to maintain health and prevent disease. According to Nurse B, many Somali women do not

want pap tests or mammograms because they are circumcised and afraid of being judged by a provider. She reports that in general a very small percentage pursue preventative screenings. She also states that many Somali women are hesitant to seek prenatal care. Due to the negative cultural stigma, care for mental health conditions is also seldom pursued. This is a significant concern for providers at her clinic (personal communication Oct. 1, 2015).

The men described how transportation is an issue for them in maintaining health and accessing healthcare. They stated that transportation used to be covered through insurance or a government program but, no longer. They report that in order to secure transportation they now need to schedule it at least two days ahead. Lack of transportation may also limit many Somali from accessing a local YWCA or YMCA with a free or reduced rate membership; a resource that may be extremely beneficial to their health. According to one man, a few seniors are lucky enough to have grown children who can bring them to and from the YMCA but most are here alone.

Nurse B provided more specific information about her Somali patients and compliance with physical therapy treatments. She informed me that although their initial compliance and follow-through is good, if they begin to feel any relief, they stop going to therapy. *“They stop going after temporary relief”* but the patients then return to her clinic with the same issues, *“year after year it’s still there”* (personal communication, Oct. 1, 2015). She cites the cost of physical therapy services as prohibitive for many Somali patients as well as the need to return to a physician for continued approval of physical therapy services. In her experience, patients have varying levels of results based on where they receive services. Long standing established clinics are more effective but

may have a longer wait time to be seen for an initial evaluation. The wait can be up to a week or two (personal communication Oct. 1, 2015).

Discussion

In researching the healthcare needs, preferences, and practices of the Somali refugee community in Minnesota, three major areas of analysis emerged that may explain the healthcare disparities that currently exist for this community. The first is that both healthcare clinicians and Somali patients tend to be focused on the instrumental function of healthcare when more attention needs to be paid to the expressive function. The second is Somali's cultural preference for and practice of receiving immediate treatment and results from their healthcare interventions are in potential conflict with Western medicine's value on correct diagnosis and evidence based care. Third, there is a lack of cultural reciprocity, or sharing of healthcare values and practices between healthcare providers and Somali patients.

Focus on Instrumental Aspects of Healthcare

As described previously, instrumental functions of healthcare have the purpose of treating a specific impairment such as loss of range of motion or decreased strength. Successful execution of the instrumental function of care in physical therapy could include prescribing the correct stretching or strengthening exercise to treat a patient's impairment. An example is teaching a patient who has had a total knee arthroplasty (TKA) or replacement how to increase the flexion or bend in their knee to improve their ability to ascend and descend stairs.

The expressive function of care includes those aspects of care that contribute to the patient's overall experience. These can be equally important in helping a patient meet

their goals. This could include asking the patient who has had a TKA about their living situation; do they have stairs in their home? Do they have stable housing? It may be as simple as learning how to pronounce the patient's name correctly. The purpose of the expressive function of care is to show respect for the patient and to treat them as an individual, not just a diagnosis that can be treated with a canned "cookbook" approach.

Responses from the focus group participants support the idea that most of their interactions with healthcare providers focus on the instrumental function of care. Observed during both focus groups, but especially with the women, was their unanimous response to the question posed about healthcare in the United States; that it is excellent and they appreciated everything about healthcare in America. Even though with additional questioning, the men began to share what didn't work for them about healthcare in the United States, the women consistently spoke nothing but praise for the U.S. system, "*all of them good*" (FG A, p. 2), "*so far we don't see anything we didn't like*" (FG A, p. 1).

When the expressive functions of care are met, patients feel valued and more than just their diagnosis. If they are not met, patients may not feel respected. Nurse A confirmed this finding stating that many Somali refugees may not follow prescribed medical treatment, especially if they don't believe it to be the correct diagnosis or course of action, "*if they don't believe they were given the right diagnosis they just won't follow up or do what they're asked to do*" (personal communication, Sept. 8, 2015). Additionally, many patients are afraid of being judged for conditions such as female circumcision so they will not share this important health information with providers (personal communication, Sept. 8, 2015).

Despite Nurse A's comment that many Somali patients will not follow recommended treatments if they do not feel respected or feel that they have been given the incorrect diagnosis and treatment, all of the focus group participants, male and female responded they would follow the recommendations of their healthcare provider. They made no mention of the need to feel respected. Pavlish et al. (2013) describes the healthcare system in Somalia as a hierarchy (p. 356) and it was clear to this researcher that the Somali refugees in the focus groups had significant respect for all healthcare clinicians and their knowledge level. What may be missing, however, is having a relationship with their providers. This discrepancy may be due to their instrumental functions of healthcare being adequately met but not the individual expressive functions of care.

In Somalia it is common for patients to have a more personal relationship with their doctor or nurse (Nurse A, personal communication, Sept. 8, 2015). They know more about each other than just medical conditions. They may know each other's families and spend time socializing outside of a medical facility. There appears to be a disconnect between the fast paced, productivity driven state of the current U.S. healthcare system and the Somalis' need for relationship building with their healthcare providers. According to Nurse A, it should be

“a simple relationship, building trust and getting to the point where we are sharing stories with one another and really going on the journey of health together and making decisions as one versus this ‘I’m going to tell you from my expert lens what you should be doing because I’m a nurse

and I've gone through training' mentality" (personal communication, Sept. 8, 2015).

Although discussion thus far has focused on the deficient execution of the expressive functions of healthcare with the Somali refugee community in Minnesota, there are also significant needs in the execution of the instrumental functions of care. As cited earlier, Minnesota is home to some of the worst disparities in the nation between immigrant groups and native born Minnesotans (Minnesota Department of Health as cited in Pavlish, et al., 2010, p. 353-354). Many of the focus group participants commented on the challenges of navigating the U.S. healthcare system, finding transportation, and other contextual factors that impact their ability to access care. When transportation is provided, for example, compliance and follow through with medical visits improves (FG B, p. 2). A female participant described how her housing situation negatively impacted her ability to arrive to appointments on time. The fact that she was living with five of her children in a two bedroom one bathroom apartment was a barrier for her. Her sleep was often disturbed and getting her time in the bathroom was challenging.

Several of the Somali men mentioned that they qualify through their health insurance for a free membership to the local YMCA. Even though programs such as free or reduced memberships to a local YMCA exist, other barriers such as transportation are limiting the effectiveness of these programs. If Somali refugees don't drive, own a car, have someone to drive them, or know how to access public transportation they are not going to be able to get to the YMCA. This is reminiscent of my mistake earlier in my career thinking that translating our professional website into Somali would improve their

access to our services when many don't own or even know how to use a computer. What may work for native born Minnesotans may not work for the Somali refugee community.

Focus group participants in this study voicing their appreciation for and satisfaction with our healthcare system supports the results of a study by Navulauri et al. (2014). Their findings indicate that immigrants and refugees themselves do not focus on identifying or overcoming the internal barriers to accessing healthcare that are unique to the individual person until the structural barriers such as insurance and transportation are resolved (p. 8). As indicated by several participants in this study, these structural barriers have not yet been fully resolved. Additionally, the focus group participants felt that American providers were better educated and had access to more technology, adding to their initial satisfaction with our healthcare system.

Unfortunately, many immigrants and refugees report that they do not feel valued or respected by their healthcare providers. Although not reflected in the findings of this study, as a result of not feeling valued, patients may ignore the recommendations of the provider in order to maintain a sense of dignity (Basanez et al. 2013). When a provider's focus is primarily on the instrumental function of care it may be easy to categorize immigrants by cultural group, treating all in a similar manner or to not see each patient as an individual. Nurse B cautions against this, "*don't assume there is one way to approach Somali*" (personal communication, Oct. 1, 2015). There is significant diversity amongst the individual members of the Somali immigrant community.

It is within physical therapy clinicians' scope of practice to take the time needed to learn about the individual needs and preferences of patients in order to adequately deliver the expressive purpose of care. The APTA Core Value of altruism calls clinicians

to this level of practice. To be altruistic, the needs of patients should consistently be put ahead of the providers. Altruism calls for physical therapy clinicians to serve underserved populations and the Somali refugee community in Minnesota is currently underserved. Altruistic practice guides clinicians to go beyond the expected level of practice to meet patients' needs (<http://www.apta.org/CoreDocuments/>). Data from the interviews with healthcare providers in this study highlight Somali refugees' need for time to tell their healthcare story and establish a relationship with providers. This is needed to adequately provide the appropriate expressive function of care.

Difference in Healthcare Delivery

This study found many Somali have a preference for immediate and instant results from their diagnostic tests and healthcare interventions. This preference differs from current practice in the American healthcare system which values an accurate diagnosis and care that is based on evidence. For example, in physical therapy a patient may access services because they are experiencing knee pain. An immediate pain relieving intervention might include an ultrasound treatment or a massage to the area. Those interventions may relieve the pain temporarily but will not resolve the issue long term. They simply treat the symptom and not the cause of the knee pain. Many PTs and PTAs today in the United States are significantly decreasing the use of these pain relieving interventions because the efficacy of the treatments are not supported by current evidence; their effectiveness is temporary at best. Instead they may prescribe exercises to strengthen the surrounding structures to address the cause of pain but results or pain relief may not be evident for several days or weeks. In Somalia, patients would typically receive a treatment that would have an immediate effect on their pain. Massage is often a

preferred treatment for pain with Somali patients, if they “*feel pain, like a bad back, then my mom or sister come massage my back*” (FG A, p. 6), “*if we need like a massage, the doctor will order us and then go to a place*” (FG A p. 2). This is an example of how the healthcare priorities and practices of the Somali refugees and the physical therapy community do not always align.

The data gathered from study participants support that many Somali refugees have a preference for and practice of receiving immediate medical attention and treatments for their conditions. “*If we feel pain or fever, we go to the hospital or emergency*” (FG A, p. 3). Nurse B stated that her Somali patients often want an “*instant fix*” (personal communication, Oct. 1, 2015) when seeking the care of a health provider. That instant fix could be a prescription medication, a massage or another pain relieving intervention.

Pavlish et al. (2013) describe that in Somalia, patients expect immediate benefit or relief when seeking care from a healthcare provider (p. 356). Due to the war and famine that many Somali refugees experienced prior to coming to the United States they have a tendency to focus just on their immediate safety and needs (Morrison et al., 2012, p. 967) and thus are only satisfied with treatments that have immediate results. Somali patients may not comply with preventative care, or in the case of physical therapy, interventions such as stretching and strengthening that may not result in an immediate change or pain relief but are necessary to treat an impairment long term.

Adding to the issue is the seemingly ever decreasing length of time that physical therapists are able to spend with their patients during the initial visit. It is often not enough time to perform all of the necessary tests, measures, and come up with a PT

diagnosis with time remaining for any type of intervention. It is fairly common that the interventions or treatments themselves begin on the second visit after the diagnosis has been made. If Somali patients do not understand this, they may be likely to not return for a second visit because from their perspective, nothing was done on the first visit that satisfied their needs.

In Somalia, patients could expect to be seen by a healthcare provider or folk healer the same day they needed treatment. There are no appointments; it is first come, first serve and patients would receive some sort of treatment. This system mirrors that of our urgent care facilities or emergency departments. This may explain why many Somali refugees view these resources as their first choice when they need medical attention, even if the condition doesn't warrant this type of facility based on American medical standards.

A resounding theme during the male focus group was their desire to have the correct medication prescribed when they seek care from a physician or nurse. In fact, when asked what is the biggest problem for them with the healthcare system in the United States the answer most gave was medication. The men expressed frustration that they were sometimes not prescribed the correct medication or that insurance wouldn't pay for the prescription. Although they appreciated and saw the value in other prescribed treatments such as exercise, medication came up over and over again both as a problem but also as the main solution for their health issues.

Both of the nurses interviewed also spoke about medication. Nurse B felt frustrated that because of the regulations they must adhere to as a federally qualified health center. Prescribing medication is one of the only treatments or interventions that

they can provide on-site. Federally qualified health centers receive funding from grants under section 330 of the Public Health Service Act and are subject to specific guidelines that determine what services they can provide and bill for. She knows that her patients often need additional services and that the medication itself will not solve their health issues (personal communication, Oct. 1, 2015). Working in a drop-in center, Nurse A does not prescribe medication but she helps the Somali community understand the many medications they have been prescribed. For a variety of reasons, many Somali refugees are not taking the correct dosage or frequency of medication, they are sharing medications with each other and polypharmacy or taking too many different medications has become an issue (personal communication, Sept. 8, 2015).

The difference in practices and delivery of healthcare in Somalia and the United States, combined with both the provider's and patient's tendency to focus on the instrumental function of healthcare may contribute to the health disparities that exist for the Somali refugee community in Minnesota.

Cultural Reciprocity

Practicing cultural reciprocity could improve patient compliance and health outcomes. According to Beatson (2013) "cultural reciprocity" occurs when in addition to listening to the patient and learning about their values and preferences, the provider also shares their views and practices pertaining to healthcare (p. 145). Based on the exchange of information the patient and provider can collaboratively design a treatment plan acceptable to both.

An example of how cultural reciprocity could improve effectiveness of care pertains to the concepts of time and timeliness. According to Parve and Kaul (2011), the

Somali perception of time is different; they do not place as much value as most Americans do on arriving on time for appointments as other commitments may take priority (p. 53). When Somali patients are late for appointments, physical therapy and other healthcare clinicians may feel disrespected and assume that Somali patients don't value the care they are receiving or the provider's time. It is usually not that Somali patients are intending to be disrespectful, but that they have a different cultural norm pertaining to set appointments. Compounding this issue are the many contextual factors that may negatively impact a patient's ability to be on time for an appointment. The clinician sharing their value of arriving on time for appointments is an opportunity for cultural reciprocity.

Preliminary review of the data collected from the focus groups indicated that since the Somali community prefers immediate results they may be less likely to value patient education, a key component to a successful physical therapy plan of care. Further analysis of this data and the information provided by the healthcare providers interviewed indicated this was an incorrect assumption or conclusion. Instead, a similarity emerged regarding the importance of education. Somali patients want to be informed about their medical condition and in physical therapy and clinicians put a lot of emphasis on providing that patient education.

Physical therapy clinicians and all healthcare providers need to allow time during appointments to inquire about the culture of patients, not just pertaining to healthcare but whatever contextual factors that may impact their health. Additionally, it cannot be assumed that Somali patients fully understand the healthcare system in the United States or the values of professional healthcare providers. The answer is not that clinicians

assimilate to the Somali culture or vice versa, but to have an exchange of information. Consideration should be given to the values and practices of the patient and equally important is for the healthcare provider to share his/her own values and practices that shape how care is provided.

While every patient is different and unique there are several strengths of the Somali community as a whole that can be leverage to improve access and care. According to Nurse A, Somali highly value relationships and community members are extremely supportive of each other. One of their biggest strengths is their connectivity to each other. They are especially supportive of one another during the decision making process and tend to make decisions as a family or a community. She also described how there are many leaders and advocates in the community and women in particular tend to take on this role. They will ask and advocate for what they and the rest of the community need in terms of exercise and nutrition. They are typically very excited to share information and resources with each other (personal communication Sept. 8, 2015).

Another opportunity for exchanging information through cultural reciprocity is in the context of religious practices. Having different beliefs and practices does not have to increase healthcare disparities if they are discussed and practices are incorporated into the plan of care (Hill et al, 2012, p. 79). Religion plays an important role in the lives of many Somali refugees. Patients place more value on the spiritual benefits of observing Ramadan than the physical health benefits from eating throughout the day, exercising, or taking an oral medication (Pathy et al., 2011, p. 47). Clinicians need to ask about religious practices that may impact a patient's health and inform them of their own practices if they differ from the patients. It is likely that Muslim patients may not set or

keep appointments during Ramadan and their eating, exercise, and medication habits are affected by their observation of this holy month.

Recommendations

The culture and practice of medicine in Somalia is different than in the United States. Healthcare providers in the U.S. have more professional education than those in Somalia, there are different protocols for accessing care, and different treatments or interventions that are prescribed. The purpose of this research was to identify the healthcare needs, preferences, and practices of the Somali refugee community in Minnesota to inform the practice of physical therapy clinicians. Recommendations include implications for physical therapy education, clinical practice, and the vision and values of the physical therapy profession.

Physical Therapy Education

Providing culturally appropriate care and practicing altruism should be content included in the didactic educational preparation of PTs and PTAs. Strategies to incorporate this content into curricula could include a case based, or problem based learning (PBL) approach. A patient scenario could be developed with several contextual considerations that may include socioeconomic status, ethnicity, and gender in addition to a physical impairment. This pedagogical approach allows students to develop the practical skills they will need as a clinician treating patients with many factors that impact their health. Students work together in small groups around a particular paper case and are able to learn from each other and develop critical thinking skills as they develop a “respect for contextual specificity” (Leon, Winskill, McFarland, and del Rio, 2015, p. 92-93). The patient in the case could be a Somali refugee and one task or

learning issue for students would be researching Somali cultural norms and healthcare practices, sharing information with their classmate and analyzing together the implication on the plan of care.

Lab practical exams are common in physical therapy education; part of the evaluative criteria could include the student's ability to engage in cultural reciprocity or the ability to articulate their values or practices of Western medicine in addition to asking the patient questions about theirs and providing a hands-on skill or intervention. There are numerous opportunities to integrate different contextual factors, not just ethnicity, that impact health and wellbeing into existing assignments or assessments. This helps promote patient or person centered care and decreases the incidence of "othering" (Boutin-Foster et al., 2008, p. 318) or referring to patients as their diagnosis in non-human terms.

Clinical Practice

There are several strategies that can be incorporated into clinical practice that may improve care and outcomes for the Somali refugee community. Most physical therapy clinics have scheduled appointments for patients. In addition to appointments that are scheduled in advance, clinics could establish "walk in hours" or designate one clinician per day who is available for walk in appointments. This would help meet the needs of patients who value a set schedule and timeliness and those that value the flexibility to receive treatment at a time or day convenient for them.

Consideration should also be given to the physical space of a clinic and how treatments are provided by clinicians. Space should be designated for single gender exercise or treatment instead of one large gym space which is common in hospitals and

physical therapy clinics. This could be accomplished by having a separate room or with room dividers and privacy screens. Nurse A suggests taking the time during appointments to create a welcoming atmosphere for patients by offering an orientation to the clinic prior to or as part of the initial visit (Morrison, et al., 2012, p. 973). Desks, computers, and clipboards which clinicians use to document can be perceived as a physical barrier between patient and provider. Nurse A recommends asking questions about the patient's family, their life in Somalia, and how they came to the United States without taking notes prior to any questions about their health. Begin the appointment by having a conversation without the physical barrier of a patient chart or a computer. Tea may also be served as a sign of hospitality (personal communication, Sept. 8, 2015).

There are also strategies to improve the communication between patient and provider about health conditions and treatments. Clinicians could engage with previous Muslim or Somali patients and ask them to serve as peer tutors by providing information to the community, either one on one or in a group setting. Handouts of exercises or treatments could be endorsed by religious or community leaders. Clinical guidelines and practices could be co-created by clinicians and members of the Somali community (Pathy et al., 2011, p. 44, 51).

Physical therapy providers are often limited in how much time they have available to spend with a patient during an appointment due to productivity requirements or the number of patients on their caseload. Partnering with community health workers (CHW) can be an effective strategy to achieve cultural reciprocity, improve patient compliance, and decrease health disparities (Katigbak, Devanter, Islam, & Trinh-Shervin, 2015, p. 872). CHW can assist “people from diverse populations overcome barriers that prevent

them from accessing and benefitting from health services”

(<https://www2.stkate.edu/publichealth/community-hw-cert>). They are people from within a community who share various characteristics with their patients such as ethnicity, immigrant or refugee status, or language. Their role is to empower community members by modeling behavior, improving communication between provider and patient and act as a bridge between two cultures (Katigbak, et al., 2015, p. 872). Community health workers can take the time clinicians may not have to listen, be empathetic and guide immigrant and refugee patients through the U.S. healthcare system.

APTA Vision and Core Values

The vision statement of the APTA, “transform[ing] society by optimizing movement to improve the human experience” (www.apta.org/Vision) challenges physical therapy clinicians to meet the needs of all of society, regardless of cultural preference, practice and values. Strategies to successfully live into the Vision include clinicians actively engaging with community members. Individual chapters (states) of the APTA can financially sponsor or volunteer time at local community events, participate in school career and health fairs, meet with various community members to find out what their needs are and what physical therapy clinicians can learn and gain from the community.

Another opportunity to impact society is to engage in advocacy. Advocacy efforts should be not be focused solely on PT practice or access issues but issues such as homelessness and housing, livable wages, public transportation, the education achievement gap, and the declining prevalence of physical education in primary and secondary education. All of these issues impact patient’s ability to access our services and live healthy lives.

Limitations

The non-random selection and the small sample size of participating Somali immigrants and nurses in this study may not be representative of Somali immigrants, or the nurses who work with them, throughout the United States. This limits the generalizability of the qualitative findings; the immigrants who participated in the focus group were essentially self-selected. The need for interpretive services led to financial and time constraints that impacted the number of focus groups from which to collect data. This also prohibited the researcher from confirming the data with focus group participants after transcription. It is unknown whether the beliefs, opinions, and experiences of the immigrants who did not have the opportunity or choose to participate would be similar to the 13 who did. Also, having an additional researcher to perform independent coding of the data would have increased the dependability of the results.

This research study identifies inequities based on being a Somali refugee. Somali refugees in Minnesota have higher rates of chronic disease and experience challenges accessing healthcare based on insurance requirements, communication issues, cultural differences, and various other contextual factors such as transportation that can impact access to care. Future research on health inequities in the Somali community could incorporate intersectionality theory in the research design and analysis. Weber and Parra-Medina (2003) state that “intersectional approaches... provide a powerful alternative way of addressing questions about health disparities that traditional approaches have been unsuccessful in answering (as cited in Sen, Iyer, and Mukherjee, 2009, p. 399). An intersectional research approach could describe how several dimensions of an individual Somali refugee intersect, for example gender, age, race, and socioeconomic status.

Limiting research to inequity and disparity of a population as a whole, such as Somali refugees, may in fact reinforce the injustice by simplifying the cause to one dimension (Bauer, 2014, p. 11).

Conclusion

The vision of the American Physical Therapy Association is to “transform society by optimizing movement to improve the human experience.” The demographics of society in Minnesota are changing. In order to transform all of society, including the Somali refugee community, clinicians must learn about and consider their patient’s individual healthcare needs, preferences and practices. My goal as a physical therapy clinician is not to force assimilation for patients to mirror *my* human experience; rather to improve *their* unique human experience. Making recommended modifications to physical therapy education, current practice, and within the professional association may result in improved health outcomes for Somali immigrants and refugees. The results of this research can serve as a tool to guide all physical therapy clinicians in more effectively meeting the diverse needs of all patients to truly transform society.

References

- American Physical Therapy Association. Professionalism in physical therapy: Core values (BOD P05-04-02-03). <http://www.apta.org/CoreDocuments/>.
- American Physical Therapy Association. Vision statement for the physical therapy profession (2013). <http://www.apta.org/Vision/>.
- Barnett, W. S. (2011) PTs should advocate for prevention reimbursement. *PT in Motion*, February, 2011, 8 – 10.
- Basáñez, T., Blanco, L., Collazo, J. L., Berger, D. E., & Crano, W. D. (2013). Ethnic groups' perception of physicians' attentiveness: Implications for health and obesity. *Psychology, Health & Medicine*, 18(1), 37-46.
- Bauer, G.R., (2014). Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity. *Social Science & Medicine*, 110, 10-17.
- Beatson, J. E. (2013). Supporting refugee somali bantu mothers with children with disabilities. *Pediatric Nursing*, 39(3), 142-5.
- Burks, D. J., & Kobus, A. M. (2012). The legacy of altruism in health care: the promotion of empathy, prosociality and humanism. *Medical Education*, 46(3), 317-325.
- Carreon, D., Davidson, P., Andersen, R., & Nakazono, T. (2011). Altruism in dental students. *Journal of Health Care for the Poor and Underserved*. 22. 56-70.
- Carroll, J., Epstein, R., Fiscella, K., Gipson, T., Volpe, E., & Jean-Pierre, P. (2007). Caring for Somali women: Implications for clinician–patient communication. *Patient Education & Counseling*, 66(3), 337-345.
- Chaudry, A. N., & Beasley, E. (2012). Linguistically competent care for patients with

- limited English proficiency: A necessity for best practice in physical therapy. *HPA Resource*, 12(3), 24-26.
- Clarkson Freeman, P. A., Penney, D. S., Bettmann, J. E., & Lecy, N. (2013). The Intersection of Health Beliefs and Religion Among Somali Refugees: A Qualitative Study. *Journal Of Religion & Spirituality In Social Work*, 32(1), 1-13.
- Dharod, J. M., Croom, J. E., & Sady, C. G. (2013). Food Insecurity: Its Relationship to Dietary Intake and Body Weight among Somali Refugee Women in the United States. *Journal Of Nutrition Education & Behavior*, 45(1), 47-53.
- Donnelly, T., & McKellin, W. (2007). Keeping healthy! Whose responsibility is it anyway? Vietnamese Canadian women and their healthcare providers' perspectives. *Nursing Inquiry*, 14(1), 2-12.
- Dotson, M. J., Dave, D. S., Cazier, J. A., & Spaulding, T. J. (2014). An Empirical Analysis of Nurse Retention. *Journal Of Nursing Administration*, 44(2), 111-116.
- Filippi, M., Faseru, B., Baird, M., Ndikum-Moffor, F., Greiner, K., & Daley, C. (2014). A Pilot Study of Health Priorities of Somalis Living in Kansas City: Laying the Groundwork for CBPR. *Journal Of Immigrant & Minority Health*, 16(2), 314-320.
- Hanson, J. L., Balmer, D. F., & Giardino, A. P., (2011). Qualitative research methods for medical educators. *Academic Pediatrics*, 11(5), 375-386.
- Hem, M. H., Halvorsen, K., & Nortvedt, P. (2014). Altruism and mature care: Some rival moral considerations in care ethics. *Nursing Ethics*, 21(7), 794-802.
- Hill, N., Hunt, E., & Hyrkäs, K. (2012). Somali Immigrant Women's Health Care Experiences and Beliefs Regarding Pregnancy and Birth in the United States. *Journal Of Transcultural Nursing*, 23(1), 72-81

- Jim, J., Sklar, G.E., Oh, V.M., Li, S.C. (2008). Factors affecting therapeutic compliance: A review from the patient's perspective. *Therapeutics and Clinical Risk Management, 4*(1), 269-286.
- Katigbak, C., Van Devanter, N., Islam, N., & Trinh-Shevrin, C. (2015). Partners in Health: A Conceptual Framework for the Role of Community Health Workers in Facilitating Patients' Adoption of Healthy Behaviors. *American Journal Of Public Health, 105*(5), 872-880.
- Krueger, R.A., & Casey, M. (2009). *Focus groups: A practical guide for applied research*. Thousand Oaks, CA: SAGE Publications, Inc.
- Leon, J. S., Winskell, K., McFarland, D. A., & del Rio, C. (2015). A case-based, problem-based learning approach to prepare master of public health candidates for the complexities of global health. *American Journal Of Public Health, 10*(5). S92-S96.
- Minnesota Community Measurement (2014). 2014 Health equity of care report: Stratification of health care performance results in Minnesota by race, Hispanic ethnicity, preferred language and country of origin. Retrieved from www.mncm.org
- Mirza, M., Luna, R., Mathews, B., Hasnain, R., Hebert, E., Niebauer, A., & Mishra, U. (2014). Barriers to Healthcare Access Among Refugees with Disabilities and Chronic Health Conditions Resettled in the US Midwest. *Journal Of Immigrant & Minority Health, 16*(4), 733-742.
- Morrison, T., Wieland, M., Cha, S., Rahman, A., & Chaudhry, R. (2012). Disparities in Preventive Health Services Among Somali Immigrants and Refugees. *Journal Of Immigrant & Minority Health, 14*(6), 968-974
- Navuluri, N., Haring, A., Smithson-Riniker, K., Sosland, R., Vivanco, R., Berggren, R.,

- & Rosenfeld, J. (2014). Assessing Barriers to Healthcare Access Among Refugees Living in San Antonio, Texas. *Texas Public Health Journal*, 66(3), 5-9.
- Nicholls, D. (2009). Qualitative research: Part three – Methods. *International Journal of Therapy and Rehabilitation*, 16(12), 638-647.
- Parve, J., & Kaul, T. (2011). Clinical issues in refugee healthcare : The Somali Bantu population. *Nurse Practitioner*, 36(7), 48-53.
- Pathy, R., Mills, K. E., Gazeley, S., Ridgley, A., & Kiran, T. (2011). Health is a spiritual thing: perspectives of health care professionals and female Somali and Bangladeshi women on the health impacts of fasting during Ramadan. *Ethnicity & Health*, 16(1), 43-56 14p.
- Pavlish, C., Noor, S., & Brandt, J. (2010). Somali immigrant women and the American health care system: discordant beliefs, divergent expectations, and silent worries. *Social Science & Medicine*, 71(2), 353-361.
- Remen, R. N. In the service of life. [Web log post] Retrieved from <http://www.ic.sunysb.edu/Clubs/buddhism/dailylife/helpserve.html>
- Sen, G., Iyer, A., & Mukherjee, C. (2009). A methodology to analyse the intersections of social inequalities in health. *Journal of Human Development and Capabilities*, 10(3), 397-402.
- Sethia, B. (2013). In praise of idealism in healthcare. *Journal of The Royal Society of Medicine*, 106(9), 344-345.
- Simmelink, J., Lightfoot, E., Dube, A., Blevins, J., & Lum, T. (2013). Understanding the Health Beliefs and Practices of East African Refugees. *American Journal Of Health Behavior*, 37(2), 155-161

- Tiilikainen, M., & Koehn, P. (2011). Transforming the boundaries of health care: insights from somali migrants. *Medical Anthropology*, 30(5), 518-544
- Wallin, A., & Ahlström, G. (2010). From diagnosis to health: a cross-cultural interview study with immigrants from Somalia. *Scandinavian Journal Of Caring Sciences*, 24(2), 357-365.
- Watts, N.T. (1971). Task analysis and division of responsibility in physical therapy. *Physical Therapy*, 51 (1), 23 – 35.

Appendix A
Focus Group Consent Form

Consent to Participate in Research
Providing Culturally Appropriate Physical Therapy to Somali Refugees in Minnesota

Introduction and Purpose

My name is Jessica Scholl; I am a physical therapist assistant and a graduate student studying organizational leadership at St. Catherine's University in St. Paul under the supervision of Dr. Amy Ihlan, a faculty member in the Department of Organizational Leadership. I would like to invite you to take part in my research study, which concerns understanding the healthcare needs, preferences and practices of the Somali community in Minnesota.

You were referred as a possible participant in this research byfrom Health Commons. Please listen to the description of this study and ask questions before you agree to participate.

Procedures

If you agree to participate in my research, you will be a participant in a focus group of up to 5 Somali men and/or women at a time that is mutually agreeable by all participating. The focus group will be held in the Health Commons space in the Chase Building of Riverside Plaza. A community cultural liaison will be present to provide translation. The focus group will involve a series of questions related to your experience with health and healthcare. It should last approximately 60 - 90 minutes. With your permission, I will audiotape the focus group. The recording is to accurately record the information you provide, and will be used for transcription purposes only. Prior to transcription, I will play the audiotape to another trained healthcare interpreter fluent in Somali and English to ensure accuracy of the initial translation. You will not be identified as a participant. The recording and notes will be destroyed at the conclusion of the study. If you choose not to be audiotaped, I will take notes instead. If you initially agree to being audiotaped but feel uncomfortable at any time during the focus group, I can turn off the recorder at your request. Additionally, if you prefer not to continue in the focus group at all, you can stop at any time. Please let me know if you would prefer to be in a focus group with only participants of the same sex, such as all women.

I expect to conduct 2 – 3 focus groups of up to 5 participants each.

Risks and Benefits

The study has minimal risks but there is the possibility of emotional stress associated with sharing your experience.

You will be given a \$10 gift card to Target as a thank you for participating in the focus group.

Confidentiality

Your study data will be confidential. Your identity and any identifiable information will not be known. If results of this study are published or presented personally identifiable information will not be used.

To minimize the risks to confidentiality, I will store all transcripts and notes in a secured computer drive accessible only by me. All identifying data will be coded, with only me knowing the true identify of each respondent.

At the conclusion of this project, I will destroy the recording and notes.

Rights

Participation in research is completely voluntary. You are free to decline to take part in the project. You can decline to answer any questions and are free to stop taking part in the project at any time. Whether or not you choose to participate in the research and whether or not you choose to answer a question or continue participating in the project, there will be no penalty to you.

Questions

If you have any questions about this research, please feel free to contact me. I can be reached at 612-532-7833 or jjscholl@stkate.edu. I am also available for questions every Tuesday from 11:15 – 12:00 at Health Commons in the Chase Building.

If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

CONSENT

You will be given a copy of this consent form to keep for your own records.

If you wish to participate in this study, please sign and date below.

Participant's Name (*please print*)

Participant's Signature

Date

Appendix B
Interview Consent Form

Consent to Participate in Research
Providing Culturally Appropriate Physical Therapy to Somali Refugees in Minnesota

Introduction and Purpose

My name is Jessica Scholl; I am a physical therapist assistant and a graduate student studying organizational leadership at St. Catherine's University in St. Paul under the supervision of Dr. Amy Ihlan, a faculty member in the Department of Organizational Leadership. I would like to invite you to take part in my research study, which concerns understanding the healthcare needs, preferences and practices of the Somali community in Minnesota.

You were selected as a possible participant in this research because of your extensive professional work with the Somali community in Minnesota.

Procedures

If you agree to participate in my research, I will conduct an interview with you at a time and location that is mutually agreeable by you and me. The interview will involve a series of questions related to your experience. It should last approximately 30 – 45 minutes. With your permission, I will audiotape the interview and take notes during the interview. The recording is to accurately record the information you provide, and will be used for transcription purposes only. The recording and notes will be destroyed at the conclusion of the study. If you choose not to be audiotaped, I will take notes instead. If you initially agree to being audiotaped but feel uncomfortable at any time during the interview, I can turn off the recorder at your request. Additionally, if you prefer not to continue the interview at all, you can stop the interview at any time.

I expect to conduct only one interview; however, follow-ups may be needed for added clarification. If so, I will contact you by email with my request for additional information or clarification to interview responses.

Risks and Benefits

The study has minimal risks.

There is no direct benefit to you for taking part in this study; you will not be paid for taking part in this study.

Confidentiality

With your consent, I would like to identify you by name, title and association in this research.

To minimize the risks to confidentiality, I will store all transcripts and interview responses in a secured computer drive accessible only by me.

At the conclusion of this project, I will destroy the recording and notes.

Rights

Participation in research is completely voluntary. You are free to decline to take part in the project. You can decline to answer any questions and are free to stop taking part in the project at any time. Whether or not you choose to participate in the research and whether or not you choose to answer a question or continue participating in the project, there will be no penalty to you.

Questions

If you have any questions about this research, please feel free to contact me. I can be reached at 612-532-7833 or jjscholl@stkate.edu.

You may ask questions now, or if you have any additional questions later, the faculty advisor, (Dr. Amy Ihlan, ajihlan@stkate.edu), will be happy to answer them.

If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

CONSENT

You will be given a copy of this consent form to keep for your own records.

If you wish to participate in this study, please sign and date below.

I consent to be identified by name, title and association in this research study:

Participant's Name (*please print*)

Participant's Signature

Date

Appendix C
Focus Group Questions

1. Please share your first name with the group and how long you have lived in Minnesota.
2. Please share how you came to live in Minnesota?
3. Before coming to the United States how did you treat illness or pain for you or your family?
4. How do you treat illness or pain now living in the United States?

For the purposes of this research, I am defining healthy as being free from illness or pain.

5. Has your health improved or gotten worse since coming to the United States?
6. What do you like most about healthcare in the United States?
7. What do you not like about healthcare in the United States?
8. Do you feel that healthcare providers in the United States are sensitive to your healthcare needs and preferences?
9. What advice would you give a healthcare provider treating a Somali patient?

Appendix D
Interview Questions

1. Please describe the unique healthcare needs, practices and preferences of the Somali patients you see?
2. What strategy or strategies have you successfully used in meeting the healthcare needs of the Somali community in Minnesota? Without naming the individual, please provide an example.
3. What strategy or strategies have you used when treating the Somali community in Minnesota that has not been successful? Without naming the individual, please provide an example.
4. What advice would you give a healthcare provider treating a Somali patient?

