

Understanding Communication Channels in Somali Communities in King County

PROJECT BACKGROUND

In March 2011, in an effort to better understand communication channels among the Somali community in King County, the Vulnerable Populations Action Team (VPAT) at PHSKC applied for and was selected to conduct a Northwest Preparedness and Emergency Response Research Center pilot study. The impetus for the project was the result of lessons learned from two previous public health emergencies: (1) the carbon monoxide (CO) poisoning during the December 2006 windstorm, that disproportionately affected people from new immigrant population groups, including Somalis; and (2) the 2009 H1N1 pandemic when, in spite of extensive efforts to outreach to minority population groups during the vaccination campaign, the success was limited.

PURPOSE AND SPECIFIC AIMS

The main purpose of this project was to determine the methodology required to build an ongoing mechanism for rapidly testing and disseminating emergency messaging in the Somali community, along with several specific aims:

1. Improve the capability of public health departments to develop and disseminate culturally relevant, appropriate, and accessible health protection messages, materials and communication strategies for the Somali community.
2. Improve the capability of public health departments to communicate life-saving health information with low literate, limited English proficient Somali residents.
3. Extrapolate and apply lessons learned from this project, as appropriate, to other limited English speaking communities.

METHODOLOGY

A qualitative study was conducted involving key informant interviews and a consumer panel model developed in collaboration with community partners from the Somali population, consistent with community based participatory research (CBPR) principles.

Seventeen in-depth key informant interviews were conducted with community leaders to learn about the Somali community's knowledge, attitudes and beliefs about health and vaccines; communication preferences, and trusted sources of information within each community. Interviewers asked key informants what would be needed to establish a rapid message testing system in their specific community (e.g., who would best serve as community panelists, how should Public Health convene trusted leaders to develop and disseminate messages, what are the best channels for distribution (in-person, over the phone), how much knowledge would be necessary, would compensation be needed).

KEY INFORMANT INTERVIEW FINDINGS

Health Beliefs

- Somali people's knowledge and approach to health and health related issues vary significantly depending on their level of education, their age and length of time in the United States, and their interpretation of the Muslim faith.

You know, Somalis now—we have two Somalis now, we have American Somalis, and we have people who came here as adults like us. Children who were schooled here are of the digital age. Then the

other group who are elderly and have never been educated, don't even read their own language, they go to Somali restaurants and grocery stores and want to sit with people and know what's going on back home, or what happened here. And there are people like myself and Mohamed who sometimes go to the internet, read newspapers, read books. These groups are completely different.

Somalis make decisions differently based on education level; more educated Somalis make decisions as a family and less educated leave decision to male figure.

- Disease prevention is not a well understood or adopted concept in the Somali culture. It was the consensus of the interviewees that Somali people typically go to the doctor only when they are really sick and in need of treatment.

We don't have prevention in our community. It does not exist. The only thing we have is when something happens, we like to do intervention.

Going to the doctor and using western medicine is seen as a last resort and something one only does after they have exhausted all other options. Prevention is not seen as a possibility and in some cases it is seen as God's will that one is sick.

There is the belief that when death comes, that's my time. If I'm meant to be sick, I'm going to be sick. What is, Allah wills it. So it takes a lot to get people to keep appointments, get vaccines.

- Central to the lack of preventative health is the strength of the Muslim religion to Somali identity and the certitude that only Allah can provide protection and that if one gets ill, Allah has decided it is their fate.

Somalis, they always trust fate, they trust their almighty God, Allah, and they believe that they go to hospitals only when necessary. But it's the culture that they don't get preventive measures. And this is due to the previous experience back home where there are no sufficient health centers back home, so they consider only hospitals are meant for the sick people, not for prevention purpose.

And the belief that when death comes, that's my time. If I'm meant to be sick, I'm going to be sick. What is, Allah wills it.

Somalis believe that their life can only be taken by Allah; they may die from a disease but it is because their time has ended.

- Health is important and Somali's do take preventive measure to maintain good health, particularly through the use of herbal remedies such as black or nigella seeds (haba soda in Somali) and honey. Herbal medicine and traditional health practices are often used instead of or in conjunction with prescribed medication. Similarly, after learning about potential side effects of medication (or vaccines), many would avoid taking it unless absolutely necessary.

Somalis use honey, lemon tea and other natural medicine before medication.

The people will tell you to take haba soda, to take honey, to take other things, but that's not information that a person will take as a real cure.

I eat honey. That's my favorite. Every morning with coffee. And also, the prophets say that honey is good...Yeah, anything the prophets say has a religious connection, and people use it because they believe that if the prophet says so, there's benefit to it.

- Somalis often distrust the US healthcare system, to some extent due to their unfamiliarity with how medical services are provided here compared to their previous experience in Somalia. For instance, interviewees mentioned that even receiving generic drugs instead of a brand named prescription leads to distrust and oftentimes people may avoid taking the medication as instructed. Additionally, providers not taking enough time to fully explain treatment options may also contribute to this skepticism.

Somalis sometimes have to get low quality medication from the government because insurance doesn't cover the good medication; concept that medication is too expensive; expensive medication is more effective than cheap medication.

Some people are suspicious of vaccines, they think vaccines are a way for others to hurt them. The whole idea comes from medical insurance/medical coupons—they think that if they have a medical card from the state, there are a lot of things they will not be eligible for. They get that information from health providers—oh, your insurance is not going to cover it. It seems like there are subsets—some people are covered, but others are not. Misinformation in this country. Here, a lot of misinformation about medications. In our country, that's not relevant—you get your prescription and that's it. Here, information is misinterpreted. If get told their coupon doesn't cover medication, and they get a different medication, they feel like it's not real medicine. It's not going to help. People need to be educated about this.

The other problem to that kind of vaccinations available everywhere—shopping malls, pharmacies, everywhere—they don't see that these guys are doctors. So there are trust issues there. They could get immunizations with their doctors, but not other facilities like clinics or malls or Walmart or... That's another problem.

I was very, very surprised when I first came to the United States and I saw an advertisement on TV about medicine. I was very, very surprised because medicine, my interpretation of it was that, when you need it, if you need medicine, you go and get it. But I was not thinking that they were advertised on the TV and they ask you to buy it... Because when we were back home, we would take medicine only when we were sick.

Immunizations and influenza vaccine

- Oftentimes vaccines are seen as only needed for children (such as being mandatory for school) or for elderly and pregnant women.

Generally, vaccination is considered to be something that's good for the kids, but it's not something that's concerning to older people. That's the general concept that Somalis have about vaccination. So they consider it something meant for the young kids. That's how the country used to be back home. Mostly vaccination used to take place in educational centers like schools. So that's the concept that most Somalis have, that it's meant for kids.

The idea I have so far is that if [the vaccine is] good for the elderly, frail, young children... But for middle aged people?

Priority should be given to women, pregnant women and children, and I believe, uh, the same is for the community—there is a concern for children, elderly, women, especially those who are pregnant

In fact, they don't believe that there's a conspiracy about vaccinations. But they see vaccination as something meant to prevent serious diseases for the children. And they believe that it's meant for kids and not adults. So that's the reason that only kids are vaccinated. And this is really reference to what was going back in Somalia, as I stated earlier, because of the scarcity of vaccination itself and because of the scarcity of or limited resources, of medical supplies in our country.

- Once people learn that vaccines contain bacteria or viruses that normally cause the disease they are intended to prevent, people might be scared away if they're not educated as to how vaccines work.

There is a lot of cynicism toward vaccines and vaccine-related medications and their approach to it is very conservative. There is not a lot of trust, there is a he say/she say type of misinformation that they held either from back home or within this country.

In Somalia they don't know what the vaccine has in it; if they learned what was in the vaccine they might not want to take it.

- Interviewees had varied views of porcine gelatin content as a deterrent to vaccination (as in other health supplements such as vitamins), largely dependent upon each individual's own interpretation of their Muslim faith. Several interviewees made the distinction between a preventative measure versus a life-saving measure. As vaccines are strictly preventative, many of those we interviewed would decline to take it if it contained porcine gelatin regardless of the severity of the illness it would protect against. Similarly, medicines containing alcohol are also avoided.

There is a difference between vaccination and cure. If it's a cure, then that depends upon the decision of the doctors or the health centers. But if it's their choice when it comes to vaccination, if they know that it contains some ingredients that's not Halal, or something related to pork, generally they would not accept that.

To tell you the truth, a medicine is a medicine. Something that is life-saving is very important, whether it's tradition or in the Islamic Sharia, you take the medicine, wherever it comes from, or whatever products are in it, you should have to take the medicine as it is because it is saving your life.

People want to know what's in the vaccine; is it something they could take because of their Islamic faith.

I wouldn't think twice about getting the vaccine and vaccinating my child; my family is more liberal so they would get vaccinated.

- Many of those interviewed were aware of the rumors about a link between immunizations and autism, and were familiar with the experience of many Somali families in Minneapolis where a disproportionate number of Somali children diagnosed with autism. Additionally, several interviewees remarked that they had family members with autism or were acquainted with families who had autistic children located in King County.

A lot of people don't want vaccines because of autism. I don't know where they got that info, but they spread it everywhere. No one wants their kid to get autism.

There's issues going on in the Somali communities about immunizations and a lot of Somalis, not a lot of them, but a huge level of the Somali community have a concern the side effect of immunization for the children. And they believe, some of them, that immunization cause autism for the children. And that is a lot of concern of the Somali community. And also the other part of the Somali community concern is the gelatin used in (can't understand) vaccines—whether they are halal or not. And that causes a lot of discomfort in the community.

Autism. We don't have it back home, but Somali kids have it here. And I called a Somali doctor, my cousin, and he said it's not good to do three shots in the same day; they don't give multiple shots on the same day in Somalia.

[Autism is] Not as much a problem here as much as in Minnesota, but there is concern about autism or ADD or ADHD (mental disorder)

Some Somalis believe vaccines will make them disabled. Some believe will get sick from vaccine. Some believe problems w/brain from vaccine (e.g. autism). Community has second-hand info, which is wrong.

Some people think it's a conspiracy to try to get adults to get vaccinated as well. Conspiracy to give adults autism. They see on the TV that vaccines cause autism. Back home, didn't diagnose people w/autism. People had it, but didn't know what it was. Here we have special Ed; back home there was no special Ed—if you couldn't go to school you stayed with the family. Autism is becoming taboo here. We need outreach and education.

- Generally, the informants interviewed understood what was meant by “seasonal flu” or influenza and most did not consider it to be serious, especially in comparison to other diseases experienced in Somalia.

Flu is not considered as serious in Somalia because people are scared of the other more serious diseases (TB, malaria).

Most people know what the flu is but they don't view it as scary or serious.

Malaria, that's a serious one. But flu?

In America there's winter, and there's seasonal flu. We have one season there (back home), so we're not accustomed with that.

- Informants also made clear that there is not a direct translation for the word ‘flu’ into Somali. The words typically used for flu is *hargabka* which in Somali means *coughing; something that comes and goes away*; or *Durey* which means *coughing, running nose*.

The translation when you are coughing and have a little fever; it is hargab.

There is no difference in language between flu and cold.

- Key informants also identified logistical and economic barriers to people opting to be vaccinated or seeking out other preventative services. Barriers included inadequate resources to pay for immunizations, and health care generally, and the lack of health insurance. Somali people also lack

access to transportation, especially single moms and elders. This makes it difficult for them to access health services that are not close to home.

Transportation is another barrier, especially for elderly and women. They don't have any transportation, some don't know how to drive.

Transportation, and how to get from here to there if the mom decides to go her four, five children to the clinic, how can she do that and it's very urgent you are talking about very emergency situation.

- Rumors spread misinformation throughout the Somali communities in King County, mostly due to a lack of available and accessible information. Barriers to vaccinations include limited English proficiency, literacy in both English and Somali, a lack of translated or accessible information and further issues with lack of interpreters that speak and understand specific dialects.

The concern that I have is would the people in the Somali community who cannot read, write, etc. get the communication properly? First is how to communicate that there is a problem. Unless we have a sort of network created by Public Health that communicates the seriousness of the disease to different ethnic groups, it will be very challenging.

Sometimes there is nobody at the clinics to explain what the vaccine is and why it's needed. Some of the interpreters can't bridge the cultural gap. There are also a lot of different dialects in Somali, such as Bantu. Interpreters may not really understand what the patient is saying.

Health concerns

- Diabetes and hypertension were health concerns repeatedly identified by key informants as being most prevalent. Informants also mentioned asthma, cholesterol, autism and other developmental disorders among children as important health issues facing their communities.

We have more asthma, issues related to being overweight, we need more nutritional food. A lot of elderly people don't know how to use their medications. I have concern also about mental health issues. Anxiety. STD/HIV. Woman needs support through pregnancy. Diabetes. Blood pressure. Heart attack.

- There was concern about unhealthy eating habits, especially sugary drinks and the lack of vegetable consumption. Even the traditional consumption of Somali tea is seen as concerning for some as it is customarily drunk with a significant amount of sugar.

Need for information about the link between sugar and diabetes; Somali tea has a lot of sugar; put sugar in milk, coffee, tea, juice; mothers put sugar in milk for babies; half cup of sugar in 6 or 7 cups of tea.

- Lack of physical activity among their community members, in both adults and children was identified as a health concern.

Inactivity; kids just sit around; people have health problems because they are inactive; they don't make the connection that your body will hurt if you sit down all day

- Increase in unhealthy behaviors among Somali youth such as gang activity, drugs, smoking and the use of hookahs (shisha) was worrisome to many Somalis.

A lot of Somali youths are smoking hookahs. Need information about that—PH should come up with information for community based organizations to disseminate—in Toronto they did PSAs on radio and TV.

- Mental health issues, particularly post-traumatic stress disorder (PTSD) and depression, were identified as health issues prevalent in their communities, though related stigmas prevent many people from seeking help.

Mental health. In our country, if you have mental problems you are considered crazy. Stigma is too much. I mean, something like post-partum depression can be stigmatized and can isolate you even more. You harm yourself, and they don't talk about it. If people get together and have conversations around mental health, that would be great.

Nobody knows it, nobody diagnoses [PTSD]. A psychologist here said 90% of Somali people are mentally ill because of those symptoms.

Communication challenges and recommendations for overcoming them

Diversity among Somali community

- Somali communities in King County are often fragmented even though they share a common language and religion. Community decentralization, competition for limited resources and cultural divisions contribute to the fragmentation. A limited or single communication strategy may not be adequate to reach all Somalis.

In fact the most important thing is they must be informed of the seriousness of the situation. This will be through community centers, community leaders, places of worship, like our mosques. So the word should be spread to them so that they realize the situation.

I believe the best way will be convening through phone calls and emails from the King County. So that the issues will have more importance if the communities disseminate information for themselves.

Come together, get information, get contact information for a lot of people, and go into neighborhoods to disseminate information.

- Additionally, differences associated with level of education, socioeconomic level, age, length of time in the United States and interpretation of their religious faith indicates that there is no “one” Somali audience. Multiple messages and strategies may be required.

You know, Somalis now—we have two Somalis now, we have American Somalis, and we have people who came here as adults like us. Children who were schooled here are of the digital age. Then the other group who are elderly and have never been educated, don't even read their own language, they go to Somali restaurants and grocery stores and want to sit with people and know what's going on back home, or what happened here. And there are people like myself who sometimes go to the internet, read newspapers, read books. These groups are completely different.

There are two groups of people. Quite liberal, and some other right-wing types. Some people might trust their doctors and listen to their doctors. And some of them, it comes again to leaders who convey a message to heads of households. Imams, community leaders, elders have a lot of influence over husbands. If I took the microphone and told 100 people, men and women, to get a vaccine, they would tell 1000 people by that night.

Trusted sources of information

- Somali and other health professionals were identified as the most trusted messengers of health information though information of all types received from Somali religious leaders (Imams) is considered to be highly trustworthy and influential on health behaviors.

You know the mosque the people trust. The mosque is most of the people's religion. The leaders of mosques don't say don't take this or don't take this, they say this is very important for them, defense for the disease. The mosque will be explaining what issue will be important for us.

They get these health information they trust their doctors and they trust their advice. They trust their mosques, and they trust their community leaders. And those who are educated, they trust community forums, too.

For immigrants, everything is new for them. Don't really trust non-Somalis. Need connection with community. A lot of Somali families now have stricter religion in Somalia—gov't forces on them. Nice to have community leaders that are trusted.

Ethnic media would also be important to use to deliver messages.

- Although Somali community centers were considered to be useful hubs for disseminating information, several interviewees mentioned that executives of community based organizations were not necessarily seen by Somalis as health leaders or experts and would likely not be effective in communicating the importance of taking actions related to health.

My point of view [a community leader] is nothing to somebody else, another Somali. But the Imams of the mosques, if they get that letter or get information from the scholars, they can tell the people, and the people take it.

Communication channels & messaging

- Somalis have a tradition of oral communication and information spreads quickly and easily by word of mouth. Rumors and misinformation also spread easily. Due the oral tradition, face-to-face messages, and forums with expert presenters was a repeatedly identified to be effective in getting information to communities.

Somalis, they get information from the word of mouth. That's the most important--word of mouth. That's the Somali culture, it spreads fast, and people trust those kinds of information that they heard from their relatives, trusted people, trusted elders, but, ah...television also, internet, radio—they may get also those informations from those other media.

Doctors, mosques, and leaders like us. Some communities are not getting a lot of information, especially when it's not in their language. Workshops in the community, local channel on the radio, local TV... Get someone like Mohamed or you to educate, increase awareness. And hire more people from similar backgrounds/culture.

- In addition to religious leaders as trusted sources of information, Mosques are also seen as primary place to disseminate, post or present information. Other key places to disseminate information include Somali community centers, schools, halal food stores and at Somali restaurants or coffee/tea shops.

[Religious] leaders are the number one community leaders that are really trusted so any decision that has something to do with outreach should be included religious leaders. Health care professionals are also a trusted source of health information. Community leaders should also be included, but I will emphasize the first two.

Somali language and pictorial, at CBO's, mosques, and...And, what do you call it, Somali/ethnic malls or businesses.

The community center is number one source that I'd like to distribute flyers because people come here for many other services such as green card services, such as citizenship application services, after school program services, so people come to the center, so center is main center where you can distribute, convey or share information with them. Mosques, or mosque is another place that we can share this because larger people go there and pray in the mosque, so that's another...School officials, such as, for example, teachers and social workers and principals also are important in order to convey the message. Health centers, also, health centers and clinics.

- *It is important to focus messaging on positives, such as potential benefits—especially if the topic is new for the Somalis or if a lot of misconceptions about potential negative outcomes are pervasive. Additionally, the truth is more important than messaging (e.g., informing that porcine gelatin is in vaccine) to create a desired action.*

So I believe outreach, specific outreach related to vaccination should be put together and workshops that people can attend should be held so that people can get their informations, the positive information related to vaccination.

Don't trust medicines. We are a very oral society. Countering all of that with positive information will be good and also having information in places where people congregate. Have Somali person go to where they are; they're not going to come to you.

People need to know what is true so they can make their own decisions.

- *Also, when designing flyers with health information, it is recommended that messages are presented in both Somali and English and include visuals.*

In fact, both Somali language and English language are effective. There are some Somali people who themselves don't read Somali itself. Ah, but there are many students in this country who are able to speak English language and read it. And any information that they have read in English they can translate or pass to their family. So Somali language and English language are both important. So any publications for this emergency should be written in both languages. It will help them. As regards pictorial--yes. Any visual is important and it has got, ah, a very good impact on the response from the people. So visual is important, with pictorial.

You have to translate flyers into Somali because if you don't you are assuming people can't read and that is insulting; still translate even if people can't read; half English and half Somali is good

RECOMMENDATIONS FOR NEXT STEPS

- *Consider developing a Somali liaison position (to link Somali community with Public Health); Seattle School District has such a position and it is working out very well for communicating with families.*

- Public Health and healthcare partners in the community should implement key findings from the interviews, including:
 - Include both English and Somali on all translated written materials and include visuals wherever possible
 - Present material factually so that people have the information they need to make their own decisions
 - Use positive messaging such as potential benefits to health related actions
 - Use in person, face-to-face messaging or oral communication whenever possible
 - Educate people in the community who are trusted sources for information (e.g. religious leaders, elders, health care professionals, scholars).

Somali Health Board

- Many see the potential value of having a health board comprising trusted Somali leaders that can be leveraged in case of emergency. It should include people with science, public health or medical backgrounds to represent the Somali communities.
- Outreach to other King County agencies and health systems (Children's Hospital, Harborview and community health centers) regarding this project and the concept of a Somali Health Board in order to generate interest and participation.
- Important to include people who are actually able to outreach to target population groups, including women and youth, as well as religious leaders as appropriate (porcine gelatin).
- A health board, with regularly scheduled meetings (monthly or quarterly) would be a way to maintain relationship with Public Health and King County healthcare providers and also provide education on health concerns identified by the Somali community.