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Health and prevention among East African Women in the U.S.

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Abstract

African-born individuals in the U.S. face significant health challenges, including low utilization of preventive screening services. Using a community-based participatory research framework, we describe preliminary efforts at establishing a collaborative relationship with the East African communities of San Diego, identifying salient community health needs, and developing a framework for disseminating information and addressing identified health gaps. To this end, 40 East African-born women participated in focus groups with the purpose of eliciting community perspectives on U.S. health care services, beliefs about preventive screening, and to garner recommendations for future outreach. Qualitative analyses identified participants' desire to engage in primary prevention techniques that incorporated best practices from their home countries and the U.S., and the need for health education programs to provide information on increasingly prevalent chronic diseases. The findings are discussed in connection to continued community-engaged efforts and the implications for health and resettlement policies to reduce inequities disfavoring resettled refugees.

Keywords

Refugee health; health disparities; community-based participatory research (CBPR); qualitative methods; women's health

Africans represent a rapidly growing group in the U.S. following changes to immigration laws and policies^{1,2} and Africans constitute a large proportion of the U.S. refugee resettlement program in recent years.³ Africans entering resettlement programs as refugees frequently have spent years living in violent conflict with millions in their homelands killed and displaced by long-standing wars.⁴ Yet, relative to other migrant groups (such as Southeast Asian and Latino communities) there is little information regarding changes in health for Africans following migration. The limited research to date suggests rising chronic disease incidence,^{5,6,7,8,9,10} and barriers to access and utilization of health care services.^{11,12} Many refugee communities exhibit higher incidence of both infectious and chronic diseases. Cancer represents one of the quickly rising chronic diseases, with higher incidence of cancers (e.g., cervical and liver cancers) in these communities are largely preventable through detection and treatment of viruses that are known risk factors for cancer (e.g., hepatitis, human papilloma virus).⁷ The fact that many high incidence cancers among

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African migrants can be prevented through vaccinations or stopped early through screenings underscore the importance of examining barriers to cancer prevention.

There are long-standing disparities among populations in cancer incidence and mortality for racial/ethnic minority populations, both globally⁷ and in the U.S.⁸ One important contributor to cancer disparities in the U.S. is that individuals born overseas are less likely to engage in preventive cancer screening services,¹³ which, in turn, leads to presenting at later stages of disease progression and increased mortality. In particular, African women may be at particular risk for not receiving preventive services.^{9,10,14} Research with Somali women has identified a variety of barriers to obtaining cervical cancer screening, including practical problems regarding scheduling and daycare, language difficulties, anxiety related to completing the test, negative past experiences, and concerns regarding female genital mutilation,¹⁵ combined with limited understanding of the importance and rationale for cancer screening.¹¹ Other factors identified as influencing health care utilization include gender concordance between doctor and patient,¹¹ health literacy,¹⁶ practical barriers to accessing services,¹² and concerns related to limitations of health care interpreting services.¹⁷ Moreover, low levels of health literacy contribute to limitations in understanding and navigating the health care system.¹⁸ Each of these barriers decreases the likelihood that African-born women will engage in preventive services and, in turn, be more likely to present for treatment at later stages in the disease progression. This is particularly important for African women, who have higher proportional incidence and mortality from preventable cancers, such as cervical cancer.⁷

Africans represent one of the largest refugee communities in San Diego, yet there is limited research and outreach specifically targeting health in this community. In particular, this research targets the most populous African communities in the area representing Eastern and Horn of Africa countries (e.g., Somalia, Sudan, Eritrea, Ethiopia, Tanzania)* with the goal of obtaining a representative sample of the region. Because so little research has been done with these communities nationally as well as locally, the current work provides critical formative data on issues related to health education and an example of community-engaged practices, which led to tangible health materials and outcomes. In this manuscript we will describe findings from formative research on East African women's experiences with U.S. health care services and beliefs about preventive health approaches. Next, we describe the women's recommendations for health promotion programs and collaborative steps taken to address identified health information needs. These findings serve as an exemplar for establishing an initial collaborative relationship with the East African communities, identifying their current most pressing self-identified needs, and to the further development of culturally competent programs to reduce health disparities.

Methods

The approach described integrates principles of community-based participatory research (CBPR), where health programs establish a collaborative, equitable partnership with the community that ensures a focus on strengths and resources, capacity building, and dissemination of research findings and resources.^{19,20} The research described here was the first step in identifying community needs and establishing a relationship with the East African communities of San Diego; researchers elicited feedback on recruitment and procedures from key community leaders prior to initiating the project. Participants were recruited through community-based organizations serving East African communities in San Diego, and the San Diego State University Institutional Review Board approved all research

*While the groups sampled in the current study represent Horn of Africa and East African countries, we will refer to them hereafter as "East African" for clarity and simplicity.

protocols. Research staff, including two African community health workers, recruited women over the age of 18 who were born in East Africa through distribution of flyers and in-person descriptions of the study to interested individuals. In total, 40 women born in Somalia, Sudan, Eritrea, Ethiopia, and Tanzania participated in focus group discussions; participating in either English or with assistance from Somali or Sudanese interpreters as indicated by participant preference during the screening process. There were a total of four focus groups that lasted approximately 1.5 hours and included between six and 16 participants, all of whom provided verbal consent for participation. The focus groups were audio-recorded and held between August and October 2010 in community centers convenient for participants.

Based on recommendations by community leaders, the focus groups were styled as informal discussions without additional quantitative and demographic data collected from participants. Because this was the first of such efforts in these communities, leaders highlighted reluctance from community members to providing personal information before establishing a collaborative relationship and rapport. Therefore, no quantitative measures were collected during the focus groups and additional information on participant demographics is not available. Two groups included single nationalities (one Sudanese and one Somali group, the two largest communities in the area) while the other two groups included a mix of nationalities. Two groups were facilitated in English alone and two groups were translated during the session (1 Somali, 1 Sudanese Nuer dialect) with participants indicating their language preference during the screening process. Providing opportunities for different group formats at enrollment appeared to adequately accommodate participants' linguistic needs.

The semi-structured interview included an initial set of questions, with follow-up and probing questions used to further explore key topics raised by focus group participants.²¹ Table 1 provides an overview of the key questions in the semi-structured interview guide.

Data analysis

The focus groups were analyzed using a systematic approach²² in which specific questions from the interviews provided a starting point to identify themes across the focus groups. After initial review of focus group discussions,²³ data analysis followed a systematic and iterative process that was driven by the purpose of the formative research. The primary foci of analyses were notions and experiences with preventive health care services, and recommendations for improving health outcomes within their community.

During the focus groups the research team took written notes, and following each focus group the research team met to review first impressions and to highlight any questions requiring further clarification. Next, the three members of the research team, who also facilitated the groups, listened to the audio-recordings (funding for transcription was not available for the project), reviewed initial notes taken during and after the group, and developed preliminary coding schemes independent from one another. Following the independent coding into primary themes and sub-themes, the research team held regular meetings to review and revise the codes and to discuss key findings. The codes and themes were further refined through the iterative process of reviewing detailed session notes and coding schemes, developing visual displays of the data, and seeking supporting, disconfirming, and clarifying evidence across participants and focus groups by the authors. Discrepancies in codes were resolved through group consensus.

Results

All the focus groups highlighted their perceptions of the importance of prevention and self-care in warding off ill health, yet they also identified cultural and practical barriers to engaging in preventive services and emphasized the importance of incorporating cultural practices from their homelands into self-care in the U.S. The identified barriers included a perceived sense of cultural incompatibility with the U.S. health care system, with women identifying such practices as long-term treatment with medication for chronic diseases as counter-intuitive and instead reporting a desire to prevent diseases before they begin. Moreover, the groups had recommendations for community-based education and holistic services that would provide them with necessary tools to maintain health for them and their families. In turn, the recommendations were incorporated into next steps of community-engaged efforts leading to sustainable community change. Table 2 provides an overview of key themes.

Notions of prevention

There was a prominent theme with participants in all four focus groups reported wanting to know the general signs and symptoms of disorders that were new to them, such as diabetes and cancer, and occurring with increasing frequency since coming to the U.S. All of the groups reported a desire to prevent diseases and to focus on the things they could do to care for themselves and stay healthy. One woman said

In Sudan, so you don't go to the doctor right away because there are some cultural medications that you use...In America, they say every single day you have to go see the doctor...We believe there are some kinds of sicknesses you don't have to go to see the doctor. There are some ways you can take care of [sickness] your own way.

Within their cultures and traditions, health does not first come by way of pills and surgeries, but rather through knowing the signs and symptoms of diseases and the use of home remedies. The women in all four focus groups repeated their desire to translate their rich histories of self-care to address the new health concerns and diseases they are facing in their new environment. They viewed this as an important addition to medical care and treatment.

One Somali participant highlighted her strong desire to engage in preventive behaviors. She said that since she came to the U.S.,

I am always hearing many different diseases, and often I heard it is too late. So I will like to know the steps to prevent these diseases. Bad diseases like cancer, it was not known in our home country but it is very common in here. If not a problem, I want to know how to prevent it and keep it from developing.

She said diseases like diabetes and high blood pressure were worrisome and she wanted to prevent them. While all groups discussed cancer after being specifically queried on the topic, three out of four groups spontaneously raised concerns about the high incidence of diabetes and high blood pressure in their communities. Several women in one group raised uncertainty about the potential causes of cancer and whether some factors were true causes or myths. For example, women raised concerns about drinking tap water and receiving yearly mammograms (through radiation exposure) as causes of cancer. The women in all the groups expressed a desire for additional accurate health information about chronic diseases. Other research conducted with Somali adults in San Diego support these findings of low levels of health literacy, cancer awareness, and educational achievement. For example, 64% of women reporting they did not know what cervical cancer was, 20% were positive that their healthcare providers had screened them for cervical cancer, approximately one-third were positive they had been screened for breast cancer, and 75% reported they did not know

how to do breast self-exams.²⁴ Similarly, Somali adults in San Diego report low levels of educational achievement, with 45% of Somali adults reporting no formal education and an additional 26% reporting primary education only.²⁵ While systematic assessments have not been conducted with the other East African communities, they are believed to have similarly low levels of health literacy and these similarities were reflected in the focus group discussions.

Barriers to care

The majority of women in one focus group (a group consisting of mixed nationalities) reported they engaged in U.S.-based forms of preventive care, including mammography, Pap smear, and seeing a doctor for an annual check-up. However, in the three other focus groups the majority of women reported negative past experiences with preventive care and raised barriers to engaging with the health care system. One woman said, “We need the check-up, all the women we need the check-up because it’s very important. A [each] year, I think the American people they go a [each] year for the check-up. But for Sudanese people they don’t go. Me, I don’t go.” When asked why she did not go if she thought it was important, she said it was because she could not afford the cost of the medical visits; cost was raised as a barrier to going to the doctor in 3 of the 4 focus groups. Another woman identified an additional reason, which was addressed in all four groups: “We think it is not very important—it doesn’t matter if you go or you don’t go. But we need someone that can educate us more about *why* do you need a check-up. Why do you need a female check-up?” Other reasons cited for not going for annual check-ups included discomfort experienced during the procedures; feeling they are a spectacle (e.g., other providers invited to examine the women alongside the doctor); modesty concerns related to the small size of the robes they are given; assignment to a male doctor; and, an overall lack of trust and comfort with the medical system, which was raised in all four groups. The variability in comfort and utilization of preventive screening across the groups seemed to coincide with general awareness of patient rights and awareness of the utility of the screens. The themes of gender concordance and modesty concerns were most pronounced for the Somali participants who constitute the largest East African community, with over 20,000 Somalis living in San Diego.²⁴

Strengths of the U.S. health care system

Women not only brought up concerns about the U.S. health care system, but praise as well. In two of the four focus groups, the women identified several strengths of the U.S. health care system, including the opportunities for vaccinations and ultrasounds to ensure a healthy pregnancy. In particular, all the women reported they go to the doctor when they are pregnant, with several women agreeing that the ability to see child development in the womb was an important advantage of the U.S. health care system. They highlighted other advantages to U.S. health care, such as getting immunizations and the benefits of technology. Therefore, despite the practical barriers identified in accessing the U.S. health care system, many women also saw several advantages to the health care provided in the U.S. While women reported a great appreciation for self- and homeopathic care, this was not to the exclusion of Western medicine.

Recommendations and hopes

While all the focus groups highlighted worse health since migrating to the U.S. and some of the challenges of the U.S. health care system, the tone of the groups was not hopeless and the women often used humor throughout the groups to lighten the mood. The women had many recommendations for ways in which their experiences could be improved. All the groups reported they hoped for opportunities to learn to care for themselves in the face of new challenges and threats to health. Moreover, the groups had many recommendations on the ways in which community-based education and holistic services would give them the

power to better care for themselves and their families in the U.S. These recommendations fell into three categories: (1) the need for education on patient rights; (2) the need for education on specific disease signs, symptoms, and treatments; and (3) the need for environmental changes to support their health behaviors and health care utilization.

Two of the four focus groups highlighted the need for community members to be aware of their rights as patients. For example, many highlighted lack of community awareness about women being able to request a female doctor or to ask for clarification and the rationale for medical treatments and recommendations. In a group where most of the women do not go for regular check-ups, one woman said

It's very important to educate before we go to the doctor what we have to do. For the African society, this way what we can ask, we have no idea. We are just going because we are sick. But, when you go there, what kind of rights we have. It's very important, what to ask the question, how we feeling inside and how to open up ourselves. Just education, it's very important for the African community.

In addition, the women reported they did not understand the role of confidentiality in the medical profession and an underlying fear that others will find out what is wrong with them which can be a source of shame.

Moreover, women want information on how to be healthy and utilize existing services to stay well.

As an African lady, or a Sudanese lady, we have been here in this country for some time and it's not like we get some information. But for you guys [people born in the U.S.], you have like easy way that you know where to run and where to get information and where you could get help. But we need you guys to bring it to our community that we can have access to the thing outside over there. Which is why we are grateful to you to come here today and for our meeting because we need a little help.

One woman suggested:

I would like to see if there's a way that someone could come to the community and teach you some signs about sickness. Like, for example, if you have like a cancer, so what are the signs for that? To be aware of it. If you have like some flu—because like some of the flu symptoms has come and then they cannot treat it. But there's a way that if someone teaches you how to do it, then you can take care of by yourself. Because it is not all sicknesses you have to go to the doctor, there are some sicknesses you can take care of for your own way.

In addition, participants in all four groups reported several environmental and systemic barriers to engaging in healthy behaviors and interfacing with the health care system. They highlighted the need for advocacy and environments that accommodate their needs. In particular, given their neighborhood conditions, women and children stayed inside their homes in order to stay safe. One Somali woman said, “It is hard for us and for kids to exercise. All of our kids are in trouble because they don't have any activities to do, they are always sitting home.” However, alternatives, such as women-only fitness facilities were either not available or financially out of reach. Therefore, the limited availability of safe and inexpensive physical activity resources was a concern for mothers and children alike.

More than any other systemic barrier, women in all four groups reported translation services were among the largest barriers to quality health care services. Despite regulations requiring the provision of interpreter services for medical care, the lack of interpreters at health care facilities came up in every group. Additionally, they reported the desire for in-person

interpreters to provide translation services and patient navigation to help them understand their medical conditions and treatments and to better navigate the complicated health care system. This theme was underscored by one woman's statement:

We have a lot of problems with the doctors. When our kids are sick, there are no translators. Our English is not that well or some of us don't even speak English. When we ask for translators they said, "You don't need one. We don't have it." And if she ask them to bring a translator the doctors say, "We don't have translators, you can bring your own if you want." This occurs in clinics.

Another woman in the group agreed that knowing English does not make the medical language easier to understand, "I can say 60% I don't even understand when they are speaking, because they speak fast and I can't follow...that is the first issue we are facing."

The women reported that many local health care providers have turned to using the "blue phone" interpreting services²⁶ to assist patients. One woman described her own experience using a phone interpreter, stating if she does not understand, she is "not able to call him [back] and said I didn't understand, can you explain again please? So, states like Minnesota has this ideal program [for] their patients and their insurance coverages." They also highlighted the lack of interpreting services available at pharmacies and that the need for interpreters expands beyond the initial encounters with medical providers. Each of these key points highlights the women's recommendations to have in-person and medically trained staff to ensure the patient and medical provider can effectively communicate with one another.

Finally, two of the four groups recommended greater provider training in understanding their cultures and the importance of providers not rushing through the appointment. One woman described a positive experience with a doctor, stating how important it was that doctors "take the time. I understand there is other people waiting, sure, there is life. When did it start? How is she feeling? The other doctors they know this...Thank God this doctor is there!" She highlighted the importance of feeling attended to and heard by this doctor and her desire to continue care with that provider. Moreover, they hoped that doctors would be educated to be aware of the women's desire for gender concordance in treatment and the importance of privacy and modesty concerns. The participants highlighted the importance of provider and clinic education to ensure they are prepared and willing to accommodate the religious and cultural values of their patients.

Research to action

Based on the findings, a series of steps were prioritized to effectively meet the most pressing issues that could be expeditiously addressed within a larger-scale more long-term effort toward sustainable change. In following a CBPR approach, the first step in this process was to establish an East African Women's Health Advisory Committee to provide guidance on key community issues and to ensure follow-up on identified needs and to support a sustained, collaborative relationship. The committee includes East African community members, East African community leaders working for local non-profits and advocacy organizations, and local researchers with experience working with the East African communities. The committee meets approximately every other month and has provided guidance and oversight to follow-up efforts, including additional research, program development, dissemination of information, and grant development.

Two major initiatives following the research include issues to address the lack of translation services and increasing knowledge of existing programs and supports available for refugees in the region. In California, medical practitioners are mandated to provide translation services, yet the focus groups highlighted this is not always implemented. Without accurate

communication between patient and provider, health education and preventive services are rendered ineffectual. Previous efforts in the region had developed bilingual language cards for the Latino, Vietnamese and Somali communities, which request translation services for their respective language when individuals present at a health care facility. Through existing connections with community organizations and translators, the cards were translated into other languages to ensure more individuals were able to secure translation services when needed.

Second, San Diego is home to a variety of social services and programs targeting refugee and underserved communities, yet there was limited knowledge of available programs. A comprehensive list of refugee-focused resources was developed in 2007 and served as a basis for an updated resource list updated and augmented to reflect the broad range of services available approximately five years later. The Advisory Committee provided guidance to expand the list to incorporate religious and cultural organizations as well as maintain resources related to refugee resettlement and health care services available in the region. Follow-up sessions were held with focus group participants to ensure that research findings were accurate and to discuss and disseminate developed resource materials. Moreover, dissemination through the local forum for refugee-related organizations and individuals ensured that the materials got back to community members who would benefit from the developed materials. The resource list and translation cards are now housed on the refugee forum website for continued access and distribution. Moreover, an agreement was made with a local informational resource (211 San Diego: <http://www.211sandiego.org/>) that they would incorporate the refugee resources into their online and telephone support system so that the information would continuously be updated and sustained indefinitely. These two examples, in addition to several other more long-term initiatives arising from the research, represent easily achieved, short-term strategies that directly addressed identified community needs by networking existing resources. Moreover, both efforts incorporated existing infrastructure to ensure that the information can be indefinitely sustained and disseminated to the broader refugee community of San Diego.

Discussion

The focus groups identified East African beliefs about the U.S. health care system and preventive care and garnered recommendations for improving health literacy and utilization among this underserved population. In particular, the East African women in these groups highlighted their strong desire for prevention of chronic diseases, despite research showing low rates of preventive screening and primary care utilization within these communities.^{11,14} Similarly, the types of preventive services the East African women in the focus groups desired were more primary prevention efforts and to incorporate naturopathic treatments and the healthier lifestyles practiced in their homelands. These findings underscore there are many strengths and healthy behaviors that the East African communities bring with them to the U.S. which should be emphasized and incorporated into ongoing health programs, not only within the East African communities represented in the focus groups but within the broader host community as well.

Health education and prevention programs early in the resettlement process are critical for cost-effective care, yet current refugee resettlement programs have no national framework for providing needed health information to incoming refugee communities. Moreover, materials and efforts should target specific groups in their own language.²⁷ Public health prevention approaches are an important addition to existing services to ensure successful health promotion within the East African community and exemplify the recommendations made by the women in the focus groups. The focus groups highlighted the significant need to provide health education on new and rising incidence chronic diseases to promote health

literacy and health behaviors within the East African communities. Supporting the development of culturally competent materials and procedures, in addition to those we created, within existing resettlement and community-based organizations that are recognized and trusted sources within refugee communities is essential.

Health literacy among immigrant and refugee communities is a significant factor and those “with the greatest health care needs have the least ability to comprehend information required to navigate and function in the U.S. health care system.”¹⁸ [p. 147] The concerns raised in this research, included a lack of understanding of not only disease signs and symptoms but of how to effectively navigate the U.S. health care system as well. Paasche-Orlow and colleagues¹⁶ identified three principles to address the health care inequalities linked to health literacy: (1) to use universal precautions to ensure patients understand; (2) to make patient-centered care a priority; and, (3) to develop interventions that acknowledge limited literacy and other frequently co-occurring social vulnerabilities that influence health outcomes. Each of these points was raised in the current focus groups and underscores the vulnerability of refugee communities compounded by their complex health needs.²⁸ Therefore, any new health education programs must keep in mind the health literacy needs of these communities and work to enhance skills and understanding of how to navigate the U.S. health care system.

Linguistic barriers are among the most straightforward, yet costly, barriers to address in the health care system. Other research has highlighted the link between low English proficiency and adverse events in medical care.²⁹ These findings underscore the medical necessity to provide professionally trained interpreters to overcome the limitations in provider-patient communication. Moreover, regulations and standards put forth at the state and national levels outline the need for training and education to ensure quality medical translation services are accessible to all who need it.³⁰ Despite the fact that translation services are mandated in the state in which this research took place, it is a continuing problem for refugee communities.

Limitations

There are a number of limitations to the current study, including the lack of random sampling employed for recruitment and the small sample size. In addition, the groups were facilitated in English, so it is likely that the least acculturated community members (who may be retaining more behaviors from the country of origin) were not included in the current study. Individuals with low English facility may be among the most marginalized from the U.S. health care system and available health resources; therefore, this is an area that requires further research and outreach. However, the individuals in the focus groups reported high levels of chronic disease concerns alongside being separated from U.S. health care services; therefore, the current sample included African women in need of greater support to combat health concerns as well. The focus groups were not transcribed due to financial limitations and no quantitative data were collected on the women who participated. Consequently, we do not have information on how long the women had lived in the United States, their level of acculturation, or their personal health concerns. The decision to frame the research as an informal community discussion (i.e., not including questionnaires) was made by community leaders and helped to establish trust with participants, which likely enhanced later community-engaged efforts. Lastly, there are no objective measures of health, such as medical records from either Africa or the U.S. In general, the research in this field lacks objective data on African migrant health and efforts to examine post-resettlement health evaluations and medical records are recommended.

Conclusions and future directions

Research with refugee and other underserved and vulnerable populations must be in support of sustained efforts to address the health concerns it identifies. The formative research described here provides important baseline data on local community needs and supported subsequent steps to ensure a collaborative relationship between the community and academic partners that best meets the community's needs. The research provided a method of prioritizing need and ensuring programs address the most pressing issues as perceived by the community.

More generally, there is a need to support culturally driven methods of preventive care and healthy lifestyles that combine best practices of both the countries of origin and the U.S. health care system. While past research has highlighted limited engagement by East African communities in preventive health care services, the current study underscores these findings might be limited by the type of preventive health services in question. That is, while cancer screening rates are lower in these communities, other types of prevention were eagerly discussed and desired by the East African women in the current sample. If only quantitative data of screening rates are examined, indeed there is a long road toward shifting East African views on incorporating preventive health measures. However, through the qualitative data we see that the notion of prevention is central to East African perspectives of health. Therefore, public health approaches that engage East African communities with strengths-based and health-promoting methods, including *promotora*-based approaches (i.e., natural community leaders serving as health educators), may provide an important tool for halting and reversing the rapid health transitions described by the current sample and in the research literature.³¹ Future research and outreach would benefit from employing CBPR methods to develop, adapt, and evaluate successful chronic disease health education programs that incorporate a range of preventive health behaviors, including but not limited to cancer screening programs.

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Table 1

Semi-structured interview guide used during focus group discussions.

1	What do you see as the most pressing health concerns for you and your family?
2	How have your health concerns changed since coming to the U.S.?
3	What are the challenges that make it difficult for you and your family to stay healthy in the U.S.?
4	Do you feel like you are receiving good healthcare in the U.S.? (Follow-up questions: What health needs do you feel are/are not being met? Do you go to the doctor for each year for health check-ups or only when something is wrong/you are sick? What problems come up when you try to go to the doctor? What have been your experiences with cancer screening services (e.g. mammograms)? Do you think mammograms are important to get?
5	We are hoping to develop some programs for African women around health concerns. If you were to attend a program, what topics would you want to have covered?
6	Would you be interested in participating in future research? For example, would you be willing to spend about 1–2 hours with us individually and provide information about your health and about your lifestyle? (Follow-up questions: Do you think type of research can be meaningful? What would make it more likely that you would participate in a research study? Why wouldn't you want to participate?)

Table 2

Key themes on health from qualitative analyses of focus groups.

1. Notions of prevention
a. Desire for self-care in preventing chronic diseases (e.g. homeopathic remedies)
b. Increased knowledge of signs and symptoms of chronic disease
c. Increased understanding of rationale for annual check-ups and screening services
2. Barriers to care
a. Cost
b. Language (lack of interpreters)
c. Trust and comfort with medical providers and system
3. Strengths of the U.S. health care system
a. Immunizations
b. Technology for prenatal care
4. Recommendations for enhancing care and utilization
a. Education on patient rights
b. Environmental changes to support healthy lifestyles and health care quality (e.g. Translation services, provider training on cultural competence)