Published in final edited form as:

Prog Community Health Partnersh. 2015 ; 9(1): 83–90. doi:10.1353/cpr.2015.0011.

Somali Perspectives on Physical Activity: Photovoice to Address Barriers and Resources in San Diego

Kate Murray, PhD, MPH^{*},
UC San Diego

Amina Sheik Mohamed, MPH,
UC San Diego/United Women of East Africa Support Team

Darius B. Dawson, MA,
San Diego State University

Maggie Syme, PhD, MPH,
San Diego State University

Sahra Abdi, BA, and
United Women of East Africa Support Team

Jessica Barnack-Tavlaris, PhD, MPH
The College of New Jersey

Abstract

Background—Though many immigrants enter the U.S. with a healthy body weight, this health advantage disappears the longer they reside in the U.S. To better understand the complexities of obesity change within a cultural framework, a community-based participatory research (CBPR) approach, *Photovoice*, was utilized focusing on physical activity among Muslim Somali women.

Objectives—The CBPR partnership was formed to identify barriers and resources to engaging in physical activity with goals of advocacy and program development.

Methods—Muslim Somali women ($n = 8$) were recruited to participate, trained and provided cameras, and engaged in group discussions about the scenes they photographed.

Results—Participants identified several barriers, including safety concerns, minimal culturally appropriate resources, and financial constraints. Strengths included public resources and a community support system. The CBPR process identified opportunities and challenges to collaboration and dissemination processes.

Conclusions—The findings laid the framework for subsequent program development and community engagement.

Keywords

health disparities; exercise; needs assessment; community health partnerships; health promotion

Approximately one-third of the United States (U.S.) population is obese (1). While immigrants are more likely to have a healthy body weight than native-born individuals upon entrance to the U.S., this health advantage erodes over time (2). Immigrants entering a new country must respond to changes in their daily lives and environments. For some communities, daily lifestyle changes can be exacerbated by cultural beliefs about weight and food norms (3-5). Rapid shifts in body weight have been evident for African migrants, with research revealing changing nutritional habits (6) and 75%-85% of African-born women are overweight or obese in resettlement countries (7-9).

The Somali community represents one of the largest refugee communities resettled in the U.S. over the past 15 years (10). The country has experienced widespread violent conflict since 1991 (11) and approximately 1.5 million *persons of concern*¹ are still in that region today (12). Shifting obesity profiles are evident for Somali women, with only 5% of adults classified as obese in Somalia (2) whereas numbers for women in resettlement countries are nearly 7 times higher (8). There is ample evidence documenting the influence of community context on physical activity (e.g. 13). However, for Somali women, who almost universally identify as Muslim, the limited affordable, safe opportunities for physical activity in low-income communities are further restricted by cultural and religious practices related to modesty (14-16). Moreover, low literacy rates (approximately 38% in Somalia) (11), further limit access to existing information and resources for intentional physical activity.

Community-based participatory research (CBPR) methods include actively engaging communities in the research and intervention processes to promote positive change (17, 18). Community-engaged efforts are particularly important when working with forcibly displaced communities (19). CBPR methods emphasize community members and researchers sharing their knowledge, expertise, and resources to initiate changes for healthier living (17). Engaging communities to initiate and sustain changes in the built environment is an essential component to obesity and disease prevention (20).

Photovoice is an example of a CBPR method that empowers the community to guide the research agenda and intervention development (21, 22). When using the Photovoice method, participants are provided cameras to take pictures on a particular topic (23). The pictures become visual data, which helps to overcome potential literacy barriers and may be more appropriate for cultures with oral rather than written methods of conveying information (24). Participants engage in group discussion guided by the images in order to allow participants to expand on their motivation for taking the picture and their beliefs about the issues of importance. Initial research with the target community identified physical activity as an area for future health interventions (25). However, little is known about Somali views of physical

¹*Persons of concern* include all individuals identified by the United Nations High Commissioner for Refugees (UNHCR) as in need of international protection, including individuals internally displaced within their home country as well as refugees and asylum seekers who have fled to another country seeking protection.

activity as a way to maintain health and the perceived barriers and resources available to promote physical activity. Therefore, the purpose of this study was to employ the Photovoice technique with adult Somali women in San Diego, to gain a better understanding of beliefs, attitudes, and experiences with physical activity. The longer-term goal was to increase access to culturally appropriate physical activity opportunities.

Methods

Community Partnership

Prior to initiating this study the partnering organizations collectively identified and prioritized physical fitness with the goal of addressing chronic disease prevention (25). This project built on long-standing collaborations utilizing CBPR to promote healthy East African communities in San Diego. Most of this work occurred in the City Heights neighborhood, one of the most diverse neighborhoods of San Diego and home to many refugee-serving organizations. Letters of support were obtained from partnering community organizations and a community advisory committee provided guidance for the project. The East African Women's Health Advisory Committee was formed in January 2011 and includes community members, advocates, and researchers who meet quarterly to discuss outreach and research focused on East African women's health. This study also received IRB approval from the sponsoring institution.

Recruitment

A female, Somali community representative (ASM) served as a liaison to the Somali community and assisted with recruiting, translation (English/Somali), group facilitation, data analysis and interpretation, and presentation of results to community and professional audiences. She has worked in this capacity in San Diego for approximately 10 years and is identified by the community as a leader in community health advocacy. The bicultural research team member disseminated recruitment materials in Fall 2011 through existing community organizations serving Somali women. Announcements about the project were made at community gatherings and interested participants were screened to ensure they met selection criteria (i.e. over age 18, self-identified as Somali, and was born in Africa) and an initial group meeting was scheduled. The groups were facilitated in Somali.

Sample

This was a convenience sample of eight adult women. One participant attended the initial session but subsequently traveled out of state and was unable to take photographs or attend the final two sessions; therefore, her data are not included. The mean age of the eight women was 45.88 years ($SD = 7.47$). All of the women were Muslim Somali refugees who had lived in the U.S. an average of 14.29 years ($SD = 5.22$). Five women were employed and four women reported a household annual income less than \$10,000. None of the women were meeting current physical activity recommendations for adults. Based on self-reported height and weight, seven of the eight women were overweight or obese (Mean BMI = 31.49, $SD = 5.23$).

Procedures

Following Photovoice methodology (22, 26), eight women participated in three sessions: 1) orientation to the project and photography, 2) group discussion of the photographs and participant generation of themes, and 3) a final session in which the preliminary findings were presented, discussed, and refined. Throughout the sessions the community representative provided translation to facilitate discussion between non-Somali researchers and community members. During session one, participants were informed of the project and signed the informed consent. Following were instructions on digital camera use, obtaining consent to photograph, and limited guidance for picture content—should be related to supports and barriers for physical activity in the community. Approximately two weeks later the women returned for the second session where they chose 2-3 photographs that represented the challenges and resources related to physical activity in their community. The “SHOWed” methodology (27) was implemented where the participant briefly explained: 1) what she **S**aw in the picture, 2) what she thought was really **H**appening, 3) how it relates to **O**ur lives, 4) **W**hy the situation exists, 5) how we can become **E**mpowered through new understanding, and 6) what we can **D**o. Following each participant's photo description, the group further discussed the photographs to obtain other participants' views about the issues. For the third session, held approximately one month later, the group met to discuss the findings and planned the next action steps based on the results and priorities of the community. Through a collaborative discussion of the preliminary themes, a set of barriers and resources related to physical activity in the Somali community were established. As part of the advocacy emphasis in this Photovoice project, the women identified key stakeholders with whom they wanted to share the results and co-construct the next steps for action. Upon completion, each participant was given a photo album including her photos and the 2-3 photos chosen by each of the other participants. In addition, they were given a \$50 gift card. All sessions were audio-recorded and transcribed by a trained research assistant. The Somali community representative and another researcher reviewed all transcriptions for accuracy.

Data analysis

A thematic analysis approach was used to analyze this group-generated qualitative data (28). As the data were generated, emerging themes were used to inform and guide subsequent discussion. Analysis involved continuous comparison within and across data sources. At the conclusion of the Photovoice sessions, three members of the research team—including the bicultural research team member—analyzed the qualitative data through a multi-step coding process. Initially, the researchers each read through the transcripts to identify and code meaningful segments. The researchers then met together to discuss and categorize the concepts into preliminary themes based on similar constructs. Themes were identified and labeled and relationships between themes were determined. Differences in categorization or identification were discussed amongst the three coders, with modifications conducted as needed. This inductive approach allowed for the generation of concepts and themes as well as identifying conceptual linkages in order to build a framework for understanding physical activity in the Somali community. In the final session, the researchers and community members reviewed the initial coding, and made revisions and elaborations to the coding scheme, as indicated by the group discussion.

Results

Barriers to Physical Activity

There were 3 major themes (safety, religion, and cost) that emerged pertaining to barriers to physical activity. Table 1 provides a list of the key themes and the number of pictures associated with each theme.

Safety—Safety was the theme discussed most frequently, and researchers identified 3 subthemes: environmental conditions, presence of gangs, and the presence of dogs.

Environmental Conditions: Women spoke about environmental conditions preventing them from walking in their communities, including nonexistent or badly damaged sidewalks. Participants reported the streets are poorly maintained and high traffic volume on streets without sidewalks poses an additional danger. One woman described a picture of a badly damaged street close to her home and said, “So, the problem with this picture is there is no sidewalk. You’re always afraid of the cars.” This leads her to drive places in her car rather than walk. Other environmental conditions posing a threat to safety included sanitation issues (e.g., refuse on the sidewalks, streets, and parks), which served as a barrier for the women and their children.

Presence of Gangs: The neighborhood and nearby parks are not considered safe to the women because of known gang presence. Women did not want themselves and/or their children exposed to drugs and violence in order to engage in physical activity. One woman took a picture demonstrating the issue of both sanitation and gang presence. In describing it, she said:

...as you can see there's some uh trash on the sidewalk. There's um...[a] signature of a gang or signs of a gang signs on the street. It's not clean...it's not safe...for walking, it's not safe, because it's...because of the gang signs, she doesn't feel safe walking here (translator).

Presence of dogs: The women reported that dogs made them feel unsafe in their community and many reported past experiences of being attacked or bitten by dogs. The women reported encountering dogs in public spaces frequently off their leashes. They reported this made them anxious and reluctant to utilize parks and public spaces and stated their desire for more dog-free spaces. Women reported feeling harassed by dog owners and that owners would let their dogs off the leash in order to incite fear and to bother the women. However, the women reported understanding the importance of dogs to their owners and the challenges of advocating for dog-free zones, stating, “We know that dogs are like their children.” See Figure 1.

Religious Practices—Women talked about how some of the available physical activity resources are not compatible with their religious practices. The women reported the importance of modesty and their desire to exercise in women-only facilities, especially when wearing “workout clothes” or bathing suits. Many women lived in apartment complexes with pools, which they could not utilize. One woman took a picture of a pool and described

it by saying, “It’s against our religion to swim in a public place like that. It’s not covered and it’s not appropriate for us (translator).” One woman mentioned when trying to workout at a fitness facility the employees told her she could not use the exercise machines due to her attire. She indicated that she was told, “this is not safe, you cannot use this [wear the hijab and long clothes] on the machines [or] you get stuck.”

Financial issues—The women reported low-income levels (4 of the 8 women reported < \$10,000 household income per year). The financial barriers women reported included the direct costs associated with gym memberships and fitness equipment, and opportunities for time away from work and family responsibilities (e.g. childcare, cooking, cleaning, elder care). This theme came up during group discussion, but was not directly photographed.

Community Strengths and Resources for Physical Activity

The major themes pertaining to community strengths and resources were: public resources in the community, private resources available to some women, and community support systems. The women considered the following to be resources and strengths given perceptions of safety for them and their children. However, not all women perceived the strengths mentioned and not all women felt they had access to the identified resources.

Public Resources—The public resources that some women identified included certain parks, public pools (for their children), shopping malls, and farmer’s markets. Particular parks were favored because they were perceived as safe and clean. Although women reported they could not utilize most public pools, they acknowledged them as resources for their children. Some women mentioned walking around shopping malls to stay physically active. One woman spoke positively about a local farmer’s market that provided resources including space to walk, a safe place for children to play, and a way to buy inexpensive fresh produce.

Private Resources—Some women mentioned private resources, for example some local schools had space for parents to be physically active and some housing complexes have playgrounds. Women saw these as positive and safe resources. Children’s sports leagues were also mentioned as sources of physical activity.

Support System in their Community—A resource cited less often was having a support system. The women reported many family responsibilities, so if the physical activity cannot involve their children, they rely on other women to help watch their children or help with responsibilities. Support was seen as necessary for some women to be able to be physically active. For example, one woman took a picture of a playground at her apartment complex and said, “There’s more than one parent there most of the time, so if she has to go in, like for example make prayers or she has to go pray, she can leave the kids with them... neighbors are taking care of each other...(translator).”

Creating Change: Opportunities and Challenges

The women's ideas for opportunities for change were linked to the barrier themes. The first 2 themes (increased safety and resources) were discussed as changes women “wished” or “wanted” to take place, whereas the third theme was action-oriented.

Increasing Safety—Increasing safety was the most frequently discussed theme. Women indicated the need for more police involvement in their communities in order to address gang and violence issues. Women also wanted to see more city involvement in addressing structural issues (streets with large potholes, dangerous or absent sidewalks, lack of bike lanes). City involvement was also suggested to improve sanitation on the streets and in parks. Women would also like to see more areas designated as “dog free.” The women were provided resources with numbers to call to report graffiti, crime, damaged roads and sidewalks, and other concerns to help increase safety in their own neighborhoods.

Increasing Resources—Women discussed their desire for increased resources for themselves and for their children. Women reported wanting to see more affordable gyms or clubs devoted to women only, in order to overcome religious and financial barriers. There was also a desire for more family programs and programs for children, and the women identified many potential community partners to generate additional safe and low-cost opportunities for physical activity for the whole family. These included communicating with their children's school about opening resources to women before or after school, working with local parks and recreation departments to increase compliance with regulations requiring dogs to remain on leashes, and working with city officials to report sidewalks and streets requiring attention to enhance opportunities for walking in their neighborhoods. Women also discussed the possibility of contacting the local YMCA to request a “women only” swimming hour. Steps were made in each of these domains, including the local YMCA initiating a program for women-only swimming once per week on a sliding fee scale. This program was identified on the local KPBS Public Broadcasting station as a noteworthy program (29).

There were also suggestions made for increasing individual physical activity levels. For example, women discussed the possibility of creating a list of physical activity resources in the community, because many were unaware of some of the resources mentioned. There was also discussion about finding more resources for home fitness (e.g., videos). A list of local physical activity resources has subsequently been compiled and efforts are underway to develop videos featuring cultural dances and exercises from various East African communities. These efforts have included collaborations between community members, organizations, researchers, and advocates.

Lessons Learned

As progress has been made in advocating for and obtaining physical activity resources for East African Muslim women, there have been unanticipated consequences. While the KPBS feature was intended to raise community awareness of the unique challenges to physical activity faced by Muslim women, the feature incited considerable public debate on creating separate programs and opportunities for diverse communities. The public commentary on

the video's online forum highlighted the divisiveness of immigration and cross-cultural diversity and the ways in which public resources and programs are used and/or adapted for use within diverse communities. This series of events represented a significant challenge to the community and research partners and is a rarely discussed potential reaction to successful CBPR programs.

This research highlights a successful CBPR program utilizing Photovoice to better understand and advocate for community change related to physical activity. This research addresses a population that has received little attention in health behavior research, yet has a growing need for resources and many self-identified challenges to initiating and maintaining physical activity. This study illuminates these areas of need for Muslim Somali women and suggests important areas for intervention. The community-driven advocacy efforts for physical activity programs described here also highlight the complexity of enabling change within the larger sociopolitical context. Future efforts would benefit from an emphasis on promoting health and opportunities for a healthy lifestyle for all U.S. residents—regardless of race, religion, or nationality.

Conclusions

The current research highlighted the numerous challenges faced by Somali women in the U.S. to being physically active, with the majority of challenges similar to those faced by others living in impoverished and high-crime settings. The identified barriers included high levels of crime within their neighborhoods and local parks, poor infrastructure, and limited financial resources. These challenges require ongoing advocacy to promote healthy environments and equal opportunities for healthy lifestyles. However, there are additional barriers faced by Somali women that include limited culturally and religiously appropriate facilities and experiences of discrimination.

While the U.S. Muslim community includes 3-7 million individuals and is expected to become the largest minority religion in the U.S. within the next 10 years, there is little research examining the impact of discrimination and Islamophobia on Muslim Americans (30). Public opinion polls indicate conflicting attitudes toward Islam in the U.S., and little change in public opinions over the past decade (31). While there has been significant growth (900%) in research over the past 10 years (30), more is needed to identify ways of decreasing stereotypes and prejudices against Muslim Americans. In an era of increasing polarity in beliefs about immigration reform and cross-cultural diversity, more strategies are needed to enhance community dialogue on how to respond to the emotionally charged rhetoric that can arise when advocating for change. With ever-increasing levels of human movement and cultural diversity in every country around the globe, the need for such strategies is paramount in efforts to promote health equity.

The current research included a convenience sample of Muslim Somali women in San Diego; therefore, it may not be representative of other Somali or Muslim communities varying in age, acculturation and location. Our sample size was small; however, in a review of 31 studies that used Photovoice as a CBPR method (26), samples were as small as 4 and as large as 122, with a mean of approximately 20. A strength of the study was that women

were able to participate in their native language; however, a potential limitation is the possibility that information was lost in translation. We attempted to reduce this problem by having a female community representative whose native language is Somali, and is fluent in English, conduct the translations. Nevertheless, further efforts to more systematically assess physical activity and intervention programs for this underserved community are warranted. Similarly, very little is known about the unique health profiles and health behaviors practiced within the Somali and other refugee communities. Future studies may focus on contrasting previous physical activity level and type of activity with current, post-immigration levels. Additional CBPR that furthers these efforts and assesses community health concerns with empirical rigor are needed.

Acknowledgments

This research was funded in part by the National Cancer Institute Comprehensive Partnerships to Reduce Cancer Health Disparities program, grants #1U54CA132384 and #1U54CA132379, and MRSG-13-069-01-CPPB from the American Cancer Society.

References

1. Flegal KM, Kit BK, Orpana H, Graubard BI. Association of all-cause mortality with overweight and obesity using standard body mass index categories: A systematic review and meta-analysis. *JAMA : The Journal of the American Medical Association*. 2013; 309(1):71–82.10.1001/jama.2012.113905
2. Bruning, N.; Yeh, MC. Obesity. In: Loue, S.; Sajatovic, M., editors. *Encyclopedia of Immigrant Health*. New York: Springer; 2012. p. 1143-6.
3. Elmubarak E, Bromfield E, Bovell-Benjamin AC. Focused interviews with Sudanese Americans: perceptions about diet, nutrition, and cancer. *Preventive medicine*. 2005; 40(5):502–9.10.1016/j.ypmed.2004.09.021 [PubMed: 15749131]
4. Gardner K, Salah S, Leavey C, Porcellato L. ‘The perfect size.’ Perceptions of and influences on body image and body size in young Somali women living in Liverpool-a qualitative study. *Diversity in Health and Care*. 2010; 7:23–4.
5. Renzaho AMN. Challenges of negotiating obesity-related findings with African migrants in Australia: Lessons learnt from the African Migrant Capacity Building and Appraisal Project. *Nutrition & Dietetics*. 2009; 66:145–50.
6. Burns C. Effect of migration on food habits of Somali women living as refugees in Australia. *Ecology of Food and Nutrition*. 2004; 43:213–29.
7. Drummond PD, Mizan A, Burgoyne A, Wright B. Knowledge of cardiovascular risk factors in West African refugee women living in Western Australia. *Journal of immigrant and minority health / Center for Minority Public Health*. 2011; 13(1):140–8.10.1007/s10903-010-9322-z [PubMed: 20140515]
8. Guerin PB, Elmi FH, Corrigan C. Body composition and cardiorespiratory fitness among refugee Somali women living in New Zealand. *Journal of immigrant and minority health / Center for Minority Public Health*. 2007; 9(3):191–6.10.1007/s10903-006-9030-x [PubMed: 17252194]
9. Renzaho AM, Nowson C, Kaur A, Halliday JA, Fong D, Desilva J. Prevalence of vitamin D insufficiency and risk factors for type 2 diabetes and cardiovascular disease among African migrant and refugee adults in Melbourne: a pilot study. *Asia Pacific journal of clinical nutrition*. 2011; 20(3):397–403. [PubMed: 21859658]
10. Office of Refugee Resettlement. *Refugee Arrival Data*. Washington, D.C.: 2011.
11. Central Intelligence Agency. *The World Factbook*. Somalia Washington, D.C.: CIA; 2013 May 20. 2013
12. United Nations High Commissioner for Refugees. 2013 UNHCR country operations profile-- Somalia. Geneva, Switzerland: UNHCR; 2013.

13. Gordon-Larsen P, Nelson MC, Page P, Popkin BM. Inequality in the built environment underlies key health disparities in physical activity and obesity. *Pediatrics*. 2006; 117(2):417–24.10.1542/peds.2005-0058 [PubMed: 16452361]
14. Caperchione CM, Kolt GS, Mummery WK. Physical activity in culturally and linguistically diverse migrant groups to Western society: a review of barriers, enablers and experiences. *Sports medicine*. 2009; 39(3):167–77.10.2165/00007256-200939030-00001 [PubMed: 19290674]
15. Devlin JT, Dhalac D, Suldan AA, Jacobs A, Guled K, Bankole KA. Determinants of physical activity among Somali women living in Maine. *Journal of immigrant and minority health / Center for Minority Public Health*. 2012; 14(2):300–6.10.1007/s10903-011-9469-2 [PubMed: 21479887]
16. Jiwani N, Rail G. Islam, hijab and young Shia Muslim Canadian women's discursive constructions of physical activity. *Sociology of Sport Journal*. 2010; 27:251–67.
17. Israel BA, Schulz AJ, Parker EA, Becker AB. Review of community-based research: assessing partnership approaches to improve public health. *Annual review of public health*. 1998; 19:173–202.10.1146/annurev.publhealth.19.1.173
18. Tanjasiri SP, Lew R, Kuratani DG, Wong M, Fu L. Using Photovoice to assess and promote environmental approaches to tobacco control in AAPI communities. *Health promotion practice*. 2011; 12(5):654–65.10.1177/1524839910369987 [PubMed: 21955822]
19. Ellis BH, Kia-Keating M, Yusuf SA, Lincoln A, Nur A. Ethical research in refugee communities and the use of community participatory methods. *Transcultural psychiatry*. 2007; 44(3):459–81.10.1177/1363461507081642 [PubMed: 17938156]
20. Keener, D.; Goodman, K.; Lowry, A.; Zaro, S.; Kettel Khan, L. Recommended community strategies and measurements to prevent obesity in the United States: Implementation and measurement guide. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2009.
21. Catalani C, Minkler M. Photovoice: a review of the literature in health and public health. *Health education & behavior : the official publication of the Society for Public Health Education*. 2010; 37(3):424–51.10.1177/1090198109342084 [PubMed: 19797541]
22. Wang C, Burris MA. Empowerment through photo novella: portraits of participation. *Health education quarterly*. 1994; 21(2):171–86. [PubMed: 8021146]
23. Lopez, EDS.; Eng, E.; Robinson, N.; Wang, CC. Photovoice as a community-based participatory research method: A case study with African American breast cancer survivors in rural eastern North Carolina. In: Israel, BA.; Eng, E.; Schulz, AJ.; Parker, EA., editors. *Methods for conducting community-based participatory research for health*. San Francisco: Jossey-Bass; 2005. p. 326-48.
24. Lightfoot, E. Cultural health assets of East African immigrant communities in the Cedar-Riverside neighborhood of Minneapolis. Minneapolis: Brian Coyle Center; 2011.
25. Murray KE, Mohamed AS, Ndunduyenge G. Health and prevention among East African women in the U.S. *Journal of health care for the poor and underserved*. 2013; 24(1):233–46.10.1353/hpu.2013.0029 [PubMed: 23377731]
26. Hergenrather KC, Rhodes SD, Cowan CA, Bardhoshi G, Pula S. Photovoice as community-based participatory research: a qualitative review. *American journal of health behavior*. 2009; 33(6):686–98. [PubMed: 19320617]
27. Wang CC. Photovoice: a participatory action research strategy applied to women's health. *Journal of women's health / the official publication of the Society for the Advancement of Women's Health Research*. 1999; 8(2):185–92.
28. Braun V, Clark V. Using thematic analysis in psychology. *Qualitative research in psychology*. 2006; 3(2):77–101.
29. Burks, M. YMCA offers women-only swim hours for Muslim women. *Speak City Heights*. 2012. <http://www.speakcityheights.org/2012/06/ymca-offers-women-only-swim-hours-for-muslim-women-and-girls/>
30. Amer MM, Bagasra A. Psychological research with Muslim Americans in the age of Islamophobia: Trends, challenges, and recommendations. *The American psychologist*. 2013; 68(3):134–44.10.1037/a0032167 [PubMed: 23586489]
31. Pew Research Center. After Boston, little change in views of Islam and violence. Washington, D.C.: Pew Research Center; 2013.

Figure 1.

“She is in this specific picture she's kind of scared because she had to go on one side because of the dog and the side that she goes is either the water because it was in a lake or she would go into the bushes so she's scared of snakes or other things, so she doesn't feel it's safe for her.” (translator)

Table 1
Key themes from photos and focus group discussion

Key Themes	Number of Photos
1. Safety Barriers	13
a. Environmental Conditions	6
b. Gangs	2
c. Dogs	3
2. Religious Barriers	5
3. Financial Barriers	0
4. Resources	7
a. Public Resources	6
b. Private Resources	2
c. Support Systems	3

Note. Several pictures were discussed and categorized under multiple categories and themes