The Office of Refugee Resettlement (2010) reports more than 2.6 million refugees have come to the United States (U.S.) since 1975. Refugees are marginalized populations who are forced from their countries of origin as victims of ethnic and religious persecution, civil war, and political disenfranchisement (U.S. Citizen and Immigration Services, 2011). The Somali Bantu are distinguished and separated socially from the native Somali people based on their physical characteristics of curly hair, dark skin, and cultural disadvantage; as the Bantu were slaves in Africa (Van Lehm an & Eno, 2003). The standard of living was low in southern Somalia, with no electricity or running water in homes. For years, the Somali government barred the Bantu from education and political involvement, which led to high illiteracy rates and social isolation among the Bantu (Van Lehm an & Eno, 2003).

The Somali Bantu population, who resided in the same city in the Northwest U.S. where this research was conducted, is comprised of approximately 246 individuals (Idaho Office of Refugees, 2008). The research participants resettled here from United Nations’ (U.N.) refugee
camps in Kenya from 2003 to 2006. Before their arrival, they had little or no experience with Western culture, technologies, or healthcare in the U.S.

A particularly vulnerable subset of the Somali Bantu population is the elderly refugee (Agency for Healthcare Research & Quality [AHRQ], 2010). From a historically pre-literate society with no written language, the elderly Somali Bantu struggled to learn English four to seven years after their arrival in the U.S. The elderly Somali Bantu encountered a vastly different environment for receiving healthcare upon their arrival to the U.S. than what they had experienced in Africa. Healthcare changed for these refugees when they entered the refugee camps, where access to healthcare was extremely limited. Refugees were required to wait in long lines, which were already formed by sunrise, to obtain medical care. A second change occurred when these elders arrived in the U.S. with limited or no English skills. The elderly Somali Bantu were faced with an unfamiliar healthcare system, medical insurance forms, appointment schedules, transportation barriers, in addition to the associated mental and physical changes associated with aging. Adjusting to the U.S. healthcare system is a tremendous task for young refugees, and is an even bigger challenge for the elderly.

Once in the U.S., support for refugees from resettlement agencies for housing and healthcare issues lasts for a period of four to eight months (Office of Refugee Resettlement, 2010). Assistance from resettlement agencies for refugees is limited by policies established by the Office of Refugee Resettlement (ORR) in the Department of Health and Human Services Administration for Children and Families (HHS/ACF). These programs provide transitional assistance to refugees and other designated groups; services may include paid interpreters, transportation, and English classes. After this period of four to eight months, self-sufficiency is expected and resources must be obtained by individuals without government assistance. Meeting this timeline can be problematic for the elderly refugee. Bruno (2011) points out that refugees represent an underserved population that is targeted for assistance with resettlement policy reform.

**Problem and Significance to Nursing**

Little is known about elderly refugees and how they adjust to healthcare after resettlement. The Somali Bantu represent a population of refugees who are extremely disadvantaged due to social class and linguistic barriers in Africa. It is not known how the elderly Somali Bantu refugees manage their interactions with the US healthcare system. Nurses need to better understand how the elderly refugees adjust, and how cultural and language differences impact these adjustments. Nurses need to discover and describe cultural care values and beliefs of elderly Somali Bantu related to the issues raised through the cultural community assessment. Nurses have a responsibility to perform culturally appropriate assessments and implement culturally congruent interventions. Information on refugee adjustment will help nurses to: provide high quality care, advocate for individual patients and their families, and positively impact public policy.

**Purpose and Theoretical Framework**

The purpose of this research study was to discover and describe the factors that impact adjustment of the elderly Somali Bantu to the American healthcare system, with the ultimate goal of positively impacting practice. The Community as Partner Model (Anderson & McFarlane, 2010) and the six cultural phenomena of Giger and Davidhizar’s (2008) Model for Cul-
tural Assessment were used to guide the community and cultural assessment that resulted in the data used for the study.

**Research Methods**

Springer, Black, Martz, Deckys, and Soelberg, in 2010, undertook a qualitative descriptive study using Community-Based Participatory Research (CBPR) methods with the Somali Bantu refugees. CBPR is based on the principles of collaboration, equitability, and community partnership. Researchers worked with community members to define community concerns, implement research, and disseminate and apply findings (Hartwig, Calleson, & Williams, 2006; Johnson, Sagal, & Shipp, 2009).

In order to obtain good understanding of the research question, the researchers needed to be deeply intertwined with the community, making CBPR the ideal choice for the research method. Researchers utilized CBPR principles of collaboration, equitability and community partnership by seeking the advice and guidance of a Somali Bantu refugee community advisory board during multiple phases of the study. The length of the researchers’ community engagement spanned 2 years. A secondary analysis of data from the elderly participants, combined with a focus group with other elderly Somali Bantu refugees, provided data for this qualitative descriptive study focused solely on elderly Somali Bantu refugees.

**Ethical Considerations**

According to the U.S. Office of Research Integrity (ORI), refugee populations are defined as a vulnerable research population due to: language barriers, issues of health literacy, poverty, prejudice, violence and trauma, healthcare access, and the challenges of resettlement in a foreign country (Steneck, 2004). A university Institutional Human Subjects Review Board (IRB) approval was obtained. Steps were taken, through interpreters, to ensure the informed consent of these individuals during the observation, interviews, and the elder focus group interview. Because the Somali Bantu do not have a written language and many of these refugees do not read or write English, the consent form was interpreted for them in their native language. The IRB approved the tape recording of the participants’ consent to participate in the study, and to allow the researchers to tape record the interview. The interpreters confirmed that participants understood the consent and agreed to participate.

**Population, Participants, and Process**

The Somali Bantu consider the age of 50 to be elderly. Elderly Somali Bantu refugees (self-reported age of 50 or older) were included in this study. In addition to age, inclusion criteria for the current study included having lived in the area for four or more years, and having experiences with healthcare in the U.S. since arrival. For this qualitative descriptive study, a focus group was held with six elderly Somali Bantu refugees. In addition, a secondary analysis was performed using a larger qualitative cultural and community assessment involving Somali Bantu refugees (Springer, et al., 2010). Data from Springer, et al. (2010) included:

- Direct observations of the community while visiting and participating with the elderly Somali Bantu. A total of 25 observations were performed, with at least two researchers spending at least 2 hours in the community for each observational experience.
- In-depth interviews: A total of eight interviews (four males and four females) with elderly refugees were performed. Interviews were completed in a non-threatening setting,
usually the refugee’s apartment. Interviews were tape recorded with one researcher leading the interview and a second researcher taking field notes.

- One focus group with six elderly Somali Bantu (two males and four females) was completed in a location convenient to the refugees. Focus group questions specific to this study were based on a preliminary analysis of the data from the elderly in the community assessment and were reviewed by the Somali Bantu community advisory board for cross-cultural understanding and accuracy. The focus group questions were modified and trialed with additional members of the community advisory board to ensure cultural appropriateness.

Ages for the elderly participants are estimates, as there are no birth records from their native country. The majority of elderly Somali Bantu refugees are given January 1 and an estimated year as a birth date for official records. Many of the elderly within this community of Somali Bantu refugees have been in the U.S. since 2003.

Participants were asked to describe their experiences with attaining healthcare in the U.S. Follow-up prompts such as ”Tell me how you dealt with that”, and open-ended questions focused on difficulties in obtaining healthcare, factors that made it easier to obtain healthcare, and any issues surrounding language and transportation as it related to healthcare. The focus group was facilitated by the first author and audio-taped, and extensive field notes were taken. Languages spoken by participants included Af Maay Maay and Kizigua. A male interpreter, who was a member of the community, was present and interpreted the questions and responses.

Data Analysis

Data were analyzed using a thematic analysis as described below (DeSantis & Ugarriza, 2000). The English translation of the interviews and focus group were transcribed verbatim. The researchers independently read and re-read the data. Codes were developed inductively and notes were made about assumptions and relationships among codes. The researchers discussed the possible meanings of the codes based on what was known of the culture and community from observations and engagement with the population.

As the codes were reviewed, categories began to emerge from the codes. Categories were color-coded and arranged to denote potential relationships between the categories. Themes emerged as the categories were explored. Analysis was accomplished with both research team members. The researchers utilized negative case analysis for codes that did not fit into themes to ensure ontological authenticity, which involves all stakeholders in the construction and interpretation of the data (Guba & Lincoln, 1989). The team discussed all codes and themes with community members, with a focus on codes that did not clearly fit into themes.

Data Rigor

Data collection through interpreters presented several challenges. Formal interviews and the focus group were tape recorded and the translated English version was transcribed. The researchers were unable to find reliable transcription services in Af Maay Maay and Kizigua. They relied on notes taken by the research team, listening repeatedly to the voice tones, and transcribing the interpreted interviews. Notes were taken by a second researcher who attended the interviews and focus group. Notes were compared and both researchers agreed on the findings. To validate interpretation, tapes from two
interviews were sent to an independent interpreter from the community to validate the accuracy of the interpretation. This community does not have certified interpreters in Af Maay Maay and Kizigua, thus community members who were fluent in English, Af Maay Maay and Kizigua were used as interpreters. Both interpreters utilized for this process confirmed close to word-for-word accuracy in the audio-taped interviews they heard.

Credibility of the data was reinforced through prolonged engagement with the community for a period of over 2 years. The Somali Bantu community advisory board meetings offered the research team insight into participant responses and confirmed researcher understanding of the codes and themes. Member checking with the advisory board and peer debriefings among the research team were utilized to verify what researchers had seen and heard in the field.

Findings

A number of themes emerged through the data coding process, which demonstrated the complex nature of adjustment for the Somali Bantu elderly. With the use of their community interpreters, the elderly felt they navigated the healthcare system adequately (i.e., understanding the importance of being on time for medical appointments). Themes that described factors impacting the elderly Somali Bantu’s adjustment to the healthcare system included: using interpreters, understanding difficulties about healthcare providers and systems, taking medications, finding transportation, having no money, reporting bad dreams, sadness, and memories of Somalia; incorporating beliefs and rituals into their healthcare and receiving care for female problems. Themes are described in the terms used by the refugees.

Using Interpreters

All elderly Somali Bantu required an interpreter for communication with the healthcare provider, despite having been in America for six or more years. One elderly man said, “I go to clinic, experience with doctor is good now. They know I’m a refugee. I’m with an interpreter.” A 50 year old female echoed, “Interpreter helps me understand at doctor’s office.”

A male participant stressed the importance of having the “right” interpreter. “Not the right interpreter. One time I went to the hospital, they got a Somali interpreter. The interpreter told the doctor I had leg pain when I said my foot was hurting. Sometimes we take children to talk for us.”

Difficulty Understanding Healthcare Providers and Systems

Learning English in the U.S. is difficult for this population. The Somali Bantu were farmers in their native country and had no access to schools. In the refugee camps, children were provided with some education; typically, women and the elderly did not attend school. Historically, the participants explained, “Main job in Somalia was farming. Our clan came from the Juba Valley. Government prevented education.” A 60 year old male mentioned that, “[In America] have schools for children, everyone can learn… [in Somalia] we end up no education.”

Age played a part in the ability to learn a new language, as most of the participants attested. The interpreter noted, “For a person like him [older male], he may not get it faster. He may learn a few words from his son.” A female, while looking down, said, “I try and try to learn English in those classes. I go for a while, but I don’t remember when I get home and no one to talk to. Maybe I’m old.”

Taking Medications

The Somali Bantu elders discussed how they
received healthcare in Africa. “We got up before the sun. We stood in long lines all day and they gave us a bag of pills. We took them until they were gone. No hospitals. If we don’t get better, we pray.”

The majority of participants stated that taking American medicine was not a problem as long as they had an interpreter to help them. One elderly man said, “Not a problem [understanding how to take medication]. Pharmacy will explain to me. When I come home, family can explain to me.” This may not be the case for some, as one woman pulled out four empty push packs of medication (a month’s supply of a thyroid medication, hypertensive medication, calcium supplement and a sleeping aid). She did not understand the instructions and had taken all of the medications at once, making her very ill. She had not refilled the prescriptions since that time. Receiving medication refills also presented a problem when participants forgot to obtain the refills. A focus group participant exclaimed, “Appointment reminders are good. You have an appointment, they call you. Doctor says if you miss three appointments, we can’t take you anymore.”

Finding Transportation

Adjusting to the U.S. has been difficult due to transportation. The majority of participants interviewed could not walk long distances (to the bus stop) or they did not drive. Personal transportation is frequently only available through family members. Public transportation presented barriers due to lack of English skills and diminished mobility needed to get to the bus stop. The interpreter explained, “When she tries to get a taxi, she tries to explain where she needs to go and they don’t understand. The interpreters can’t take them because agency won’t pay.”

A 50 year old male stated he needed his son to take him to the doctor’s office, but this was sometimes hard to do because of his son’s work schedule. The interpreter then offered, “In Boston they have their own transportation. A van come to pick the people up at the apartments and take them to their appointments. They go by all the people’s places, then when you’re done, they come to pick you up.”

Having No Money

This community of Somali Bantu elders defined themselves as 50 years of age and older. There was a gap in Medicare coverage for those 50 to 64 years of age and many were jobless and did not have the money to go to the doctor. They used over-the-counter medications in lieu of a doctor’s visit or waited until they were severely ill and ended up in the emergency department.

For the refugee who is 65 years and older, Medicare benefits are available. For those younger than age 65 years who do not qualify for Medicare, financial hardship surrounds the need for medical care. One man stated, “If they have Medicaid, they go to doctor and pharmacy to get pills. The problem is most do not have Medicaid [19-64 year olds]. They have to pay so they don’t go to the doctor.” The interpreter further illustrates, “Like her, she takes it from her pocket, she under 65. That’s why she can’t go all the time to the doctor. Even when she’s sick, she goes to get the over-the-counter medicine. She goes to the hospital and has six prescriptions. But now she has bill of $25,000 and can’t pay this.”

Reporting Disturbing Dreams, Sadness, and Memories of Somalia

The majority of participants indicated they had bad dreams and memories. A 60 year old male responded, “Yes. Dreams. Talk to doctor about it. Worry about people left behind [refugee camps] in Africa. Phone communication only. Feel like they are mental problem. Don’t worry about it.” An elderly female participant stated, “Yeah, sometimes I have these. I talk to my doctor about it. The doctor gave me
Another 50 year old female explained to the interpreter, “Yes, sometime she’ll start crying herself, remembering when she has dream. She says, ‘Everyone come here’ and tells them about it.” An elderly man had made adjustments through his farming saying, “I don’t think in America. In Kakuma, yes, because you can still see people who are still trying to do bad things. Right now I don’t have any bad feeling. I’m working on the farm, gives me energy.”

Incorporating Beliefs and Rituals into their Healthcare

The Somali Bantu elderly voiced great trust in the healthcare providers here in the U.S. If someone did not get better, they believe God could ultimately heal the person. Prayer was an important part of their healing. Healing rituals that included indigenous African herbs and roots had been abandoned by these participants due to the absence of these plants in North America. Some participants voiced concern that the healthcare provider would not feel these practices were acceptable and that they might be pressured not to use such remedies. They still used prayer, drumming, singing, henna, and teas to care for their illnesses, yet they were very willing to trust the new American healthcare system.

All elderly Somali Bantu refugees interviewed held the belief that God played a hand in their health and illness. Several stated that “Everything was from God” and that “If [ill people] not helped [by the doctor], we pray for them.” A 60 year old male explained, “In Somalia we use burning points on the head of babies with big heads.” Since there were no hospitals available, one man stated, “At home, used drumming, oil body, fruit and leaves for sick person. No hospital, everyone used the practices.”

Receiving Care for Female Problems

The last theme that arose from the interviews and observations was that of female problems. Observations made during interviews indicated that the elderly women were not included in conversations and that if men were present, the women deferred any comment to the men. During a flu shot clinic in an apartment complex laundry room, the women became very vocal and interactive only in the absence of men. When using interpreters, it was noted that women would only answer the question asked, and did not engage in conversations regarding their care or seemingly advocate for themselves. The women mentioned that they could not speak easily to a male doctor about their “female problems” and preferred a female physician and interpreter. Female problems were identified as bladder or vaginal infections, difficult pelvic exams, and labor and delivery complications due to female circumcision (Parve & Kaul, 2011).

Discussion

From their time of arrival until six to seven years afterward, the elderly Somali Bantu have faced many challenges in their adjustment to the new ways of American culture. When they set foot on American soil, they began to learn the rules, expectations, and tasks of becoming a new resident with the assistance of resettlement agencies. The 50 to 64 year old Somali Bantu who were not disabled needed to find employment; a difficult task if they did not have English skills. They also needed to learn the technology of their new home (e.g., light switches, microwaves, and phones) while managing finances, shopping, driving, and learning how bills were paid, and what happened if they were not.

In terms of healthcare, the elderly refugees needed to adjust to health screening, immunization schedules, work with agency case workers
to make appointments, and arrange for transportation and interpreters. They needed to fill out Medicare forms and manage their own disease with little knowledge of insurance systems, health information, or the side effects of multiple medications (polypharmacy). This all needed to be accomplished within an eight to twelve month time frame while refugee resettlement program benefits still covered them.

Given the numerous and complex tasks in obtaining healthcare, the elderly Somali Bantu remained reliant on interpreters. The elderly refugees described their reliance on interpreters, instances of being provided with wrong interpreters, and times when they relied on children to interpret for them. These experiences are not unique when interpreters are utilized in healthcare.

Not having the correct interpreter is especially troubling for the Somali Bantu. Not only are there differences in dialect, but also remnants of hostility exist between the ethnically suppressed Bantu and their suppressors, the native Somalis (Hadziabic, Heikkila, Albin, & Hjelm, 2011). Rosenberg, Seller, and Leanza (2008) studied interpretation provided by professional interpreters and by family members. The researchers recommended always using a professional interpreter for accurate interpretation; a luxury these elderly refugees did not always have.

Only 5% of the Somali Bantu have formal education, making illiteracy a prevalent problem (Parve & Kaul, 2011). These elderly refugees discussed difficulty being able to learn English. Even patients who speak English may not be able to read or write it (Parve & Kaul, 2011). The elderly in this sample were primarily women, had little to no schooling, and had never learned English. According to Alwan, Wilkinson, Birks, and Wright (2007), educational attainment is an indicator of self-rated health in people 75 years and over. This population is at significant risk of health issues due to low education and literacy factors. Understanding how and when to take medications was described by the sample as a factor in the adjustment to the U.S. healthcare system.

Transportation to healthcare appointments is challenging for many elderly including the Somali Bantu (Parve & Kaul, 2011). Missed appointments are a common occurrence; some local providers reporting up to fifty percent of appointments being missed (Personal communication, Saint Alphonsus Medical Group (2009). No information was found regarding transportation issues for Somali Bantu refugees, however, in the Karen refugee population, researchers identified language and transportation as major obstacles in locating and accessing healthcare (Mitschke, Mitschke, Slater, & Teboh, 2011). While some elderly may have access to bus routes, physical mobility hindered getting to the bus stop and standing there during inclement weather.

The World Health Organization (Campanini, 2001) estimates that, of the people who experience traumatic events as a result of armed conflicts, ten percent will have serious mental health problems and another ten percent will develop behaviors that will hinder their ability to function effectively. While these refugees did not label feelings as depression, they spoke of having bad dreams and the impact of these dreams on their lives. A combination of post-migration stressors; including the demands of acculturation, poor nutrition, lack of access to care, decreased support systems and a possible increase in care-giving responsibilities, coupled with continued tensions and upheaval in the country of origin are thought to exacerbate the already high levels of stress and risk of depression experienced by refugees (Dow, 2011; Parve & Kaul, 2011). Nurses need to ask about troubling
dreams when interacting with refugees. It is important to know if the refugees are struggling with the effects of post-traumatic stressors so appropriate interventions can be developed to prevent episodes of anxiety or depression (Dow, 2011).

Religion plays an important role in health and illness. In a study by Carroll (2007), 41% percent of studied Somali Bantu respondents volunteered information on the role God or Islamic religion played in influencing their health. Springer et al. (2010) point out that the Somali Bantu “live their lives according to the tenants of the Muslim faith” (p. 176). Everything is Allah’s will. Elderly in this sample discussed trust in regard to healthcare despite unfamiliar pills and treatments. Overwhelmingly, they trust their healthcare providers and they trust God with their health and healing. Islam has two major sects: the Shiite and Sunni (ReligionFacts, 2012). Nurses can provide more culturally appropriate care if they familiar with the basic tenets of these sects and how religious beliefs influence healing.

These elderly refugees talked about the impact of a lack of money on their willingness and ability to access healthcare. Data could not be located on the income of elderly refugees, however, the average family income among elderly legal immigrants is about half that of all elderly citizens (Kaiser Family Foundation, 2011). This is true even though elderly refugees were more than three times as likely to be living with others, including an adult child who may be working. Elderly refugees have lower incomes because they have, on average, fewer years of education, and language and cultural differences may have hindered employment opportunities. The Somali Bantu report a high level of stress due to lack of money because many have lost jobs. Many struggle with finding money to pay for medical appointments and medicine (Springer et al., 2010).

In a cross-national study, investigators identified refugees as a top research priority for gender inequities in health (Dias-Granados et al., 2011). Little is known regarding Somali Bantu elderly females and health inequities they may experience. They are vulnerable due to their lack of education and mastery of the English language. Culturally, they are disadvantaged because they believe they have no voice and are unable to question their provider (Gurnah, Khoshnood, Bradley, & Yuan, 2011). Edberg, Cleary and Vyas (2011) attribute health inequities to: healthcare bias, racism, discrimination, inadequate minority health systems, planning, and data.

Implications for Practice
Implications for nursing practice involving the elderly Somali Bantu can be discussed at several levels of care. Because language is so crucial to understanding health information, it is important for nurses to utilize interpreters for medical appointments. Populations, such as the elderly Somali Bantu refugee, have no written language, low literacy skills, and limited experience with systems such as American healthcare. Cultural sensitivity and awareness of this elderly refugee population involves having knowledge and empathy for where the refugees have come from, what they have endured, and the challenges they now face. Understanding the lived experiences of the elderly Somali Bantu enables and informs the healthcare provider about how to approach care and health education for vulnerable, ethnic populations. Practitioners need to take time to talk with the refugees to thoroughly understand the barriers that may be present. Elderly Somali Bantu refugees may face barriers such as transportation and limited social support that can negatively impact health.
Coordination and Communication

Fragmented care can be avoided, as well as unnecessary trips to the emergency department, if designation of primary care providers and medical homes are established when the elderly Somali Bantu refugee first arrives under the refugee resettlement program coverage. Coordination between local healthcare providers and systems can smooth an elderly refugee’s transition between his or her initial entrance health screening and the subsequent assignment of a medical home for chronic disease management and primary care for acute illness. Interpreters are critical to the healthcare process. Accurate health communication cannot be transferred between provider and patient unless English language proficiency by the refugee has been obtained. Rosenberg, Seller, and Leanza (2008) emphasize the importance of working with a professional interpreter to maintain accuracy of communication with patients they do not share a common language with. Nurses can also take a proactive role in learning languages other than English, and engage in refugee community activities such as health fairs, flu clinics, and social events to establish trust and relationships within these groups.

It is important to assess the level of client literacy when working with refugee populations, but it is sometimes difficult to determine to what extent one’s verbal comments are understood. The elderly Somali Bantu refugee will nod their head in agreement even if they do not understand or agree; this is done out of politeness or respect (Van Lehman, & Eno, 2003). Miscommunications may occur due to language barriers, limited health literacy, and variances in cultural contexts. This uncovers a need for further education surrounding medication safety and an understanding by the Somali Bantu elderly of what conditions are being treated. Health education instruction, by using visual media and storytelling, could be utilized by nurses and other healthcare providers at the point-of-service and in educational workshops to minimize language barriers and improve the elderly refugees’ understanding of health information.

System Complexity

American healthcare is delivered in a complex system with many components to understand. Healthcare providers who are aware of the complex nature of refugee health and the time it takes for the elderly refugee to adjust to healthcare systems will be able to better assist in this process and improve healthcare outcomes for the Somali Bantu elderly. It seems the healthcare system anticipates that all recipients of care will fit into the mold of typical case studies and treatment protocols. When faced with cultural extremes from dominant American societal norms, such as illiteracy, lack of health insurance coverage, and complex case management, many providers are hard-pressed to find treatment plans that are culturally congruent. Challenges presented to healthcare providers working with the elderly Somali Bantu include setting aside additional time during visits for interpretation, asking extra questions, and filling out forms. Understanding cultural differences, religious beliefs, and hurdles faced by refugees can assist nurses in providing culturally sensitive and congruent care. Nurses can help the elderly Somali Bantu navigate through the healthcare system by referring them to extended English language learning and cultural orientation classes, and developing interactive health education programs.

Public Health Policy

There is a need to advocate for refugees as a nursing profession so that politicians and program administrators are informed as to the continuing issues this population faces. Nurses can
advocate for changes to laws related to Medicaid eligibility, or advocate with clinic managers to ensure interpreters are provided based on language spoken and not country of origin. It is equally important to advocate for policies and programs that support adjustment to our healthcare systems to ensure positive health outcomes. It is also important to educate community health professionals about refugees and foster an environment of acceptance to their cultural differences in order to assist them with a smooth adjustment process. To decrease transportation barriers, it is important for public health nurses to deliver services (such as immunization campaigns) at common sites where refugees can easily assemble. These interventions are especially important for the elderly Somali Bantu refugees who struggle with language and transportation issues.

**Conclusion**

The journey of adjustment has not ended for the elderly Somali Bantu considering the complex nature of U.S. healthcare and the multi-fac-torial influences of refugee resettlement. Nurses and allied healthcare professionals can assist vulnerable populations, such as elderly refugees, by increasing the awareness of healthcare providers to the background and cultural variances that exist in the clients they serve. Cultural competency is gained by “seeing through the eyes of others” during our encounters with diverse populations. Allowing sufficient time and resources to work with elderly refugees, especially the Somali Bantu, are critical to positive client outcomes. Continued research and collaboration between healthcare professionals, community members, agencies, and policy makers needs to occur in order to build adequate support networks for elderly refugees. Culturally appropriate and sustainable programs for elderly Somali Bantu refugees are needed for them to obtain English language skills and health literacy, understand healthcare access, find transportation to medical appointments, and to help them adjust to a complex system of American healthcare.

**References**


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