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KNOWLEDGE, ACCESS AND PRACTICE: UNDERSTANDING THE AFFORDABLE CARE ACT FROM THE VOICES OF SOMALI IMMIGRANT WOMEN IN THE UNITED STATES

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Abstract: Previous literature acknowledges a lack of insurance as a deterrent in seeking healthcare, thus impacting the overall health status of Somali immigrant women (Francis, Griffith, and Leser 2014). This paper builds on the previous literature and addresses the following: *a)* understand the link between the social determinants of health framework and the Affordable Care Act; *b)* explore Somali women's attitudes about the feasibility of access and knowledge of the Affordable Care Act, specifically the Medicaid expansion and health insurance marketplace; *c)* address Somali women's encounters with doctors and practitioners post-enactment of the Affordable Care Act. Using interview data from twenty Somali women, common themes elicited were the following: miscommunication among Somali immigrant women and their healthcare providers, feelings of social anxiety and other mental health issues, as well as poor patient and doctor relationships. The project is a community-engaged research study that collects data on individuals' knowledge with the Affordable Care Act by working with members of several Somali led organizations to identify additional key issues within the community. Furthermore, this project challenges the complexity of adapting and integrating into an unfamiliar culture due to language barriers and approach to medical practices, i.e. views about medical practices may be due to cultural values and beliefs about health. In conclusion, this paper provides demographic data about the impact of health disparities on Somali refugees and immigrants by including how they view access to healthcare, identify barriers to information and care provided by health practitioners, and examine their needs in terms of preventive care.

Keywords: women's health, immigration, Affordable Care Act, social determinants of health, culture.

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INTRODUCTION

Access to quality and affordable healthcare continues to be a basic need that varies depending on an individual's socioeconomic status, geographical location, immigration status, and the political climate. Open enrollment of the health insurance exchange began in the fall of 2013 with the enactment of the Affordable Care Act (ACA); the primary goal of ACA was to increase access to health insurance for all Americans. According to the Health Insurance Marketplace Summary Enrollment Report, over 8 million people purchased health insurance through the marketplace between October 2013 and April 2014 (Assistant Secretary for Planning and Evaluation, 2014). At the end of open enrollment in 2016, 12.7 million people were enrolled in the health insurance marketplace. ACA is also known as the Medicaid Expansion plan because it provides health insurance for Americans who were not previously covered under Medicaid and uses federal poverty levels as a baseline for coverage. Thirty-two states including Ohio chose to provide subsidies for individuals and families living less than 138 per cent below the federal poverty line. In order to understand the impact of the Affordable Care Act, this paper focuses on an examination of the United States public healthcare between October 2013 and July 2016, specifically for Somali immigrant women.

The requirements for Affordable Care coverage for immigrants are worth examining in detail to provide a context for understanding the health status of Somali immigrants. According to the National Immigration Law Center, naturalized citizens have the same access and requirements as the US-born citizens to federal-state public health insurance, while lawfully present immigrants have limited federal coverage and undocumented immigrants have no federal coverage (www.NILC.org). However, under the ACA, there are some special provisions that states can choose to provide Medicaid and Children's Health Insurance Program (CHIP) for pregnant women and children "regardless of their date of entry", non-emergency doctor visits at

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local community health clinics, and emergency Medicaid for undocumented immigrants (www.NILC.org). To protect the vulnerability of the participants of the study, questions regarding immigration status were excluded from the study but it is important to highlight the different requirements in relation to immigration status. Furthermore, Murdie et al. (1995) argue that a larger proportion of the Somali women are the primary caregivers and decision makers about the healthcare options for their families. This finding provides more reasons to examine the impact of the ACA for Somali women due to their knowledge regarding their overall health status and their families.

This project contributes to three disciplinary fields in its examination of the health status of Somali immigrants, specifically Somali women in Columbus, Ohio. First, the field of medical sociology seeks to understand the role of health in a particular society based on its social and cultural practices. In this vein, this project analyzes a discussion of the health status and access to health insurance for Somali women, i.e. the feasibility of access and knowledge of the Affordable Care Act, specifically the health insurance marketplace and Medicaid expansion plan. Furthermore, this project challenges the complexity of adapting and integrating into an unfamiliar culture due to language barriers and approach to medical practices, i.e. views about medical practices may be due to cultural values and beliefs about health. Secondly, the field of Demography investigates changes in population due to mortality, fertility and migration rates. Therefore, this project provides demographic data about the impact of health disparities on Somali refugees and immigrants by including how they view access to healthcare, identify barriers to information and care provided by health practitioners, and examine the needs in terms of preventive care. Lastly, racial and ethnic relations studies critically address common assumptions and presuppositions about race and ethnicity and develop theoretical tools for interpreting everyday life between ethnically diverse groups. Therefore, this project understands the social construction of race and ethnicity from a global, yet

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local perspective by providing key stakeholders in the Somali immigrant community with efficacious and culturally appropriate awareness messages and programs in Columbus, OH. The link between culturally appropriate messages and healthcare is central because they can help reduce the severity of morbidity and mortality patterns within the Somali community.

In this follow-up research project, I address the impact, if any, of the Affordable Care Act on a particular community, Somali women in Columbus, Ohio. First, the paper provides a background on the evolution of the United States public healthcare system and addresses the role of marginalized populations in regard to access to healthcare. Secondly, the paper establishes a theoretical foundation for why it is important to understand and examine the intersections of race, health, and class for Somali women and the ACA. Next, the paper provides the methodology employed to collect and analyze interview data. The paper concludes with a discussion of the implications of the changes in access to healthcare insurance for Somali women.

A SNAPSHOT OF THE UNITED STATES HEALTHCARE SYSTEM

In 1965, Medicaid was adopted as the main federal-state public health insurance program for the low-income population. Under the initial Medicaid program, if states voluntarily participated, they received grants to provide medical aid for eligible residents to assess a set of medical and long-term care benefits. Over time, the family income threshold changed to reflect the cost of living and inflation, and by 1972 all states except Arizona participated in Medicaid. In the 1980s, a shift toward corporatization and privatize occurred in the US healthcare system. Furthermore, Medicaid changed to payments by diagnosis instead of treatment and private insurance companies implemented the change as well. Under the Omnibus Budget Reconciliation Act, children 6 to 18 years old below the Federal Poverty Level began receiving mandated coverage and

“many states began greater use of Medicaid managed care for delivery of care and expanded coverage to previously uninsured populations like childless adults (Kaiser Foundation: 2)”.

By 2000s, semi-universal health care insurance re-emerged as a topic of discussion for states, specifically Maine, Massachusetts, and Vermont and in 2010 Congress passed the Patient Protection and Affordable Care Act to begin in 2013. The primary goal of the ACA is to fill in the health insurance gap because a larger proportion of the US families' incomes are above the Federal Poverty Level to qualify for Medicaid and are therefore without health insurance coverage. Prior to the enactment of the ACA, immigrants were more likely to be uninsured in comparison to US citizen, 59 per cent vs. 28 per cent, respectively in 2006 (Kaiser Foundation: 1). Similarly, Portes, Fernandez-Kelly, and Light (2011) examined the intersection of being poor, uninsured and an immigrant and concluded the aforementioned individuals often lacked access to healthcare and devised different coping mechanism due to the rising cost of healthcare. This paper is timely due to the enactment of the ACA and builds on the current literature but with a special focus on understanding the impact on a marginalized group, specifically Somali women.

Currently, immigration policies and the ACA are a topic of discussion due to changes in the political agenda of the Office of the President of the United States of America. On the 27th of January 2017, President Donald Trump signed an executive order banning immigrants from entering the United States for 90 days from the following seven countries: Iraq, Iran, Libya, Somalia, Sudan, Syria, and Yemen. The executive ban on immigrants from the aforementioned countries was met with harsh criticism and a series of appeals and was repealed by the US 9th Court of Appeals on 9 February 2017. Furthermore, the House released an outline to repeal the Affordable Care Act due to the cost of managing a governmental health care plan (*New York Times*, February 2017). Additionally, the Office of the President continues to make changes to the travel ban in the form of appeal, however, immigrants from Somalia remain banned in the

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executive order. The implications of the vicissitudes in the flow of Somali immigrants into the United States and in the terms of eligibility of ACA are important to further understand and examine the encounters of Somali immigrants, specifically Somali women.

The purpose of the paper is to provide a critical examination of the intersectionality of migratory flow, ethnicity, and access to affordable and quality healthcare. The paper seeks to shed light on the feasibility and knowledge of ACA to provide a greater context of and lessons learned from the encounters of Somali women immigrants with healthcare in the Columbus, Ohio. Columbus provides a lens to understand the impact of ACA and the Medicaid expansion, and the consequences if it is repealed. As of December 2016, approximately 71,000 Columbus residents received subsidies under the ACA ([www. policy-matters.org](http://www.policy-matters.org)). The findings from this study are also important and timely due to changing policies in regard to ACA and immigration.

THEORETICAL FRAMEWORK

Powerful, complex relationships exist between health and biology, genetics, individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual or population's health, are known as "social determinants of health" (World Health Organization 2010). The Social Determinants of Health (SDH) from a community-engaged research approach served as the foundation for the development of the project. The SDH is a framework that posits there are factors and resources essential to the health of individuals and communities. Variables included as social determinants of health include social networks, culture, racism and forms of discrimination, physical living conditions, education, income, norms, social

support, culture, and social capital (Anderson et al. 2003). Within the SDH framework, improvements to mortality and morbidity can be achieved by addressing these social determinants of health. Research has shown that improvements in health and well-being are achieved by addressing the social and environmental determinants of health within the SDH framework (Anderson et al. 2003).

In order to further elucidate these determinants, I use a community-engaged approach and focus on the following social determinants of health: culture, forms of discrimination, and socioeconomic status. The aforementioned social determinants of health provide a contextual lens to understand the Somali immigrant community and build on the themes that emerged from Francis et.al (2014). Community-engaged research is an approach that enables researchers to strengthen links between the community and researchers (McDonald n.d.). This approach is different from community-based participatory research (CBPR); in CBPR the community identifies the research topic. Specifically, both approaches encourage recognition of the strengths of community institutions and individuals and encourage people and groups to build on those strengths (McDonald n.d.). However, the community-engaged research is not characterized by the methods used, but the principles that guide the research and the relationships between researchers and the community (Lasker, Weiss 2003). I incorporate a community-engaged research study that collected data on individuals' knowledge with the Affordable Care Act by working with members from several Somali led organizations to identify additional key issues within the community.

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METHODOLOGY

Study Population

Somali women were recruited from the Columbus, Ohio area by word of mouth and key informants. Similar to my previous work, I worked closely with Somali leaders to identify study participants. The majority of families are female-headed households (Murdie et al. 1995) thus by focusing on Somali women, the project provides a context for understanding the health status of Somalis in Columbus, Ohio. Furthermore, Columbus is the second largest Somali community in the US and Ohio enacted the Medicaid expansion and is, therefore, a significant site of investigation to address the link between culture, forms of discrimination and socioeconomic status and the enactment of the Affordable Care Act among Somali women. I recruited a broad cross-section of Somali women with diverse socioeconomic status characteristics¹. I employed a purposive snowball sampling technique, a systematic judgment sampling whereby those contacted identify others who can be included in the study (Ervin 2007). To be eligible for the study, the inclusion criteria required that the participants meet all of the following: 1) be female; 2) be 18 years old; 3) born in Somalia; 4) currently resides in Columbus, OH; 5) be a head of household. I reserved the right to exclude individuals who are less than 18 years and/or are currently ill.

Data Collection

The Affordable Care Act plays an important role in the health status of Somali women if they are eligible for the benefits. Specifically, in Francis et al. (2014) several participants acknowledged the lack of insurance as a deterrent in seeking healthcare, thus impacting their overall health status. To build on the findings of Francis et al. (2014), after receiving Institu-

tional Review Board approval from Denison University, in the summer of 2016, I interviewed approximately twenty Somali women to investigate the relationship between 1) the link between the Affordable Care Act and the following social determinants of health: culture, forms of discrimination, and socioeconomic status; 2) Somali women's knowledge of the Affordable Care Act and access to healthcare, and 3) Somali women's encounters with doctors and practitioners post-enactment of the Affordable Care Act². I hypothesized, based on the Health Insurance Marketplace Summary Enrollment Report, that although the Affordable Care Act is available, Somali women may not enroll or may be suspicious of enrolling in the Healthcare Insurance Marketplace due to language barriers and perspectives of the American medical system. See Appendix A for sample interview questions for participants.

Face-to-face semi-structured interviews were conducted in English in a private conference room at a local Somali non-profit organization. Each interview lasted approximately 30 to 60 minutes. Participants were given \$10 gift cards to compensate for their time and travel. Similar to the 2014 project, verbal consent was given to avoid the problems associated with verbal consent of immigrant/refugee populations (Johnson et al. 2009). Interviews were audiotaped to ensure accuracy. A research assistant transcribed all of the interviews.

Data Analysis

I used open coding to analyze and define the themes from the interviews. The coded data reflect the themes from the interviews. A research assistant and I identified themes. The themes that emerged are the following: 1) An overview of Knowledge of Medicaid, Obamacare, the Affordable Care Act; 2) General Access to Information: Search & Availability; 3) Language and Access; 4) Frequency of Doctor's Visits; 5) doctor Preference and Gender Dynamics; 6) healthcare Service Satis-



faction; 7) The Relationship between Religion and Health; 8) Interconnection between Culture and Health; 9) The Role of Doctor and Skepticism of Western Medicine; 10) Payments as Inhibitors to Quality healthcare; 11) Understanding the Somali Community.

RESULTS

Demographics: 20 participants were interviewed. The mean age of the participants was 40.39 ± 12.34 years [range 19-72]. Sixteen participants (80 per cent) were married and four (20 per cent) were single. Seventeen (85 per cent) of the twenty participants reported having children. All of the participants were Muslim. On average, the participants lived in Columbus, Ohio an average of three years. The themes were grouped into four content areas: *a)* Knowledge of the Affordable Care Act; *b)* Feasibility and Access to Healthcare Information; *c)* Culture of Medicine within the Somali Community; *d)* Healthcare Service Satisfaction.

Knowledge of the Affordable Care Act

Participants were asked to if they heard of ACA and if so to discuss their understanding of ACA and to describe the terms of eligibility. Participants began to use the term Obamacare interchangeably with ACA very early on in the interview. Additionally, more participants were comfortable with describing the terms of eligibility for Medicaid than ACA. Participants also indicated they had more conversations about Medicaid with family and friends and only a few conversations centered around ACA.

Quote #1: Yes, I have heard of the ACA and I know that a lot of people who did not have insurance before and they are now eligible to

get insurance. For example, the Limited Expansion, to my understanding, pregnant moms and the younger children, especially if they are low-income families use to have Medicaid but are now covered under ACA [...] So yes, I am aware of the ACA and I know it's best for the low-income populations.

Quote #2: I work with United Healthcare, so I am familiar with the ACA even though I am more familiar with Medicaid. My understanding is that we have more of an adult expansion after the ACA was enacted and it is for individuals who did not qualify for health insurance before can qualify now.

Quote #3: Yes, I have heard of the Affordable Care Act, and that it was an initiative by the Obama Administration to kind of democratize access to healthcare. I know that it is mandatory, I believe it's mandatory and I believe, to be eligible, if I remember correctly you have to meet certain income requirements.

To build on the participants' knowledge of ACA, also known as Obamacare, they were asked how they seek out ACA information and if it was in their first language Somali. Participants were clear that most often the information was discussed through word of mouth and within the community. Information regarding ACA was available in English and Somali. However, participants discussed the low literacy rates of Somali immigrants in English and Somali and described the inability to read English and/or Somali as a barrier to quality healthcare. Participants suggested a video in Somali to combat this barrier.

Quote #1: Yes, I do know that. But a majority of the population, especially the Somali population are not aware of that. The reason as I said it earlier was because they don't have information that is written. Some of it is written in their own language or some of them they cannot read the information. Even if it is out there, very few people who are educated are aware of that. But the majority I don't think are aware of that.

The first content area of knowledge regarding the ACA for Somali women is important to address and builds on the literature by several scholars (Gany and De Bocanegra 1996; Portes et.al. 2011). Specifically, Portes et al. (2011) found that although the participants of the study may be legal immigrants only $\frac{1}{3}$ had health insurance. Portes et.al. (2011) findings are aligned with the narratives of the participants of the study in terms of discussing the ACA eligibility and how to navigate signing up the Medicaid expansion plan.

Feasibility and Access to Healthcare Information

Participants who indicated they are eligible for ACA were asked to describe the feasibility of ACA in regard to accessing quality doctors and healthcare information. Additionally, participants were asked to discuss if they utilize services as preventative and/or treatment. Lastly, participants discussed different barriers to access quality healthcare and information. According to a study conducted by Call et al. (2014) to address barriers of healthcare for an ethnically diverse population in Minnesota found that 72 per cent and 63 per cent of the participants reported at least one or more barriers to cost and coverage and access, respectively; cost and coverage and access barriers included not knowing what the plan covers and where to go with questions.

There were large differences in how feasible accessing ACA based on educational attainment and length of stay [range 8 months – 16 years]. The educational attainment of the participants ranged from no formal schooling to post-secondary education. 25 per cent of the participants had post-secondary educational attainment. For example, a participant with post-secondary education describe the feasibility of ACA as the following:

Quote #1: At the time, I was on student insurance from The Ohio State. I continued to be on that insurance. Now that I am in post-candidacy and I am in a different state and different city I had to look into health care options. And in fact, I did look into getting coverage with the ACA, but I actually found that private insurance was cheaper.

However, several participants with elementary education and newly arrived in Columbus, Ohio stated the following:

Quote #1: When we came to the country, they gave us a lot of letters/documents. If it works, then we stick with it.

Quote #2: I came to the US, and that was the first application I filled out.

Participants addressed patient-doctor gender discordant, treatment in the doctor's' office and language as barriers. For example, there is a need for medical translators to help newly arrived Somali immigrants navigate ACA.

Quote #1: We don't speak English most of the time, so we need the interpreter.

Quote #2: I do think that it's quite challenging for people who don't speak English, people who are new to the country to kind of seek out information on the program. Because I know that when I was seeking out information, and I was attempting to sign up online, speak to somebody [and] it was a bit arduous. So, I could definitely see how it would be challenging for somebody who doesn't have the education and with the speaking abilities that I do.

Quote #3: They get the card, but they don't know about the next steps. After 6 months or a year, these are the next steps you need to take. If you do not do that, you will not be eligible. They think it is a one time shot, and once you get it you have it forever, and that's not the case. You also have to make sure that when you send letters, that people understand what you are saying to them. Maybe a phone call would be better asking if they received the letter? "Did you understand what we were asking for?". If not, maybe the interpreter will ex-

plain to them that they need to come down to the office and we will help you fill out the paperwork. They will help the client not have any surprises when they go to the doctor's office.

The aforementioned findings are also aligned with Call et.al (2014) findings in which 29 per cent of the participants indicated at least one or provider-related barrier, such as the doctor language and cultural discordant. Patient-doctor gender discordant was also mentioned as a barrier to accessing quality healthcare. There were mixed messages in regard to patient-doctor discordant within the community.

Quote #1: There is a lack of female doctors. We love female doctors compared to male doctors. Also, the physicians that maybe speak our language, that is very limited.

Quote #2: Some ladies prefer women. If they are shy, they want a woman. The individual culture of a person might insist on having a female doctor.

In contrast, the following participant highlights a different perspective. This is in contrast to the literature that suggests that Muslim women will only receive treatment from women doctors and suggest there may be a preference (Pavlish, Noor, Brandt 2010).

Quote #1: We know that if you are sick and you need to go to the doctor. I sign a form saying that it is okay that a man or woman treat me. It is not against our culture. I just prefer a woman.

The finding regarding the intersection of the gender, health, and religion builds on the research of Francis et al. (2014) in which participants highlighted that quality of care is the most important in regard to healthcare regardless of religion or gender of the doctor.

Culture of Medicine within the Somali Community

Participants were asked to discuss the intersectionality of health and culture to connect and build on the understanding of ethnicity and the ACA within the Somali community. Furthermore, the project sought to examine the impact of their social environment on their perspective of the ACA. Examples of social environment include but are not limited to their network of family and friends that they talk to, work with, attend church and/or school and interact with on a consistent basis. A common theme emerged from the discussion in that health and religion are separate.

Quote #1: Islam has played a role more than Somali culture because, within Islam, there is this really big push to really take care of your body and think of your body as a blessing from God and to protect and to be mindful about not putting anything bad in your body and to treat it well. For people who have that conceptualization, you become really mindful with how you treat yourself. I think that's something many Somali women are aware of when they are choosing healthcare options.

Quote #2: Health is first. Religion says that it is better to choose a female doctor. If it is an emergency or childbirth, you cannot say, "I'm not going to deliver" because it is two people's lives. It has nothing to do with religion, so you have to accept it.

Quote #3: Islam is not going to prevent you from looking for health, check-ups or taking care of yourself.

Quote #4: But when you are a Muslim, anything that will help your life medically is good. We don't refrain from any medication or any blood transfusion because we are Muslim. As long as it will help your health, you go for it.

Quote #5: I think culture is multifaceted because the Somali community is one particular culture that I happen to be a part of, but I am also a middle-class American. I think middle-class Americans who



tend to have higher educational level are more knowledgeable about alternative health options, eating well and these kinds of things do influence that. I try to live a healthy lifestyle and I think that is more of an implication of someone who is educated and in the middle class in this country. I feel like you are exposed to information that other people are not who may be cultural and linguistic minorities.

There is a large body of scholarly work that suggests due to cultural values and underutilization of health insurance, immigrants are less likely to seek Western mental health services (Rodriguez 1992; Lu 2002; Ngo-Metzger et al. 2003; Sudano 2003; Kandula et al. 2004). Although the participants do not state it as explicitly as mental health, they interrogate the intersection of health and culture and challenge the current body of literature and suggesting a new framework to understand the Somali immigrant community, specifically Somali women.

There were several perspectives from the participants on discussing ACA within the community. Some of the participants suggested that they did not talk about ACA within their community due time and other commitments, while others talked amongst friends and family.

Quote #1: We go to work, and we come home, and we don't have time to think about it. We have Medicaid or ACA and that's all we know.

Quote #2: They actually have been hiring people with Somali language skills to go out into the community and kind of educate people on the program and how to sign up. So, I will say, that even with that said, there are still certainly programs, at least here to reach out to people, and I'm not really sure how widespread that it is.

Quote #3: We talk about it. A friend of mine has Obamacare and if she works, they discontinue her benefits and if she doesn't work, they continue her benefits.

Quote#4: I think the discussions, unfortunately with ACA, have been the same as they have been before. We don't have access to this

information... There is a lack of information, although in the state of Minnesota, the state side of it, whoever is working on this, has employed Somali people to go out into the community. But still, I think there are large sections of the community who don't know about the healthcare option. And this was in the middle class, Somali population. Ohio typically tends to be a little behind when reaching out to cultural and linguistic minorities in Columbus. I can't speak for Ohio, but in Minneapolis, there is this sense of "What is this?"

Although community discussions are important to understand how information is disseminated, there is a lack of research to address this mode of communication in relation to the ACA within the Somali community. This study addresses how central community discussion is to the Somali community. Furthermore, it would be also beneficial to further address the role of community healthcare educators within the Somali community.

Healthcare Service Satisfaction

Several questions were included in the interview guide to examine the treatment during doctor visits. Participants were asked if they encountered any issues with health practitioners and/or doctors in regard to receiving care and/or the quality of care. Some participants highlighted that doctors do not want to prescribe natural remedies and problems with the receptionist as concerns while other participants were satisfied with their healthcare services.

Quote #1: I would say that I'm somebody who has always been interested in natural medicine, alternative medicine. I find that traditional health insurance providers, and I'm not sure about Obamacare, really don't allow you to seek alternative means for treatment whether it's acupuncture or whatever it is. I feel like everything is limited to what you would get from someone trained in Western medicine.

Quote #2: Sometimes, a receptionist will tell you to go to the emergency room, which you don't want to go to because you want to

go to your family doctor because you have insurance. Sometimes they push you towards the ER because they say that the doctor is busy and doesn't have time. I'm assuming if the doctor knew that, he would do something about it.

Quote #3: Yes, we do talk about it and personally I don't have any problems. But I hear from other people that they have some issues and some doctors do not accept their cards. For me, sometimes they don't accept my card on weekends.

Quote #4: For example, they might have a limited number of physicians, or they may be overcrowded. Your appointment could be at 9 or 9:30 but you might not go back until 6 pm. Because there are a limited number of physicians who are available to provide care for this population, so they are there all day.

Quote #5: It happens sometimes. But sometimes you go to the ER and there are a lot of people and it is a serious situation, so you are going to be last.

Call et al. (2014) employed Poisson regression analysis and found a significant relationship between provider-related barriers for Somali immigrants compared with whites controlling for demographics (i.e. age, sex, marital status, and educational attainment) and health status. The authors suggest an increase in cultural competency education for healthcare professionals, in addition to more respect for different cultural and religious beliefs as a solution to the lack of healthcare service satisfaction. In the summer of 2016, the Columbus Department of Public Health started an initiative to provide cultural competency training to healthcare professionals serving diverse populations. Future research will address the impact of the cultural competency training in regard to healthcare service satisfaction within the Somali community.

There are also some skepticisms within the community in regards doctors and practitioners that lead to poor healthcare satisfaction. Participants were reluctant to go the doctor as a

preventative measure and often sought healthcare services as the last resort.

Quote #1: Somalis go to the doctor's when they're sick, they don't go for routine checkups or preventative care. Somalis don't understand the preventative healthcare. Everything in Somalia, specifically, healthcare is free.

Quote #2: There is a big gap. Back home, you don't look for that unless you need to. For example, if you are really sick then you go to the doctor. So, a lot of people wait until the last minute. Someone would be diagnosed for cancer, and then that would be the third stitch for medication because they didn't seek medication one and two. Most of the community, by the time they are diagnosed with cancer or other diseases, they are hospitalized.

Call et. al (2014) suggest a relationship between poorer health status and provider-related barriers for non-English speakers. The participants in this study highlight the transition in how one understands health care in Somalia to shifting to navigating healthcare in the United States. Part of the narrative the participants speak to the intersection of class, acculturation, and health status.

DISCUSSION

The goals of the project were to investigate the relationship between 1) the link between the Affordable Care Act and the following social determinants of health: culture, forms of discrimination, and socioeconomic status; 2) Somali women's knowledge of the Affordable Care Act and access to healthcare, and 3) Somali women's encounters with doctors and practitioners post-enactment of the Affordable Care Act³. Key findings included: 1) A community-engaged research study on individuals' knowledge of the Affordable Care Act elicited a robust set of data to understand and identify additional key issues within the

Somali immigrant community; 2) The project challenged the complexity of adapting and integrating into an unfamiliar culture due to key issues such as language barriers and approach to medical practices, i.e. views about medical practices may be due to cultural values and beliefs about health; 3) The paper provided demographic data about the impact of health disparities on Somali refugees and immigrants by including how they view access to healthcare, identified barriers to information and care provided by health practitioners, and examined the needs in terms of preventive care; 4) Knowledge and access to information on the ACA are varied and limited for women within the Somali community in Columbus, Ohio.

The research project provided empirical evidence to answer three research questions. First, the social determinants of culture, discrimination, and socioeconomic status significantly influenced access to ACA for Somali women. Secondly, Somali women know about ACA but access medical services differently depending their length of time in the US, language acquisition and educational attainment. Specifically, the collective narratives suggest an awareness of ACA (varied) but a lack of understanding of how it works and more familiarity with Medicaid (limited). Therefore, the policy implications of this project suggest more continuous community outreach to the Somali community regarding the changes within ACA and additional cultural competency training for medical professionals to ensure fair treatment of Somali patients, specifically Somali women.

The impact and significance of the project provide an opportunity to address the role of health disparities among the Somali community following the adoption of the Affordable Care Act by improving the cultural competency of the health practitioners. Research suggests that a lack of cultural competency from health practitioners can negatively impact patients' care (Purnell 2013). Therefore, this research provides a regional contribution to examine the relationship between culture, knowledge, and access to healthcare from an immigrant perspective and fits within the scope of *Glocalism*. Finally, the goal

of the project is to continue investigating and examining topics that are socially and culturally relevant to the Somali community. I will disseminate findings to the community in the form of a town hall meeting/community forum to continue the discussion for next steps. The findings will also serve to help health practitioners find best practices through cultural competency while in consultation with the Columbus Public Health Department to provide better health outcomes for the Somali immigrant population.

Lastly, there have been drastic changes to immigration policy and the ACA under the Trump administration. According to the US Immigration and Customs Enforcement Report for the Fiscal Year 2017, forced removals of Somali immigrants have more than doubled from 198 to 521 in 2016 and 2017, respectively (US Immigration and Customs Enforcement, 2018). Additionally, efforts to repeal the ACA continue but to date have not been successful in the Senate. However significant changes in the ACA include ending the coverage requirement and adjustments in the ACA marketplace (Park, 2017).

STRENGTHS AND LIMITATIONS

Due to the study's qualitative methodology and small sample size, reported findings are descriptive in nature and are only generalizable to the target community. The strengths of this study include an examination of the perspectives on the knowledge of the Affordable Care Act, the feasibility and access to healthcare information, the culture of medicine within the Somali community, and healthcare service satisfaction for individuals who are part of this community. The study also offers potential suggestions to guide and educate doctors on cultural sensitivity and provide a resource to the larger Somali community.

The findings of this study suggest there are varying degrees of information in regard to the Affordable Care Act, which is due to language barriers and access to quality information and

healthcare services. Specifically, the data suggest that a newly immigrated Somali woman with limited English proficiency accessed ACA information differently than a Somali woman with a Master's degree from a US based university. Therefore, additional barriers to the dissemination and availability of the information on the ACA include length of stay and educational attainment. The dissemination of information needs to be multifaceted to ensure widespread access to healthcare as a preventative measure rather than the only treatment.

APPENDIX

Somali women interview questionnaire

Pseudonym

Demographics

- City of residence
- Age
- Education
- Marital Status
- Born in the US or years in the US

Knowledge

1. Have you heard of the Affordable Care Act? If so, can you describe your understanding of the ACA? Do you know the terms of eligibility?
2. Did you seek information about the Affordable Care Act or was information provided to you? Are you aware of the ACA covers preventative and/or intervention healthcare?
3. If and when you received this information, was it in your first language?
4. Are you familiar with the Health Insurance Marketplace? If so, in what capacity? Are you knowledgeable of how to select the best healthcare plan and the associated costs?

Feasibility and Access

If the participant indicates she is currently eligible or currently enrolled in the Health Insurance Marketplace:

1. What are the options and feasibility of navigating the Health Insurance Marketplace?
2. Do you currently have access to a doctor and/or medical services? If so, do you utilize the services as preventative and/or treatment? If not, can you discuss the barriers preventing you from having access?

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3. Have you experienced any issues in payment for care under the Affordable Care Act for the following:
 - a. Routine check-ups (medical and dental)
 - b. Mental health
 - c. Non-routine procedures (such as surgery or visits to specialists)
4. Is the payment for care accessible under the Affordable Care Act for family members of the primary applicant?
5. Have you encountered any issues with health practitioners and/or doctors in regard to receiving care and/or the quality of care?

Culture

1. Is there an intersection between your ethnicity and your perspective on the Affordable Care Act? If so, describe the intersection.
2. Is there an intersection between your ethnicity and your approach to the Affordable Care Act? If so, describe the intersection.
3. Does your social environment affect your perspective on the Affordable Care Act? Examples of social environment include but are not limited to your network of family and friends that you talk to, work with, attend church and/or school and interact with. If so, please explain.
4. Do you identify with any religion? If so, what religion(s)? Does your religion influence your perspective on medical coverage (whether private or government-funded under the Affordable Care Act)? If so, please explain how?
5. Is the Affordable Care Act discussed within your community? If so, please explain in what context?

NOTES

¹ I define socioeconomic characteristics as educational level, occupational status, age, and income level.

² Sample saturation occurs by the twelfth interview (Guest et al. 2006).

³ Sample saturation occurs by the twelfth interview (Guest et al. 2006).

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