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The New Mainers: An Exploratory Analysis of Healthcare Experiences in the Somali Bantu Community

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The New Mainers: An Exploratory Analysis of Healthcare Experiences in the Somali Bantu Community

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Abstract

Healthcare inequities within the United States' Western model of medicine have existed for hundreds of years. The purpose of this year-long project was to analyze the existing qualitative and quantitative studies of healthcare barriers for the Southern Maine Somali Bantu population, as well as compiling narrative pieces from Maine non-governmental organizations that provide community resources. In doing so, the idea of healthcare access and literacy was analyzed through means of understanding systemic barriers. Overall, the findings of this exploratory project point to a lack of cultural humility within medicine, the importance of recognizing intersectional identities in quality of healthcare, and the usage of healthcare literacy as a means for the healthcare system to exclude the Somali Bantu community from receiving equitable care.

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Table of Contents

Introduction

A History of Somalis in Maine

Violence, prejudice, and injustice. All are rooted into the history of the Somali Bantu people and the stigma surrounding their forced enslavement. In the late 20th century, a civil war broke out in Somalia and the Bantu group was immediately targeted. For historical context, the Bantus are a minority group in Somalia that have been discriminated against for being culturally, ethnically, and socially different from the majority Somali group. As early as the 16th century, ancestors of the modern-day Bantu groups were forcibly brought from Zanzibar as enslaved laborers on plantations. The effects of colonization were apparent in the treatment of the Bantus in the years to come. Italy, which gained control of Somalia in the late 19th century, had made the state a part of the protectorate Italian Somaliland and allowed for the continued enslavement of Bantus in agricultural labor.

Due to the years of stigma surrounding the Bantus, the Italians also treated Bantu as inferior to the ethnic Somalis. Feelings of negative sentiment and animosity had perpetrated violence for centuries and it came to a sudden head in the late 20th century. In the aftermath of the Cold War, Somalia's dictator-president Siad Barre had nationalized land, which disenfranchised Bantu farming communities across Somalia. His plans to invest in different areas across Somalia through educational, infrastructural, and healthcare reforms tactically excluded Bantu-centered areas. Barre's reign in Somalia was

marked by turmoil and his relationship with the United States directly affected the country's stability. The United States had provided military and economic support to Somalia due to its strategic position in terms of its location between the Persian Gulf and the Indian Ocean (SBCA). After the fall of the Berlin Wall, the United States severed all support to Somalia and Barre was forced to abdicate power to anti-government coalitions and fled to Kenya. The Bantus, under Barre, had faced prejudice in all forms but his military support had somewhat quelled extremists who sought to target them. With his government left in shambles, the Bantus were the first to be targeted. The Somali Civil War yielded heinous war crimes that, to this day, have not been given proper attention within the international justice system. At the time, it was identified as, "The worst humanitarian disaster in the world today" by the former director of the U.S. Office of Foreign Disaster Assistance Andrew Natsios. Bantu families were forcefully evicted from their land and subjected to cruel and violent torment. Between anti-government militia movements and famine, the Bantus were forced from their homes and displaced both physically and mentally. Many of them fled across domestic borders towards Kenya. Even more fled the African continent and found temporary placement in other countries. Families looked towards the United States and, after months of research, ultimately chose Maine (MAIN).

The United States' most northern state was an ideal relocation because of low crime rate, affordable housing rates, and structured education. Here, the Somali Bantu community could start fresh after being faced with violent backlash in their home country. When they traveled 7,237 miles away to the greater Lewiston area, what they

found was a little more than they bargained for (Iftin 2015). They arrived in the New England metropolitan area and were immediately met with obstacle after obstacle as they tried to settle within the new healthcare system. Families, young adults, and elderly all struggled to find and access safety nets of hospitals, clinics, and other providers. The question that came about was: How could the United States accept a community of people that they could not- and would not- provide equitable access to healthcare for? Structurally, United States healthcare is built upon a bureaucratic system of an established hierarchy that prioritizes market-based regulations and lacks the ability to provide universal quality care for even its citizens.

In terms of the Somali Bantu community of Maine, the important questions regarding healthcare access and literacy can become convoluted in regional policies and dominant hegemonic narratives. In approaching their healthcare experiences, there can be a few derived hypotheses.

Firstly, Somali Bantu healthcare literacy and access is affected by the systemic prejudice present in the domestic healthcare system. This looks like a few different things; there is the way providers are trained in medical school in terms of excluding intersectional education and considering the differences between patients. There is also the idea of community healthcare workers not being available in quantities to meet the needs of the Somali Bantu community.

The second piece surrounding the focus of the thesis is healthcare literacy being used as an “othering” technique by the system, which produces the highlighted barriers of this paper. Essentially, health literacy is the ability of an individual to understand and

navigate their health options and navigate. In terms of the Somali Bantu community, it is used as a way to alienate them further from general healthcare access. Rather than reconcile with the reality that literacy coincides with transparency and access from the providing government, it is used as a way to blame and reinforce the existing barriers. In terms of the Science, Technology, and Society role on how to address this plight and its role within a medical setting, there is the societal aspect of ingrained medical racism that affects access and health literacy. On a larger scale, the technology piece of how language translation and other intersectional health techniques could be utilized to create a more equitable healthcare system. Piecing together the different aspects that surround the Somali Bantu community's healthcare experience, this thesis is a contextual analysis of the healthcare experience and how the industry disadvantages The New Mainers.

Literature Review

Identifying and Categorizing General Barriers

Concerning the framework of my project, some of the cornerstones include Central Maine publications. The Bowdoin-based *CORE* piece overviews some of the most important aspects of my research, including the facets that exclude the Somali Bantu community from healthcare options on both a regional Maine and national level. It

is the framework of my own research in terms of what questions I asked. It offers valuable stakes in the argument because it provides contacts I utilized within my field research. In addition to providing insight on the Maine-based healthcare system's relationship with the Somali Bantu community, it analyzes the substandard provider training available. This is where Warwick Anderson's piece on "Teaching Race in Medical School" comes into play as an important STS perspective in the difference between race and ethnicity in medicine. The fine line is seldom understood by providers and can serve as an additional barrier to marginalized patients. This aspect in my literature review can be tied nicely together with the work of Hayley Fitzgerald, who discusses the six main stressors on Maine-based Somali Bantus; "economic stressors, discrimination, difficulties with acculturation due to language differences, parenting differences, and pressure to find employment." Together, these pieces bring together a resulting analysis that coupled with my own research.

Healthcare Narratives

The backbone of my research centers around narratives from Somali residents themselves about what they have experienced. Northeastern University- based Ashley Houston conducted a study on young Somali adults trying to make their way through a broken system that gives tremendous insight on how there are inequities that contribute to the societal hierarchy. Houston's piece shows that there is inequity for those of median age. Additionally, this section of my research is where autobiographies play a very

important role in shaping these types of experience. They also helped supplement arguments posed by publications that focused on Somali Bantu mothers, who had valuable commentary on provider's verbal etiquette. Abdi Nor Iftin's acclaimed autobiography details a young man's journey to Yarmouth, Maine amidst the turmoil of his home country and new country. His struggles within the system give narrative perspective on what the studies show through logistics. After interviewing the agricultural organization the Somali Bantu Community Association, Iftin's unfamiliarity with the United States' frigidity towards identity becomes clear with the system's inability to shift towards more open conversations about healthcare access and literacy.

Cultural Humility: A Lack of Compromise in the Western Medical Model

The word cultural humility was not officially recognized until the late 1990s. As the Boston Medical Center explains in their Policy and Industry piece, cultural humility "involves understanding the complexity of identities - that even in sameness there is difference- and that a clinician will never be fully competent about the evolving and dynamic nature of a patient's experiences". In approaching medicine with this mindset, ideally, there will be a reduced amount of bias within practicing medicine because of the physician's awareness of their own implicit prejudices. While not a perfect solution to the large abyss that is health inequity, it does allow for physicians to somewhat embrace both

sides of the provider-patient interaction through an understanding of identities. In terms of the patient, it recognizes what the patient needs as opposed to the mentality that provider training is flawless.

A valuable piece that offers up an interdisciplinary approach in recognizing what is important to the patient in healthcare is "Caring for Somali women: implications for clinician-patient communication" by Jennifer Caroll and a Rochester-based team that interviewed 34 Somali women in Rochester, New York. This study focuses on the alternatives for the existing Western medical model that excludes BIPOC individuals- including women- that may offer potential solutions to the obstacles faced. Increased patient-provider interaction, which included language interpretation and health literacy within the clinical setting were found to be successful cornerstones. It couples well with Susan Bell's piece on how language interpretation in clinical settings was very effective in fusing together provider-patient relationships within Somali Bantu communities. This type of tool is very important in healthcare because being able to understand the patient in every sense of the word can allow for a more efficient procedure. An interesting part of the alternative side of medicine comes through the integration of more healthcare workers within the Somali Bantu community that are designated as community health workers (Cowenhoven 2017). With this, it is important to understand what a community healthcare worker is. A large umbrella term, community health workers wear a few different hats. They are often synonymous with outreach workers, family advocates, health educators, medical liaisons- among other titles. Essentially, their job is to connect marginalized communities with health organizations and clinics. They may provide

translation or interpretation services and are a pipeline to different health. What this recommendation brings is a fascinating perspective where perhaps MD and DO practitioners should not be at the forefront of health. It should in fact be workers who are trained in specific Somali Bantu healthcare.

From a historical point of view, the Black Panther Party's creation of the Peoples' Free Medical Clinics was something that resonated with some of the opinion pieces within my research. In a sense, the people run the medical system and do it in spite of the existing hegemonic system. While the situation between The Black Panther Party and the Somali Bantu community differ in historical context, they have the same issues present. That being there was a lack of support and specialized care from the government for Black bodies, which meant there were people needing to take community healing support into their own hands. As of right now, there is no universal model of medicine that is conducive to all different races and ethnicities. Particularly in the United States, the medical industry thrives on making sure all practices and training are completely uniform. With uniformness comes a lack of recognizing identity.

Fatuma Hussein of the Immigrant Resource Center of Maine and the United Somali Women of Maine stated it perfectly when she discussed the idea of community and ancestral healing finding a balance with Western healthcare in her keynote lecture at the University of New England. The way Fatuma looks at it, when a child is fussing or does not feel well- parents may read the Quran to them as a way to facilitate the community's spiritual healing. In the Western version of healthcare, culture is not embraced as a factor into how healthcare or wellness is perceived. Spirituality and

community healing is not embraced within medicine, which is not only challenging for different marginalized communities to understand but, it also perpetuates the idea that there is only one right way to practice medicine and understanding your patient is not at all something to consider nor think about.

Methods

A General Overview of Literature Analysis

Analyzing existing studies that encapsulate healthcare inequities through quantitative and qualitative data, I also consulted Maine non-for-profits, governmental organizations, and representatives from the Somali Bantu community. Combining both into a capstone project that looks at barriers through an STS lens of how advancing medical practices still exclude marginalized communities through inadequate provider training. In terms of procedure for my study, I analyzed existing studies that specifically look at different experiences in the Somali Bantu community. Anecdotal evidence points to the idea that Somali Bantu community members within the Southern Maine area have experienced healthcare experiences. From families, young adults, to elderly, it is clear across the board that there are discrepancies in the quality and security of their healthcare. Identifying different commonalities across each correspondence and identifying the most prevalent barriers and how they structure into healthcare

experiences. Each representative received a flexible questionnaire with guiding questions that allowed for a more informal conversation to take place. The latter was centered around a few central questions that coincide with my research hypotheses: In terms of identities, do Southern Maine healthcare providers have training that specializes in cultural humility? Describe the differences in obtaining clinical care within the Somali Bantu community between someone with documentation and someone without. What does representation look like in terms of care providers that speak Somali? These inquiries helped loosely guide their responses for insight into the healthcare experiences of Somali Bantus as providers and non-for-profits giving aid.

A Global Perspective

2000 was the year of a new millennium. Commerce, technology, and infrastructure was advancing at a rapid rate. Consequently, it was also the turning point in the Somali Civil War, which had begun in 1991. As previously discussed, the overthrow of the government resulted in tens of thousands displaced Bantus from their land by militia forces. The resettlement of Somali Bantus in the United States was a whirlwind of activity, as about 1,000 of them set their sights on Southern Maine (Huisman 2011). Upon their arrival, a term that was used to describe the growing Somali Bantu population in the small cities stretching across inland and coastal Southern Maine was “The New Mainers”. Referencing their recent settlement and new contribution to Maine’s social and

cultural profile, it became used to reference the new generation of Maine inhabitants that would share their experience with the domestic community and attempt to start a new life.

When fleeing your home country to settle in an unfamiliar one, there is already an immense amount of pressure. Adding the additional worry of how you will be perceived in a medical setting is almost unimaginable. Now, in terms of medicine, what are the inequity factors that drive the resulting biases in medicine?

Nina Sun discusses in her piece, “Human Rights and Digital Health Technologies” how digital health technologies can contribute to expanding health inequity, widening the “digital divide” that separates those who can and cannot access such interventions”. What this entails is that racial biases perpetuate racial grouping and stereotyping that affects the type of care they can receive. This idea is not a tangible one but, after conducting my own research, was revealed through correspondence with the organizations.

Referring to Figure 1, the difference between race-based medicine and race-conscious medicine can be determined. The type of model that we use in the United States is centered around race-based medicine. This type of idea referring to race as a medical technology is something that my colleague Fariel LaMountain explored further in her thesis. From a STS point of view, the idea of race in medical school is something that factors heavily into how people are equipped for care. Warwick Anderson’s “Teaching `Race' at Medical School” is an interesting look into how race and ethnicity are often two synonmyous terms that are not usually understood. Anderson offers up the

notion where because of this, there is a lack of understanding concerning how people need to be treated with this type of identity in mind.

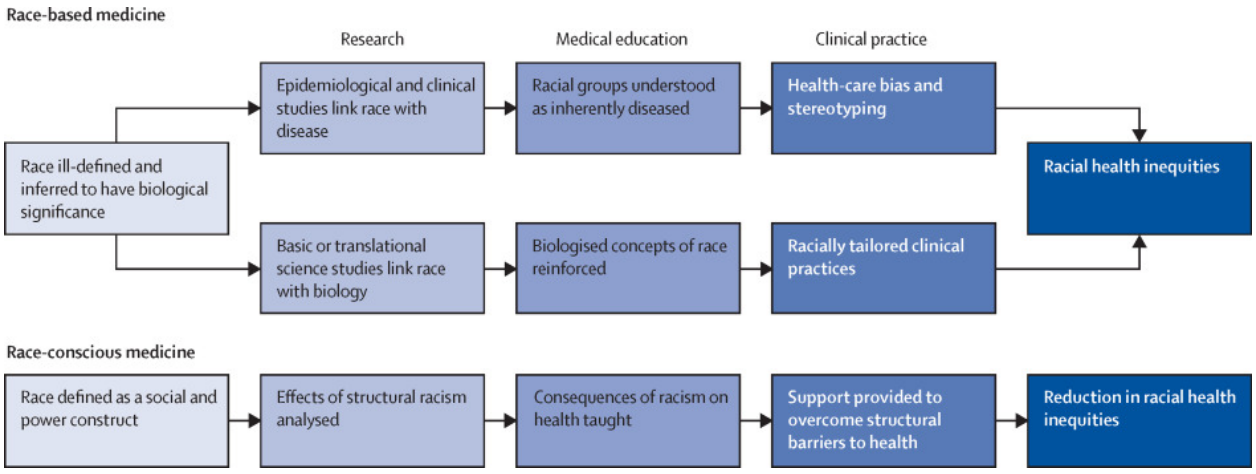

Figure 1. A diagram that shows the difference between race-conscious medicine and race-based medicine. The idea is to have one recognize social constructs and have providers engage in cultural humility with a recognition of system biases.

Cerdeña JP, Plaisime MV, Tsai J. From race-based to race-conscious medicine: how anti-racist uprisings call us to act. Lancet. 2020 Oct 10;396(10257):1125-1128. doi: 10.1016/S0140-6736(20)32076-6. PMID: 33038972; PMCID: PMC7544456.

Thus, the small state of Maine unfortunately experiences this trickle down effect in healthcare policies because of the societal racism that is deeply ingrained. In terms of what types of experiences are happening in Southern Maine, there is a very good insight in what occurs through studies done by Northeastern institutions. Ashley Houston's research based from Northeastern overviewed young Somali adults with ages ranging from late teenage to adult years. Within the healthcare system, they were not afforded equal opportunity because of socioeconomic boundaries that centered around cost. It was

clear that provider training did not contain any kind of cultural humility, or a respect and understanding of different aspects of a person's identity.

This study is not the only look into the types of barriers that exist. There are a few other qualitative and quantitative studies that not only identify barriers but also look into how there are alternative models for facing these issues. The truth is that the current model is ineffective because it refuses to help marginalized communities which, in turn, continues to perpetuate violence against non-white communities. The first thing that is important to note about the barriers is that they can be summed up into four main categories.

A large one is the national health care system, which of course offers a strict criteria that cannot always be met because of documentation status. This is something of note within the Somali Bantu community because there are different situations for different individuals. There are three types of classifications that determine health resources from not only the national level but the Maine level (Agrawal 2016). This project is a cumulative analysis of the healthcare experiences through access and literacy of the entire Somali Bantu community however in terms of what is available, it differs between those who have specific status over others. This is the reality of Western healthcare so, it is important to acknowledge this aspect in the overall thesis.

Figure 2 is a visual representation of what this difference looks like through a metaphoric hierarchy. Refugees have access to national healthcare, regional healthcare, and most public insurances with benefits for employee security. They are given this refugee status while still outside the United States and sponsored. Asylum seekers are

different in that they have been status at the point of entry or after entering their new country. They are afforded less health care opportunities than refugees in that they are able to have regional healthcare for minors but not entire families nor are they able to rely on employee benefits (Xin 2018). The last are undocumented individuals, who have extremely limited access to federally funed programs.

There is a national crisis in terms of undocumented folx not receiving proper care. According to the United States Department of Agriculture, “53% of domestic farmworkers” and laborers are undocumented. Those who utilize the existing medical system hover between 38% and 53%. What this entails is undocumented folx, including those in the Somali Bantu community, being afraid or untrusting to utilize resources. This comes as no surprise, as there is generational distrust within marginalized communities because of the systemic racism present within our healthcare system.

Status-Determined Health Services in Maine:

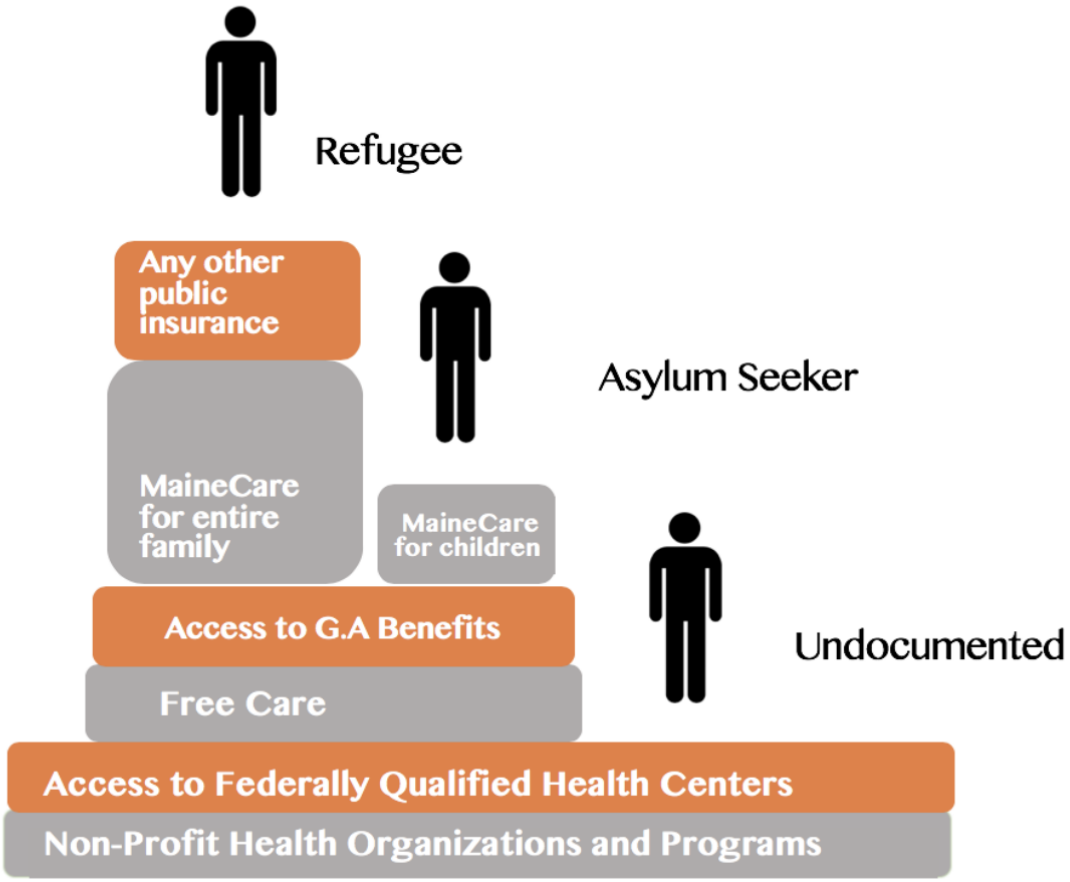

Figure 2. This diagram shows the designations between refugees, asylum seekers, and undocumented folx. https://community.bowdoin.edu/news/wp-content/uploads/2018/10/Major-Barriers-to-Healthcare-Access-for-New-Mainers-2-1.pdf

What makes this so complicated is that all three exist within the Somali Bantu community and all three receive different levels of care. Something that was very evident within the narratives of both Cynthia Anderson and Catherine Besteman's novels was that there are adjustments for not only those displaced but, those who live in communities that

gain new neighbors over a period of time. This type of societal reaction is something that also factors into the psychological factor of receiving healthcare. In short, because there are sometimes push backs against displaced individuals inhabiting a new place, it can trickle into the quality of healthcare received. For example, within the initial surface research conducted, there was not a percentage available of healthcare providers that could speak Somali and engage with different aspects of their patient's documentation status, gender identity, income, health conditions, family accomodations, and other aspects. Language is extremely important in giving healthcare to marginalized communities and Bell's piece ties in how it is so important to directly understand a patient's symptoms, which can be hard to do if that is a barrier.

Another layer is gender identity's representation in the healthcare field. Jennifer' Caroll's overview of Somali women and a study about patient communication found that many of the Somali women preferred having a female identifying provider in the room during their care. This is something that is often overlooked as a patient necessity but it factors heavily into the overall quality of care. This was further explored in Hill's piece on Somali natal care- specifically how expectant or current mothers have a sense of trust in their providers when they feel they have a sense of control in their situation. Having a sense of cultural humility and understanding of intersectionality in the workplace is something that can be so valuable to caring for another human being.

Additionally, having an element of health literacy between patient and caregiver is another level of comfort to the parties involved. One study method used is a parameter of patients' medical awareness called Patient Activation Measure (PAM). Lower PAM

scores from patients reflects a lower health literacy rate. According to a study done, “24% of Portland respondents had a Level 1 score”. Level 1 is the lowest score and is indicative of the fact that marginalized Portland communities could greatly benefit from community health workers (Cowenhoven 2017).

Having this would lower stigma in asking for help, as well as prioritizing mental health. Displacement effects on mental health are large parts of how people can function in new environments. The 5 stressors that were deduced from mental health effects within Somali communities were broken down into: “economic stressors, discrimination, difficulties with acculturation due to language differences, parenting differences, and pressure to find employment.” (Fitzgerald 2017). Mental health effects of marginalized folx is something that factors into why organizations like the Black Panther Party organized their own medical care. Alondra Nelson’s book gives a look into how social justice and medicine goes hand in hand through the lens of dismantling systemic racism within the hospital system. While this was decades ago, it does offer an alternative method into creating a community healing system. Ultimately, what this project entails is possibly exploring a model that would be better suited for the Somali community. “Improving the wellbeing of the world’s migrants requires an intersectional lens that focuses on the diverse circumstances and locations in which migrants are situated” (Spitzer 2019). In other words, the only way Somali Bantu healthcare will improve is if an intersectional approach is made.

Field Research: Interacting with Maine Healthcare Advocacy Partners

During the research portion of my thesis, I wanted to integrate my own commentary into the existing literature about the Somali community. Their healthcare access is something that has been in conversation for a long time. As a precursor, I want to stress that I was fortunate enough to be privy to some very important anecdotal narratives from the non-governmental organizations that represent and support the Somali Bantu community. However, I am simply an academic that had the opportunity to do so and in no way represent the healthcare plights of the Somali Bantu community. My overall goal for this thesis was to have an analytical look at their experiences and hopefully provide a platform to further amplify their voices. The advocacy done by their community and affiliated associations for a more inclusive healthcare system is beyond the work that I could possibly do within a year.

During the planning stages of my thesis research, I took inspiration from a few different peer-reviewed sources in terms of how they conducted field work to collect narratives regarding Somali Bantu healthcare in the Maine and Greater New England area. Close attention was paid to what types of questions or hypotheses were being posed, what specific focus of healthcare inequity was being studied, and how they analyzed their findings.

When thinking about the methods used within my research, something that distinguished Matteen Hakim's piece is its presentation format and the fact that it actually is a student project for a medical student in their rotation during their final year of study. Hakim's focus on the Somali community of Southern Maine- specifically Lewiston- and the different types of barriers within the community parallels my own thesis topic. The presentation is broken into what problems appear to be, the pecuniary implications of public health, anonymous community perspectives, the methodology (incorporating Somali voices into the healthcare narrative), the results (or perspectives given) from interviews, limitations, and recommendations for future research. This piece was a really important stake in the methodology because it does have similarities to the way I am approaching analysis for healthcare barriers. Additionally, it mirrors the interview style of community outreach that I hope to accomplish in my ethnographic approach to interviews in the field. One of the main aspects of the piece that I also found to be similar to mine was the types of people being interviewed and the approach to advocating for community healthcare workers.The future research area of the presentation was also interesting because I feel that expanding on the point of increased language accessibility is something that my project looks at in my written analysis of different barriers. Hakim's final product is something that offers great insight on the healthcare provider side of Somali healthcare literacy and accessibility.

As a methodology, it matches up with my vision and also offers up important potential points about connecting community advocates with healthcare support organizations for my own research. The second piece that supplements Hakim's piece and offers up an interesting perspective for student researchers within the Lewiston area is authored by three graduates, who had a similar methodology to both me and Hakim in terms of conducting field research. The one thing that makes it different is its focus on the transportation access issues of the Somali community, which is something that I had explored at all within my research. It is something that I feel needs to be explored within my paper. There are points brought up about not simply just logistic access but, there is the notion of biases within those who are supposed to provide transportation. There is also the idea of barriers not being fully understood by domestic-based organizations, which may not know how to collaborate with community advocates (Caldwell 5).

My thesis is simply a hybrid ethnographic-analytical look at the work they do in conjunction with the peer-reviewed sources that provide quantitative data. The two main organizations I had the privilege of interacting with were the Maine Access Immigration Network (MAIN) and the Somali Bantu Community Association (SBCA). My key contacts for each were Mohammed Hassan and Muhidin Libah, respectively. Hassan is a community health worker originally from Somalia and later moved to Syria where he worked with Somali refugee families. Conversational in over four languages, Hassan has practiced medicine in Somalia, Saudi Arabia, and partnered with the United Nations High Commissioner for Refugees in Damascus, Syria. He joined the Portland-based MAIN specifically to provide care for those that are disadvantaged by the public system because

he has a huge commitment to ensuring equal access for all those who do not know how to advocate for themselves or their families.

Muhidin Libah is the executive director of the Somali Bantu Community Association in Lewiston. He arrived in Southern Maine around 2001 and grew up in a Kenyan refugee camp following the Somali military conflict. He attended the University of Southern Maine and founded several non-for-profits in addition to the SBCA. His mission upon arriving in Maine was to empower Somalis through land cultivation and a sense of community. Agricultural wellness is a pinnacle in Somali Bantu culture and something that was difficult upon arriving in the United States was for the community to preserve their culture. Referencing back to Fatuma Hussein's lecture about Western medicine, there is a separation between patient and provider in the clinical setting that goes far beyond just medical expertise. When a patient arrives into a space where the provider giving them catre does not look like them, there is a high chance of implicit bias concerning that individual's identity and the care they can receive.

Technical Procedure

To better understand the role of the non-governmental organizations that represent healthcare advocacy for the Somali community, my original plan was to hold interviews with organization representatives using either the phone or a virtual software. Before the interviews, there would be a consent form sent, which is included in this methods section. During the actual interview, there would be guiding questions that would steer the

conversation but give the interviewee full autonomy and treat the prompts as a starting off point. The questions were structured around understanding exactly what the organizations do, the role the organization has in the healthcare conversation, the effects on the Somali Bantu community of the medical training for providers in Maine, and the overall experience of the Somali community in the United States' medical system. The idea behind this type of field research was to combine these collected narratives with the literature analysis to better prove or disprove some of my hypotheses.

In terms of limitations, there were some challenges that did influence the way I conducted my research. Due to COVID-19 complications and important work occurring on a day-to-day basis for the organizations, my interactions were limited to email correspondence. Essentially, all materials were sent over email and the questions turned into shorter essay prompts for the representatives to answer. In an ideal world, interviews would be conducted face-to-face, however, because of health concerns due to the pandemic, safety had to be prioritized.

Following the correspondence, I was able to compile key points from both Muhidin Libah and Mohammed Hassan that were incredibly beneficial to my own field analysis. The following anecdotes from both are direct quotes in response to the open-ended questions sent to them over email. Incredibly thorough, the answers reflect my initial hypotheses very strongly in terms of systemic barriers factoring into the quality of care due to existing prejudice. They also touch upon how healthcare access and literacy is directly linked to the ease of navigating a system that does not take intersectionality into account. An interesting aspect of both these organizations is that

while their missions are directly linked to forms of healthcare advocacy- whether it be more resources to clinical care or agricultural health and wellness- they are both incredibly different. However, their responses to the prompts yield similar themes of access inequity and the difficulty the Somali community has in terms of a lack of cultural humility within Western health. This was incredibly fascinating because the organizations have different missions but nearly the same fundamental values of connecting and empowering the Somali Bantu community. It is clear within the anecdotes provided to me from both Hassan and Libah that the healthcare experiences of the Somali Bantu community and the organizational approach to them operate in a variety of different ways. For example, the SBCA's health and wellness commitment through agricultural empowerment was a wellness initiative that I had never been exposed to. However, after learning more about the Somali Bantu identity and what the organization does, the importance of health and wellness through the growing, harvesting, and celebration of food should absolutely be recognized as a form of healthcare.

Anecdotes

Maine Access Immigration Network (Mohammed Hassan)

Explain a little about what your organization does to support the Somali Community?

"We are a non-profit ethnic based community organization that helps immigrants who speak different languages including the Somali speaking community in Maine by providing health literacy educational meetings to communities in partnership with major healthcare providers, helping newly arriving immigrants access to social services such healthcare, food, housing and other needs by connecting them to providers in Maine. We also advocate when needed to certain vulnerable individuals. We partner with providers to help them perform research projects for the communities we serve".

What is the experience of a newly-arrived family or individual in terms of obtaining physicals/general health check-ups?

"Newly arrived Somalis come to the US with different immigration categories such Refugees, Family Reunion and rarely as Asylum seekers (undocumented) . Free health care coverage depends which category of immigration they arrive here, those who enter as refugees can get Medicaid health insurance which covers all health and other social services at least for the first few months until they earn income while asylum seekers are not eligible free healthcare coverage except children and pregnant women, same are also those who enter with family reunion visa".

How have the communities of Southern Maine transitioned after the arrival of the Somali community?

"Somali communities in Maine experience hardships due to all barriers such as language, culture, and the weather but they transition from being an immigrant to becoming hard working individuals with citizenship while their children enroll in higher education and integrate with the mainstream population and we help them navigate the complicated American health care system".

What does representation look like in terms of care providers that speak Somali?

"Healthcare providers are mainly white and do not speak Somali language but, providers use interpreters although lately MaineHealth is trying to diversify their residency programs with few Somali providers who speak Somali Language".

Describe the differences in obtaining clinical care within the Somali community between someone with documentation and someone without.

"As mentioned above those who legally arrive are eligible to certain level of service depending income and other factors while undocumented Somalis are not eligible for state or federal healthcare coverage except emergency medical care that may be billed to them".

Somali Bantu Community Association (Muhidin Libah)

"Somali Bantus are people who come from rural areas where there were no hospitals, running water [nor] medical services. When the people came to the USA they were overwhelmed with many different Western diagnoses and treatments, which were foreign to our community. The medical reconciliation's mission is to make sure our people get clear information about the new medical systems.

Somali Bantus were farmers in Africa, they used to live on the banks of the rivers captivating the land and fishing, hunting, and gathering, farming comes with traditional healing and treating diseases, farming was not only producing food, but it was also a way of life. Everything was around farming".

A Field Analysis of the Maine Access Immigration Network (MAIN)

The mission of MAIN is to "[address] refugee/asylee health literacy, health care enrollment, and coordination of health care services". They are funded by the Office of Refugee Resettlement Ethnic Community Self Help Grant, the Maine Health Access Foundation and the Maine Community Foundation. Partners they have around Maine are Greater Portland Refugee and Immigrant Health Collaborative, University of New England CHANNELS Project, Care Partners, MaineHealth, and Mercy Hospital. Renowned for its commitment to providing a bridge between marginalized communities

that are newly settled in Maine and health resources and practices around the state, its staff are passionate about making access more available. Their executive staff were all new to Maine and its health systems so, they have a deeper empathic understanding of the Somali Bantu community's struggles. Their organization was one that immediately struck me as an important outlet to consult because of the staff's personal connection to healthcare access, the vast resources they provide, and their plethora of community healthcare workers available.

Mohammed Hassan is one of these community healthcare workers and he was able to provide me with more context about MAIN and the different experiences that occur in the healthcare system. One thing that MAIN does to address the issue of literacy and access is providing educational meetings for those that need assistance navigating the healthcare system. As Hassan articulated, when new arrivals enter the state of Maine, they immediately become a number. Everything depends on status and even those who enter Maine with some type of citizenship do not always qualify for benefits. Something that was quite shocking that Hassan revealed was the fact that emergency services are often the only qualified medical care for the Somali community and yet they are often billed for it. This goes hand in hand with the idea of rooted systemic prejudice affecting the care they can receive. Even though there are those in the Somali Bantu community that technically qualify for Medicaid and regional healthcare, these benefits are short term and financially unreasonable.

Even more limiting are the opportunities for undocumented members of the greater Somali community. Referencing back to Darlene Ineza's study, a direct quote from a Maine-based physician is that "Undocumented don't have a voice at all. In my experience, I have never seen any undocumented patients" (18). This is echoed within Hassan's conversation with me; in my field research I was unable to obtain many resources directly available to not only the undocumented members of the Somali Bantu community but, all of Maine's minority communities. No doubt this is a structural issue overall in the United States, however, it seems so much more apparent in Maine because of the state's lower population density. The reality of the benefits available federally for newer arrivals is that there are far and few between. Hassan's experience is primarily centered around connecting health services with Somali Bantu community members who seek out guidance. Something that Hassan also does is being responsible for combing through Maine healthcare legislation in order to better understand how best to help the Somali Bantu community members based on their situation. This, I argue, is just another reason why community healthcare workers are so important to marginalized communities.

As explained in Warwick Anderson's medical education training piece, there is so much risk for biases when providers are simply given the general medical training that operates on nearly a purely academic-level. There is no incorporation of socioeconomic identity when treating patients, which is why initiatives such as the Black Panther Party's community clinics arose. There is so much room for error in treating patients that do not

have the same identity as their provider. In terms of my first hypothesis about prejudicial influence on healthcare access and literacy, this was a watershed moment that occurred during my research. It made me realize how far the roots of racism and classism reach and their effect on not only the healthcare system but, the other systems that coincide with how our medical model operates. This is a large-scale problem that has so many controversial opinions on how to solve it but, the addition of community healthcare workers into this pipeline eases the process of finding resources that accommodate specific situations. Hassan's role is a multifaceted one that takes on the role of a medical educator, social advocate, and legal consultant. He encapsulates three very different fields but is able to combine them into a role that specializes in providing equal access. This type of role is the very antithesis for what the general Western healthcare provider looks like. Rather than conforming to a homogenous-centric model of care, community healthcare workers are responsible for zeroing in on the different communities that they serve.

In being that healthcare advocate, Hassan's job also focuses on essentially utilizing whatever tools he can to bypass systemic barriers. These previously mentioned barriers come from the existing prejudice not only in medicine but in all aspects of society. In Kristin Langellier's chapter of *Applied Communication in Organizational and International Contexts*, the author discusses how when the Somali Bantus arrived in Maine, Lewiston mayor Laurier T. Raymond wrote an open letter to Somali community advocates and leaders asking for the discouragement of future arrivals. Following this, a

white supremist group called the World Church of the Creator held a rally in Lewiston, declaring through anti-immigration sentiments that they were there to "save" the city. It is with this that I argue, how could the medical system truly be impartial when our government leaders are encouraging the exclusion of marginalized communities from seeking safety in our country? These are the problems that community healthcare workers such as Hassan seek to address through his advocacy work.

After having the opportunity to speak with Hassan, something that became a part of the two-pronged hypotheses approach to my thesis was the idea of supplementing existing medical providers with healthcare workers in the Western model. While this was a more large-scale recommendation that I formulated after my research, it is certainly something that I believe to be an important step towards stepping away from the idea that literacy and access are not connected. They are both intertwined because of hegemonic values concerning how the system makes it difficult for marginalized communities to find and access resources while also having no sense of how to navigate the healthcare system.

In terms of specialized branches of medicine, Hassan brought up an interesting point about natal care for the Somali Bantu community, which was something that came up in my preliminary analysis of literature. He discussed how there were certain exceptions to the staunch criteria of regional healthcare for expectant mothers. There were three main secondary sources for this thesis that looked at overall healthcare experiences in a clinical setting for Somali women. One was a general overview of the

experience of Somali women in a clinical setting and the other two were more specific to pre and post-natal care. The first publication was a qualitative study that took place in Rochester, NY and looked at the provider-patient relationship for 34 Somali women. While this was a study conducted in New York, it pointed to similar themes that were found in other colleague's publications about Somali women's healthcare experiences in Maine. In terms of access to emergency medical services, which often is the only one that Somali women qualify for, one patient stated: [If I don't] have transportation I can't go to the hospital. That's the problem. And if I don't have anybody to make the appointment for me I can't do it [myself]. Translators are needed." (Carroll 340). This again ties back to that idea of not having the ability to have access if one's healthcare literacy is not supported by existing systems. Another aspect of this study that touched upon the value of understanding a patient's identity was the level of comfort patients felt in settings that were not male-dominated. The study found that 62% of patients were more comfortable discussing their medical concerns if their provider was female-identifying. This is touched upon in another piece on dynamics of both expectant and recent Somali mothers. In a Portland-based journal article on group dynamics of Somali women, settings with female nurses who had previously worked with the community yielded positive results in "...[because] they had experience working with Somali women, they were able to develop trust and comfort in the groups with a relaxed and conversational approach" (Hill et al. 74). This particular study explored the different taboo topics, such as mental health with natal care, which is so important when talking about healthcare. It is a perfect representation of how understanding and respecting your patient's identity can make a

clinical visit run more effectively for both parties. The third piece on Somali women's health was a journal article from the *Journal of Midwifery and Women's Health* where they discussed health literacy for a group of Lewiston-based Somali Bantu women. "The authors found limited health literacy in a population of immigrant Somali women and created historietas (comic-book style health education brochure) that could be utilized by health care providers to improve communication and understanding of perinatal health, including emergency cesareans and postpartum depression…"(Jacoby et al. 594). What this article brings into the argument is another example of health literacy being limited because of communication issues. These expectant mothers were not able to effectively communicate their inquiries to providers because of a language barrier and a difference in cultural understanding surrounding medicine. However, this is an issue that is directly linked to how the medical model works.

Another important piece of the argument concerning health literacy that Hassan provided more context to was the idea of language interpretation. According to Hassan, most health providers do not speak Somali and are white-identifying. However, large regional medical institutions, such as MaineHealth are attempting to bring in more interpreters that can effectively aid in provider-patient interactions. Examples of how non-for-profits are partnering with large health partners to create more translated resources can be seen in Appendix B. Figures 3 and 4 refer to COVID-19 vaccine information and safety protocols about how to respond if one were to come into close

contact with an individual who tested positive. It also gives helpful background on the vaccines and where it is possible to get it administered around the state of Maine.

Figure 5 is an infographic that details the COVID-19 Vaccine Initiative within the City of Portland Public Health's Minority Health Program. The latter was founded to include marginalized voices in the conversation about the COVID-19 pandemic and how to provide access to prevention resources, as well as provide more information regarding the available vaccines. These flyers were distributed to the greater Southern Maine area where there is the highest concentrated population of Somali Bantus. There is a push from those that have been advocating for the community for years to incorporate technology such as language translation and interpretation. And, as Hassan stated, this change is starting to happen. There is a need for even more providers that can speak Somali or have an assistant interpreter because it is a human right to receive medical care that is equitable in all sense of their identity.

This technology solution to the societal problem surrounding science is one that, after conversing with Hassan, began to take shape as a possible response to my second initial hypothesis regarding how access and literacy are directly linked to large governing bodies. It becomes more clear that it is less about the fault of the communities on whether or not they actively seek out medical resources but, it is a reflection of institutions shifting the burden onto them.

In connecting with Hassan and MAIN, I was not only able to get more insight into how the healthcare system of Maine disadvantages the Somali Bantu community but, it gave me even more context into the Western model of medicine.

A Field Analysis of the Somali Bantu Community Association

The Somali Bantu identity is a unique and complex one that the Somali Bantu Community Association (SBCA) was founded to both celebrate and give the New Mainers an outlet in which they could have full autonomy over the food they grow to sustain and nourish their bodies. Farming, as Libah describes, is a pinnacle in the Somali Bantu identity. Before they arrived in the United States, farming was essentially "life". In their home country, agriculture was the main source of sustainability for the Somali Bantus. His response to the provided prompts was a combination of how medical reconciliation with their agricultural identity has blossomed into an organization that values community empowerment as a cornerstone of a holistic medical system. The SBCA reclaims their narrative through land cultivation. When they faced discrimination on a structural and military level, they were stripped of their ancestral lands. It was on these lands that they grew crops, which nourished them and provided them a space for community healing. After this was taken from them, they arrived in Maine where they were met with further systemic violence. After the Somali Bantus arrived in Maine, they faced both a lack of food and security. Those who qualified relied on food stamps and

community pantries to sustain their families. In terms of land ownership, there were often retracted leasing offers that reflected the somewhat hostile response to their arrival. A Yarmouth resident noted that, “Cultural differences, misunderstandings and miscommunications” had sometimes prompted landlords to terminate the lease” (Lim 2). However, regardless of intention, the Somali Bantu community was isolated from the domestic community. However, Muhidin Libah had a vision that they would succeed in their vision to gain land and rebuild their farming community. He founded Little Jubba farms and the SBCA, which finally found stretches of agrarian green to begin their cultivation of staple crops just in time for the spring bloom.

Their interesting contribution to the healthcare narrative about access is one that truly builds from the ground up. The biggest access barriers to sustainable agricultural health is a lack of land ownership. Recounting the emotion of being able to plant the first seeds in the Maine soil following the SBCA’s founding, members reflected back on their roots as farmers who lived and healed off the land. The impact of having the ability to farm in Maine was enormous because it meant that the Somali Bantus would be able to have a stake in their own health. Their story is one that speaks volumes about having autonomy over one’s own health. In clinical settings where they are unfamiliar with certain practices and procedures, having the ability to feed their body with food that they have grown is a step towards medical reconciliation between the West and other cultures. The SBCA’s narrative is very similar to the small seeds that they plant into the ground; it grows long branches that stretch far into the soil around it. In creating a space where

health and wellness meet, future generations will be positively affected by the advocacy done by those that came before them with a simple dream.

In addition to bridging access gaps with agricultural wellness, SBCA also provides many different resources for preemptive health education. They address nutrition, exercise, managing diabetes, information about prescription medications, and insurance coverage through their medical reconciliation program. Their approach in combining traditional Somali healing techniques and Western diagnoses is an interesting model that, after my research, would be a fascinating potential medical education compromise. Anew, there is an aspect of my research that directly correlates with the thesis' two main hypotheses. By interpreting health literacy through their own lens, the SBCA garners health access by distributing their own healthcare narratives to better advocate for a more inclusive system. They also take the burden that has been shifted onto them by the system and create their own well of resources that can be accessed by Somali Bantus across Maine and serve as that aforementioned holistic model to medical providers.

All in all, Muhidin Libah's testament about his own creation was not only enlightening but gave this thesis more depth in terms of the spectrum that healthcare alternatives can have. The SBCA's approach certainly echoed the points made by MAIN's push for more specialized healthcare workers and the importance of incorporating identity into how health is viewed.

Conclusion

Intertwining scholarly literature and my own field work, my thesis was meant to act as supplemental structuring for the Southern Somali community's healthcare narratives. In terms of my findings, it is clear that the established health literacy dilemma stems from prejudicial structures within medicine. However, the problem does not simply start and end with how providers are taught. It involves how marginalized communities, such as the Somali Bantu communities are viewed in the scheme of health access and literacy. A bulk of the burden concerning their lack of options is shouldered onto their community. The organizations that I developed ties with are both instrumental to not only addressing the systemic issues but provide their own identity-based solutions. The reality is that because they are disadvantaged in the mainstream system, they are at risk for developing health issues that are not properly treated. Within the Somali Bantu community, some of the biggest health concerns were "health behaviors (22.7%), diabetes (18.2%), and hypertension (14.4%), while those of the community were diabetes (22.5%), hypertension (18.8%) and weight (15.9%)" (Mohamed et al. 458). These conditions are all treatable, however, the lack of clarity from the health industry make it difficult for this New Mainers generation to have a strong support system. The existing barriers are due to medical school education failing to understand intersectional identities, not following a community health worker- centered model for newly established communities, and failing to acknowledge a medical reconciliation model that favors cultural humility. Provided historical context, the Somali Bantus have been discriminated

against in their own country and experienced the same type of sentiments in the United States. The contemporary Western healthcare model is complex and faceless. However, I believe that it is possible to refrain from placing blame and giving the burden of healthcare navigation. It is possible to embrace identity through healthcare and utilize healthcare workers and agricultural advocates to ensure a more equitable future. To be privy to the community narratives and have the ability to garner insight from community organizations was extremely humbling. This thesis is an extension of the passion I have for bettering healthcare and giving different communities the platform they deserve to ensure a better tomorrow for their future generations.

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Appendix A: Outreach Materials

Consent for Participation in Interview

I volunteer to participate in a research project for an honors thesis conducted by Jordan McClintock from Colby College in the STS Department.

1. My participation in this project is voluntary. I have the freedom to exit the interview at any time.

2. If I wish to remain completely anonymous: names, locations, and other details will be changed to protect anonymity.

→ There will be no other person present in the interview apart from the interviewer

→ Notes taken by the interviewer will never be shared

3. Participation will be approximately 45 minutes over Zoom or a phone call.

4. I understand that this research study has been reviewed and approved by the Institutional Review Board (IRB) at Colby College.

5. I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.

Example Interview Questions

Non-for-profit organizations and advocacy groups

- Explain a little about what your organization does to support the Somali community.
- What is the experience of a newly-arrived family or individual in terms of obtaining physicals/general health check-ups?
- How have the communities of Southern Maine transitioned after the arrival of the Somali community?

Healthcare Providers

- What does representation look like in terms of care providers that speak Somali?
- Describe the differences in obtaining clinical care within the Somali community between someone with documentation and someone without.
- In your opinion, what type of sensitivity training (or anti-bias training) were you given, if any, during your medical education or residency training.

Somali Community Representatives

- How easy it is to receive healthcare (ie: a doctor's visit, walk-in, etc?)
- Difference in receiving care for documented vs. undocumented.
- Were healthcare resources explicitly outlined upon arrival to the US?
- Is there a discrepancy in healthcare for children- particularly displaced children that have a sponsor but no legal guardian available?

Appendix B: Somali Healthcare Infographics

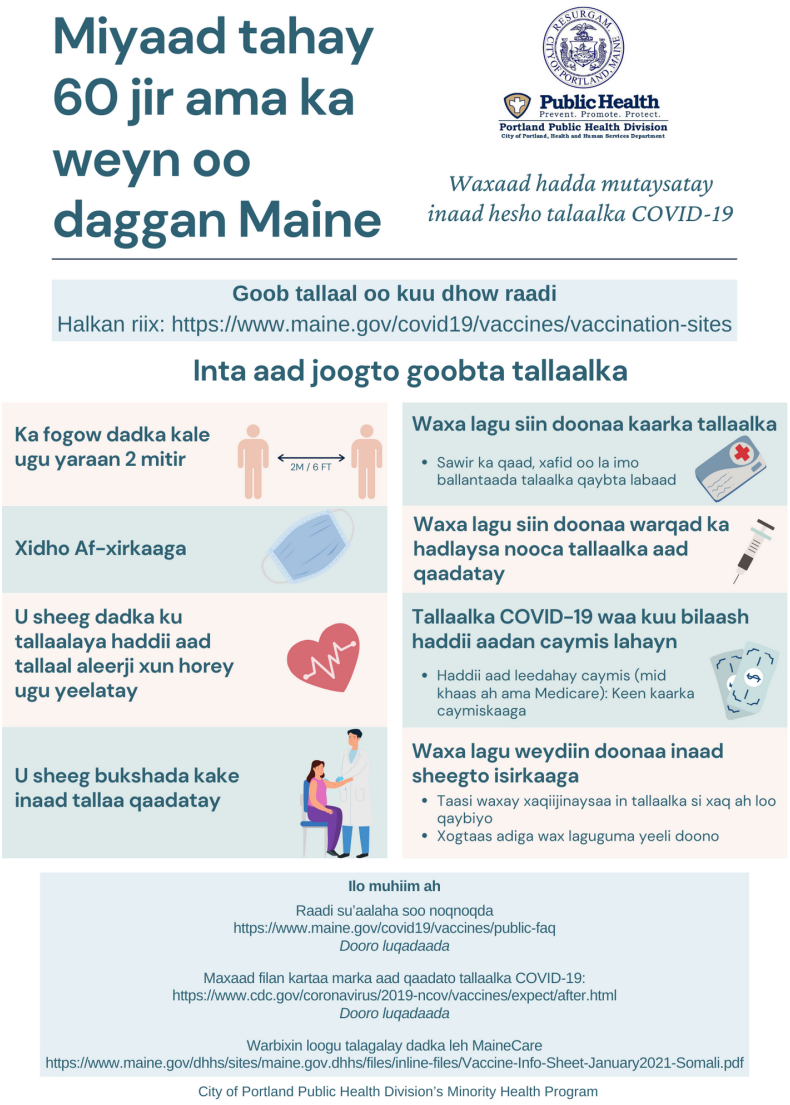

Figure 3. This Somali-translated infographic details COVID-19 safety protocols and vaccine resources.

https://www.portlandmaine.gov/DocumentCenter/View/30854/Image-COVID-19-Vaccine-60-Flyer-Somali

Figure 4. This infographic is a Somali-translated "Do's and Don'ts" for those who have close contact with someone, who has tested positive for COVID-19.

https://www.maine.gov/doe/sites/maine.gov.doe/files/inline-files/ENGLISH%20Dos%20and%20Donts%20Flyer.png

Figure 5. This Somali-translated infographic is part of the the City of Portland Public Health Division's Minority Health Program regarding their COVID-19 vaccine initiative and key contacts.

https://www.portlandmaine.gov/DocumentCenter/View/31758/Vaccine-CHOW-Flyer-Somali?bidId=