

Healthy Tomorrows Somali Bantu Project - H17MC06708

Louisville Metro Public Health & Wellness

FINAL REPORT AND ABSTRACT

PROJECT IDENTIFICATION

Project Title: Healthy Tomorrows Somali Bantu Project

Project Number: H17MC06708

Project Director: Ginger Dereksen

Grantee Organization: Louisville Metro Department of Public Health & Wellness (LMPHW)

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Project Period: 03/01/2006 through 02/29/2012

Total Amount of Grant Awarded: \$250,000

NARRATIVE

Purpose: The purpose of the Healthy Tomorrows Somali Bantu Project was to increase access to culturally competent healthcare services, health prevention and health education services as well as provide a connection to a medical home for families of the Somali Bantu refugee population who have settled in Louisville, KY since 2000.

Background: The Somali Bantu population has a rich oral tradition, no written language, and a centuries-old tradition of clan or tribal agricultural-based culture. It is a patriarchal family-

focused culture. The Somali Bantu who are in the US came from a camp in Kenya where they sought refuge when civil war broke out in Somalia. Most of the refugees in Louisville had lived in the Kenya camps for 13 years. Due to the years of oppression suffered under the Somali population, there is an intense lack of trust and respect between the Somali Bantu and the Somali populations. It was imperative that program staff understood the history and culture of the Somali Bantu if implementation is to be successful. The project staff took great strides to meet with the community leaders to build trust and rapport. Over the grant period, we held approximately 30 formal meetings with the community leaders and many informal meetings.

Because the Somali Bantu language is only a verbal language, we interpreted all health education materials into an oral format. To remove communication barriers and build trust, we assured that the contracted interpreters/lay health workers were of the Somali Bantu population – not Somali. The community leaders contributed to the process of selecting the lay health workers/interpreters and served as advisors on the most effective method to present the educational materials. Throughout the project, we contracted with a male and a female lay health worker and/or interpreter. The indigenous lay health workers provided door-to-door outreach, delivered on-site health education, and interpreted healthcare information. Medical and nutrition professionals presented educational health information that we recorded on to a DVD that the lay health workers distributed to the population. As we implemented the project, the community health care providers and staff members gained increased respect for the Somali Bantu culture and a deeper understanding of their needs.

Goals and Objectives: The goals and objectives evolved through the project and were approved by HRSA project staff.

Goal 1: Increase access to culturally appropriate and linguistically competent, quality health services, and preventative healthcare information to Somali Bantu refugee families in Louisville, Kentucky.

Objective 1: Deliver preventative healthcare for Somali Bantu women and children.

We offered preventative health services and referrals through the mobile health unit in the communities of Americana and Arcadia where the population resides. Initially we set up a walk-in-system four days a month that evolved into a more efficient appointment system.

Outcomes: During the first 12 months, the mobile health unit was available twenty-one (21) days and with the capacity for 504 appointments. By the end of the first year, we cancelled fifteen of the twenty-one dates due to no appointments. A primary **barrier** was the lack of understanding about the importance of preventative health care. Members of the community said that they did not need to schedule an appointment for preventative health services because they already had a health care home. The lay health workers surveyed 332 families and the results were that 97% of the families surveyed had both health insurance (Passport, the local Medicaid) and a health care home for their children. The survey included 540 children. The other common response from Somali Bantu community members was that they would not make a health care appointment if they were not sick. Throughout the project, we educated on the importance of preventative care.

Objective 2: Culturally competent staff will provide culturally sensitive training for the health care community with population-specific information. Project staff presented training at the

Neighborhood Place Annual Meeting in 2006 and to the Louisville Medical Society in 2007.

The training explored issues in understanding culture, overcoming obstacles and building trust when working with Somali Bantu patients. In addition, staff provided culturally specific trainings and program updates for a total of 127 other community healthcare providers and staff. Attendees received printed materials, videos, and resource list.

Objective 3: Provide population-specific health education using culturally competent staff and distribute the preventative healthcare videos to Somali Bantu families. The lay health workers/interpreters distributed videos by door-to-door outreach and staff distributed videos during presentations to the population and to partner agencies. To respect the tribal culture, the community leaders expressed that each family would share the videos with multiple others who will in turn share with others. The videos contain important maternal and child health information, covering topics including car seats, immunizations, exercise, nutrition, cancer screening, diabetes, and blood pressure. **Barrier:** This process, while respectful of the leadership, created a barrier to measurement. Conservatively we estimate that each video educated three other families for a total of 855 families educated.

To evaluate the effectiveness and utilization of the educational video material, the two lay health workers/interpreters administered 55 sets of pre and post questionnaires to participants who watched the health education videos. The LMPHW Office of Policy, Planning, and Evaluation assisted in development of project surveys and questionnaires. The lay health care worker/interpreter explained the nature of the visit, administered the pre-questionnaire, gave the family the video, and then returned a week later to administer the post-test. Initially, the results

of the surveyed were insufficient to yield results. **Barrier:** A lay-health worker, although trained on how to administer the surveys, supplied the answers to the questions and explained that the Somali Bantu would not participate in the pre-test because incorrect answers would be shameful. We overcame the barrier by assigning the responsibility to our second lay health worker who understood the process and assisted the first worker. She collected pre/post test data that indicated that the videos were well received and beneficial. To the questions on the beneficial nature of the videos, one hundred percent (100%) of the participants did watch the videos, they found it beneficial, and would be interested in more videos. The lay health workers/interpreters indicated that the participants answered the questions on the material's benefits themselves.

Goal 2: Create collaborations among community organizations, individuals, public and government entities, pediatric services, and families.

Objective 1: Operationalize the scope and functions of the Advisory Board.

During the first two years of the project, we attended and participated in bi-monthly Immigrant/Refugee Task Force meetings, the original advisory board. Participation of the advisory board members had declined leading to that board's dissolution. The problems included a lack of focus and a high turnover in leadership. Project staff attended monthly meetings until the body dissolved. The original advisory board was a broad coalition that focused on issues of Louisville refugees and immigrants. This coalition of providers created an excellent opportunity to develop new linkages for the project and to gain a wide perspective on issues that face the refugee and immigrant communities. The advisory board was restructured to be smaller, more

concentrated on issues related specifically to the Somali Bantu community and the HTPC project. This new group was called the International Table. The International Table included many of the original member and included Americana Community Center; Acadia Community Center; Neighborhood Place Bridges of Hope; Catholic Charities; Harambee Nursing Center; Mr. Issack and Mr. Muya of the Somali Bantu leadership; the Office for International Affairs; and Dr. Julia Richerson, a pediatrician and Medical Director of the Family Health Centers.

Barrier: Before the first meeting took place, there was a division in the Somali Bantu leadership. Mr. Issack and Mr. Muya had conflicting goals and interest for the Somali Bantu people. The original leader maintained most of the Somali Bantu community and the new leader primarily had participation from his family and friends. In light of the division, the leaders asked us to postpone the advisory board meeting until they had revised the community leadership structure and solved conflicting issues. Due to the importance and magnitude of cultural respect, we felt strongly that it was in the best interest of the project to concur with the leadership's request.

Objective 2: Build collaborations among community organizations. Project staff collaborated with eighteen (18) community partners, sixteen (16) through the International Table. The project staff closely collaborated with Americana Community Center, Arcadia Community Center, Neighborhood Place, Seven Counties Services, Louisville Metro Human Services, State of Kentucky Department of Community Based Services, Family Health Centers and Jefferson County Public Schools, Catholic Charities, Jefferson County Cooperative Extension Service, and the Harambee Nursing Center at the Presbyterian Community Center. We offered formal consulting and training to our partners and medical providers specific to the Somali Bantu

population. Several taskforce members attended and contributed to the HRSA technical assistance visit in October 2007.

Objective 3: Collaborate with the Somali Bantu Leaders. The project staff collaborated with the Somali Bantu leaders regularly through meetings, phone calls, and e-mails. The leaders reviewed and approved all the videos and handouts. The lay health workers/interpreters also regularly consulted with the Somali Bantu leadership and they are accountable as members of the Somali Bantu community. The leadership also reviewed and approved the fact sheet describing key points of the Somali Bantu culture (see page 15). The lay health workers/interpreters, project staff, and Somali Bantu leadership distributed the fact sheet to partners and health care providers.

Objective 4: Review existing policy and procedures around health access to immigrant/refugee families. The Louisville Metro Department of Public Health and Wellness provides services without discrimination and with appropriate language translation/interpretation. The Kentucky Public Health Practice Reference (PHPR) provides policies and procedures for safe health care delivery in local health departments in Kentucky. The PHPR outlines procedures for the use of interpreters and for mandatory language accessible services.

Objective 5: Collaborate with community partners to ensure access to a medical home and to community-based social services for the Somali Bantu families. Julia Richerson, MD, is a pediatrician and was medical director of the Family Health Center, Inc., a federally-qualified health center. She provided assistance throughout the project by advising staff, contributing to

project development, and providing project-related research and best practices. She was the main presenter in the two (2) distributed videos on Women's Health. The Family Health Centers, Inc provides primary healthcare to the Somali Bantu individuals and has opened a medical center on the Americana campus closer to the areas where the Somali Bantu reside.

Goal 4: Disseminate project results and findings, information and resources to human service and healthcare providers, government and business leaders, professional organizations, and other policymakers.

We collaborated with State Title V Director, Dr. Ruth Ann Shepherd, the AAP Kentucky Chapter, and the Community Access to Child Health (CATCH) network and disseminated information through email and meeting attendance. Dr. Julia Richerson is a member of the AAP Kentucky Chapter; and Karla Palmer, program coordinator for Outcomes & Evaluation with the American Academy of Pediatrics, is a significant contact with the AAP. The project director received emails on important news and updates from the AAP. Ms. Palmer also provided research and best practices relevant to the program and forwarded training opportunities, conferences and seminars of interest to project staff. The project developed relationships with 12 pediatric health professionals after introducing the program and provided a fact sheet on understanding the culture of Somali Bantu patients and three videos.

We presented project information to the Immigrant Health Task Force, TA visit team, Louisville Medical Society, and the community through articles in *The Courier Journal*, *Wall Street Journal*, *Louisville Metro Health Matters*, and *Healthy Happenings*. An article was published in

collaboration with Dr. Julia Richerson and appeared in the Fall 2008 edition of the *American Academy of Pediatrics CQ Newsletter*. The CQ (the Community Access to Child Health Program newsletter) is the newsletter for and about child health advocates working to expand community-based services.

Methodology: Program activities used to attain goals/objectives included contracting with an indigenous lay health worker/interpreter to conduct home visits and education. The education tool kit included recorded video presentations as leave behinds. The videos prompted discussion during home visits. The project staff and lay health worker delivered pre/posttests and conducted focus groups and interviews with Somali Bantu residents. Louisville Metro Department of Public Health and Wellness staff used the mobile health unit to provide access to preventative health for the Somali Bantu community. Staff held educational forums for healthcare providers and other community workers on the Somali Bantu culture, cultural sensitivity, and lessons learned.

We minimized costs by reproducing the DVDs in-house; professional staff providing presentations and educational sessions and partner agencies contributing in-kind meeting and workspace.

Evaluation: The Healthy Tomorrows Partnership for Children evaluation methods used were surveys, pre and post-tests, evaluation of trainings and educational videos. The Somali Bantu leaders, the advisory board and healthcare providers evaluated the Quick Reference Guide. We received technical assistance and benefited from the telephone conferences and training from MCHB and AAP.

- Design and administer surveys and pre/posttests as needed and conduct focus group to:
 - ascertain the number of children who have medical homes and
 - gauge the knowledge retained from the health education materials provided to participant.
- Monitor the number of educational videos distributed.
- Capture the number of healthcare workers trained on the Somali Bantu culture.
- Monitor the number of collaborations built with community partners to reach the Somali Bantu population and to address the population's needs.

Results and Outcomes

- 100% of the participant population is Somali Bantu.
- 97% of the 332 families surveyed that included 540 children have a medical home.
- 855 families received educational videos.
- 100% of the families that completed a pre/posttest or participated in a focus group viewed the videos and reported them beneficial.
- 127 community healthcare workers were trained on the Somali Bantu culture.
- 18 community partners and 16 advisors collaborated with the project staff.

This project offered many lessons learned and applicable, transferrable information. However, some knowledge gained is specific to projects for refugees.

Cultural Sensitivity:

- 1) When you are working with a displaced population, understand and respect the group's culture, historical experiences and related stress including relocation.

- 2) With cultural sensitivity, explain indigenous practices that are illegal in the United States; for example, with the Somali Bantu, female circumcision is a cultural practice.
- 3) Understand the non-verbal communication and language variances among cultures such as the appropriate use and interpretation of eye contact.
- 4) Understand the influence of information.
 - a. Some cultures have a high-level sensitivity to language used in health education such as in family planning and consider it “shameful.” We edited the education to assure the messages were direct but not overstated.
 - b. Be alert to the resettled population adopting negative Western behaviors such as not breastfeeding; using alcohol, tobacco, and other drugs; fast food diets; and gang associations.
 - c. Shopping is difficult when you cannot read the language on the package; such as the picture of oranges on cleaning products may be interpreted as a food product.
- 5) Understand appropriate medical protocol. For example, a male physician should not ask a Somali Bantu female about reproductive health unless the female patient’s husband or mother is present.
- 6) Other cultures may not understand the concept of time and calendars making it difficult to manage appointments.
- 7) Language may not be transferable. Use pictographs when needed.
- 8) To assure accuracy in program delivery and impact, collect information using various techniques and methods such as pre/post questionnaires, focus groups, and interviews.
- 9) Understand the cultural significance of large families when educating on family planning. As a centuries-old culture of clan or tribal tradition based on an agrarian society, Somali Bantu

value large families. Due to the harsh living conditions, violence, and poor health care in Somalia and Kenya, the death rate of newborns was 50%, with more dying in the first years of life. Their Muslim religion does not approve of birth control.

Leadership:

- 10) Involve the population in program planning and encompass all the leadership and gatekeepers, assuring leadership buy-in. For example, after discussion with the leaders, leaders did not oppose birth control because their culture believes that what is good for the group is most important. Therefore child spacing is better for the health of the mother, the baby and the older children, thus it is better for the family and better for the tribe.
- 11) Building trust with the leadership is an on-going process that requires continual nurturing especially with a previously persecuted population.
- 12) Built trust and goodwill may not be transferable after a change in leadership.
- 13) Do not circumvent the leaders, but assure the population that these leaders speak for them.
- 14) Obtain recommendations from the leaders when hiring program staff.
- 15) Leaders expect to work with other leaders. Empower program staff.

Publications and Products:

- Education and awareness article in the *Louisville Medical Society*, August 2007 (including photos), also posted on the Society's website.
- Education and awareness article in the *Wall street Journal*, (including photos) and on line <http://online.wsj.com/public/article/SB119006454887730236.html>

- Education and awareness article in the *Louisville Metro Health Matters*, (including photos) was on line.
- Education and awareness article in *The Courier Journal*, (including photos).
- Education and awareness article in the *Louisville Metro Health Matters*, (including photos) and is on the Louisville Metro Public Health and Wellness website.
- Julia Richerson. “The Somali Bantu Project” *Kentucky Pediatrics Newsletter*, Fall 2008.
- Woman’s Health Forum Part 1, video interpreted in Mai-Mai.
- Woman’s Health Forum Part 2, video interpreted in Mai-Mai.
- The World of Food & Nutrition, video interpreted in Mai-Mai.
- Educational packets that include three health education videos.
- *Working with Somali Bantu Clients Quick Reference Guide*, (please see page 15).

Dissemination and Utilization of Results The actions taken include presentation to health care providers, distribution of videos, presentations at conferences, and placing educational videos on You-tube. As discussed under goal 4, we collaborated with State Title V Director, Dr. Ruth Ann Shepherd, the AAP Kentucky Chapter, and the Community Access to Child Health (CATCH) network. Dr. Shepherd received updates through email, and we held regular meetings with Dr. Julia Richerson, an AAP Kentucky Chapter member and Medical Director of the Family Health Centers. Dr. Julia Richerson wrote an article, published in the fall 2008 edition of the American Academy of Pediatrics CQ Newsletter, the newsletter for and about child health advocates working to expand community-based services. Karla Palmer, Program Coordinator for Outcomes & Evaluation with the American Academy of Pediatrics is our most important contact with the AAP. The project director received email notices of important news and updates from the AAP. Ms. Palmer provided research and best practices relevant to the program and

forwarded training opportunities, conferences and seminars of interest to project staff. The project staff connected to 12 pediatric health professionals through a mailing that introduced the program and disseminated the Somali Bantu fact sheet and the three videos to the healthcare providers. Project staff presented to the Immigrant Health Task Force, TA Visit team, Louisville Medical Society, and the community through articles in *The Courier Journal*, *Wall Street Journal*, *Louisville Metro Health Matters*, and *Healthy Happenings*.

Future Plans and Sustainability: We plan to continue to distribute the educational videos and provide presentations to health care providers and their staff on the Somali Bantu culture. We have offered support and consultation to the Somali Bantu leadership and have encouraged health care partners to reproduce and distribute the educational videos to their patients.

Annotation: The Louisville Metro Healthy Tomorrows Somali Bantu Project's purpose was to increase access to culturally competent healthcare services, health prevention/ education information as well as to provide a connection to a "medical home" for families of the Somali Bantu refugee population who have settled in Louisville, Kentucky. This project served to eliminate barriers to access healthcare and community-based social services through partnerships and collaborations in the community and state. The project staff built relationships and collaborated with the significant human services and healthcare providers.

Key Words: Access to health care, children, collaboration, cultural sensitivity, communities, dental care, Department of Health, dissemination, education, evaluation, families, goals, health, health agencies, health care providers, language, home visits, immunizations, indigenous

outreach workers, leadership, MCH Programs, monitoring, needs assessment, nutrition, outreach, nurses, pediatricians, pregnant women, prevention, referrals, safety, sustainability, Title V trust, training, videotapes, women.

Working with Somali Bantu Clients Quick Reference Guide

Refugee:

A refugee is a person who has fled the country of his/her nationality on the basis of fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, and is unable and unwilling to return to that country for such fear. (1 {p. 5})

Religion:

As Muslims their beliefs include: existence of only one god (Allah), prophet Muhammad as Allah's messenger, the Muslim Holy Book (Qur'an), existence of angels, praying five times a day, fasting during the 9th month (Ramadan) of the Muslim Year, attending the pilgrimage in Mecca, belief in reincarnation, Resurrection Day, and prophets Issa (Jesus), Mussa (Moses), Ibrahim (Abraham), Ya'quub (Jacob), Yusuf (Joseph). (2 {p. 6})

The Islamic religion does not permit Muslims to eat pig and mammals with upper front teeth (horse). In addition, drinking alcohol is prohibited. (2 {p. 7})

Somali Bantu believe that the Qur'an heals all illnesses. It is believed that people get sick because of invisible creatures locally known as "Jinni" this is particularly the case when somebody has a mental health problem because they believe that the "Jinni" causes mental illness. It is believed that the Qur'an expels the 'Jinni' from the person. (2 {p. 11})

With regard to religious practices, the Bantu are among the more liberal Muslims in Somali society. Evidence of this are the ceremonies performed by the Bantu and the roles that women are allowed to play in the community, such as being allowed to work in the fields and, although they dress modestly by American standards, not wearing the *hijab*, which some Muslim women wear to cover themselves while in public. (3 {p. 20})

Diet:

The diet of Somali Bantus consists of maize, peas, and vegetables. They also eat fish. Traditionally, Bantus believe that the "soup" of the river fish prevents malaria and thus they eat many river fish, which supplies additional protein. (2 {p. 6 & 7})

Halal means a diet acceptable to Muslims for religious reasons. Examples of halal food: chicken, beef, goat, lamb, seafood, all vegetables, all fruits, and non-alcoholic drinks. Non-halal food: Alcoholic beverages (liquor, wine, champagne), pork, and horse. (2 {p. 17})

Medical Language:

When asking about physical symptoms, if a Somali Bantu patient reports that they have "malaria". It is being used as a slang term that indicates they have a fever. (4)

Language:

The Somali Bantu utilize two main languages, which are Mai-Mai and Zigua. (4)

Dos and Do Not's:

- When requesting an interpreter through a phone service or live in person, service providers need to make sure to specify that the interpreter is Somali Bantu and not Somali. Due to the years of oppression of the Somali Bantu by the Somalis, a lack of trust and respect could have negative effects on the interpreted communication. (4)
- Do not motion to anyone young or old with your finger. Somali Bantus take this act as an offense. (2 {p. 17})
- Dogs are not viewed as members of the family. It is offensive to Somali Bantus to have the family dog greet, sniff, and rub against them. (2 {p.17}), (4)
- Do not offer non-halal food and intoxicating beverages to Somali Bantus. Instead, clearly inform the person that the food or drink is not halal. (2 {p. 17})
- Do not make direct eye contact with the Somali Bantu. The Elders see this as a lack of manners. Young people look to the ground or elsewhere when addressing elders. In their culture, not keeping eye contact does not mean a sign of guilt. (1 {p. 10})
- Providers should build strong relationships with community leaders and elders first. (1 {p. 12}), (4)

References:

(1) Mubiy, Tuipate F. *Working with Somali Bantu: What Service Providers Should Know*. Social Work Department: Howard Center Diversity Coordinator

(2) Jewish Family Service of Western Massachusetts (2003). *Somali Bantu Cultural Guide for Agencies and Organizations*. Funded by a grant to the Hebrew Immigrant Aid Society (HIAS) from the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Refugee Resettlement Grant # 90rp0024

(3) Van Lehman, Dan & Eno, Omar (2003) *The Somali Bantu: Their History and Culture*. Center for Applied Linguistics: The Cultural Orientation Resource Center.
http://www.cal.org/co/bantu/somali_bantu.pdf

(4) Somali Bantu leaders and Somali Bantu individuals employed by the Healthy Tomorrows Project through the Louisville Metro Department of Public Health and Wellness. The intended purpose of the Healthy Tomorrows Project is to increase access to culturally competent healthcare services, health prevention and health education services for the Somali Bantu Community.

***The above information has been verified with the Somali Bantu leaders in Louisville, KY.**

For more information, please contact the Healthy Tomorrows Project through the Louisville Metro Department of Public Health and Wellness at 574-6665

ABSTRACT OF FINAL REPORT

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NARRATIVE: The program purpose was to increase access to culturally competent healthcare services, health prevention and health education services as well as provide a connection to a medical home for families of the Somali Bantu refugee population who have settled in Louisville, KY since 2000. The Somali Bantu population has a rich oral tradition, no written language, and a centuries-old tradition of clan or tribal agricultural-based culture. It is a patriarchal family-focused culture. The Somali Bantu who are in the US now came from a camp in Kenya where they sought refuge when civil war broke out in Somalia. Most of the refugees in Louisville had lived in the Kenya camps for 13 years. Due to the years of oppression suffered under the Somali population, there is an intense lack of trust and respect between the Somali Bantu and the Somali populations. It was imperative that program staff understood the history and culture of the Somali Bantu if implementation was to be successful. The project staff took great strides to meet with the community leaders to build trust and rapport. Over the grant

period, we held approximately 30 formal meetings with the community leaders.

Because the Somali Bantu language is only a verbal language, it was necessary to interpret all educational materials into an oral format. To remove communication barriers and build trust, we assured that the contracted interpreters/lay health workers were of the Somali Bantu population. The community leaders contributed to the process of selecting the lay health workers/interpreters and served as advisors on the most effective method to present the educational materials. We employed a male and a female lay health worker. The indigenous lay health workers provided door-to-door outreach, delivered on-site health education, and interpreted healthcare information. Medical and nutrition professionals made presentations on health information that we filmed and recorded for distribution by the lay health workers. Through this grant, community health care providers and staff members have gained increased respect for the Somali Bantu culture and a deeper understanding of their needs.

GOALS AND OBJECTIVES:

Goal 1: Increase access to culturally appropriate and linguistically competent quality health services and preventative healthcare education to Somali Bantu families in Louisville, KY.

Objective 1: Deliver preventative healthcare for Somali Bantu women and children.

Objective 2: Culturally competent staff will provide culturally sensitive training for the health care community with population-specific information.

Objective 3: Provide population-specific health education using culturally competent staff and distribute the preventative healthcare videos to Somali Bantu families.

Goal 2: Create collaborations among community organizations, individuals, public and government entities, pediatric services, and families.

Objective 1: Operationalize the scope and functions of the Advisory Board.

Objective 2: Build collaborations among community organizations.

Objective 3: Collaborate with the Somali Bantu Leaders

Objective 4: Review existing policy and procedures around health access for immigrant/refugee families.

Objective 5: Collaborate with community partners to ensure access to a medical home and to community-based social services for the Somali Bantu families.

Goal 4: Disseminate project results and findings, information and resources to human service and healthcare providers, governmental and business leaders, professional organizations, and other policymakers.

EVALUATION: Methods: surveys, pre/post-tests, evaluation of presentation, videos evaluated by the Somali Bantu leaders, participant interviews and focus groups, and home visits by the lay health workers/interpreters.

RESULTS/OUTCOMES: The racial and ethnic group served – 100% Somali Bantu.

Results included: (1) 97% of the population has a medical home that included 540 children; (2) 855 families received educational videos; (3) 100% of the families viewed the videos and reported them beneficial; (4) 127 community healthcare workers were trained on the Somali Bantu culture; and (5) 18 community partners and 16 advisors collaborated with the project staff.

Lessons learned and outcomes that have potential for transfer/replication: 1) Meet with the project population leadership before implementation and maintain communication. 2)

Understand and respect the population's culture. 4) Assure buy-in from the leaders and the population; 5) If the leadership changes, trust and goodwill most likely will not transfer. 6)

Understand the nuances of the culture. 7) Be able to identify sensitive topics and cultural taboos.

9) Do not underestimate word of mouth. 10) Educate from a stance of health benefits. 11) Create

an environment comfortable for asking questions; use active listening; ask participants to explain back to you what they understood. 12) Understand the trauma experienced with encampment and relocation. 13) Seek assistance from HRSA and community experts when needed. 14)

Leaders expect to work with other leaders - empower employees to act.

PUBLICATIONS/PRODUCTS: 1) Education and awareness article in the *Louisville Medical Society*, August 2007 (including photos), also on Society's website. 2) Education and awareness article in *The Courier Journal*, (including photos). 3) Julia Richerson. "The Somali Bantu Project" *Kentucky Pediatrics Newsletter*, Fall 2008. 4) Three videos: "Woman's Health Forum Part 1 & 2: The World of Food & Nutrition, interpreted in Mai-Mai. 5) Educational packet includes three videos and Quick Reference Guide to Working with Somali Bantu.

DISSEMINATION/UTILIZATION OF RESULTS: Actions taken: Presentation to health care providers, distribution of videos, website, Facebook, presented at conferences, and You-tube.

FUTURE PLANS/SUSTAINABILITY: Continue to distribute the educational videos, provide presentations to health care providers. We have offered support and consultation to the Somali Bantu Leaders if they wish to apply for funding

ANNOTATION: The Louisville Metro Healthy Tomorrows Partnership for Children, Health Tomorrows Somali Bantu project's purpose was to increase access to culturally competent healthcare services, health prevention/education information to Somali Bantu refugee population who has settled in Louisville, Kentucky.

KEY WORDS: health care, collaboration, cultural sensitivity, Department of Health, education, health care providers, indigenous outreach workers, TITLE V, trust, and videotapes.