Somali Refugee Needs and Health Status Report

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Department of Health & Human Services
Division of Public Health
Office of Health Disparities and Health Equity

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Somali Refugee Needs and Health Status Report

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Acknowledgments

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Nebraska Refugee Needs Assessment Project

According to the United Nations High Commissioner for Refugees (UNHR), the population of displaced people rose from 33.9 million worldwide in 1997 to 65.6 million worldwide at the end of 2016. Of this 65.6 million, 40.3 million were internally displaced (within their country of origin), 22.5 million were refugees, and 2.8 million were asylum-seekers. While countries such as Turkey, Pakistan, and Lebanon hosted over one million refugees each, only 189,300 refugees were resettled in the rest of the world in 2016. In 2016, the United States was the world's top resettlement country, admitting 96,900 of those refugees.[1]

In fiscal year 2016, which began in October 2015 and ended in September 2016, Nebraska admitted 1,441 refugees.[2] This was more refugees per capita than any other state, amounting to 76 refugees resettled per 100,000 residents.[3] In the past fifteen years, the top refugee groups arriving in Nebraska have come from Burma, Bhutan, Iraq, Sudan and South Sudan, and Somalia. Nebraska has seen consistent growth among these populations due to continuing conflicts.

Refugee Arrivals in the Past 15 Years

Country of Origin	Total Arrivals (2002-2016)	Percent of Total Arrivals
Burma	4,481	43.0%
Bhutan	1,446	13.9%
Iraq	1,056	10.1%
Sudan	1,043	10.0%
Somalia	689	6.6%
Other	1703	16.4%
Total Arrivals	**10,418**	

Source: Office of Refugee Resettlement, Refugee Arrival Data, 2002 – 2016

Refugees face many barriers to achieving adequate education, work, and health services. While resettlement and social service agencies are in place to assist refugees with integrating into their surrounding communities, more support is needed to adequately address refugee needs. In particular, refugees have unique health needs and often face barriers to receiving appropriate and timely health

[1] United Nations High Commissioner for Refugees. (2017). Global trends: forced displacement in 2016. Geneva: United Nations High Commissioner for Refugees.
[2] Office of Refugee Resettlement. (2016). Refugee arrival data.
[3] US. Census Bureau. (2016). 2016 Population Estimates.

care. Understanding refugee health needs and barriers to health services is imperative to helping refugees succeed in their new home.

In part due to the many barriers faced by refugees, there is limited data addressing refugee health status, risk factors, and needs. To better serve Nebraska's refugee populations, the Office of Health Disparities and Health Equity (OHDHE) conducted its first statewide Refugee Needs Assessment Survey in 2017. The survey focused on identifying key risk factors for the five largest refugee populations in Nebraska. OHDHE has published four refugee health status reports on the based on the Nebraska Refugee Needs Assessment data which can be accessed on the OHDHE website. The published reports are listed below:

- Nebraska Refugee Statewide Health Status Report
- Karen Refugee Health Status Report
- Lincoln Refugee Health Status Report
- Omaha Refugee Health Status Report

Additionally, among the reports expected to be published by 2023, the following reports will also be included:

- Iraqi Refugee Needs and Health Status Report
- Bhutanese Refugee Needs and Health Status Report
- Sudanese Refugee Needs and Health Status Report

This report will specifically present the Nebraska Refugee Needs Assessment data findings for refugees from Somalia.

Methodology

Project Development

To gain a deeper and comprehensive understanding of the health needs of refugee communities in the state, the Nebraska Office of Health Disparities and Health Equity conducted the statewide Refugee Needs Assessment Survey in 2017.

Based on the Nebraska 2007-2016 Refugee Resettlement data, the needs assessment primarily targeted the top five refugee populations from Burma, Bhutan, Iraq, Somalia, and Sudan. This report will focus exclusively on refugees from Somalia.

Mixed Methods Design

A qualitative and quantitative mixed methods approach was used in this project. Qualitative research was first conducted through focus groups and task force meetings with refugee communities and partner organizations. These focus groups and task force meetings served to address survey strategies, including training and other logistic issues, and were fundamental to the creation of the statewide quantitative needs assessment. In this survey, we did not use CDC Behavioral Risk Factor Surveillance System (BRFSS)'s disproportionate stratified sample (DSS) design. We used proportional stratified random sampling method, which involved taking random samples from stratified groups, in proportion to the refugee population.

Survey Design

Combining the findings of the focus group discussions and task force meetings, the Nebraska Refugee Behavioral Risk Factor Surveillance System Questionnaire was developed, consisting of 123 questions.

Eligibility Questions

At the beginning of the survey, participants were asked three eligibility questions. The first two questions were designed to ensure that each participant was at least 18 years of age and had come to the United States as a refugee. The third question was added to confirm that the participant was not a second-generation refugee or born in the United States.

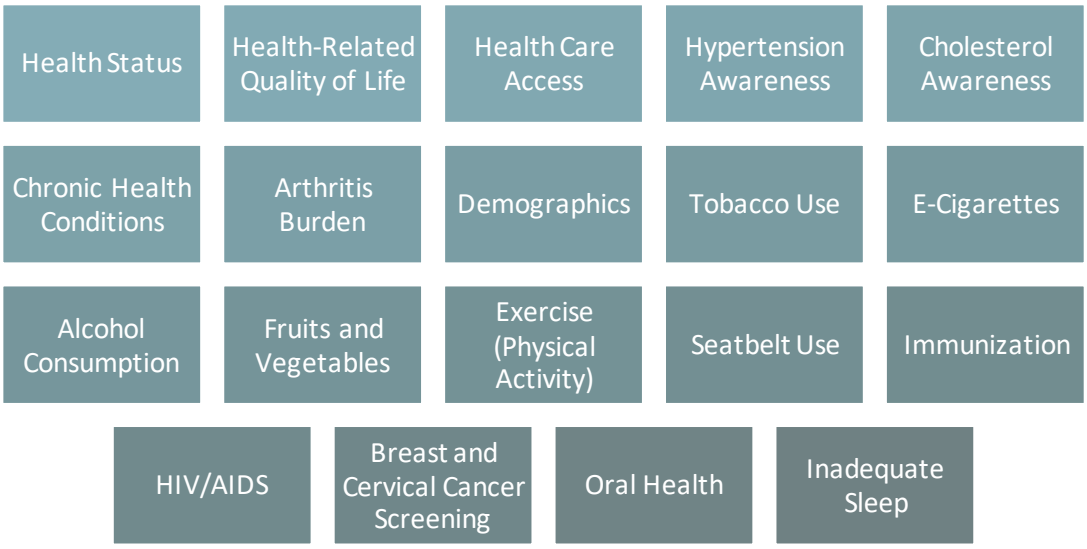
State-Added Questions

The next section included 19 state-added questions. These questions were chosen and composed after discussions between the Office of Health Disparities and Health Equity and partner organizations during focus groups and task force meetings. Many of these questions are refugee-specific demographic questions aimed at gathering detailed information about each participant, such as their home country, native language, and English level. Other questions focused on overall needs and challenges and navigating the health care system.

Core Questions

The majority of the questions in the survey were standardized questions from the Nebraska Behavioral Risk Factor Surveillance System (BRFSS). The Nebraska BRFSS has been conducting surveys annually since 1986 to collect data on the prevalence of major health risk factors among adults residing in the state. This surveillance system is based on a research design developed by the Centers for Disease Control and Prevention (CDC) and used in all 50 states, the District of Columbia, and three of the U.S. territories. Information gathered through the BRFSS can be used to target health education and risk reduction activities, to lower rates of premature death and disability. Of the survey questions, 101 questions came from the 2016-2017 CDC BRFSS core questions. These questions were grouped into the 19 sections shown below.

Core Question Sections



Implementation

Interviewers and Training

Before conducting the interviews, more than 60 interpreters were trained by OHDHE staff in a series of 20 workshops to ensure that the survey was given in a standardized manner. The training included in-depth explanations of each assessment questions as well as method to ensure data accuracy and consistency. To overcome language barriers, all interviewers selected were translators that spoke both English and the native language of the respective refugee group which included Karen, Burmese, Chin, Nepali, Dzongka, Somali, Arabic, Dinka, Nuer, Kurdish, and Kurmanji. Each interviewer went through a couple of practice interviews before starting the assessment.

Interview Method and Quality Control

The surveys were all completed in face-to-face interviews. Participants were anonymous and informed that their answers would be kept confidential. Participants were also able to skip any question they did not want to answer and could end the interview at any time.

In order to ensure the validity and integrity of the data collected, quality control measures were put in place. These measures included selecting at least 5% of participants at random and contacting them by phone or in-person to confirm selected answers. The quality control calls were completed by an interpreter other than the individual who conducted the initial interview with the participant.

Methodology Limitations and Challenges

While using a mixed methods approach and working closely with the refugee communities and interpreters helped to mitigate certain challenges, the employed methodology is still subject to limitations.

The validity of data is always a primary concern when using questionnaires, as the information collected relies on the honesty of participants. Participants may hesitate to answer sensitive questions truthfully for a variety of reasons. Social desirability bias, or the tendency of participants to answer questions in a manner they may view as socially acceptable, can lead to skewed results. For example, in a culture where

alcohol consumption is not accepted, participants may be reluctant to answer alcohol-related questions honestly.

The collected information also heavily relies on the participant's understanding of the questions. During training, interpreters were instructed to translate the questions as written and to not explain the questions to limit misinterpretation. While questions were written to ensure consistency, misinterpretation may still occur, in part due to cultural and linguistic differences. In addition, even when the questions are interpreted as intended, the participants' answers rely on their ability to accurately recall information.

Photo by Ismail Salad Osman Hajji dirir on Unsplash

According to the Centers for Disease Control and Prevention, priority health concerns among many refugee populations include various infectious diseases, such as intestinal parasites and malaria.[4] These diseases are often treated overseas before the departure of refugees to their host countries. Due to this reason, and the fact that many refugees in Nebraska have already been in the country for numerous years, such diseases were not investigated in this survey.

[4] Centers for Disease Control and Prevention. (2013). Refugee health guidelines. Retrieved from www.cdc.gov/immigrantrefugeehealth/guidelines/refugee-guidelines.html

Somali Ethnic Background

After gaining independence from Italy and Great Britain in 1960, Somalia was a stable nation. However, political instability in the early 1990s resulted in a protracted humanitarian crisis and an ongoing, territorial civil war. Recent elections have been largely peaceful and shown signs of progress, but Somalia remains deeply divided by insurgent groups and rival militias. The civil war, coupled with extreme famine (particularly in rural areas), unequal distribution of aid, and poor economic prospects, has led to the mass exodus and diaspora of Somalis worldwide[5].

Geography

The Federal Republic of Somalia (hereafter referred to as Somalia), is located in Eastern Africa and is part of the Horn of Africa, a large peninsula that juts into the Arabian Sea. Somalia borders Kenya, Ethiopia, and Djibouti, as well as the Gulf of Aden and the Indian Ocean. Although Somalia has a largely desert climate, parts of the country experience seasonal monsoons. The country is prone to recurring droughts, frequent dust storms in the eastern plains, and flooding during the rainy season. Famine, deforestation, overgrazing, soil erosion, and desertification have become major issues in recent decades[6].

Ethnic Groups

Ethnic Somalis are unified by culture, language, religion (Islam), and common Samaale ancestry. Persons of Somali origin account for approximately 85% of the population, while minority ethnic groups account for the remaining 15%[6]. The largest ethnic minority in Somalia is the Somali Bantu, whose ancestral origins include, among others, the Makua, Yao, Ngindo, and Nyasa of Tanzania, Mozambique, and Malawi. Many Bantu trace their origins to ancestors from these southeast African tribes who were

[5] Refugee Health Vancouver. Somalia Cultural Profile. 2011 [cited 2016 December]
[6] Central Intelligence Agency. The World Factbook: Somalia. [cited 2016 August]; Available from: https://www.cia.gov/library/publications/resources/the-world-factbook/geos/so.htmlexternal icon.

enslaved and brought to Somalia during the 18th century[7]. Minority ethnic groups also include Bravanese (Barawa) and Rerhamar (Arab descent); Bajuni (originating from the East African coast); as well as the Galgala, Tumal, Yibir, Gaboye, and Eyle[8].

Language

Somali is the primary official language. There are two main Somali dialects: Standard Somali and Digil/Raxanweyn Somali. Standard Somali is spoken by most Somalis, while the Digil/Raxanweyn dialect is spoken primarily in Shabelle and Juba River valleys in the south[9]. However, Standard Arabic is also an official language (according to the Transitional Federal Charter). Italian and English are common, and Swahili is also spoken in regions in southern Somalia. Indigenous languages include Maay, Oromo, Borana-Arsi-Guji, Dabarre, Garre, Jiiddu, Mushungulu, Tunni, and Boon[10].

Education and Literacy

Civil war resulted in a complete breakdown of the formal education system in Somalia. Somalia has one of the world's lowest enrollment rates for primary school-aged children, where as few as 25% of children have access to primary education, and secondary school enrollment is estimated at 6%. Of note, school enrollment in Somalia is substantially higher for boys than girls[7]. Educational opportunities for Somalis are also limited in countries of asylum. In the Dadaab Refugee Complex in Kenya, access to quality education is severely limited. The number of school-aged children in Dadaab far exceeds the capacity of schools, and schools lack adequately trained teachers and learning resources[10]. Literacy among Somalis is low. Among adults (15 years of age or older), male literacy is approximately 49.7%, while literacy among women is substantially lower at 25.8%[11].

Photo by Ismail Salad Osman Hajji on https://unsplash.com/photos/v7FT5ngIEfA?utm_source=unsplash&utm_medium=referral&utm_cont

[7] Van Lehman D, Eno O. The Somali Bantu: their history and culture. Center for Applied Linguistics. 2003.
[8] United Nations Office for the Coordination of Humanitarian Affairs. A study on minorities in Somalia. 2002. Available from: http://reliefweb.int/report/somalia/study-minorities-somalia.external icon
[9] NYS Statewide Language Regional Bilingual Education Resource Network at New York University. Somalia: Language & Culture. 2012.
[10] MacKinnon H. Education in emergencies: the case of the Dadaab refugee camps. Centre for International Governance Innovation Policy Brief 47. 2014 July.
[11] United Nations Educational, Scientific and Cultural Organization. Somali Distance Education and Literacy. [cited 2016 September]; Available from: http://litbase.uil.unesco.org/?menu=4&letter=S&programme=100external icon.

Religious Beliefs

The provisional federal constitution of Somalia recognizes Islam as the state religion and requires that all laws must comply with the general principles of Sharia[11]. Nearly all Somalis are Sunni Muslim, and it is estimated that less than 1% of the total population belongs to other religious groups (e.g. Christian, Shia Muslim)[11].

View on Health Care

The majority of Somalis, particularly those who have lived in urban areas, have had some experience with Western medicine. Providers should ask new arrivals about past experiences with Western medicine, as well as their opinions of Western medical practices [12]. However, some Somali refugees may be unfamiliar with routine preventative care, such as prenatal or well-child care [6]. Additionally, many Somalis have had experience with traditional healers. Traditional healers use a variety of methods including fire-burning (a procedure where a stick from a special tree is heated and applied to the skin to cure illness), herbal remedies, and prayer. They employ these methods to treat a variety of illnesses such as viral hepatitis, measles, mumps, and varicella (chickenpox), and may be familiar with treating hunchback, facial droop, and broken bones. Traditional doctors are believed to have the ability to cure illnesses caused by spirits [6].

Like most populations, Somalis tend to have specific care preferences, attitudes, and expectations driven by cultural norms and religious beliefs [6]. However, individual interpretations of Islam and diverse cultural practices require healthcare providers to address views and preferences of each refugee [12]. While there are no universal Islamic healthcare practices or preferences, Somali Muslims (who account for roughly 99% of the Somali population) may be more likely than the general US patient population to:

- View the health of each individual as a family concern
- Accompany family members, especially wives and children, to medical appointments
- Prefer a healthcare provider and/or interpreter of the same sex

[12] Maloof PS, Ross-Sheriff F. Muslim Refugees in the United States: A Guide for Service Providers. Washington DC: Center for Applied Linguistics Culture Profile No. 17. 2003 September.

- Feel uncomfortable disclosing health information to strangers, potentially making initial diagnosis difficult
- Express concern regarding vaccine safety, particularly with childhood measles, mumps, and rubella (MMR) vaccination
- Be unfamiliar with chronic diseases and the need to take medication for a long time
- Use herbs and other traditional medicines provided by traditional healers
- Consult traditional and spiritual healers about mental health issues
- Have dietary restrictions and avoid consuming pork products, medications with pork ingredients (common in gel formulations), and meat that is not Halal
- Abstain from alcohol
- Request vegetarian meals in hospitals, or have family bring meals during hospital stays
- Fast (avoid food, water, and medicine from dawn to dusk) during the month of Ramadan and may opt to take medications before dawn or after dusk to avoid breaking fast

When possible, providers should ask patients if they prefer an interpreter who is of the same ethnic background or gender.[13]

Somali Refugees in the United States

Somalis in the USA primarily live in Minneapolis, MN, Columbus, OH and Seattle, WA (listed in order of population). However, Somalis are also a part of what is called "second migration." Initially most Somalis were placed in Virginia, near Washington, D.C. However, due to economic reasons, many Somalis moved away from Washington, D.C. to the areas listed above. Smaller numbers of Somalis have moved to Lewiston-Portland, ME and to other rural areas.

[13] Abrar FA. Personal communication. 2018.

Refugee Needs Assessment Key Findings (Somali)

This report uses the data from the 2017 Refugee Needs Assessment to explore the health status and needs of the Somali refugees in Nebraska. The following are key findings from the report and represents the surveyed Somali refugees in Nebraska.

Challenges and Needs

- 72% of refugees from Somalia reported language barriers as their biggest challenge. This percentage was 7.4 times higher than that of the next most reported challenge: access to health services at 9.7%.
- Refugees from Somalia reported education (33.7%) as their most urgent need, followed by legal (20.1%), work (16.3%), and healthcare (13.5%) needs.

Social Determinants of Health

- Approximately 28% of refugees from Somalia had never attended school or only attended kindergarten and approximately 12% had only attended elementary school.
- Two-fifths of refugees from Somalia (40.0%) reported having graduated high school and an additional 14.5% reported having some college or technical school.
- Approximately half (50.3%) of refugees from Somalia reported being currently employed. Male refugees (60.9%) were 1.5 times more likely than female refugees (41.5%) to report being currently employed.
- The majority of refugees surveyed (61.4%) reported an annual household income of $20,000-$25,000. Female refugees (73.3%) were 1.6 times more likely than male refugees (46.3%) to report this level of income.
- Approximately 62% of refugees from Somalia reported limited English proficiency. Male refugees (62.3%) were slightly more likely than female refugees (61.6%) to report limited English proficiency.

- Over half of refugees from Somalia reported speaking a language other than English at home. Male refugees (59.2%) were more likely than female refugees (52.2%) to speak a language other than English at home.
- Approximately 43% of refugees from Somalia were married. Male refugees (50.8%) were more likely than female refugees (35.7%) to report being married.
- Approximately 91% of refugees from Somalia reported renting their home, whereas approximately 3% of refugees from Somalia (2.8%) reported owning their home.

Health Status

- Approximately one-fourth of refugees from Somalia (25.3%) reported their health status as fair or poor. Male refugees (30.3%) were 1.4 times more likely than female refugees (21.2%) to report their health status as fair or poor.
- Just under 2% of refugees from Somalia (1.6%) reported being in poor physical health on 14 or more of the past 30 days.
- Just under 1% of refugees from Somalia (0.8%) reported that poor physical or mental health limited their usual activities on 14 or more of the past 30 days.

Access to Health Care

- Only approximately one-fourth of refugees from Somalia (26.5%) reported having healthcare coverage.
- Under half of refugees from Somalia (46.0%) reported not having a personal physician.
- Approximately 28% of refugees from Somalia (27.7%) reported being unable to see a doctor due to cost in the past 12 months.
- Overall, 61% of refugees from Somalia reported having difficulty understanding information from health care providers spoken in English.
- Approximately 58% of refugees from Somalia reported having difficulty understanding health information written in English.

- Approximately 35% of refugees from Somalia reported using a family member as an interpreter when visiting the doctor.
- Over one-fourth of refugees from Somalia (26.2%) reported always using medicine from their home country instead of visiting the doctor when sick.

Chronic Disease

- Approximately 2% of refugees from Somalia reported having ever been diagnosed with a heart attack.
- Approximately 3% of refugees from Somalia had ever been diagnosed with a stroke. Male refugees (4.5%) were 2.4 times more likely than female refugees (1.9%) to report having ever been diagnosed with a stroke.
- Approximately four percent of refugees from Somalia (3.9%) reported having ever been diagnosed with asthma.
- Eight percent of refugees from Somalia reported having ever been diagnosed with diabetes. Female refugees (12.0%) were 3.9 times more likely than male refugees (3.1%) to report having ever been diagnosed with diabetes.
- Approximately 14% of refugees from Somalia had ever been diagnosed with high blood pressure. Female refugees (20.4%) were 3.6 times more likely than male refugees (5.6%) to report having ever been diagnosed with high blood pressure.

Mental Health

- Just under one percent of refugees from Somalia (0.8%) reported having poor mental health on 14 or more of the past 30 days.
- Under one percent of refugees from Somalia (0.7%) reported having ever been diagnosed with a depressive disorder. Male refugees (0.8%) were slightly more likely than female refugees (0.6%) to report having ever been diagnosed with a depressive disorder.

Health Behaviors

- Over half of refugees from Somalia (54.8%) reported having had a routine checkup in the past two years.
- Overall, 27% of refugees from Somalia had a flu shot in the past year. Male refugees (36.8%) were two times more likely than female refugees (18.8%) to report having had a flu shot in the past year.
- Four percent of female refugees (age 40 and older) reported having had a mammogram in the past two years.
- Fourteen percent of refugees from Somalia reported having ever been tested for HIV.
- Almost 15% of refugees from Somalia (14.5%) reported having visited the dentist in the past two years.
- Almost 70% of refugees from Somalia (69.1%) reported sleeping less than seven hours per day.
- Approximately 78% of refugees from Somalia reported not having any leisure time physical activity.

Treatment Received as Refugees

- Just under five percent of refugees from Somalia reported feeling that they were treated worse than non-refugees at work in the past 12 months.
- Male refugees (8.1%) were 4.1 times more likely than female refugees (2.0%) to feel that they were treated worse than non-refugees at work in the past 12 months.
- Just under five percent of refugees from Somalia (4.5%) reported feeling that their experience when seeking healthcare was worse than non-refugees in the past 12 months.
- Male refugees (9.4%) were 13.4 times more likely than female refugees (0.7%) to report feeling that their experience when seeking healthcare was worse than non-refugees in the past 12 months.

Demographics

Native Language

Somali and Arabic are the official languages of Somalia. However, the Somali language is the most reported to be the native language of Somali refugees at 96.9%.

Current Residence

Approximately 49.8% of refugees from Somali currently reside in Douglas County, 47.1% in Dawson County, and 3.1% in Hall County.

Age

~50% of refugees surveyed were between the age of 18 and 34.

~13% of refugees surveyed from Somalia were between the age of 35 and 44.

~29% of refugees surveyed from Somalia were between the age of 45 and 64.

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Respondents Demographics

More than 2,300 surveys were completed in Lincoln, Omaha, Grand Island, Lexington and other cities and towns across Nebraska. Among those surveys, a total of 293 surveys were completed by refugees from Somalia. The tables below show the number of respondents based on gender, age group and the year of arrival.

Gender	Number of Respondents
Male	133
Female	160
Refused	0
Total	**293**

Age Group	Number of Respondents
18 to 24	33
25 to 34	101
35 to 44	48
45 to 54	29
55 to 64	42
65 or older	20
Refused	20
Total	**293**

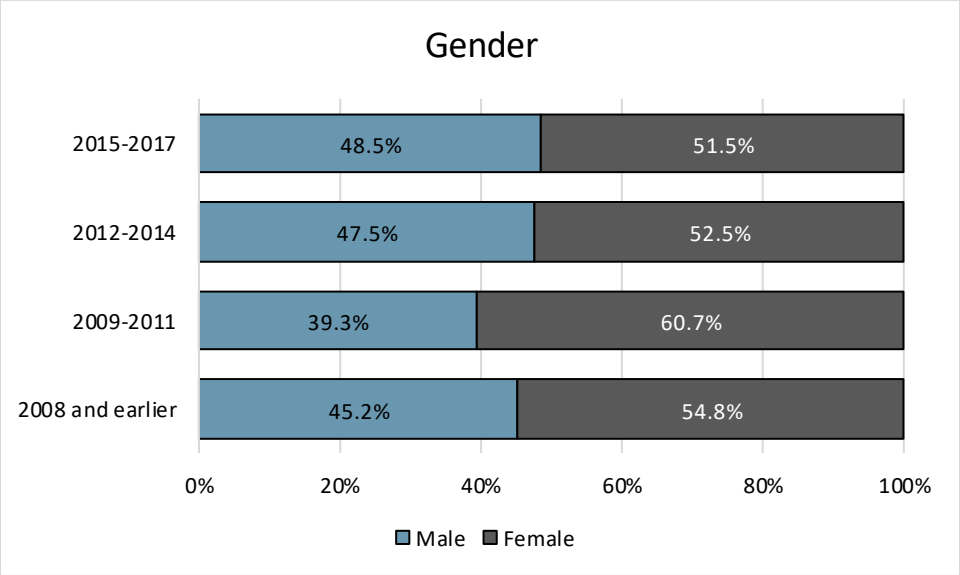
Year of Arrival	Number of Respondents
2008 and earlier	73
2009 to 2011	61
2012 to 2014	59
2015 to 2017	97
Refused	3
Total	**293**

Gender

The chart below shows the proportion of male and female refugees from Somalia.

Key Findings by Year of Arrival

- For most arrival years, there were similar proportions of male and female refugee respondents.
- For refugees from Somalia arriving in 2009-2011, there were 1.5 times more female refugees surveyed than male refugees.

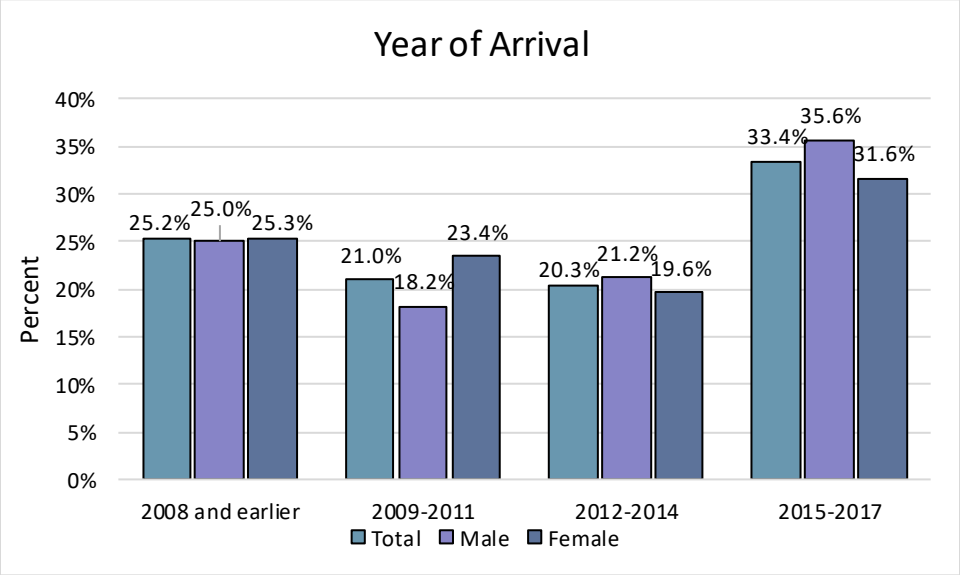


Year of Arrival

The chart below represents the year in which refugees from Somalia arrived in the United States.

Key Findings by Gender

- Approximately one-third of refugees surveyed from Somalia arrived in 2015-2017 and approximately one-fourth arrived in 2008 and earlier.
- Refugees from Somalia who arrived in 2009-2011 were more likely to be female, while refugees who arrived in 2012-2014 and 2015-2017 were more likely to be male.
- Similar proportions of male and female refugees reported having arrived in 2008 and earlier.



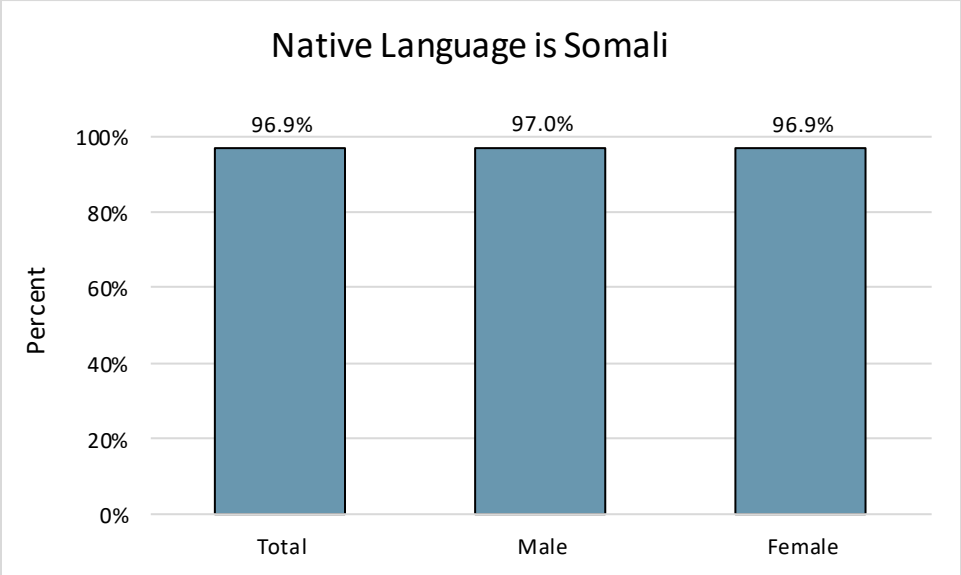
Native Language

Somali and Arabic are the official languages of Somalia. However, Somali is reported as the native language by majority of the country.

The chart below represents the proportion of refugees whose native language was Somali.

Key Findings by Gender

- Approximately 97% of refugees from Somalia reported Somali as their native language.
- Almost identical proportions of male and female refugees from Somalia reported Somali as their native language.

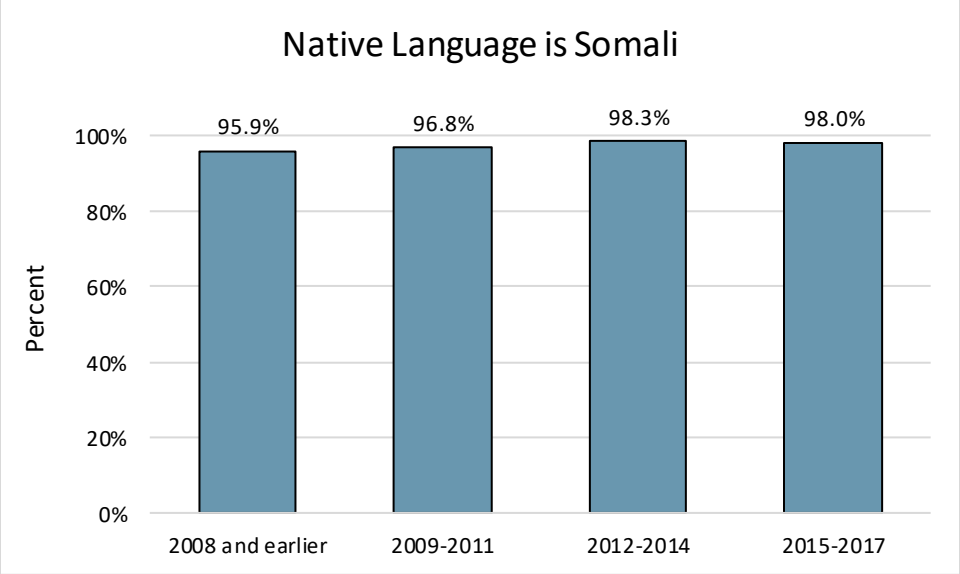


Native Language

The chart below represents the proportion of refugees whose native language was Somali.

Key Findings by Year of Arrival

- More than 90% of all refugees from Somalia reported Somali as their native language.
- Refugees who arrived in 2008 and earlier (95.9%) were least likely to report Somali as their native language.
- Refugees who arrived in 2012-2014 (98.3%) and in 2015-2017 (98.0%) were most likely refugee arrival groups to report Somali as their native language.



Current Residence

The table below represents the county of residence of refugees from Somalia at the time of the survey.

Key Findings by Gender

- Approximately half of refugees from Somalia (49.8%) reported living in Douglas County and just under half of refugees (47.1%) reported living in Dawson County. An additional 3.1% of refugees from Somalia reported living in Hall County.
- A higher percentage of male refugee from Somalia reported living in Dawson County, while a higher percentage of female refugees from Somalia reported living in Douglas County.

County	Total	Male	Female
Dawson	47.1%	54.9%	40.6%
Douglas	49.8%	39.8%	58.1%
Hall	3.1%	5.3%	1.3%

Current Residence

The table below represents the county of residence of refugees from Somalia at the time of the survey.

Key Findings by Year of Arrival

- Somali refugees who arrived in 2008 and earlier were most likely to reside in Douglas County at 54.1%.
- Those who arrived in 2009-2011 and in 2012-2014 were most likely to reside in Dawson County at 50.0% and 55.9% respectively.
- The most recently arrived Somali refugees (2015-2017) were more likely to reside in Douglas County (51.0%), rather than Dawson County (49.0%).
- Approximately 10% of Somali refugees who arrived in 2008 and earlier resided in Hall County.

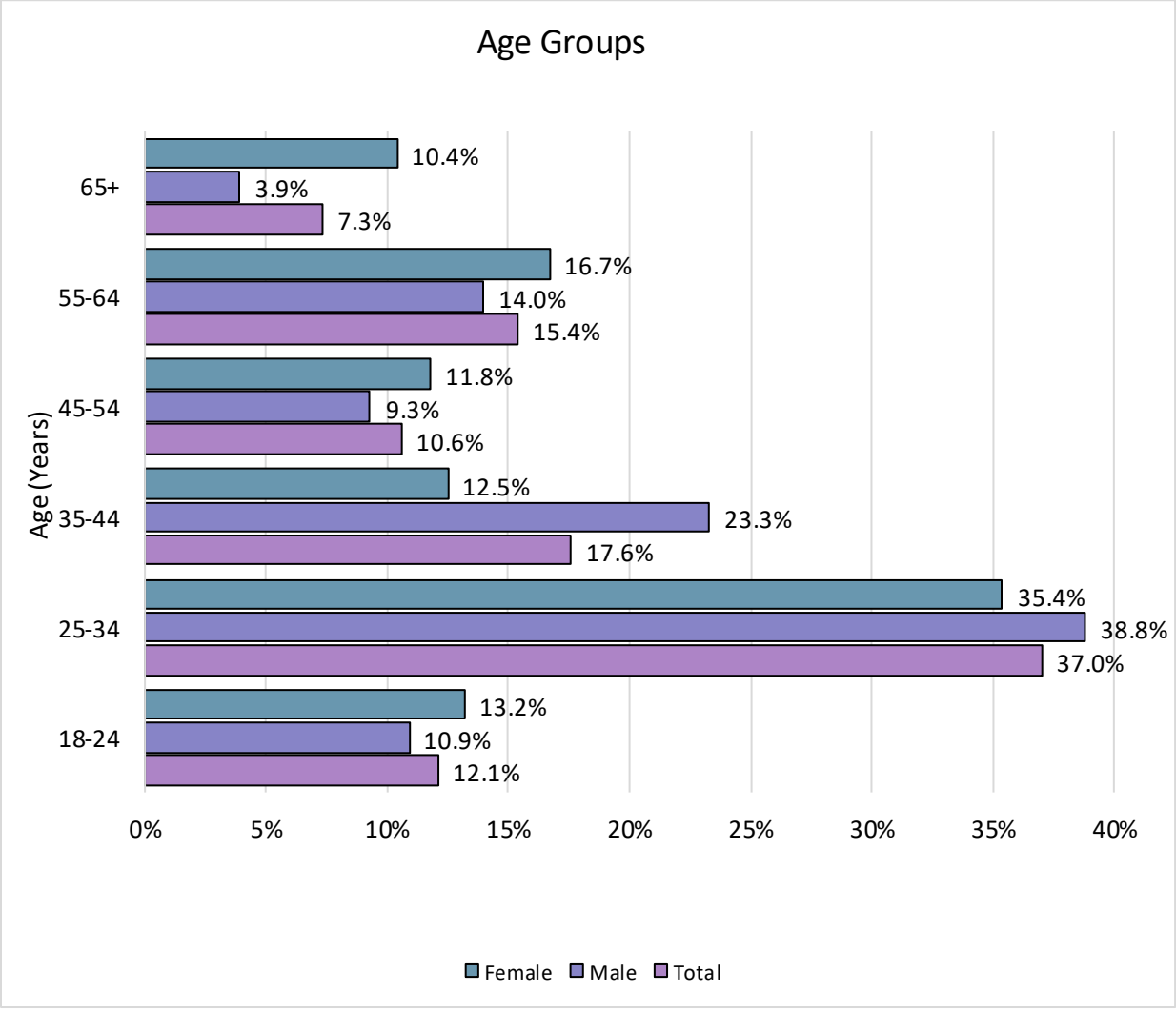
County	2008 and earlier	2009-2011	2012-2014	2015-2017
Dawson	36.5%	50.0%	55.9%	49.0%
Douglas	54.1%	48.4%	42.4%	51.0%
Hall	9.5%	1.6%	1.7%	0.0%

Age

The chart below represents the age of refugees from Somalia surveyed.

Key Findings by Gender

- The majority of refugees from Somalia surveyed (37.0%) were age 25-34. Approximately 18% of refugees from Somalia surveyed were age 35-44 and approximately 15% were age 55-64.
- The least likely ages to be surveyed were refugees from Somalia who were age 65+ (7.3%), 45-54 (10.6%) and 18-24 (12.1%).



Age

The chart below represents the age of refugees from Somalia surveyed.

Key Findings by Year of Arrival

- More than one third of refugees from Somalia who arrived in 2008 and earlier were ages 25-34 (35.9%). The next largest age group for those who arrived in 2008 and earlier was 55-64 (16.3%).
- The largest age group of refugees from Somalia who arrived in 2009-2011 was 35-44 (31.5%), followed by 25-34 (27.8%).
- The majority of refugees from Somalia who arrived in 2012-2014 were ages 25-34 (57.1%).
- The largest population of refugees from Somalia who arrived in 2015-2017 were ages 25-34 (28.6%) and 35-44 (20.0%).

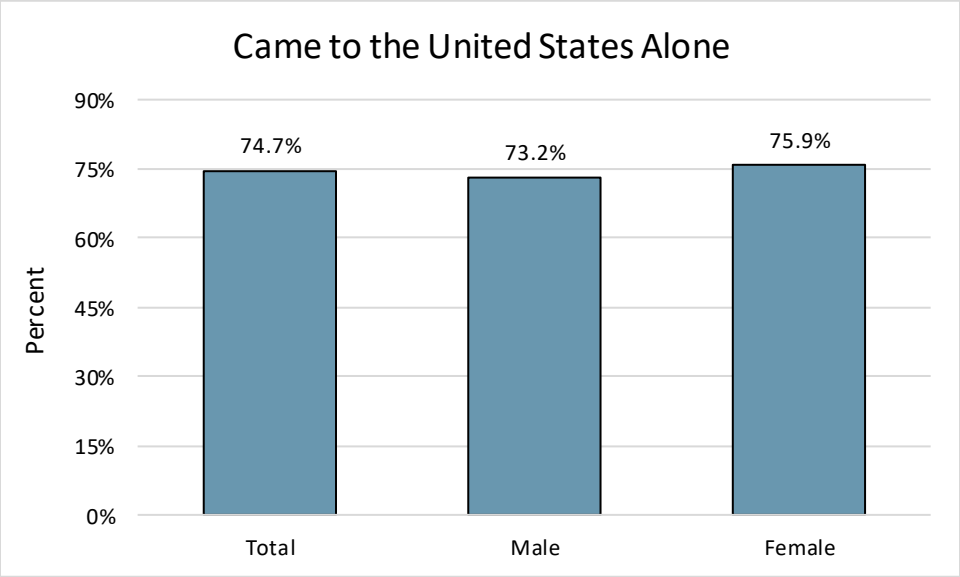
Age Group	2015-2017	2012-2014	2009-2011	2008 and earlier
18-24	15.7%	10.7%	7.4%	13.0%
25-34	28.6%	57.1%	27.8%	35.9%
35-44	20.0%	10.7%	31.5%	12.0%
45-54	14.3%	5.4%	11.1%	10.9%
55-64	14.3%	12.5%	18.5%	16.3%
65+	7.1%	3.6%	3.7%	12.0%

Arrived in United States Alone

The chart below represents the proportion of refugees from Somalia who reported coming to the United States alone.

Key Findings by Gender

- Approximately three-fourths of refugees from Somalia (74.7%) reported coming to the United States alone.
- Female refugees (75.9%) were slightly more likely than male refugees (73.2%) to report coming to the United States alone.

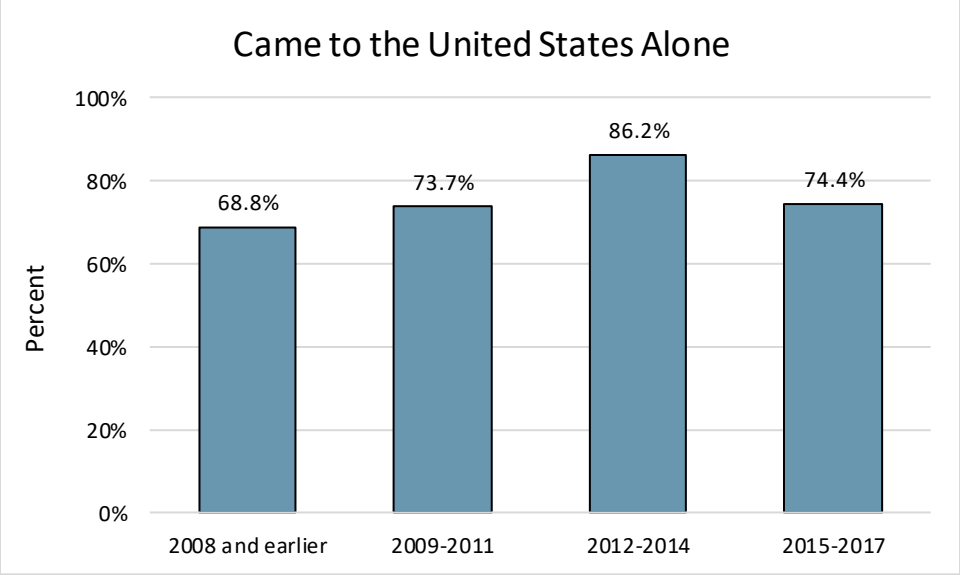


Arrived in United States Alone

The chart below represents the proportion of refugees from Somalia who reported coming to the United States alone.

Key Findings by Year of Arrival

- Refugees who arrived in 2012-2014 (86.2%) were most likely to report coming to the United States alone, followed by refugees who arrived in 2015-2017 (74.4%) and refugees who arrived in 2009-2011 (73.7%).
- Refugees who arrived in 2008 and earlier (68.8%) were least likely to report coming to the United States alone.



Challenges and Needs

The following section examines the reported greatest challenges and most urgent needs of refugee surveyed from Somalia. For both questions, participants could choose more than one response and had the option of writing in any challenge or need not listed. The pre-listed responses to these questions were generated through discussions with refugee communities prior to the creation of this survey. These two questions are listed below.

What are your biggest challenges?

Language Barriers	Mental Health Issues	Discrimination and Oppression
Transportation Issues	Documentation and Bill Pay	Navigating and Understanding U.S. Systems
Access to Health Services	Other	

What are your most urgent needs?

Financial	Social Support	Education	Work
Housing	Food	Healthcare	Legal
Interpretation	Other		

The question regarding biggest challenges focuses on hurdles in everyday life, including language barriers, having access to transportation, and other issues that may prevent refugees from thriving in Nebraska. The second question, which asks specifically about most urgent needs, identifies those areas where refugees feel they need the most immediate support, such as education, employment, or housing.

The responses to these questions, presented in the following pages, are important to understanding the situation of refugees from Somalia on a broader level. Identifying and examining refugees' biggest challenges and most urgent needs will help to ensure that future projects and support intended for the refugee community are relevant and successful. To this end, it is also important to consider the differences in responses dependent upon date of entry into the United States.

Challenges and Needs

Biggest Challenges

- **72% of refugees from Somalia reported language barrier as their biggest challenge.**
- **Access to health services (9.7%) was the second most-reported challenge faced by the Somali refugees, followed by transportation issues (9.3%)**
- **6.6% of refugees from Somalia reported that navigating and understanding US systems was a challenge.3%).**

Most Urgent Needs

The most-reported urgent needs reported by refugees from Somalia were education at 33.7% and legal at 20.1%.

Approximately 16% of refugees from Somalia reported work to be their most urgent needs.

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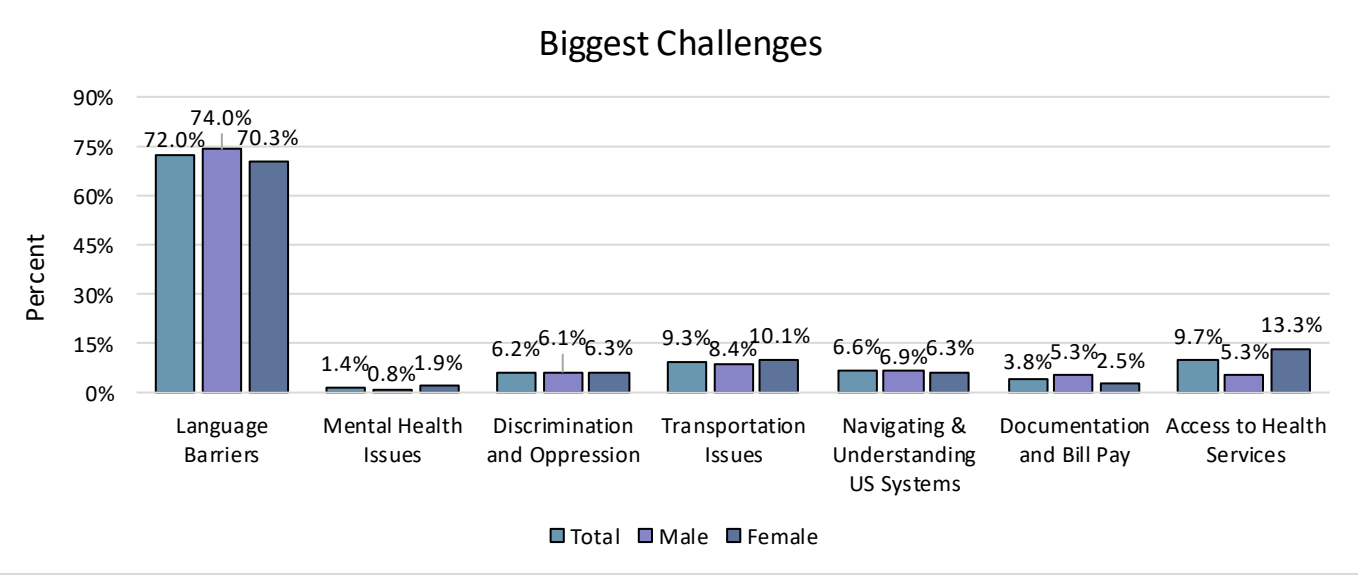
Biggest Challenges

The chart below represents the biggest challenges reported by refugees from Somalia.

Key Findings by Gender

- Overall, 72% of refugees from Somalia reported language barriers as their biggest challenge. This percentage was 7.4 times higher than that of the next most reported challenge: access to health services at 9.7%.
- Male refugees (74.0%) were slightly more likely than female refugees (70.3%) to report language barriers as their biggest challenge.
- Female refugees (13.3%) were 2.5 times more likely than male refugees (5.3%) to report access to health services as their biggest challenge.



Biggest Challenges

The tables below represent the biggest challenges reported by refugees from Somalia.

Key Findings by Year of Arrival

- Language barriers, access to health care, transportation issues, and navigating and understanding U.S. systems were among the top five biggest challenges for all arrival groups.
- Refugees who arrived in 2012-2014 were the only group to not report discrimination and oppression among their top five biggest challenges.
- Only approximately half (52.1%) of refugees who arrived in 2008 and earlier reported language barriers as their biggest challenge, compared to 77.3% of refugees who arrived in 2015-2017.

2008 and Earlier: Top Five Biggest Challenges

Rank	Biggest Challenge	Percent
1	Language Barriers	52.1%
2	Access to Health Care	19.2%
3	Transportation Issues	15.1%
4	Navigating & Understanding US Systems	12.3%
5	Discrimination and Oppression	8.2%

2009-2011: Top Five Biggest Challenges

Rank	Biggest Challenge	Percent
1	Language Barriers	80.0%
2	Transportation Issues	8.3%
3	Access to Health Care	6.7%
4	Discrimination and Oppression	6.7%
5	Navigating & Understanding US Systems	3.3%

2012-2014: Top Five Biggest Challenges

Rank	Biggest Challenge	Percent
1	Language Barriers	81.0%
2	Transportation Issues	5.2%
3	Access to Health Care	5.2%
4	Navigating & Understanding US Systems	5.2%
5	Documentation and Bill Pay	5.2%

2015-2017: Top Five Biggest Challenges

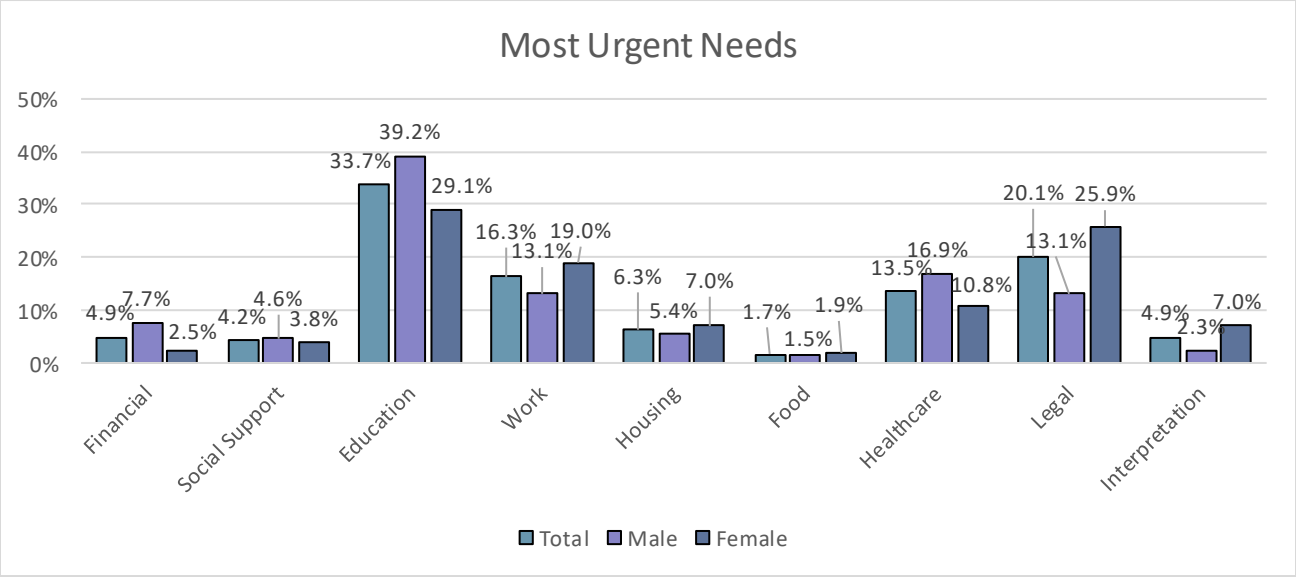
Rank	Biggest Challenge	Percent
1	Language Barriers	77.3%
2	Transportation Issues	8.2%
3	Access to Health Care	6.2%
4	Discrimination and Oppression	6.2%
5	Navigating & Understanding US Systems	5.2%

Most Urgent Needs

The below chart represents the most urgent needs reported by refugees from Somalia.

Key Findings by Gender

- Refugees from Somalia reported education (33.7%) as their most urgent need, followed by legal (20.1%), work (16.3%), and healthcare (13.5%) needs.
- Male refugees (39.2%) were ten percentage points more likely than female refugees (29.1%) to report education as their most urgent need.
- Female refugees (25.9%) were two times more likely than male refugees (13.1%) to report legal assistance as one of their most urgent needs.



Most Urgent Needs

The chart below represents the most urgent needs reported by refugees from Somalia.

Key Findings by Year of Arrival

- Education, legal assistance, healthcare, work and housing were the top five most urgent needs for all refugee arrival groups.
- Over one-third of refugees who arrived in 2015-2017 (34.7%) reported education as their most urgent need, compared to 28.2% of refugees who arrived in 2008 and earlier.
- Legal assistance was the second most urgent need reported by refugees who arrived in 2008 and earlier (19.7%) and refugees who arrived in 2015-2017 (26.5%).
- Work was the second most urgent need reported by refugees who arrived in 2009-2011 (22.6%) and refugees who arrived in 2012-2014 (17.2%).

2008 and Earlier: Top Five Most Urgent Needs

Rank	Need	Percent
1	Education	28.2%
2	Legal	19.7%
3	Healthcare	16.9%
4	Work	15.5%
5	Interpretation	9.9%

2009-2011: Top Five Most Urgent Needs

Rank	Need	Percent
1	Education	32.3%
2	Work	22.6%
3	Legal	14.5%
4	Healthcare	11.3%
5	Financial	6.5%

2012-2014: Top Five Most Urgent Needs

Rank	Need	Percent
1	Education	39.7%
2	Work	17.2%
3	Legal	15.5%
4	Healthcare	12.1%
5	Housing	5.2%

2015-2017: Top Five Most Urgent Needs

Rank	Need	Percent
1	Education	34.7%
2	Legal	26.5%
3	Healthcare	13.3%
4	Work	12.2%
5	Housing	7.1%

Social Determinants of Health

Just under 50% of refugees from Somalia did not graduate high school.

Approximately 3% of refugees from Somalia own a house they call home.

96.7% of refugees from Somalia earned less than $35,000 annually.

Just over half of Somali refugees did not speak English at home.

How do social indicators affect health?

The conditions where individuals live, work and learn can have a large and lasting effect on health. For example, poverty can limit an individual's access to healthy food options, and education and stable housing have long been linked to better health. Understanding these social determinants of health and how they affect certain populations is important to improving health outcomes for all groups.

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Social Determinants of Health

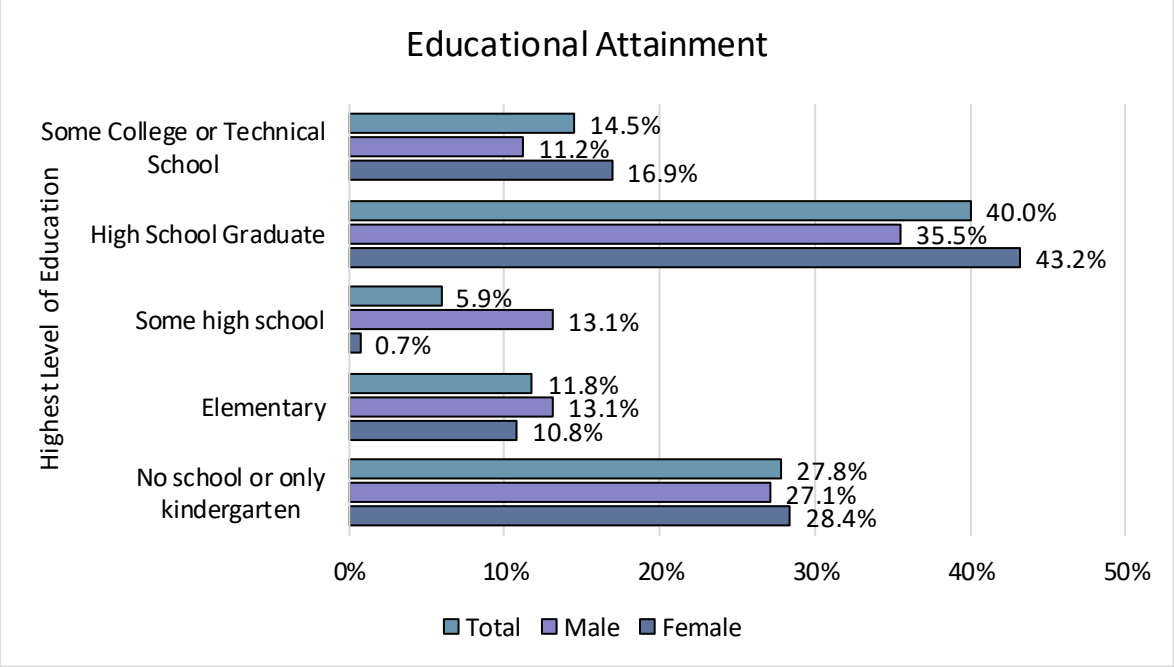
Educational Attainment

Education has long been positively associated with health. Individuals with higher educational attainment live longer and are generally healthier than are those with fewer years of schooling.[14]

The chart below represents the educational attainment of refugees from Somalia.

Key Findings by Gender

- Approximately 28% of refugees from Somalia had never attended school or only attended kindergarten and approximately 12% had only attended elementary school.
- Two-fifths of refugees from Somalia (40.0%) reported having graduated high school and an additional 14.5% reported having some college or technical school.
- Female refugees (43.2%) were more likely than male refugees (35.5%) to be high school graduates.



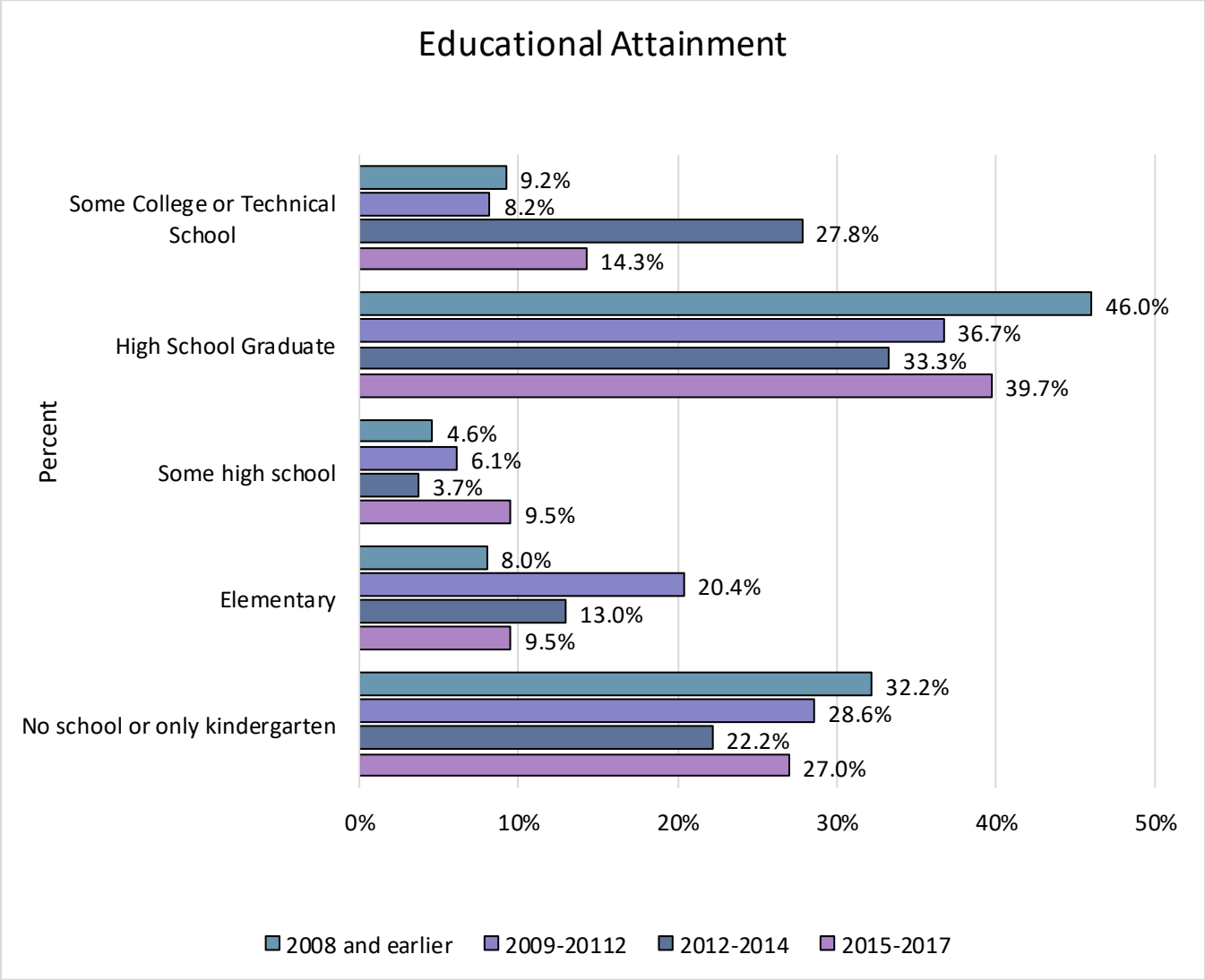
[14] Zajacova, A., & Lawrence, E. M. (2018). The Relationship Between Education and Health: Reducing Disparities Through a Contextual Approach. Annual review of public health, 39, 273–289. https://doi.org/10.1146/annurev-publhealth-031816-044628

Educational Attainment

The chart below represents the educational attainment of refugees from Somalia

Key Findings by Year of Arrival

- Refugees who arrived in 2008 and earlier (46.0%) were the most likely arrival group to be high school graduates, while those who arrived in 2012-2014 (27.8%) were the most likely arrival group to have completed some college or technical school.
- Refugees who arrived in 2008 and earlier (32.2%) were the most likely arrival group to have never attended school or to only have attended kindergarten. Refugees who arrived in 2012-2014 (22.2%) were the least likely to report the same.



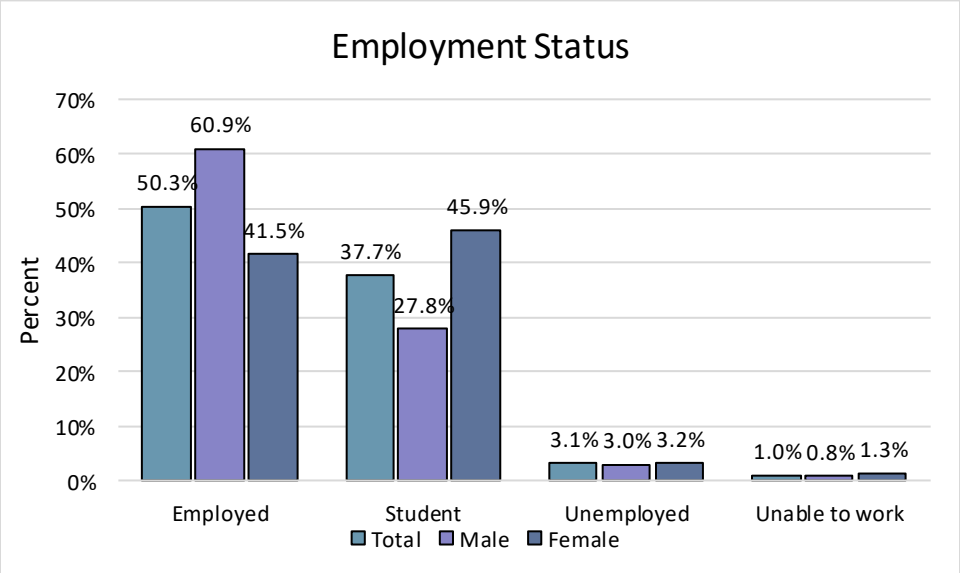
Employment Status

A secure job that pays well makes affording health care and maintaining a healthy lifestyle easier. In contrast, unemployed individuals are more likely to lack funds for health services and to be diagnosed with depression or develop a stress-related condition.[15]

The chart below represents the employment status of refugees from Somalia.

Key Findings of Gender

- Approximately half (50.3%) of refugees from Somalia reported being currently employed. Male refugees (60.9%) were 1.5 times more likely than female refugees (41.5%) to report being currently employed.
- Approximately 46% of female refugees surveyed were students, compared to approximately 28% of male refugees.
- Approximately 3% of refugees from Somalia were unemployed and approximately 1% were unable to work.



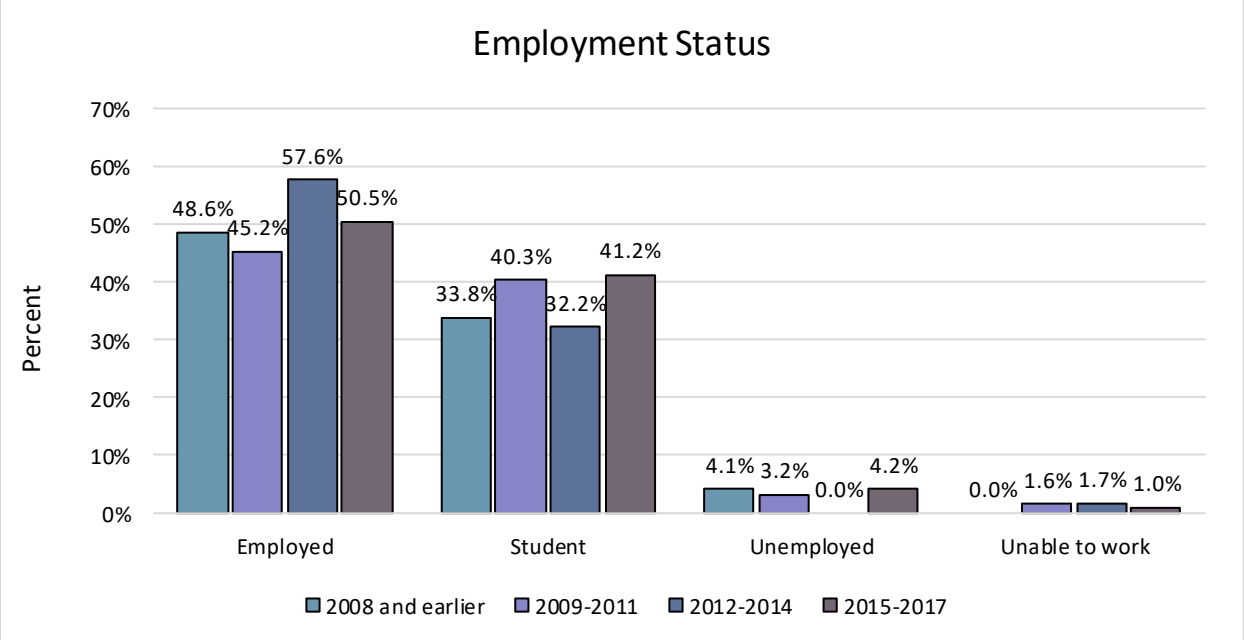
[15] Jin, R.L., Shah, C.P., & Svoboda, T.J. (1995). The impact of unemployment on health: a review of the evidence. *Canadian Medical Association Journal, (153)*5, 529-540.

Employment Status

The chart below represents the employment status of refugees from Somalia.

Key Findings by Year of Arrival

- Refugees who arrived in 2012-2014 (57.6%) were the most likely arrival group to report being currently employed. Refugees who arrived in 2009-2011 (45.2%) were the least likely arrival group to report the same.
- Approximately two-fifths of refugees arrived in both 2009-2011 and in 2015-2017 were students, compared to approximately one-third of refugees arrived in 2008 and earlier and in 2012-2014.
- Refugees arrived in 2008 and earlier (4.1%) and in 2015-2017 (4.2%) were the most likely arrival groups to report being unemployed.



Household Income

The link between income and health is complex, but it is clear that higher income is positively correlated with lower rates of death and disease.[16] Those with higher incomes are often more likely to live in better areas and to be able to purchase healthier groceries, while those with lower incomes are often faced with limited funds to spend on health care needs.

The table below represents the household income of refugees from Somalia.

Key Findings by Gender

- The majority of refugees surveyed (61.4%) reported an annual household income of $20,000-$25,000. Female refugees (73.3%) were 1.6 times more likely than male refugees (46.3%) to report this level of income.
- Male refugees (32.6%) were 2.6 times more likely than female refugees (12.5%) to report the next highest level of household income of $25,000-$35,000.

Annual Income	Total	Male	Female
Less than $10,000	2.3%	2.1%	2.5%
$10,000 to $15,000	4.7%	6.3%	3.3%
$15,000 to $20,000	6.5%	6.3%	6.7%
$20,000 to $25,000	61.4%	46.3%	73.3%
$25,000-35,000	21.4%	32.6%	12.5%
$35,000-$50,000	3.3%	5.3%	1.7%

[16] National Center for Health Statistics. (2012). Health, United States, 2011: with special feature on socioeconomic status and health. Retrieved from www.cdc.gov/nchs/data/hus/hus11.pdf

Household Income

The table below represents the household income of refugees from Somalia.

Key Findings by Year of Arrival

- Approximately 5.2% of refugees who arrived in 2008 and earlier reported a household income of less than $10,000, compared to 3% of refugees who arrived in 2015-2017.
- Approximately one out of every ten refugees who arrived in 2015-2017 reported a household income of $10,000 to $15,000.
- Just under one-fourth (24.1%) of refugees who arrived in 2008 and earlier had an annual income of $25,000 to $35,000, compared to 13.4% of refugees who arrived in 2015-2017.

Annual Income	2008 and earlier	2009-2011	2012-2014	2015-2017
Less than $10,000	5.2%	0.0%	0.0%	3.0%
$10,000 to $15,000	1.7%	2.2%	4.4%	10.4%
$15,000 to $20,000	5.2%	6.5%	8.9%	6.0%
$20,000 to $25,000	51.7%	71.7%	51.1%	67.2%
$25,000-35,000	24.1%	17.4%	35.6%	13.4%
$35,000-$50,000	10.3%	2.2%	0.0%	0.0%
$75,000 or more	1.7%	0.0%	0.0%	0.0%

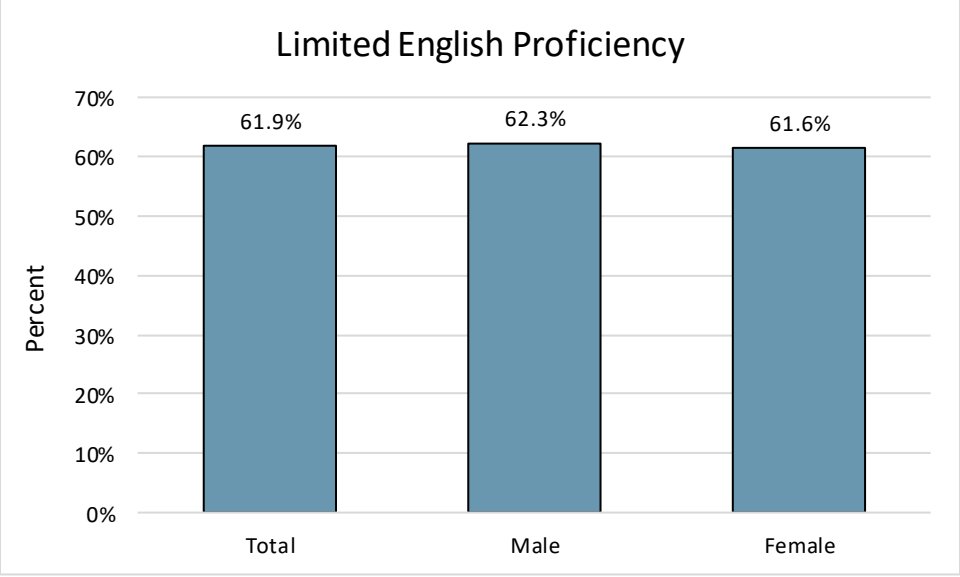
Limited English Proficiency

In Nebraska, English language knowledge is often essential in navigating the health care system. Research has shown that those with limited English proficiency are more likely to have difficulty understanding medical situations, more likely to have more trouble understanding labels, and more likely to have adverse reactions to medications.[17]

The chart below represents the proportion of refugees with limited English proficiency. Refugees considered to have limited English proficiency are those who reported speaking English "not well" or "not at all".

Key Findings by Gender

- Approximately 62% of refugees from Somalia reported limited English proficiency.
- Male refugees (62.3%) were slightly more likely than female refugees (61.6%) to report limited English proficiency.



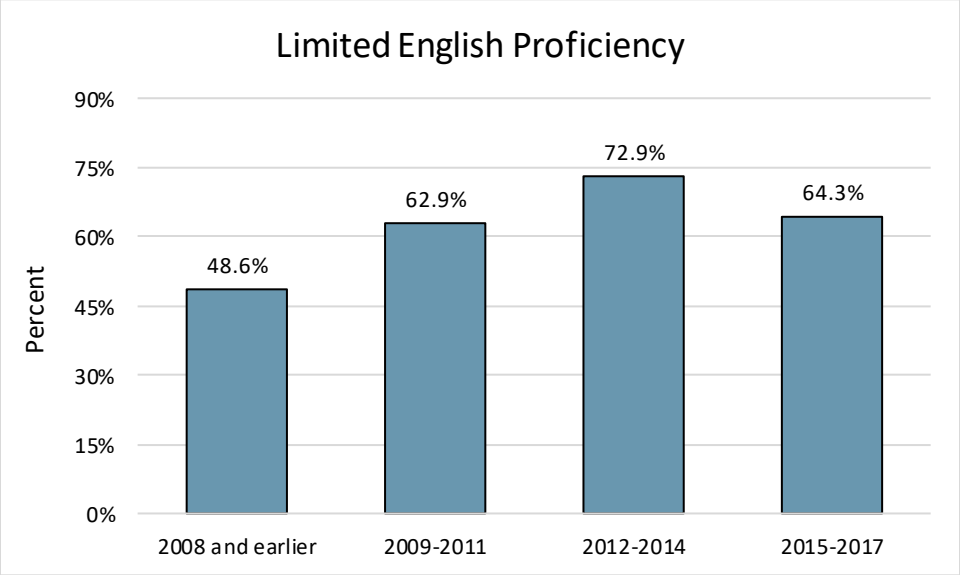
[17] Wilson, E., Chen, A.H., Grumbach, K., Wang, F., & Fernandez, A. (2005). Effects of limited English proficiency and physician language on health care comprehension. *Journal of General Internal Medicine, 20*, 800–806.

Limited English Proficiency

The chart below represents the proportion of refugees with limited English proficiency. Refugees considered to have limited English proficiency are those who reported speaking English "not well" or "not at all".

Key Findings by Year of Arrival

- Refugees who arrived in 2015-2017 (64.3%) were 1.3 times more likely than refugees who arrived in 2008 and earlier (48.6%) to report limited English proficiency.
- Refugees who arrived in 2012-2014 (72.9%) were most likely to report limited English proficiency.



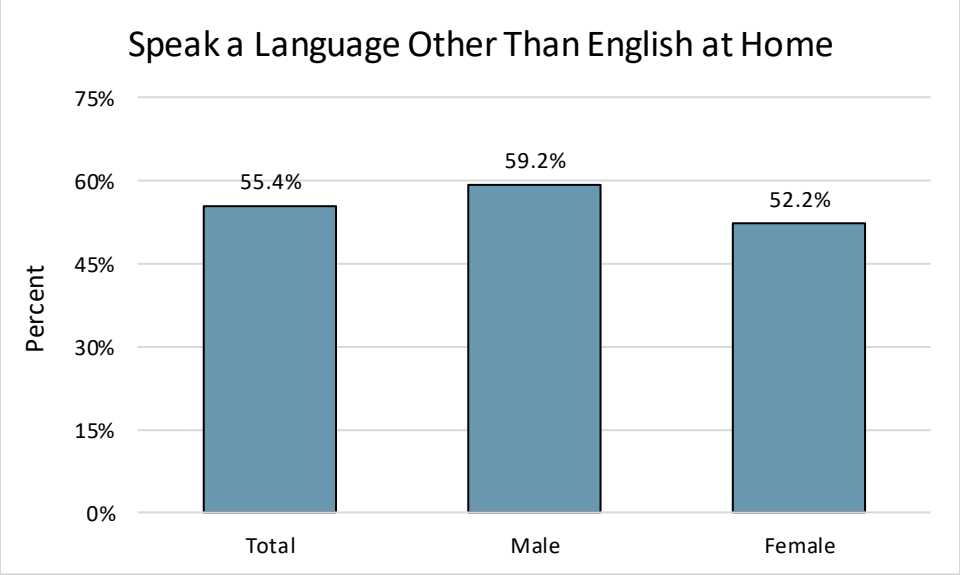
English Not Spoken At Home

Language spoken at home can be a useful indicator when evaluating health care needs. While this indicator is not an accurate measure of English proficiency, research has shown that children and adults from non-English primary language homes report lower health outcomes in several areas.[18]

The chart below represents the percentage of refugees from Somalia who reported speaking a language other than English at home.

Key Findings by Gender

- Over half of refugees from Somalia reported speaking a language other than English at home.
- Male refugees (59.2%) were more likely than female refugees (52.2%) to speak a language other than English at home.



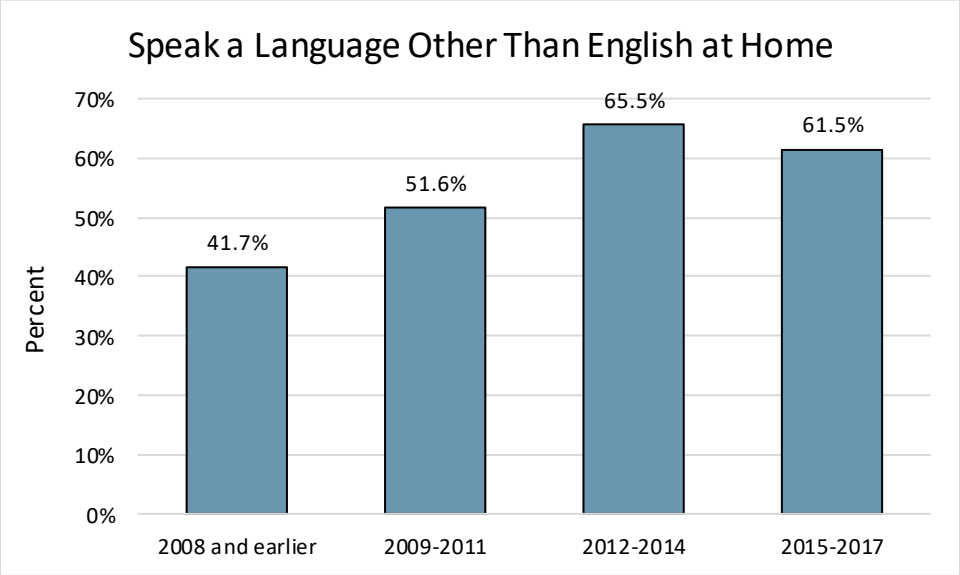
[18] Lau, M., Lin, H., & Flores, G. (2012). Primary language spoken at home and disparities in the health and healthcare of US adolescents. *Diversity and Equality in Healthcare, 9, 267-80.*

English Not Spoken At Home

The chart below represents the percentage of refugees from Somalia who reported speaking a language other than English at home.

Key Findings by Year of Arrival

- Refugees who arrived in 2015-2017 (61.5%) were 1.5 more likely than were refugees who arrived in 2008 and earlier (41.7%) to report speaking a language other than English at home.
- Refugees arrived in 2012-2014 (65.5%) were most likely to report speaking a language other than English at home.



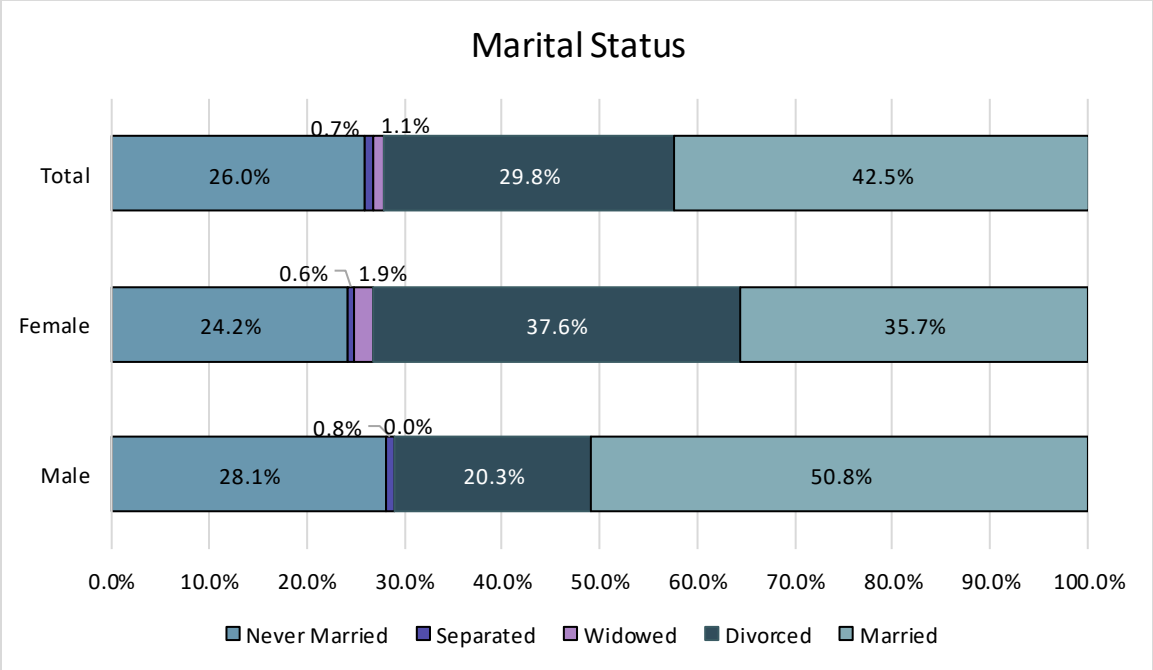
Marital Status

Marital status and changes in marital status can have implications for an individual's health. Evidence has shown that, in general, married individuals are in better health and have lower mortality risks than those who are single. Additionally, children of married parents tend to be healthier.[19]

The table below represents the marital status of refugees from Somalia.

Key Findings by Gender

- Approximately 43% of refugees from Somalia were married. Male refugees (50.8%) were more likely than female refugees (35.7%) to report being married.
- Approximately 30% of refugees from Somalia were divorced. Female refugees (37.6%) were 1.9 times more likely than male refugees (20.3%) to be divorced.
- Approximately a quarter of refugees from Somalia (26.0%) had never been married.



[19] Gallagher, M. & Waite, L. (2000) The case for marriage: why married people are happier, healthier, and better off financially. New York, NY: Broadway Books.

Marital Status

The table below represents the marital status of refugees from Somalia.

Key Findings by Year of Arrival

- Half of refugees who arrived in 2015-2017 were married, compared to approximately two-fifths of refugees who arrived in 2008 and earlier (38.9%).
- Approximately 27% of refugees who arrived in 2008 and earlier had never been married, compared to approximately 19% of refugees who arrived in 2015-2017.
- Approximately three out of every ten refugees who arrived in 2008 and earlier (31.6%) and in 2012-2014 (31.1%) had been divorced.

Marital Status	2008 and earlier	2009-2011	2012-2014	2015-2017
Married	38.9%	46.4%	37.7%	50.0%
Divorced	31.6%	28.6%	31.1%	27.8%
Widowed	2.1%	0.0%	0.0%	1.4%
Separated	0.0%	1.8%	0.0%	1.4%
Never Married	27.4%	23.2%	31.1%	19.4%

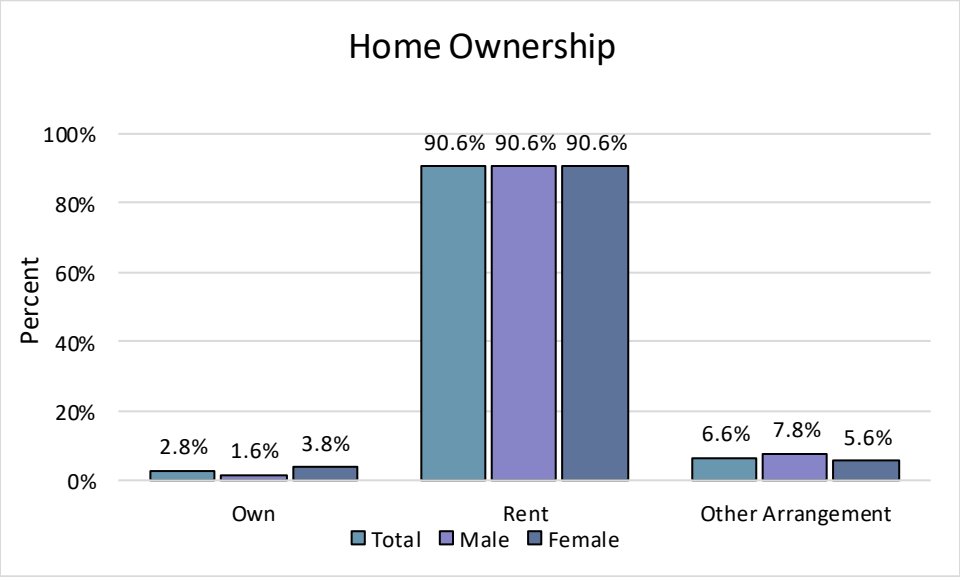
Home Ownership

Homeownership has been positively linked to physical and mental health. Studies have also found that the children of homeowners are more likely to perform better at school and have fewer behavioral problems.[20]

The table below represents the proportion of refugees from Somalia who own or rent their homes.

Key Findings by Gender

- Approximately 91% of refugees from Somalia reported renting their home.
- Approximately 3% of refugees from Somalia (2.8%) reported owning their home.
- Female refugees (3.8%) were 2.4 times more likely than male refugees (1.6%) to report owning their home.



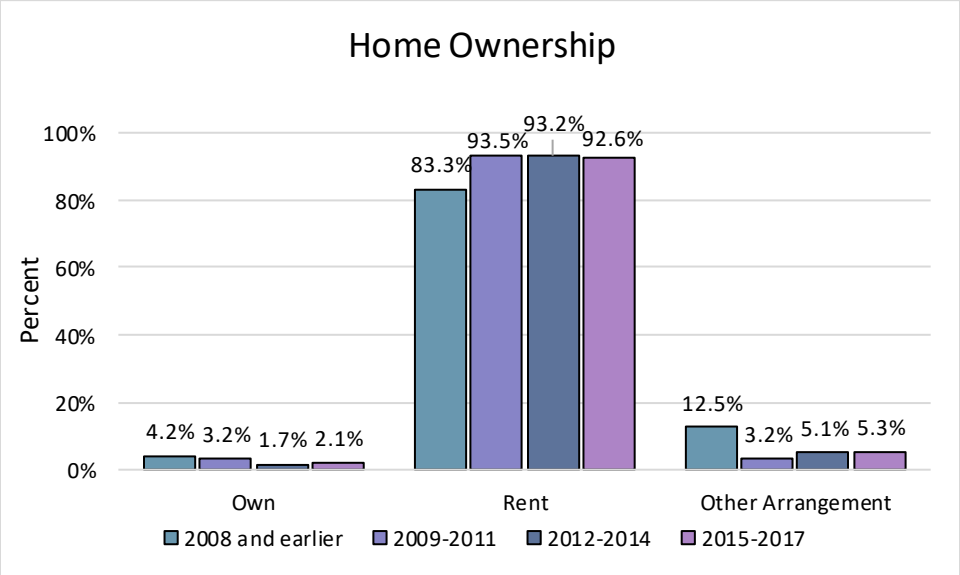
[20] Dietz, R. (2003). *The social consequences of homeownership.* Columbus, OH: Homeownership Alliance.

Home Ownership

The table below represents the proportion of refugees from Somalia who own or rent their homes.

Key Findings by Year of Arrival

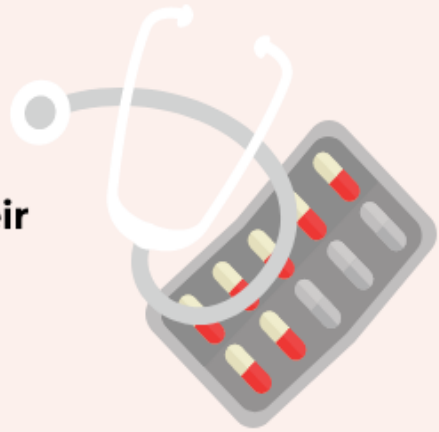
- Refugees who arrived in 2008 and earlier (4.2%) were two times more likely than refugees who arrived in 2015-2017 (2.1%) to own their home.
- Refugees who arrived in 2008 and earlier (83.3%) were the least likely arrival group to rent their home.



Health Status

Almost 2% of refugees from Somalia had poor physical health on at least 14 days in the past month.

Over 25% of Somali refugees perceived their health status as fair or poor.



Activity Limitations

Male refugees were more likely to experience activity limitations due to poor physical or mental health compared to female refugees.

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Health Status

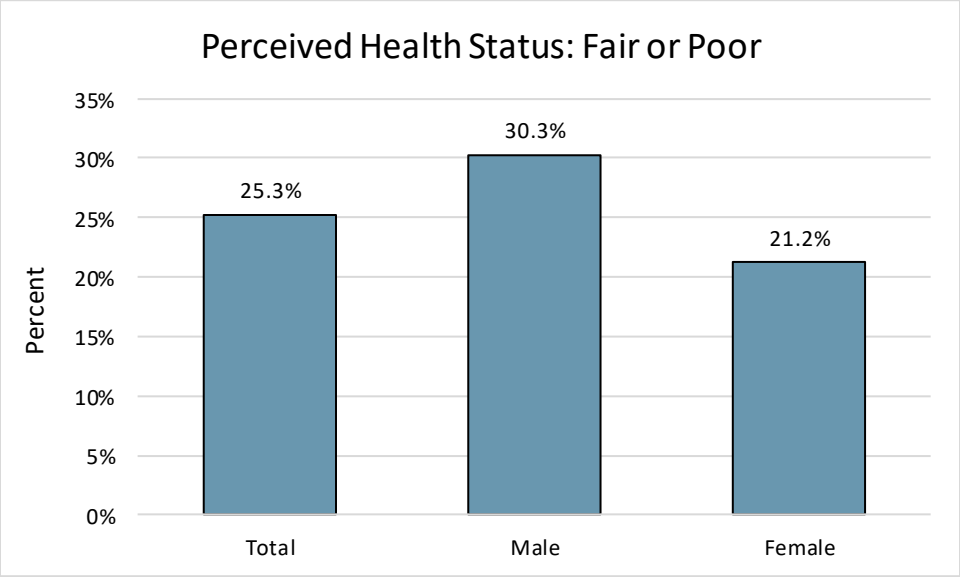
Perceived Health Status

Perceived health status measures how an individual views his or her health – excellent, very good, good, fair, or poor. Individuals who are poor or uninsured are more likely to report being in fair or poor health and have higher rates of hospitalization and mortality compared to those who report excellent or good health.[21]

The chart below represents the proportion of refugees from Somalia who considered their health to be fair or poor.

Key Findings by Gender

- Approximately one-fourth of refugees from Somalia (25.3%) reported their health status as fair or poor.
- Male refugees (30.3%) were 1.4 times more likely than female refugees (21.2%) to report their health status as fair or poor.



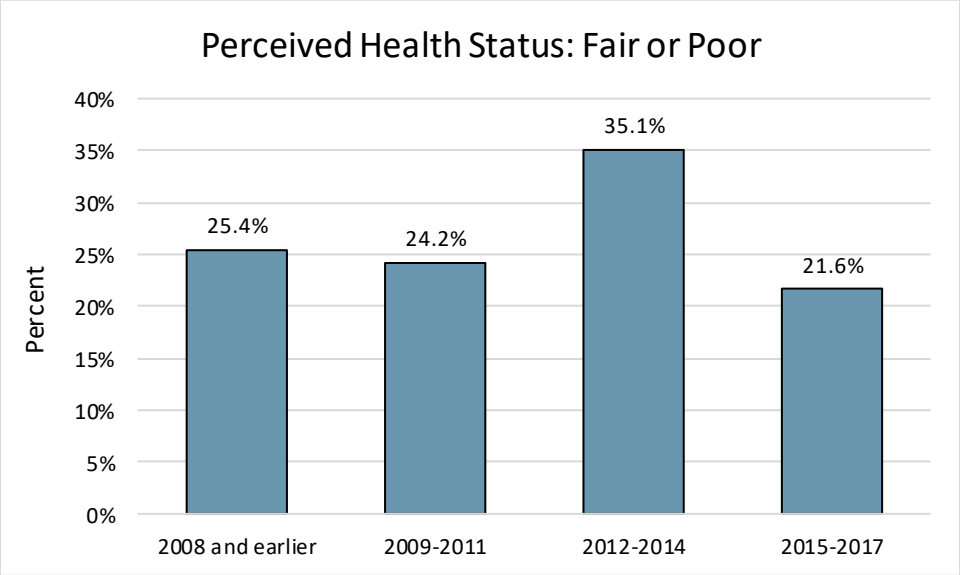
[21] United States Office of Disease Prevention and Health Promotion. (2016). General health status. Retrieved from www.healthypeople.gov/2020/about/foundation-health-measures/General-Health-Status

Perceived Health Status

The chart below represents the proportion of refugees from Somalia who considered their health to be fair or poor.

Key Findings by Year of Arrival

- Refugees who arrived in 2008 and earlier (25.4%) were more likely than refugees who arrived in 2015-2017 (21.6%) to report their health status as fair or poor.
- Refugees who arrived in 2012-2014 (35.1%) were most likely to report their health status as fair or poor.

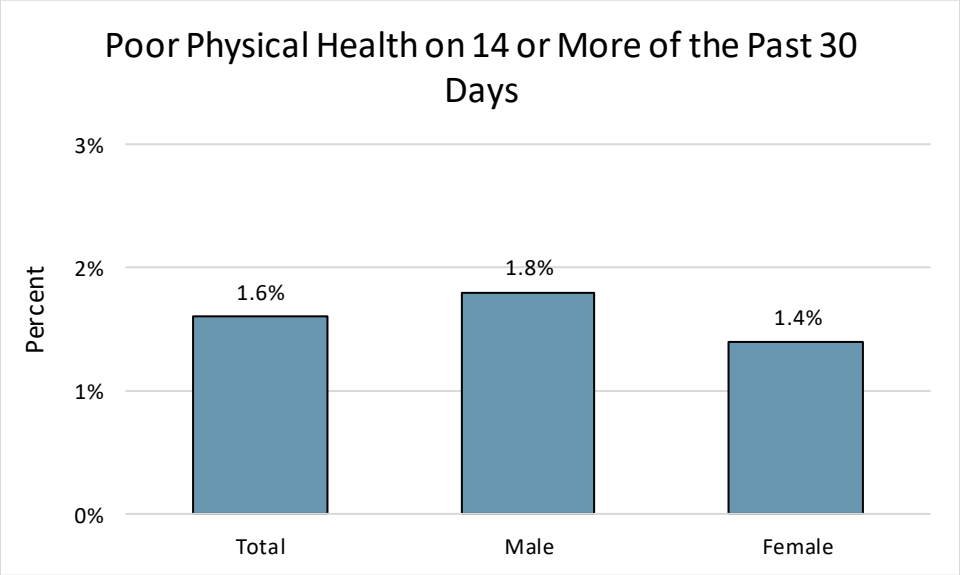


Poor Physical Health

The chart below represents the proportion of refugees who considered their physical health to be poor on 14 or more of the past 30 days.

Key Findings by Gender

- Just under 2% of refugees from Somalia (1.6%) reported being in poor physical health on 14 or more of the past 30 days.
- Male refugees (1.8%) were only slightly more likely than female refugees (1.4%) to report being in poor physical health on 14 or more of the past 30 days.

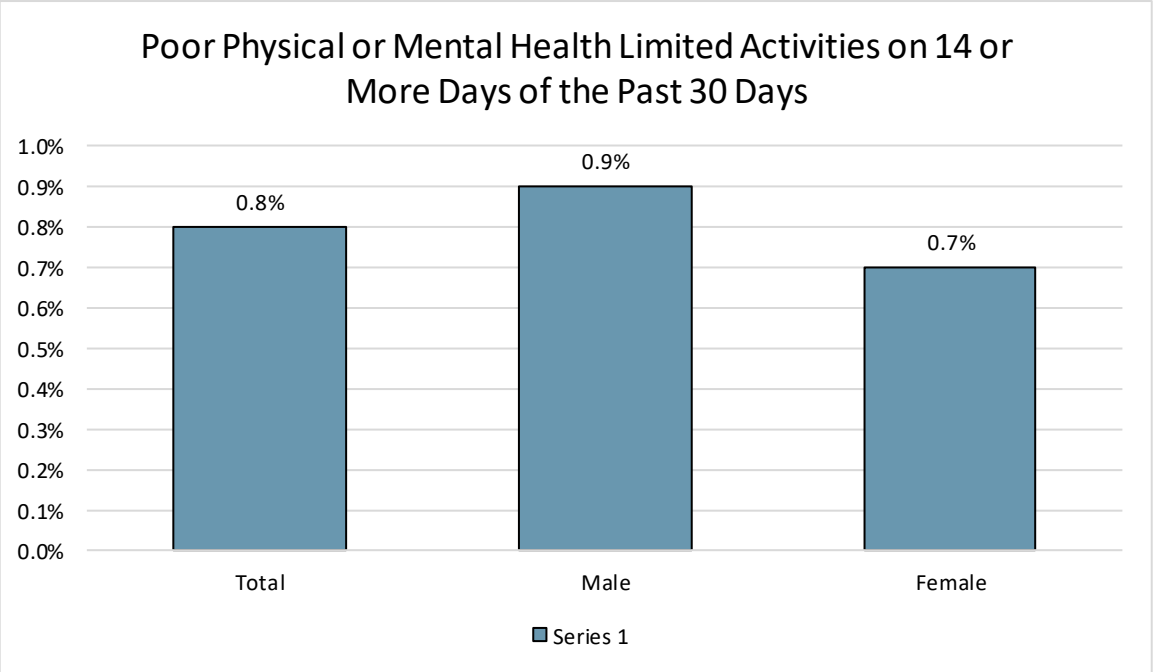


Activity Limitations

The chart below represents the proportion of refugees who reported that poor physical or mental health limited their activity on 14 or more of the past 30 days.

Key Findings by Gender

- Just under 1% of refugees from Somalia (0.8%) reported that poor physical or mental health limited their usual activities on 14 or more of the past 30 days.
- Similar percentages of male (0.9%) and female (0.7%) refugees reported that poor physical or mental health limited their usual activities on 14 or more of the past 30 days.



Access to Health Care

Health Care Coverage

Approximately three-fourths of refugees from Somalia reported not having health care coverage.

73.5%

Male refugees (30%) were more likely than female refugees (24%) to report not having health care coverage.

Personal Physician

Approximately 46% of refugees from Somalia reported not having a personal physician.

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Access to Health Care

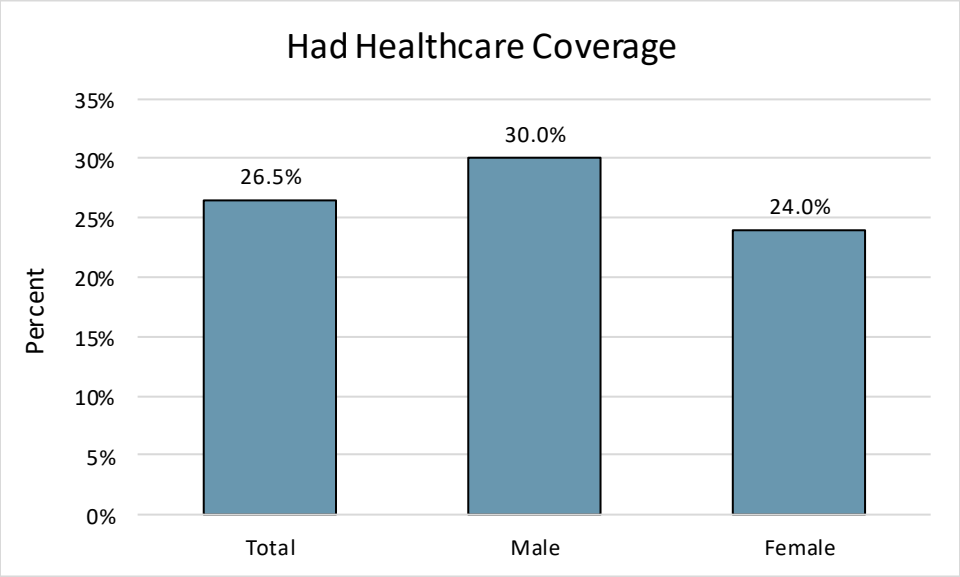
Healthcare Coverage

Lack of a health care plan or inadequate insurance coverage prevents many individuals from receiving needed care, as they are financially unable to pay for services without the help of insurance. Individuals with health insurance are generally more likely to have a primary care provider and to have received appropriate preventative care, such as early prenatal care, immunizations, or health screenings.

The chart below represents the proportion of refugees from Somalia who reported having health care coverage.

Key Findings by Gender

- Only approximately one-fourth of refugees from Somalia (26.5%) reported having healthcare coverage.
- Male refugees (30.0%) were 1.3 times more likely than female refugees (24.0%) to report having health care coverage.

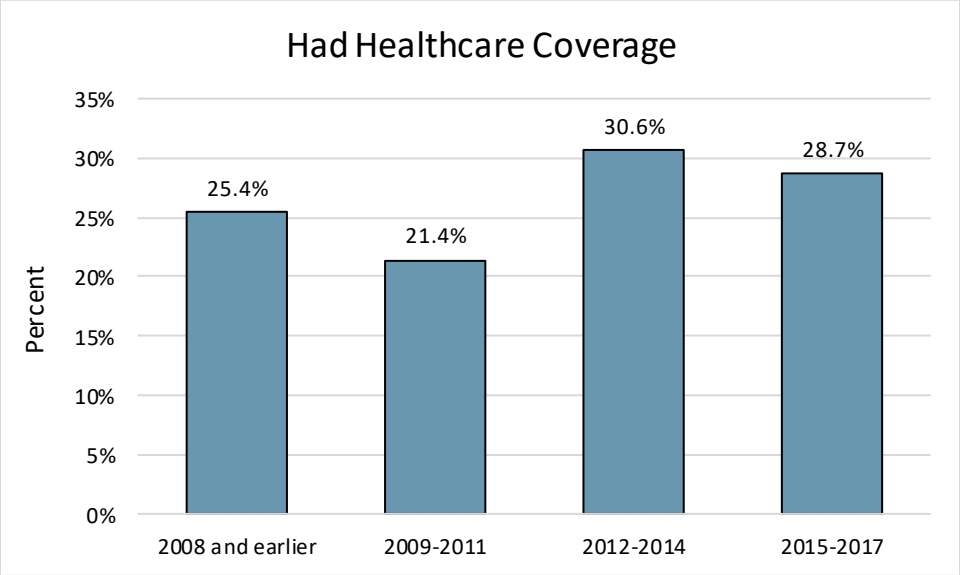


Healthcare Coverage

The chart below represents the proportion of refugees from Somalia who reported having health care coverage.

Key Findings by Year of Arrival

- Refugees who arrived in 2009-2011 (21.4%) were least likely to report having health care coverage, followed by refugees who arrived in 2008 and earlier (25.4%).
- Refugees who arrived in 2012-2014 (30.6%) were most likely to report having health care coverage, followed by refugees who arrived in 2015-2017 (28.7%).



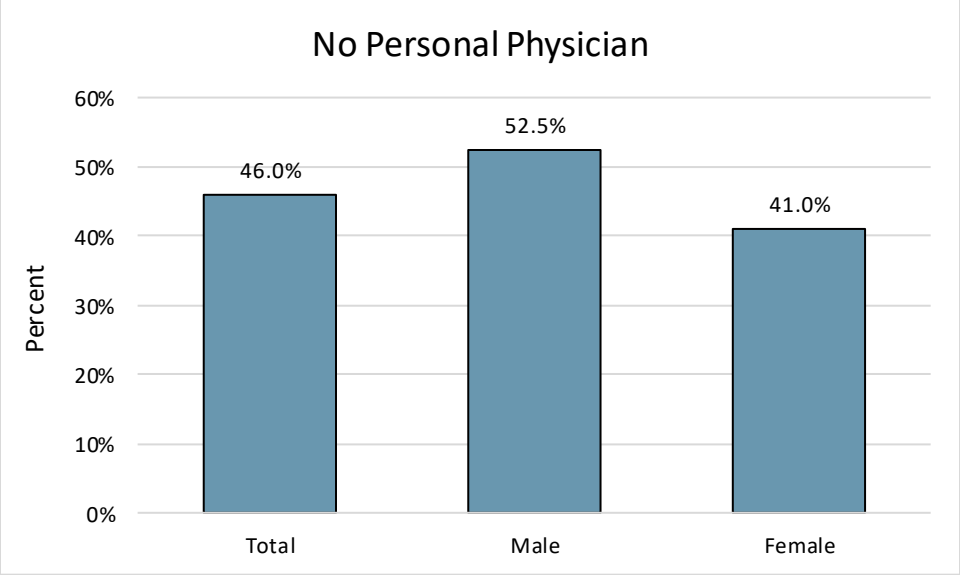
No Personal Physician

Including various specialties in the medical profession, primary care physicians provide a combination of direct care and, as necessary, counsel the patient in the appropriate use of specialists and advanced treatment locations.

The chart below represents the proportion of refugees who reported not having a personal physician.

Key Findings by Gender

- Under half of refugees from Somalia (46.0%) reported not having a personal physician.
- Male refugees (52.5%) were 1.3 times more likely than female refugees (41.0%) to report not having a personal physician.

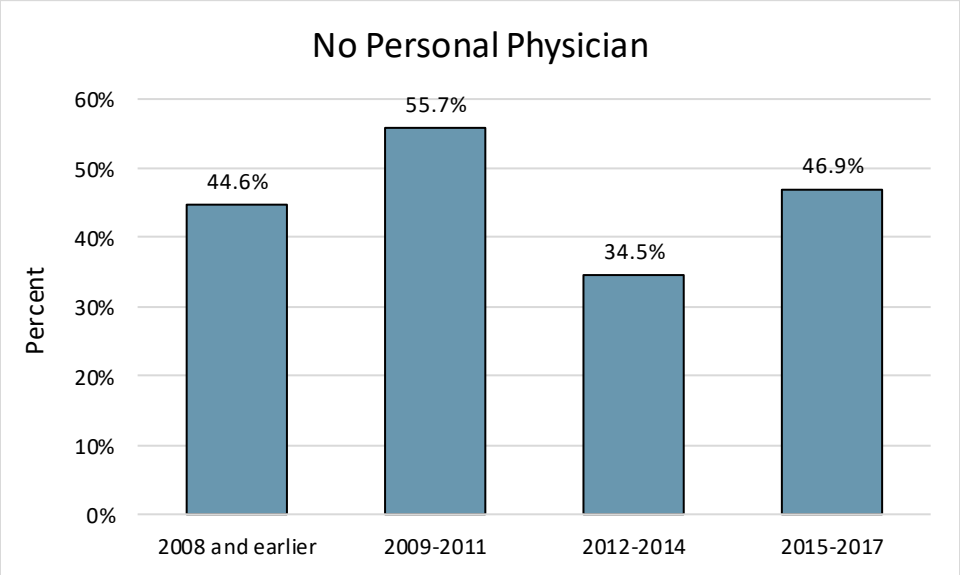


No Personal Physician

The chart below represents the proportion of refugees who reported not having a personal physician.

Key Findings by Year of Arrival

- Refugees arriving in 2009-2011 (55.7%) were the most likely arrival group to report having no personal physician, followed by refugees arriving in 2015-2017 (46.9%).
- Just over one-third of refugees arriving in 2012-2014 (34.5%) reported having no personal physician.



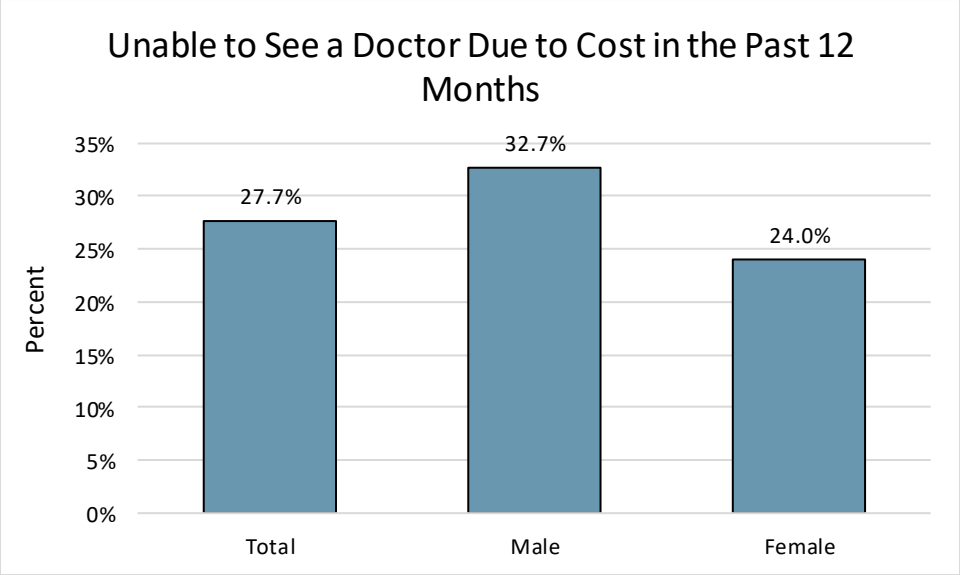
Unable to See a Doctor Due to Cost

For people with no insurance and limited financial resources, the decision of whether or not to see a doctor is often a financial choice rather than a medical one. Even when health benefits are available, they may not be sufficient to ensure access to needed health care services. Persons with health insurance may still be confronted with significant financial hardships in paying for or obtaining health services or products.

The chart below represents the proportion of refugees who reported being unable to see a doctor due to cost in the past 12 months.

Key Findings by Gender

- Approximately 28% of refugees from Somalia (27.7%) reported being unable to see a doctor due to cost in the past 12 months.
- Male refugees (32.7%) were 1.4 times more likely than female refugees (24.0%) to report being unable to see a doctor due to cost in the past 12 months.

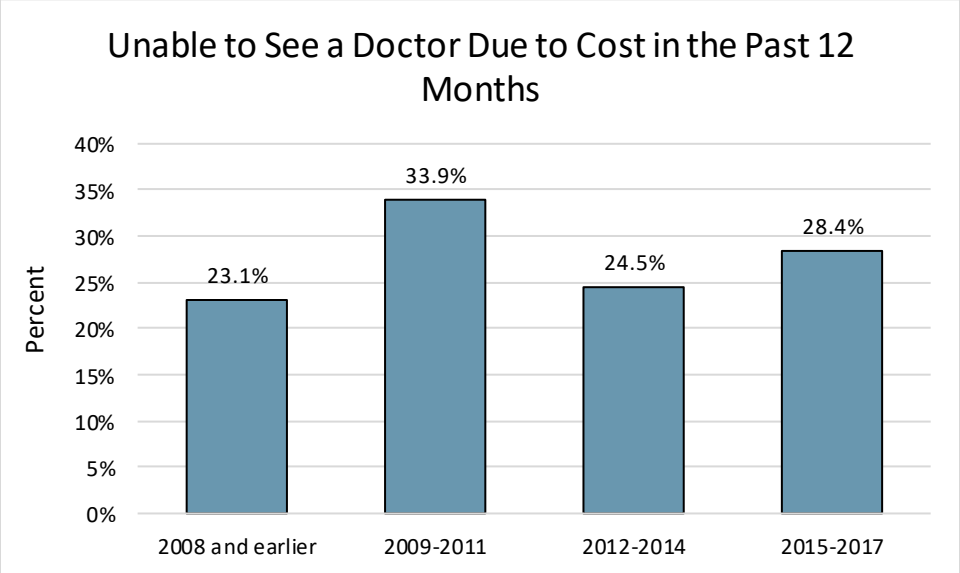


Unable to See a Doctor Due to Cost

The chart below represents the proportion of refugees who reported being unable to see a doctor due to cost in the past 12 months.

Key Findings by Year of Arrival

- Refugees who arrived in 2009-2011 (33.9%) were most likely to report being unable to see a doctor due to cost in the past 12 months.
- Refugees who arrived in 2008 and earlier (23.1%) were least likely to report being unable to see a doctor due to cost in the past 12 months, followed by refugees who arrived in 2012-2014 (24.5%).



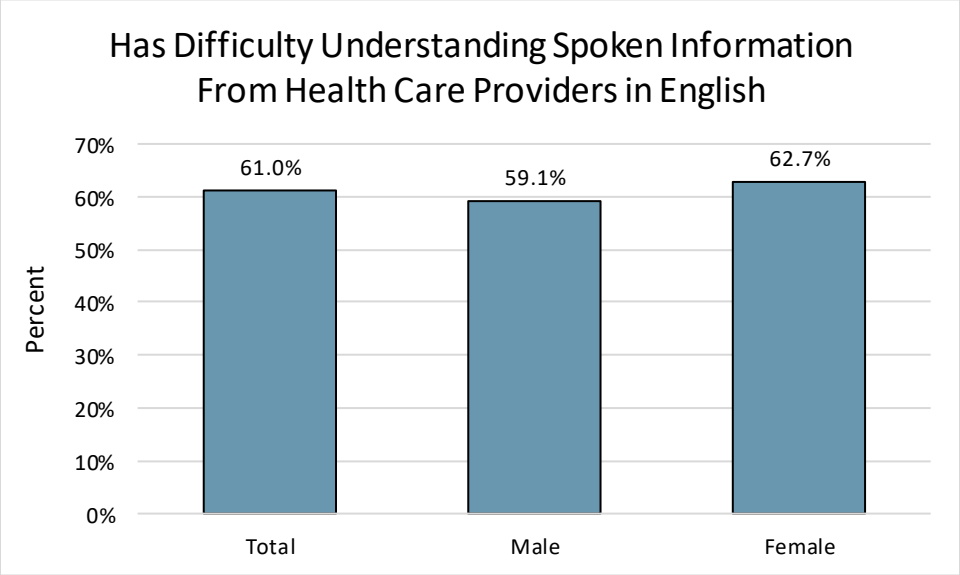
Understanding Health Information

Health literacy is defined as "the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions."[22] Having the ability to understand health information spoken in English is essential to receiving necessary and adequate health services in Nebraska.

The chart below represents the proportion of refugees who reported that it was difficult or very difficult to understand health information spoken in English.

Key Findings by Gender

- Overall, 61% of refugees from Somalia reported having difficulty understanding information from health care providers spoken in English.
- Female refugees (62.7%) were more likely than male refugees (59.1%) to report having difficulty understanding information from health care providers spoken in English.



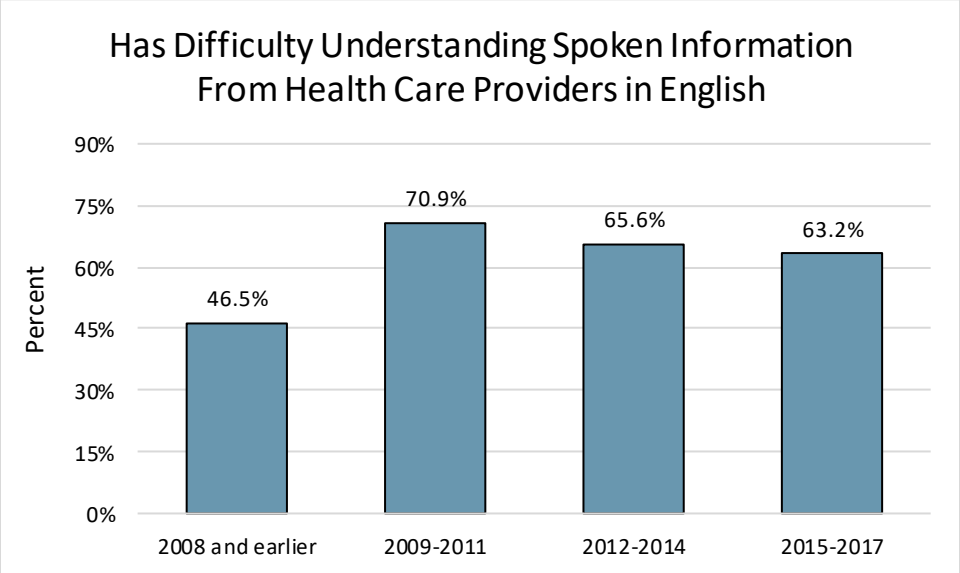
[22] Title V of the Patient Protection and Affordable Care Act, 42 U.S.C. § 5002 (2010).

Understanding Health Information

The chart below represents the proportion of refugees who reported that it was difficult or very difficult to understand health information spoken in English.

Key Findings by Year of Arrival

- Refugees who arrived in 2015-2017 (63.2%) were 1.4 times more likely than refugees who arrived in 2008 and earlier (46.5%) to report having difficulty understanding information from health care providers spoken in English.
- Refugees who arrived in 2009-2011 (70.9%) were most likely to report having difficulty understanding information from health care providers spoken in English.

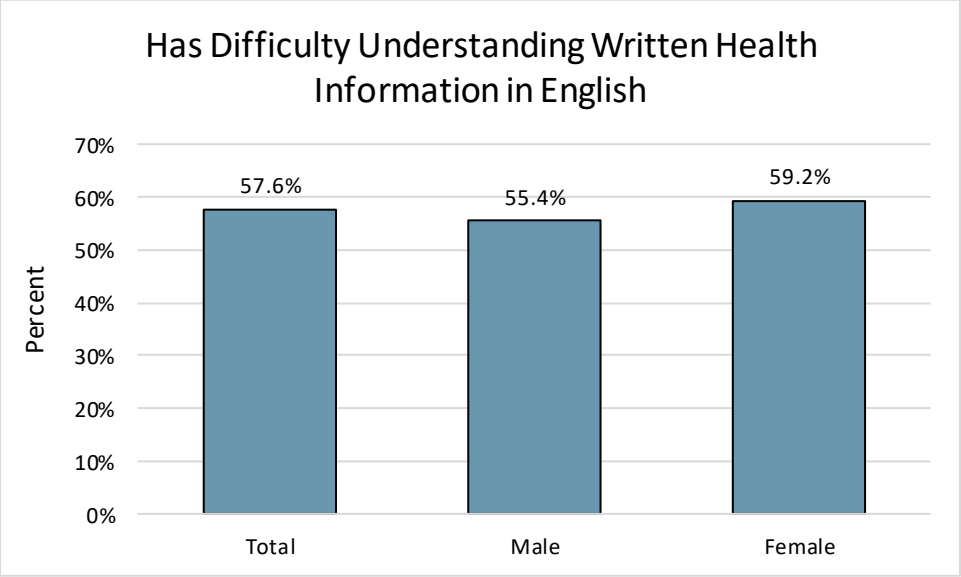


Understanding Written Health Information

The chart below represents the proportion of refugees who reported that it was difficult or very difficult to understand health information written in English.

Key Findings by Gender

- Approximately 58% of refugees from Somalia reported having difficulty understanding health information written in English.
- Female refugees (59.2%) were more likely than male refugees (55.4%) to report having difficulty understanding health information written in English.

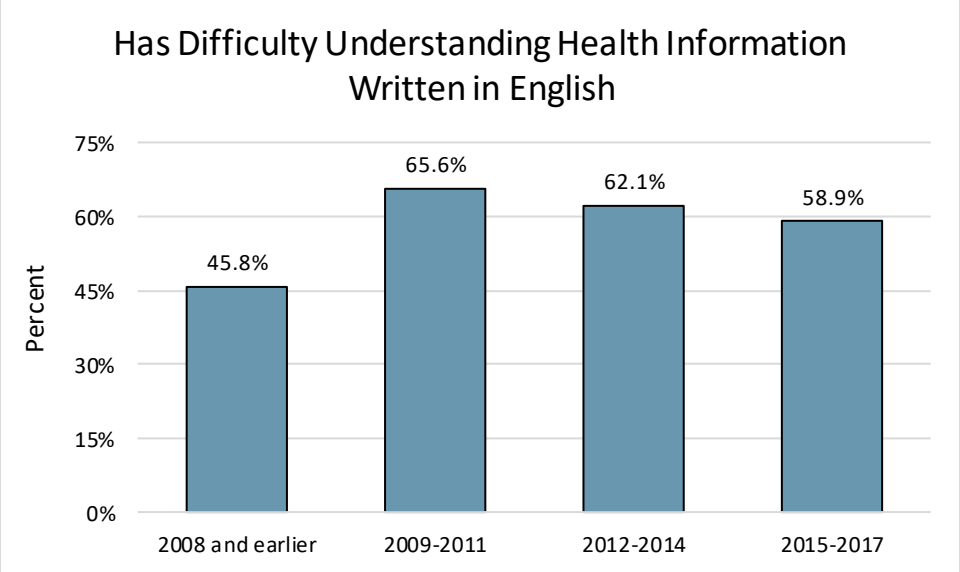


Understanding Written Health Information

The chart below represents the proportion of refugees who reported that it was difficult or very difficult to understand health information written in English.

Key Findings by Year of Arrival

- Refugees who arrived in 2015-2017 (58.9%) were 1.3 times more likely than refugees who arrived in 2008 and earlier (45.8%) to report having difficulty understanding health information written in English.
- Refugees who arrived in 2009-2011 (65.6%) were most likely to report having difficulty understanding health information written in English, followed by refugees who arrived in 2012-2014 (62.1%).

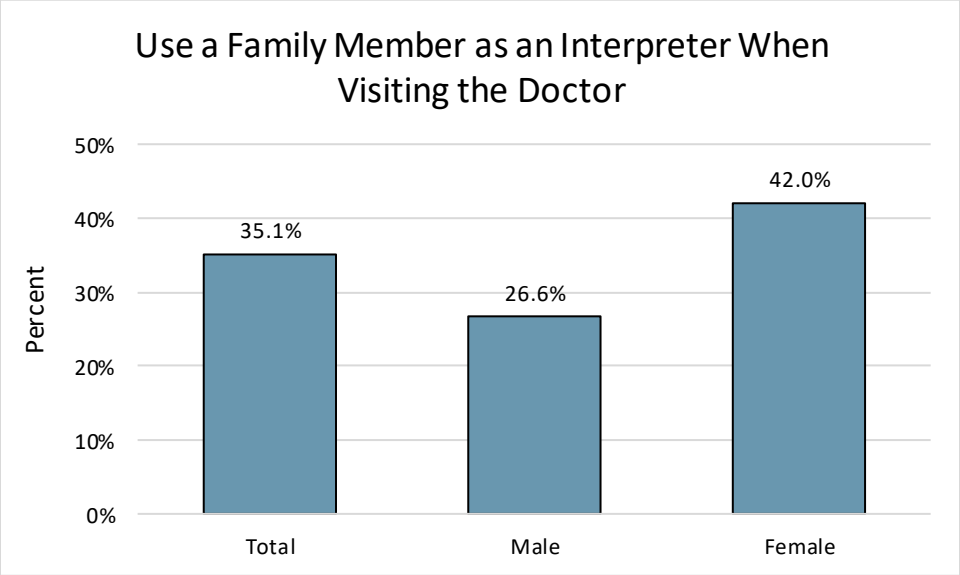


Family Member as Interpreter

The chart below represents the proportion of refugees who reported using as a family member as an interpreter when visiting the doctor.

Key Findings by Gender

- Approximately 35% of refugees from Somalia reported using a family member as an interpreter when visiting the doctor.
- Female refugees (42.0%) were 1.6 times more likely than male refugees (26.6%) to report using a family member as an interpreter when visiting the doctor.

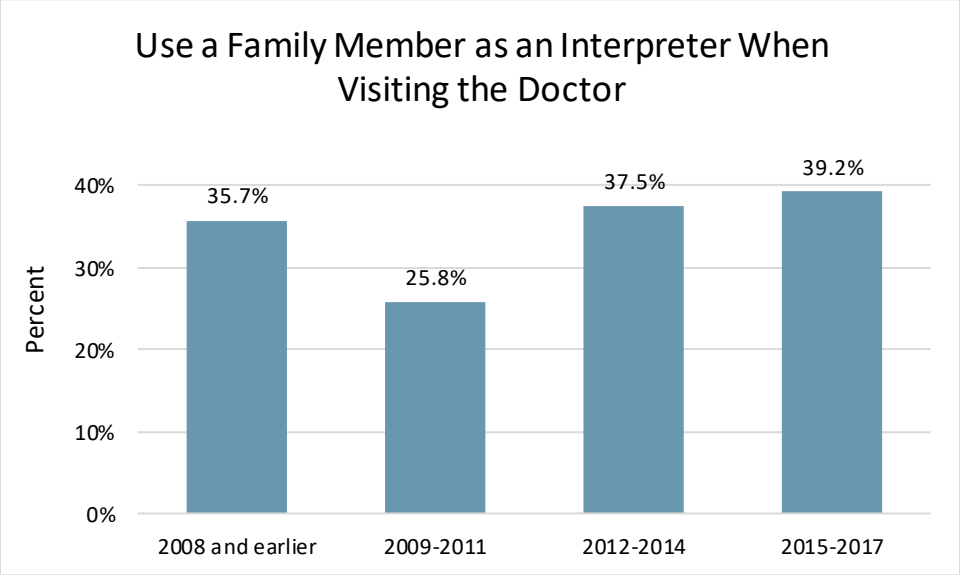


Family Member as Interpreter

The chart below represents the proportion of refugees who reported using as a family member as an interpreter when visiting the doctor.

Key Findings by Year of Arrival

- Refugees who arrived in 2015-2017 (39.2%) were most likely to report using a family member as an interpreter when visiting the doctor, followed by who refugees arrived in 2012-2014 (37.5%).
- Refugees who arrived in 2009-2011 (25.8%) were least likely to report using a family member as an interpreter when visiting the doctor.

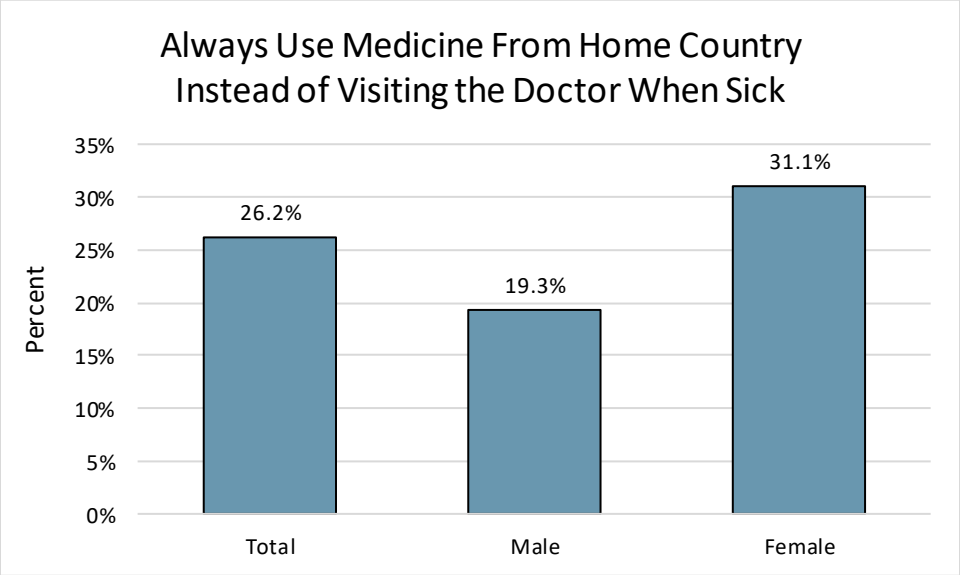


Use Medicine From Home Country

The chart below represents the proportion of refugees who reported always using medicine from their home country instead of visiting the doctor when sick.

Key Findings by Gender

- Over one-fourth of refugees from Somalia (26.2%) reported always using medicine from their home country instead of visiting the doctor when sick.
- Female refugees (31.1%) were 1.6 times more likely than male refugees (19.3%) to report always using medicine from their home country instead of visiting the doctor when sick.

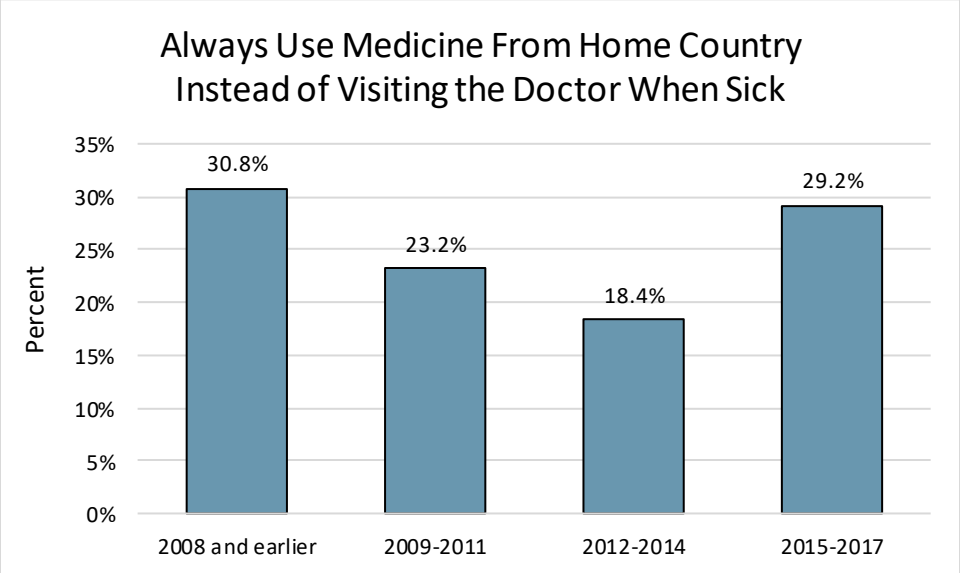


Use Medicine From Home Country

The chart below represents the proportion of refugees who reported always using medicine from their home country instead of visiting the doctor when sick.

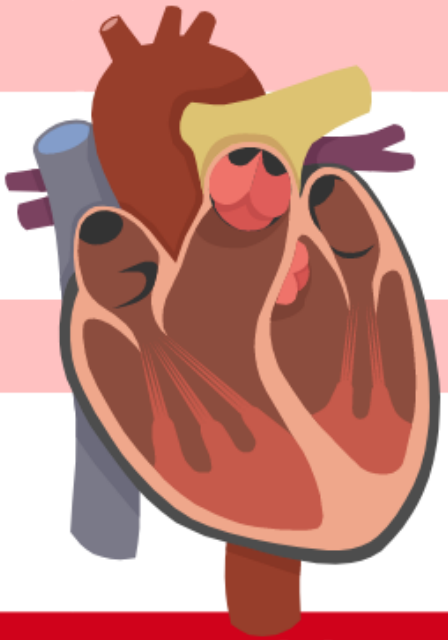
Key Findings by Year of Arrival

- Refugees who arrived in 2008 and earlier (30.8%) were most likely to report always using medicine from their home country instead of visiting a doctor when sick, followed by refugees who arrived in 2015-2017 (29.2%).
- Refugees who arrived in 2012-2014 (18.4%) were least likely to report always using medicine from their home country instead of visiting a doctor when sick.



Chronic Disease

Heart Attack



Male refugees (3.0%) are slightly more likely than female refugees (1.3%) to report having ever been diagnosed with a heart attack.

Coronary Heart Disease

Overall, 1.4% of refugees from Somalia reported having ever been diagnosed with coronary heart disease.

Diabetes

8% of refugees from Somalia reported having ever been diagnosed with diabetes.

High Blood Pressure

Approximately 14% of refugees from Somalia reported having ever been diagnosed with high blood pressure.

Female refugees from Somalia (20.4%) were more likely than male refugees (5.6%) to report having ever been diagnosed with high blood pressure.

14%

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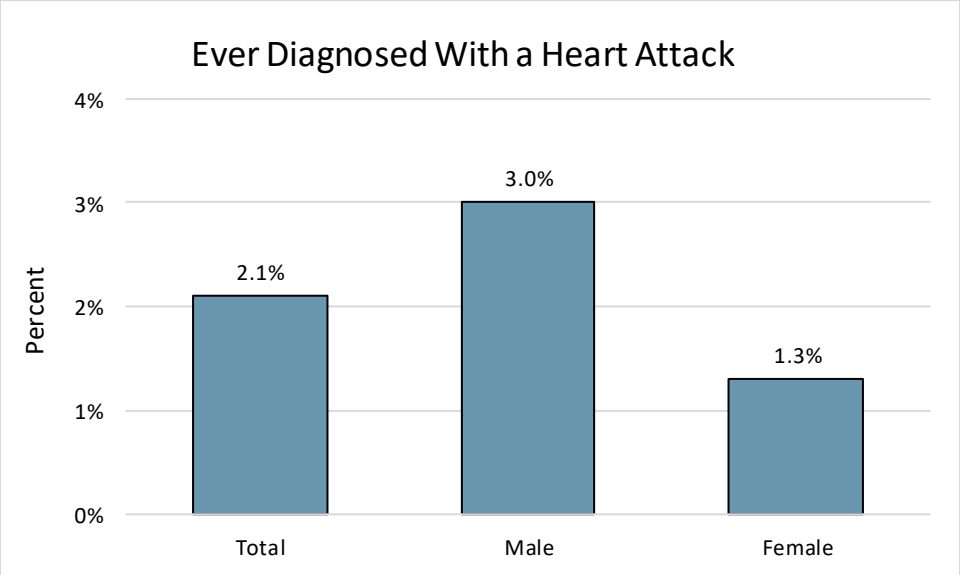
Chronic Disease

Heart Attack

The chart below represents the proportion of refugees from Somalia reporting having ever been diagnosed with a heart attack.

Key Findings by Gender

- Approximately 2% of refugees from Somalia reported having ever been diagnosed with a heart attack.
- Male refugees (3.0%) were 2.3 times more likely than female refugees (1.3%) to report having ever been diagnosed with a heart attack.

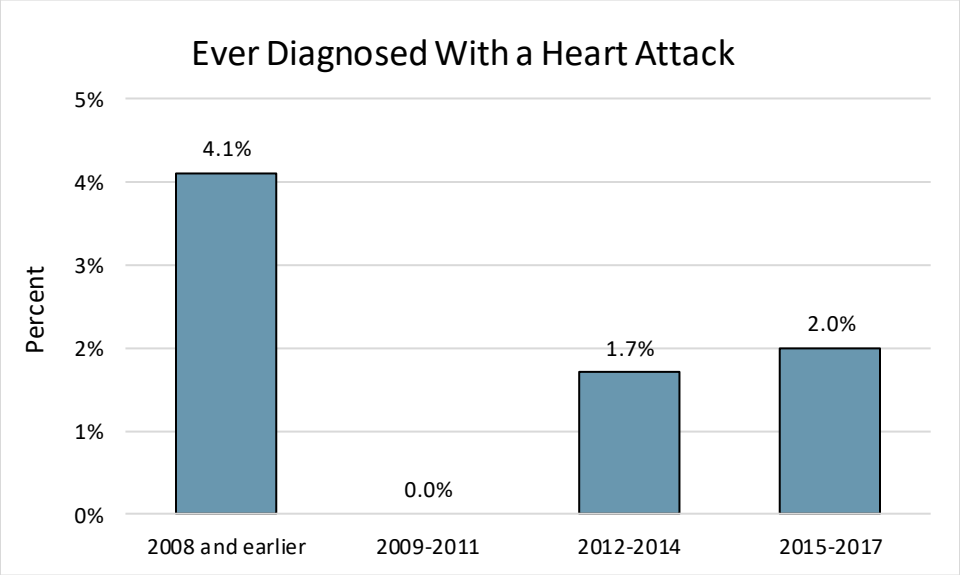


Heart Attack

The chart below represents the proportion of refugees from Somalia reporting having ever been diagnosed with a heart attack.

Key Findings by Year of Arrival

- Refugees who arrived in 2008 and earlier (4.1%) were 2.1 times more likely than refugees who arrived in 2015-2017 (2.0%) to report having ever been diagnosed with a heart attack.
- Refugees who arrived in 2009-2011 (0.0%) were least likely to have ever been diagnosed with a heart attack, followed by refugees who arrived in 2012-2014 (1.7%).

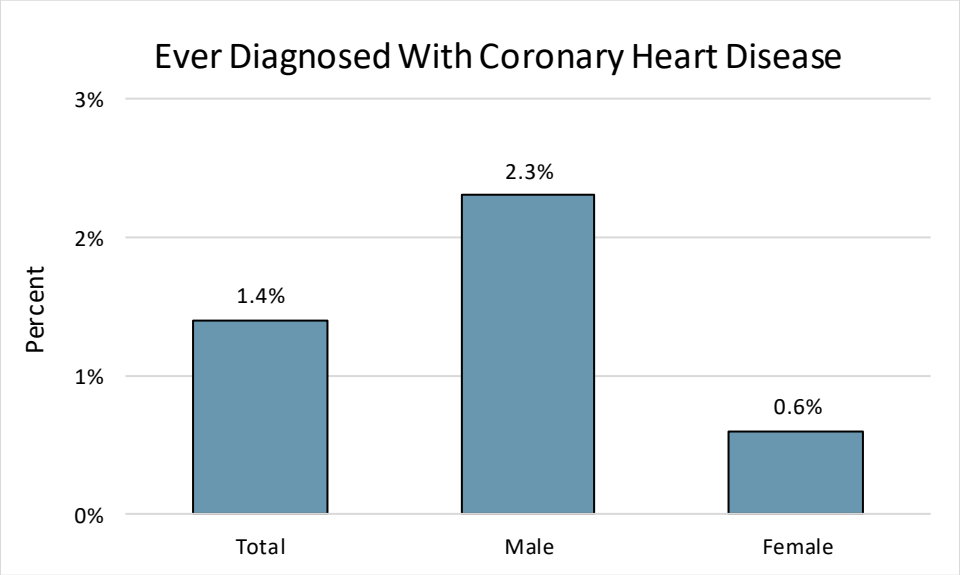


Coronary Heart Disease

The chart below represents the proportion of refugees from Somalia reporting having ever been diagnosed with coronary heart disease.

Key Findings by Gender

- Just over one percent of refugees from Somalia (1.4%) reported having ever been diagnosed with coronary heart disease.
- Male refugees (2.3%) were 3.8 times more likely than female refugees (0.6%) to report having ever been diagnosed with coronary heart disease.

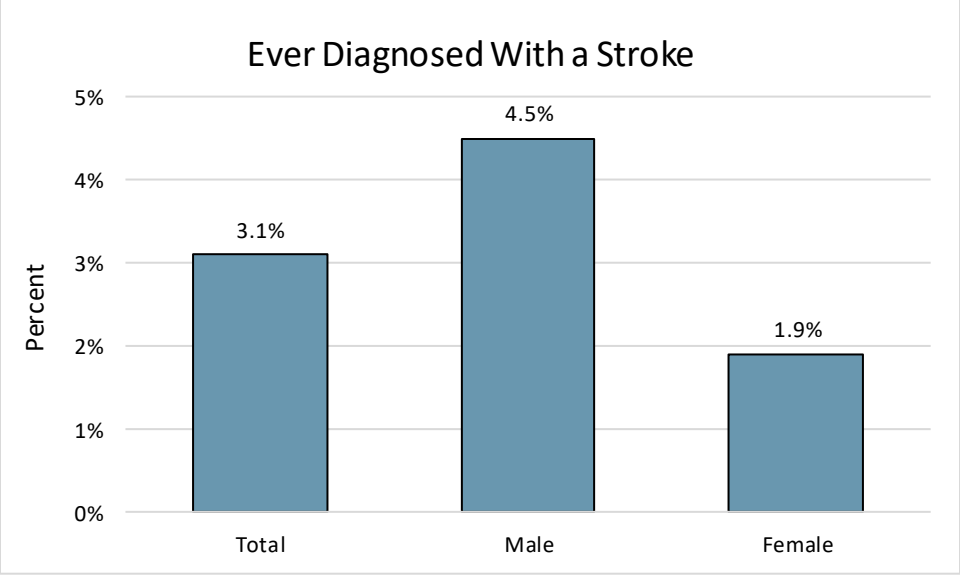


Stroke

The chart below represents the proportion of refugees from Somalia reporting having ever been diagnosed with a stroke.

Key Findings by Gender

- Approximately 3% of refugees from Somalia had ever been diagnosed with a stroke.
- Male refugees (4.5%) were 2.4 times more likely than female refugees (1.9%) to report having ever been diagnosed with a stroke.

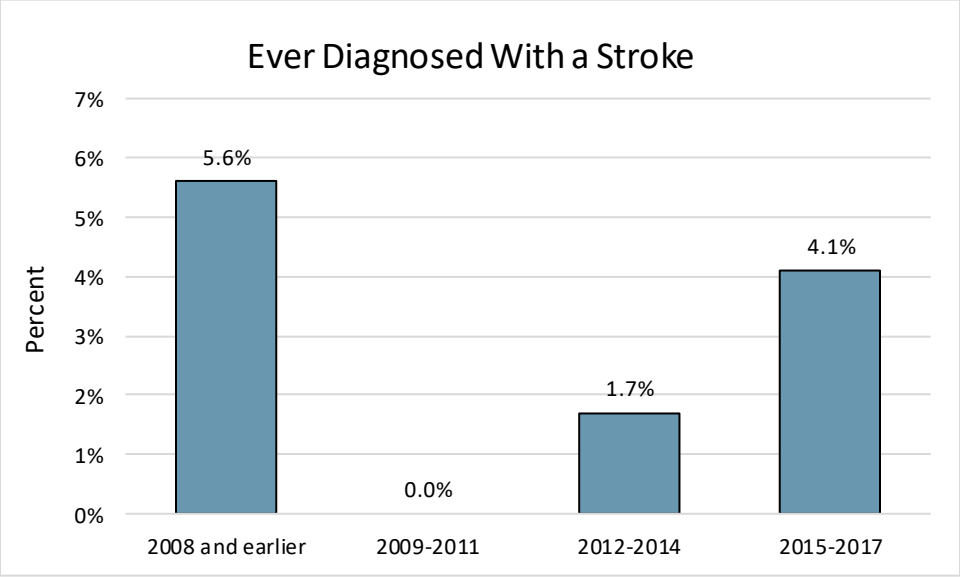


Stroke

The chart below represents the proportion of refugees from Somalia reporting having ever been diagnosed with a stroke.

Key Findings by Year of Arrival

- Refugees who arrived in 2008 and earlier (5.6%) were most likely to report having ever been diagnosed with a stroke, followed by refugees who arrived in 2015-2017 (4.1%).
- Refugees who arrived in 2009-2011 (0.0%) were least likely to report having ever been diagnosed with a stroke, followed by refugees who arrived in 2012-2014 (1.7%).

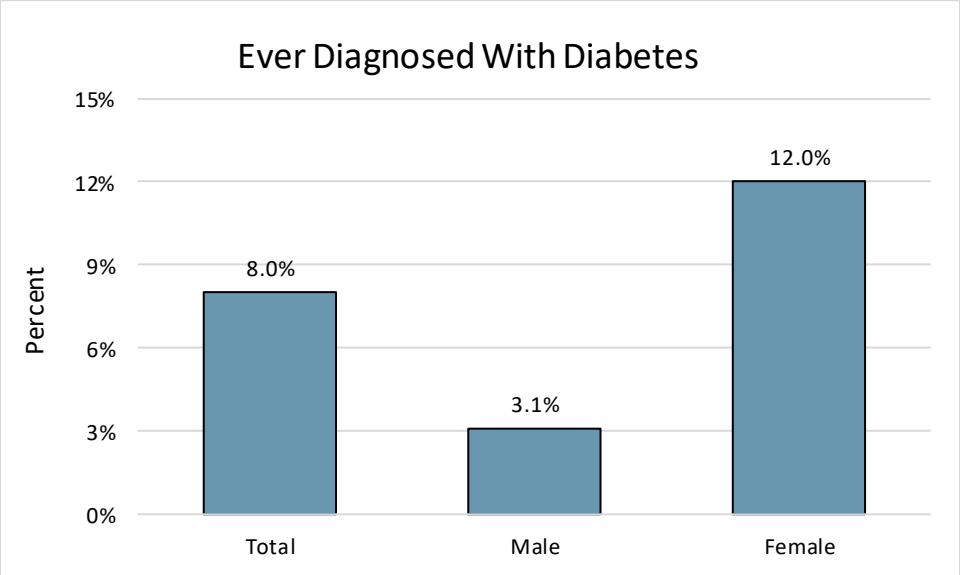


Diabetes

The chart below represents the proportion of refugees from Somalia reporting having ever been diagnosed with diabetes.

Key Findings by Gender

- Eight percent of refugees from Somalia reported having ever been diagnosed with diabetes.
- Female refugees (12.0%) were 3.9 times more likely than male refugees (3.1%) to report having ever been diagnosed with diabetes.

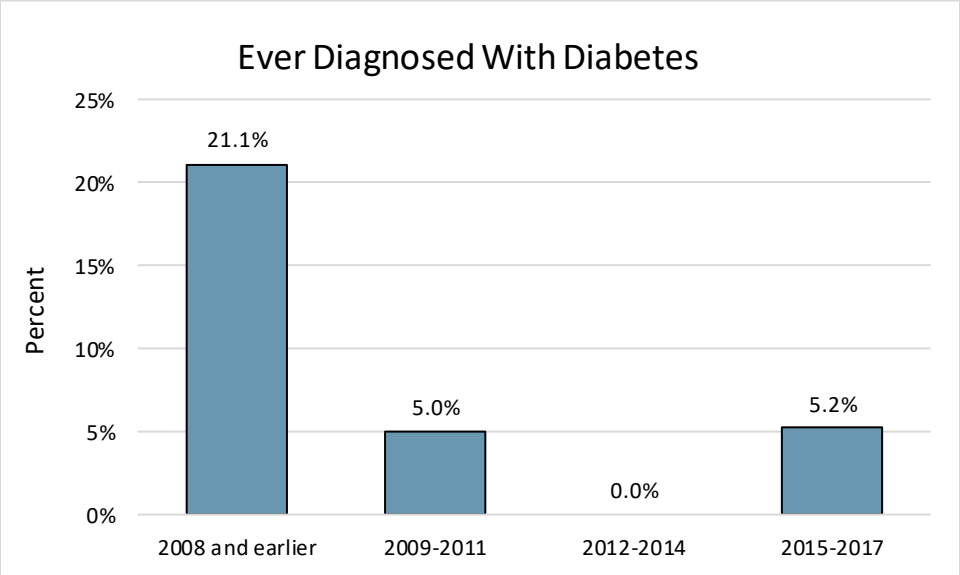


Diabetes

The chart below represents the proportion of refugees from Somalia reporting having ever been diagnosed with diabetes.

Key Findings by Year of Arrival

- Refugees who arrived in 2008 and earlier (21.1%) were 4.1 times more likely than refugees who arrived in 2015-2017 (5.2%) to report having ever been diagnosed with diabetes.
- Refugees who arrived in 2012-2014 (0.0%) were least likely to report having ever been diagnosed with diabetes.

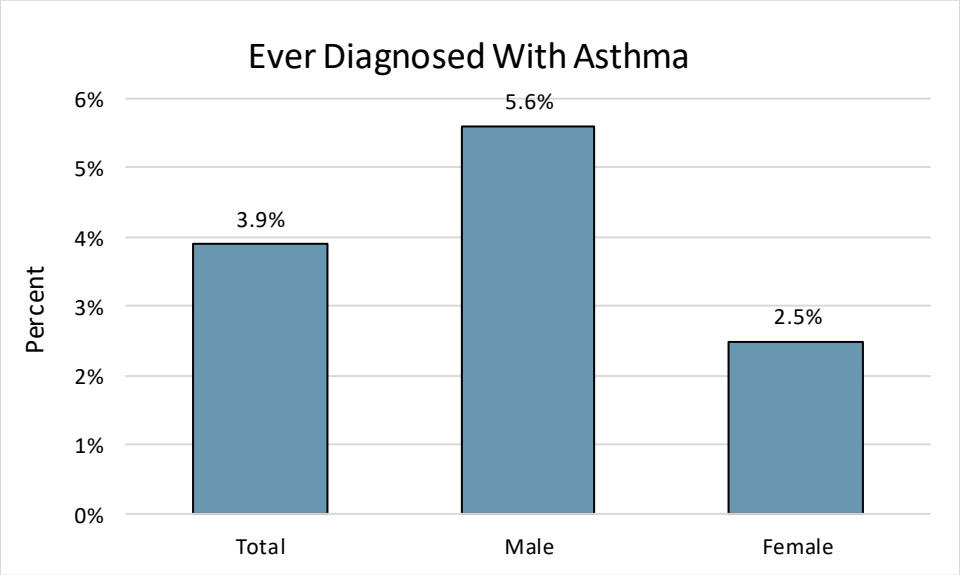


Asthma

The chart below represents the proportion of refugees from Somalia reporting having ever been diagnosed with asthma.

Key Findings by Gender

- Approximately four percent of refugees from Somalia (3.9%) reported having ever been diagnosed with asthma.
- Male refugees (5.6%) were 2.2 times more likely than female refugees (2.5%) to report having ever been diagnosed with asthma.

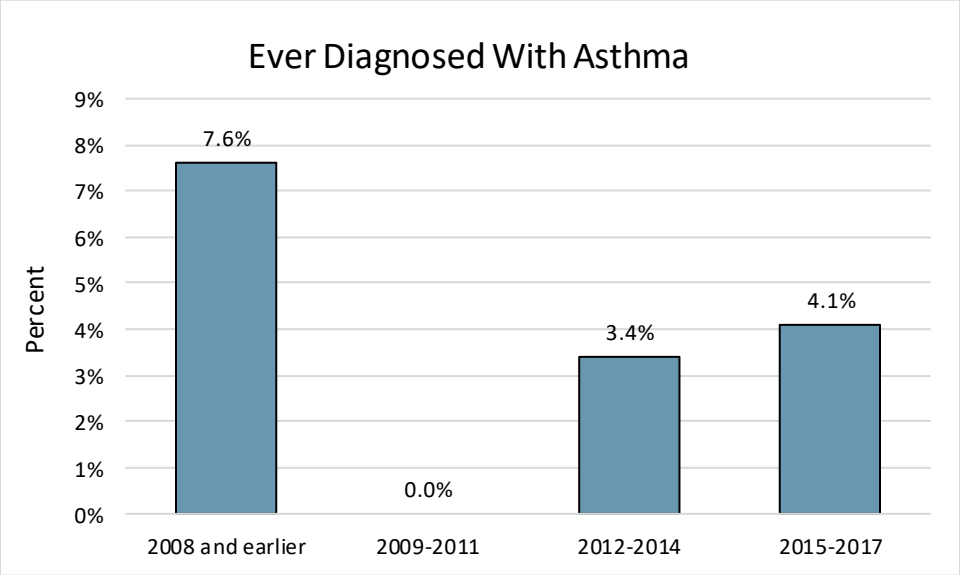


Asthma

The chart below represents the proportion of refugees from Somalia reporting having ever been diagnosed with asthma.

Key Findings by Year of Arrival

- Refugees who arrived in 2008 and earlier (7.6%) were 1.8 times more likely than refugees who arrived in 2015-2017 (4.1%) to report having ever been diagnosed with asthma.
- Refugees who arrived in 2009-2011 (0.0%) were least likely to report having ever been diagnosed with asthma, followed by refugees who arrived in 2012-2014 (3.4%).

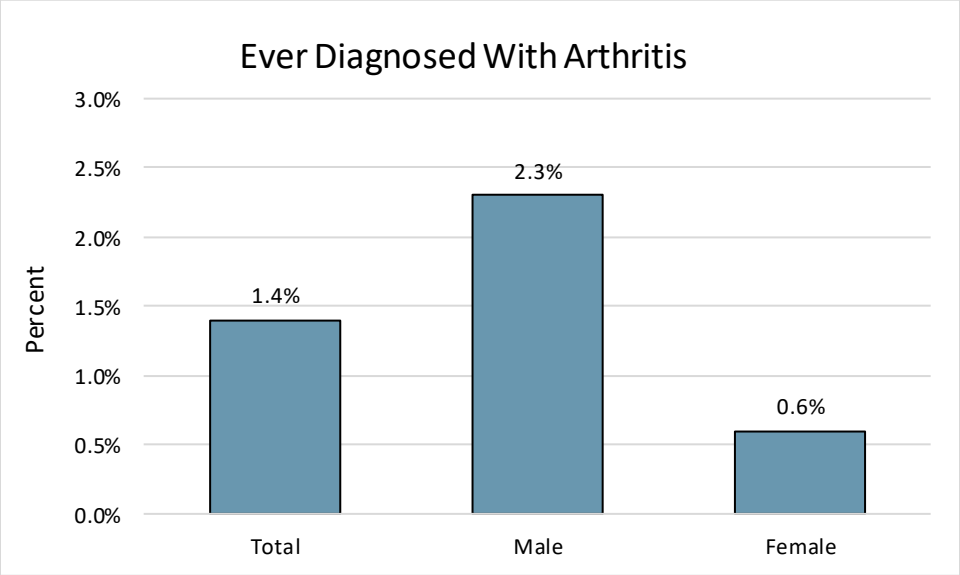


Arthritis

The chart below represents the proportion of refugees from Somalia reporting having ever been diagnosed with arthritis.

Key Findings by Gender

- Just over one percent of refugees from Somalia (1.4%) reported having ever been diagnosed with arthritis.
- Male refugees (2.3%) were 3.8 times more likely than female refugees (0.6%) to report having ever been diagnosed with arthritis.

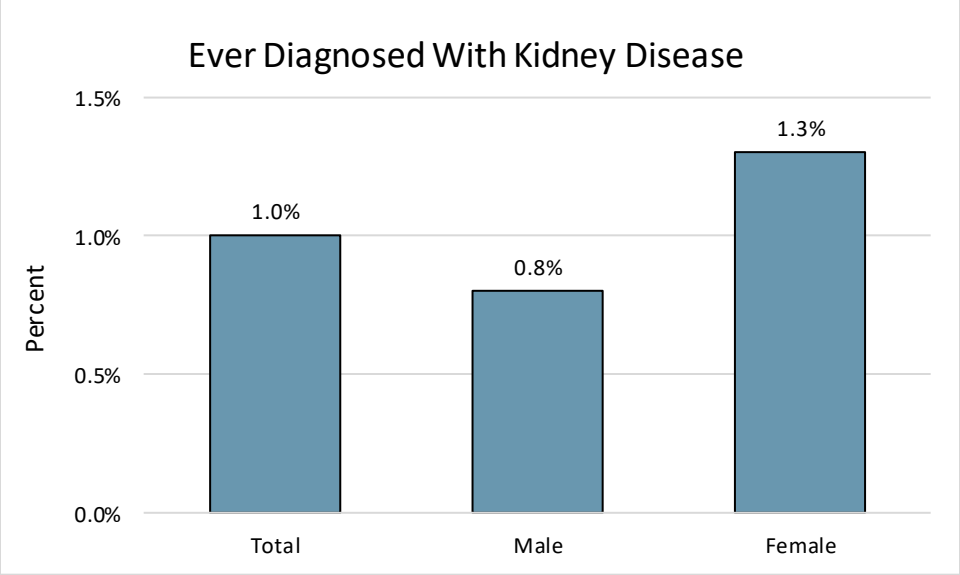


Kidney Disease

The chart below represents the proportion of refugees from Somalia reporting having ever been diagnosed with kidney disease.

Key Findings by Gender

- One percent of refugees from Somalia reported having ever been diagnosed with kidney disease.
- Female refugees (1.3%) were 1.6 times more likely than male refugees (0.8%) to report having ever been diagnosed with kidney disease.

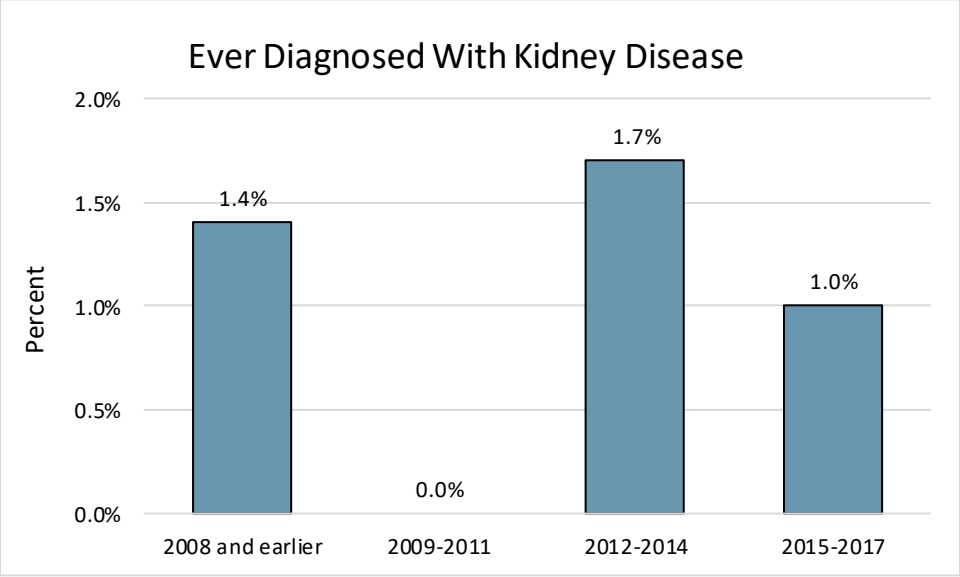


Kidney Disease

The chart below represents the proportion of refugees from Somalia reporting having ever been diagnosed with kidney disease.

Key Findings by Year of Arrival

- Refugees who arrived in 2012-2014 (1.7%) were most likely to report having ever been diagnosed with kidney disease, followed by refugees who arrived in 2008 and earlier (1.4%).
- None of the refugees who arrived in 2009-2011 reported having ever been diagnosed with kidney disease.

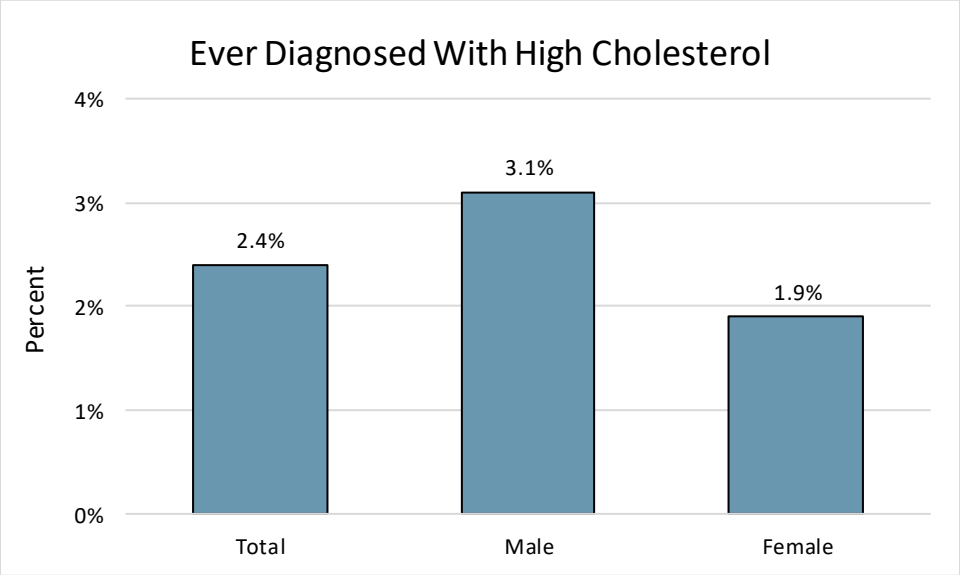


High Cholesterol

The chart below represents the proportion of refugees from Somalia reporting having ever been diagnosed with high cholesterol.

Key Findings by Gender

- Over two percent of refugees from Somalia (2.4%) reported having ever been diagnosed with high cholesterol.
- Male refugees (3.1%) were 1.6 times more likely than female refugees (1.9%) to report having ever been diagnosed with high cholesterol.

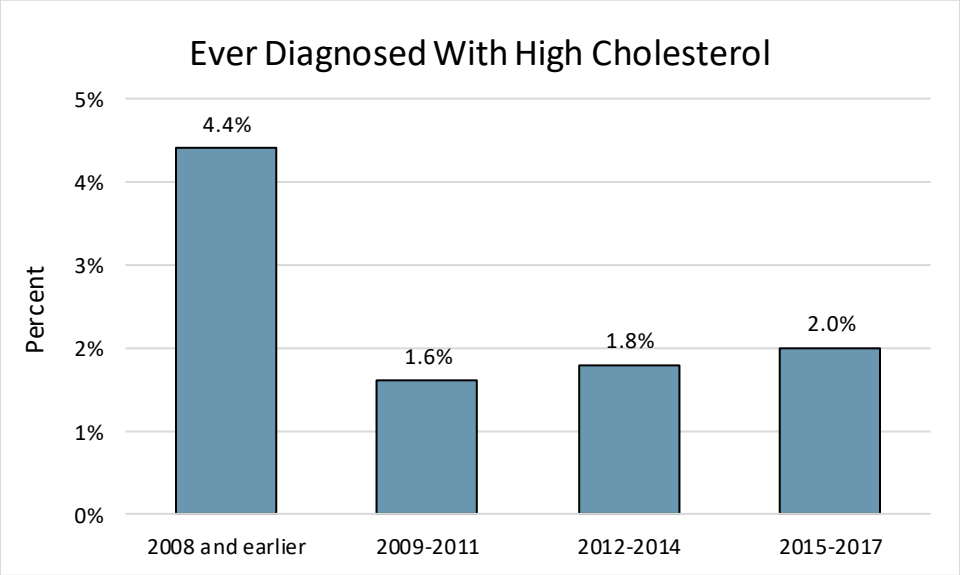


High Cholesterol

The chart below represents the proportion of refugees from Somalia reporting having ever been diagnosed with high cholesterol.

Key Findings by Year of Arrival

- Refugees who arrived in 2008 and earlier (4.4%) were 2.2 times more likely than refugees who arrived in 2015-2017 (2.0%) to report having ever been diagnosed with high cholesterol.
- Refugees who arrived in 2009-2011 (1.6%) were least likely to report having ever been diagnosed with high cholesterol, followed by refugees who arrived in 2012-2014 (1.8%).

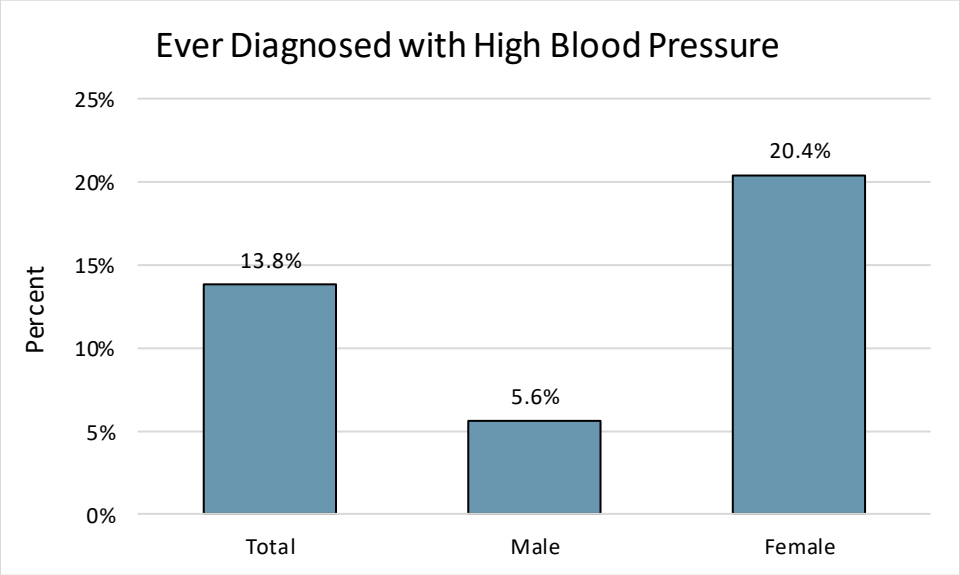


High Blood Pressure

The chart below represents the proportion of refugees from Somalia reporting having ever been diagnosed with high blood pressure.

Key Findings by Gender

- Approximately 14% of refugees from Somalia had ever been diagnosed with high blood pressure.
- Female refugees (20.4%) were 3.6 times more likely than male refugees (5.6%) to report having ever been diagnosed with high blood pressure.

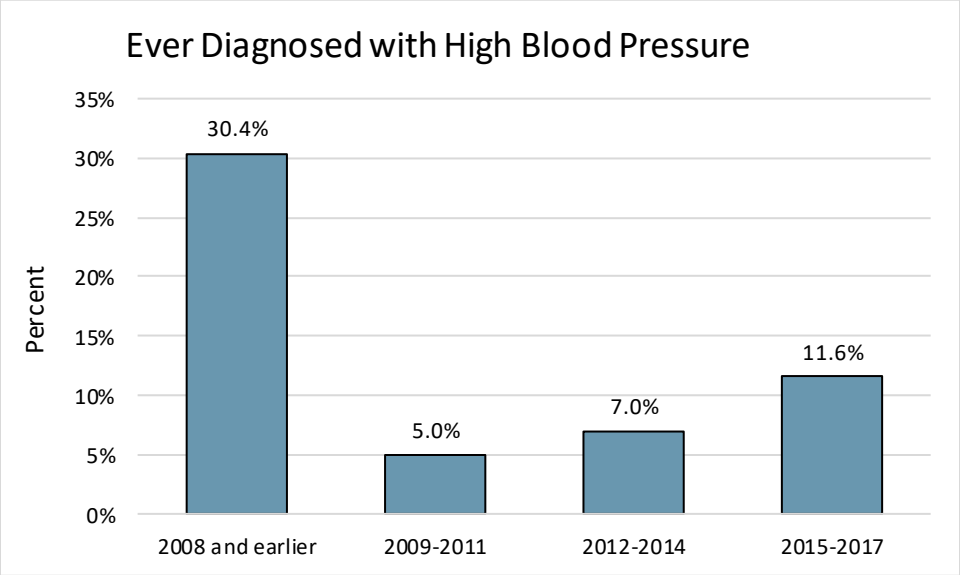


High Blood Pressure

The chart below represents the proportion of refugees from Somalia reporting having ever been diagnosed with high blood pressure.

Key Findings by Year of Arrival

- Refugees who arrived in 2008 and earlier (30.4%) were 2.6 times more likely than refugees who arrived in 2015-2017 (11.6%) to report having ever been diagnosed with high blood pressure.
- Refugees who arrived in 2009-2011 (5.0%) were least likely to report having ever been diagnosed with high blood pressure, followed by refugees who arrived in 2012-2014 (7.0%).



Mental Health

Mental Health

0.8% of refugees from Somalia reported that their mental health was poor on 14 or more days in the past 30 days.

Males from Somalia had a higher percentage of those with poor mental health compared to females.

Depressive Disorder

0.7% of refugees from Somalia reported having ever been diagnosed with a depressive disorder.

Male refugees (0.8%) were slightly more likely than female refugees (0.6%) to report having ever been diagnosed with a depressive disorder.

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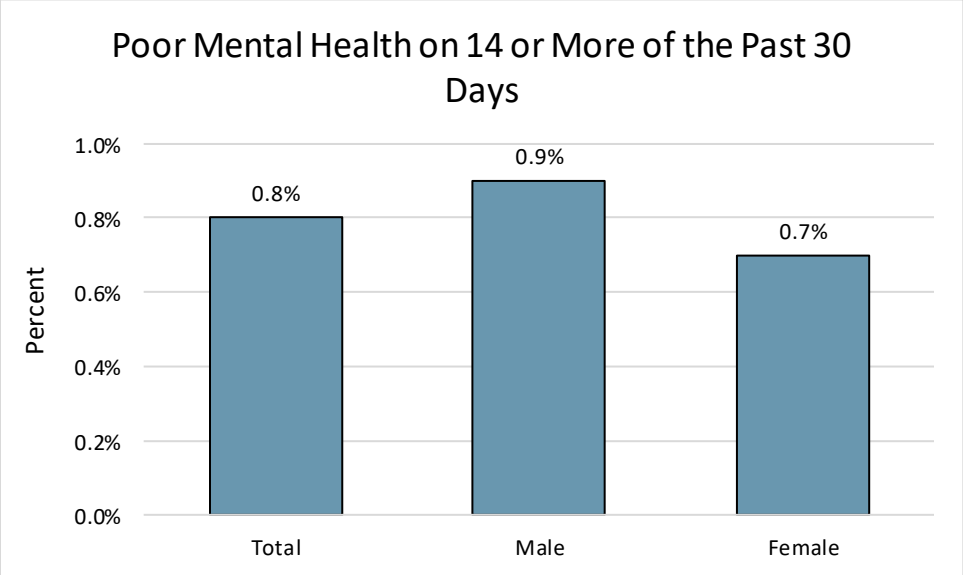
Mental Health

Poor Mental Health

The chart below represents the proportion of refugees from Somalia who reported having poor mental health on 14 or more of the past 30 days.

Key Findings by Gender

- Just under one percent of refugees from Somalia (0.8%) reported having poor mental health on 14 or more of the past 30 days.
- Male refugees (0.9%) were slightly more likely than female refugees (0.7%) to report having poor mental health on 14 or more of the past 30 days.



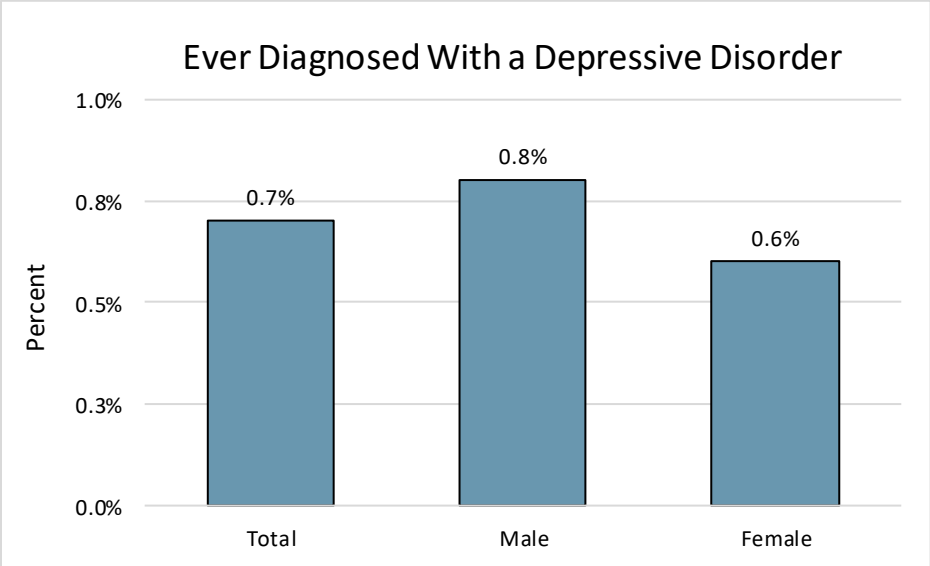
Depressive Disorder

Depressive disorders are often characterized by feelings of sadness and hopelessness, though individuals with a major depressive disorder may also experience loss of interest in activities, changes in weight or activity, insomnia and difficulties concentrating.[23]

The chart below represents the proportion of refugees from Somalia who reported having ever been diagnosed with a depressive disorder.

Key Findings by Gender

- Under one percent of refugees from Somalia (0.7%) reported having ever been diagnosed with a depressive disorder.
- Male refugees (0.8%) were slightly more likely than female refugees (0.6%) to report having ever been diagnosed with a depressive disorder.



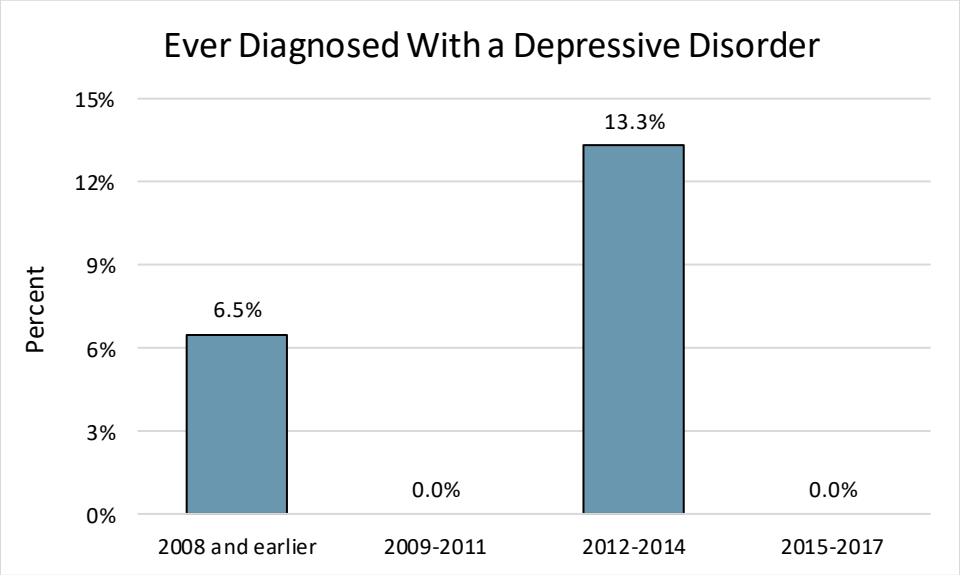
[23] Centers for Disease Control and Prevention. (2016). Depression. Retrieved from www.cdc.gov/mentalhealth/basics/mental-illness/depression.htm

Depressive Disorder

The chart below represents the proportion of refugees from Somalia who reported having ever been diagnosed with a depressive disorder.

Key Findings by Year of Arrival

- Refugees who arrived in 2012-2014 (13.3%) were by far the most likely arrival group to report having ever been diagnosed with a depressive disorder.
- Just under seven percent of refugees who arrived in 2008 and earlier (6.5%) reported having ever been diagnosed with a depressive disorder.



Health Behaviors

Routine Checkup

Over half of refugees from Somalia reported having had a routine checkup in the past two years.

Pneumonia Vaccination

Approxiamtely 3% of the refugees from Somalia, aged 65 and older, reported having received a pneumonia vaccination.

Mammogram

Only 4% of female refugees age 40 and older reported having had a mammogram in the past two years.

Dental Visit

Approximately 15% of refugees from Somalia reported having visited the dentist in the past two years.

Sleep Insufficiency

< 7 hours

Almost 70% of refugees from Somalia reported sleeping less than seven hours daily.

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Health Behaviors

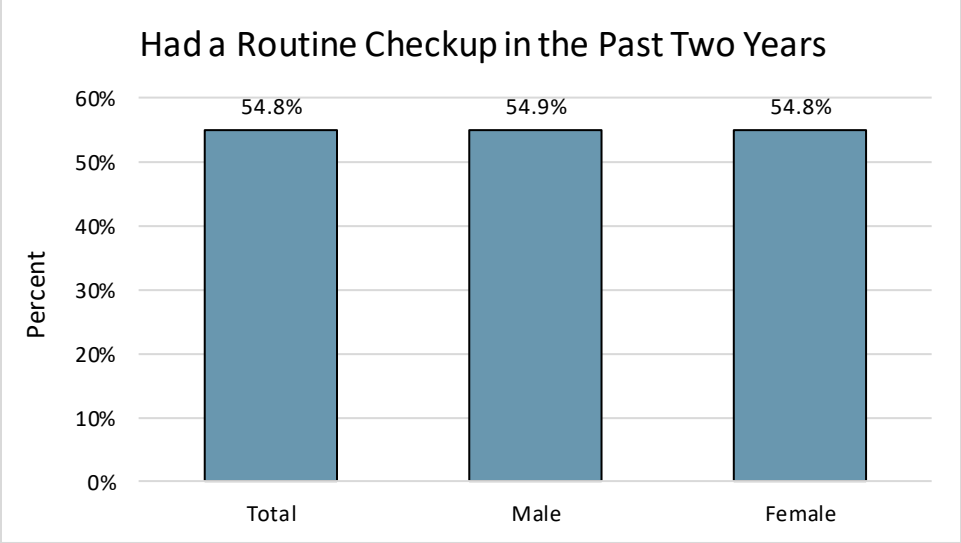
Routine Checkup

Routine checkups are helpful in finding problems before they become a cause for concern. Finding problems early makes chances for treatment better. Scheduling regular checkups with a physician is an important step in maintaining a long, healthy life.[24]

The chart below represents the proportion of refugees from Somalia who reported having had a routine checkup in the past two years.

Key Findings by Gender

- Over half of refugees from Somalia (54.8%) reported having had a routine checkup in the past two years.
- Similar proportions of male (54.9%) and female refugees (54.8%) reported having had a routine checkup in the past two years.



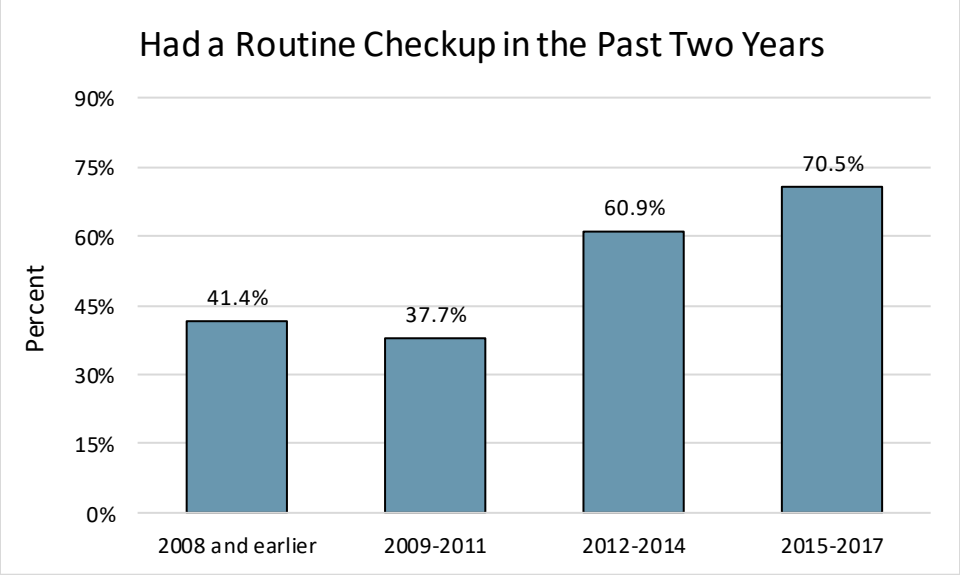
[24] Regular health checks. Regular health checks - Better Health Channel. (n.d.). Retrieved October 29, 2021, from https://www.betterhealth.vic.gov.au/health/servicesandsupport/regular-health-checks.

Routine Checkup

The chart below represents the proportion of refugees from Somalia who reported having had a routine checkup in the past two years.

Key Findings by Year of Arrival

- Refugees who arrived in 2015-2017 (70.5%) were 1.7 times more likely than refugees who arrived in 2008 and earlier (41.4%) to report having had a routine checkup in the past two years.
- Refugees who arrived in 2009-2011 (37.7%) were least likely to report having had a routine checkup in the past two years.



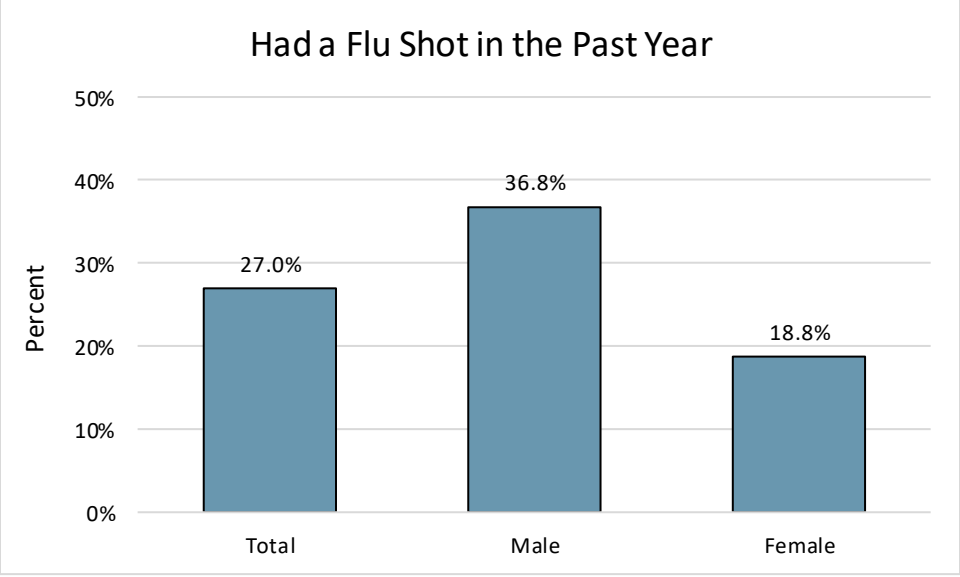
Flu Shot

Flu shots protect individuals against the most common influenza viruses and it is recommended that everyone over six months of age get a flu shot every influenza season.[25] Influenza season in the United States can start as early as October and end as late as May. Flu shots not only reduce the risk of vaccinated individuals getting sick, but also decrease the chance of spreading the flu to others and throughout a community.

The chart below represents the proportion of refugees from Somalia who reported having had a flu shot in the past 12 months.

Key Findings by Gender

- Overall, 27% of refugees from Somalia had a flu shot in the past year.
- Male refugees (36.8%) were two times more likely than female refugees (18.8%) to report having had a flu shot in the past year.



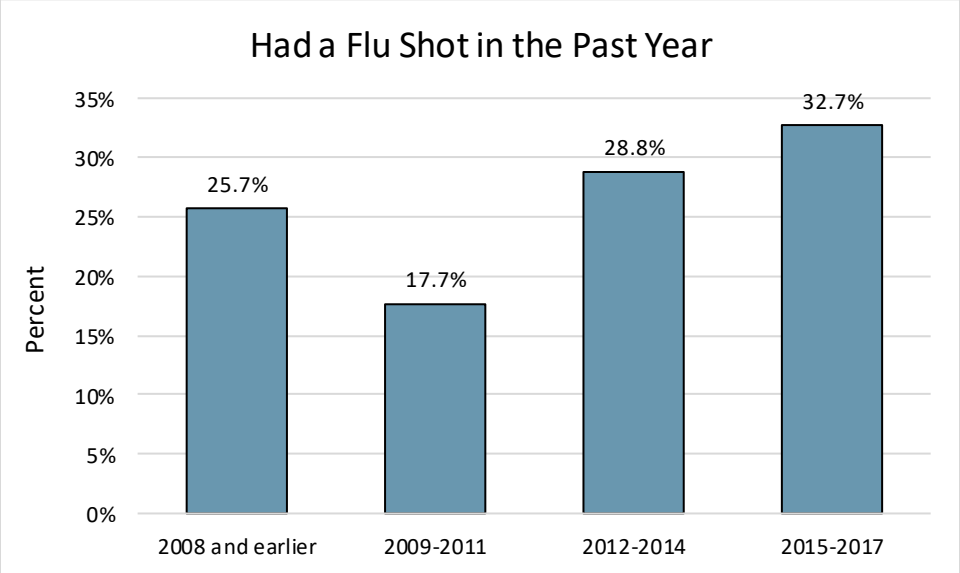
[25] Centers for Disease Control and Prevention. (2016). Key facts about seasonal flu vaccine. Retrieved from www.cdc.gov/flu/protect/keyfacts.htm

Flu Shot

The chart below represents the proportion of refugees from Somalia who reported having had a flu shot in the past 12 months.

Key Findings by Year of Arrival

- Approximately one-third of refugees who arrived in 2015-2017 (32.7%) reported having had a flu shot in the past year, compared to just over one-fourth of refugees who arrived in 2008 and earlier (25.7%).
- Refugees who arrived in 2009-2011 (17.7%) were least likely to report having had a flu shot in the past year.



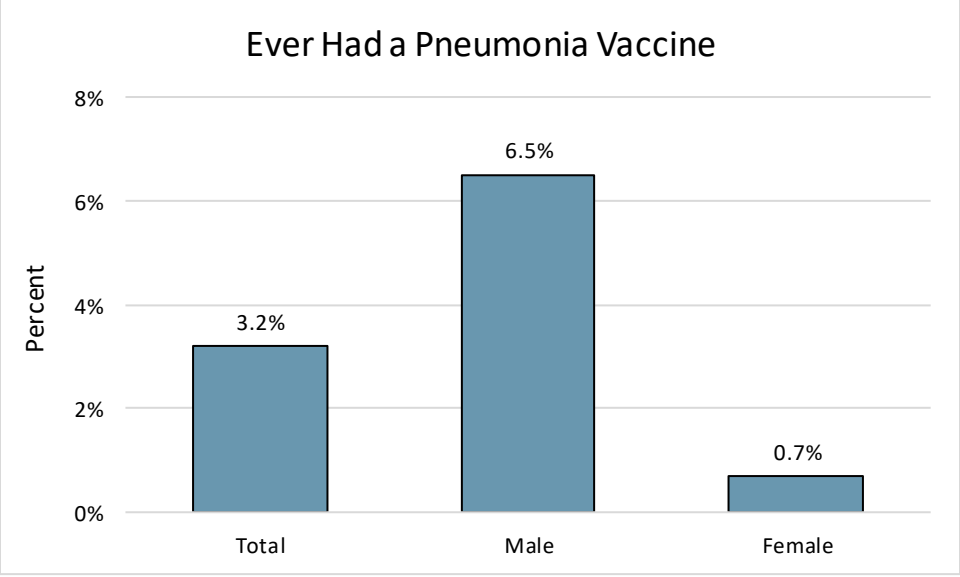
Pneumonia Vaccination

A pneumonia shot or pneumococcal vaccine is usually given only once or twice in an individual's lifetime and is different from a flu shot.[26] Pneumococcus can cause pneumonia (lung infection), ear infections, sinus infections, and meningitis. While pneumococcal disease is common in young children, adults over the age of 65 face the greatest risk of serious infection.

The chart below represents the proportion of refugees from Somalia who reported having ever received a pneumonia vaccine.

Key Findings by Gender

- Approximately three percent of refugees from Somalia (3.2%) reported having ever had a pneumonia vaccine.
- Male refugees (6.5%) were 9.3 times more likely than female refugees (0.7%) to report having ever had a pneumonia vaccine.



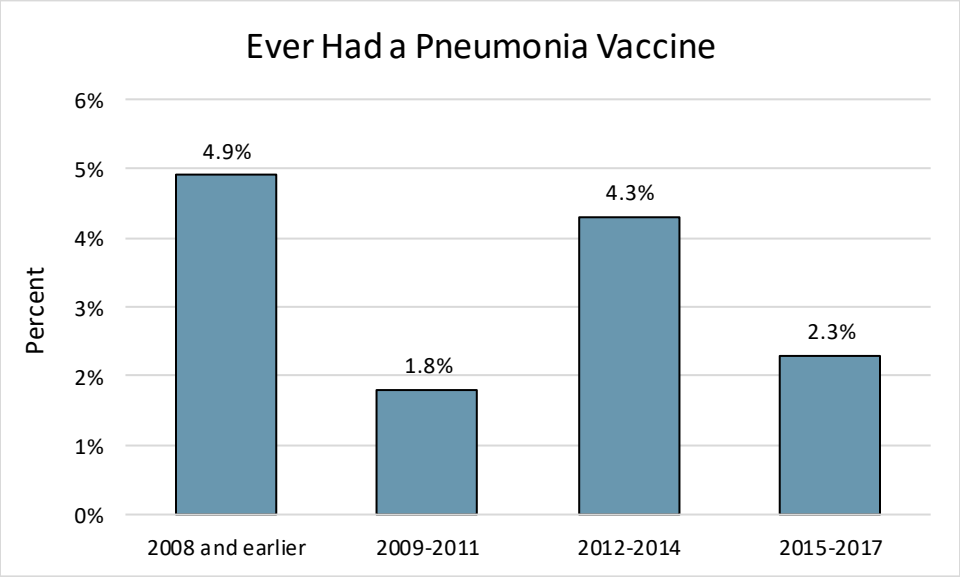
[26] Centers for Disease Control and Prevention. (2016). Pneumococcal vaccination: what everyone should know. Retrieved from www.cdc.gov/vaccines/vpd/pneumo/public/index.html

Pneumonia Vaccination

The chart below represents the proportion of refugees from Somalia who reported having ever received a pneumonia vaccination.

Key Findings by Year of Arrival

- Refugees who arrived in 2008 and earlier (4.9%) were most likely to report having ever had a pneumonia vaccine, followed by refugees who arrived in 2012-2014 (4.3%).
- Refugees who arrived in 2009-2011 (1.8%) were least likely to report having ever had a pneumonia vaccine, followed by refugees who arrived in 2015-2017 (2.3%).



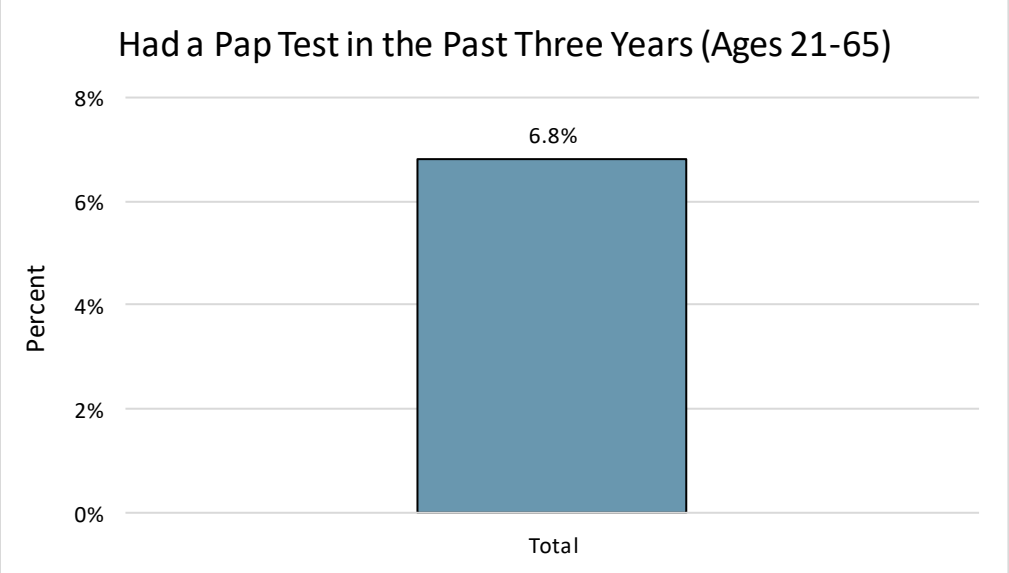
Pap Test

The American Cancer Society recommends that women begin receiving a Pap test, a screening procedure for cervical cancer, at age 21.[27] Women should continue to get a Pap test every three to five years until age 65.

The chart below represents the proportion of refugees from Somalia (age 21 to 65) who reported having had a Pap test in the past three years.

Key Findings

- Just under seven percent of female refugees from Somalia (6.8%) reported having had a Pap test in the past three years.



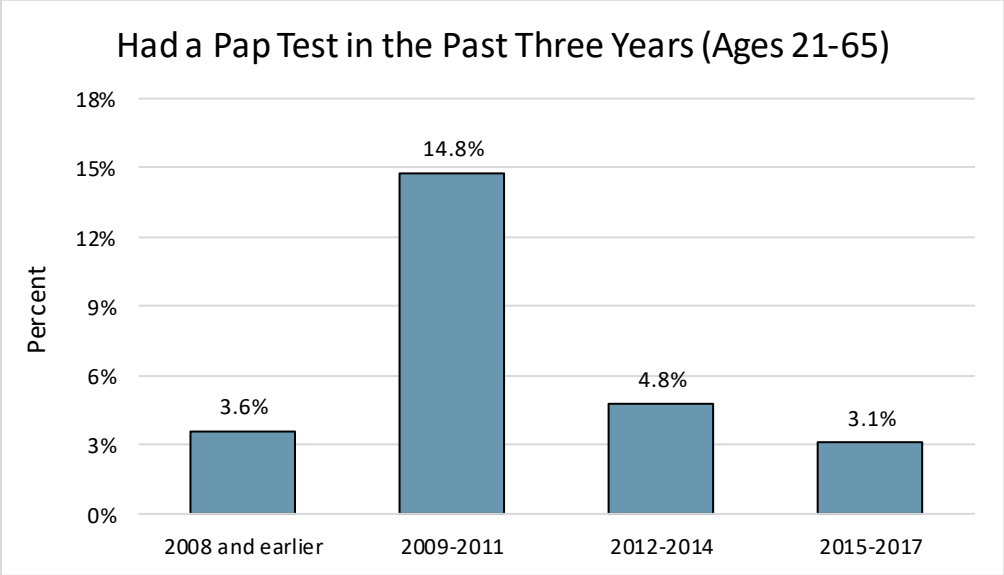
[27] American Cancer Society. (2018). The American Cancer Society guidelines for the prevention and early detection of cervical cancer. Retrieved from www.cancer.org/cancer/cervical-cancer/prevention-and-early-detection/cervical-cancer-screening-guidelines.html

Pap Test

The chart below represents the proportion of refugees from Somalia (age 21 to 65) who reported having had a Pap test in the past three years.

Key Findings by Year of Arrival

- Female refugees who arrived in 2009-2011 (14.8%) were by far the most likely arrival group to report having had a Pap test in the past three years.
- Refugees who arrived in 2015-2017 (3.1%) were least likely to report having had a Pap test in the past three years, followed by refugees who arrived in 2008 and earlier (3.6%).



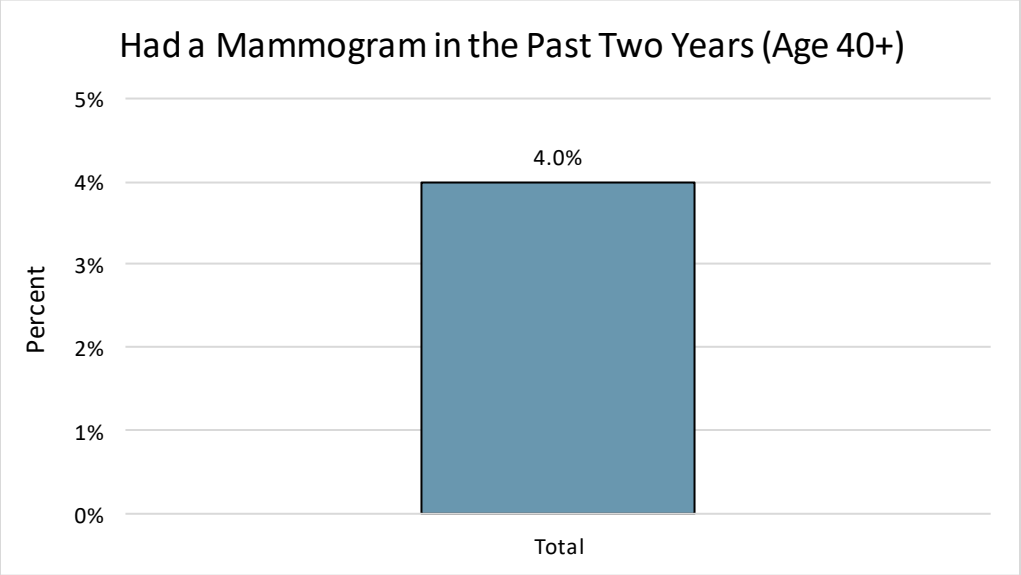
Mammogram

Mammograms are X-ray pictures of the breast used to look for signs of breast cancer. The American Cancer Society recommends that women age 45 and older should get mammograms every one or two years and women ages 40 to 44 should have the choice to start annual mammograms.[28]

The chart below represents the proportion of refugees from Somalia (age 40 and older) who reported having had a mammogram in the past two years.

Key Findings

- Four percent of female refugees (age 40 and older) reported having had a mammogram in the past two years.



[28] American Cancer Society. (2018). American Cancer Society Guidelines for the early detection of cancer. Retrieved from www.cancer.org/healthy/find-cancer-early/cancer-screening-guidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html

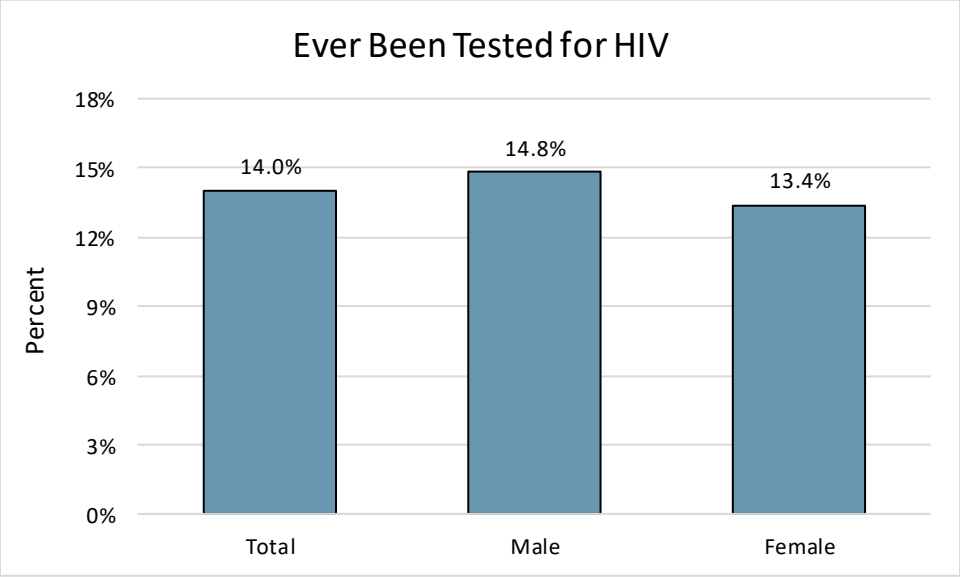
HIV Test

While Human Immunodeficiency Virus (HIV) is quite similar to other viruses, the immune system cannot completely get rid of HIV. Over time, HIV is able to destroy cells that the body needs to fight off infections.[29] If untreated, HIV can lead to acquired immunodeficiency syndrome (AIDS), which leaves the body extremely vulnerable to certain diseases and cancers.

The chart below represents the proportion of refugees from Somalia who reported having ever been tested for HIV.

Key Findings by Gender

- Fourteen percent of refugees from Somalia reported having ever been tested for HIV.
- Male refugees (14.8%) were more likely than female refugees (13.4%) to report having ever been tested for HIV.



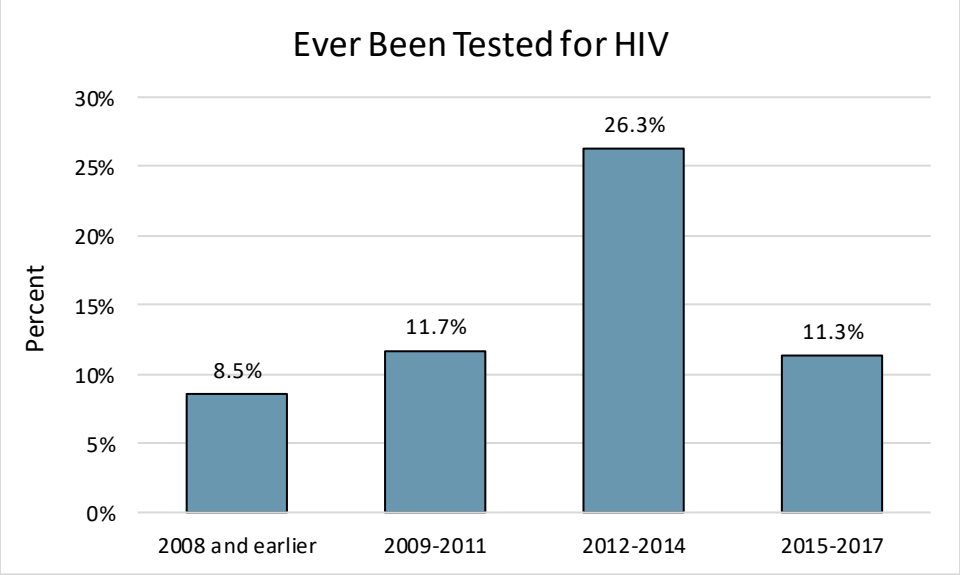
[29] AIDS.gov. (2016). What is HIV/AIDS. Retrieved from www.aids.gov/hiv-aids-basics/hiv-aids-101/what-is-hiv-aids

HIV Test

The chart below represents the proportion of refugees from Somalia who reported having ever been tested for HIV.

Key Findings by Year of Arrival

- Over one-fourth of refugees who arrived in 2012-2014 (26.3%) reported having ever been tested for HIV. This percentage was 2.2 times that of the next most likely population to report the same, refugees who arrived in 2009-2011 at 11.7%.
- Refugees who arrived in 2008 and earlier (8.5%) were least likely to report having ever been tested for HIV.



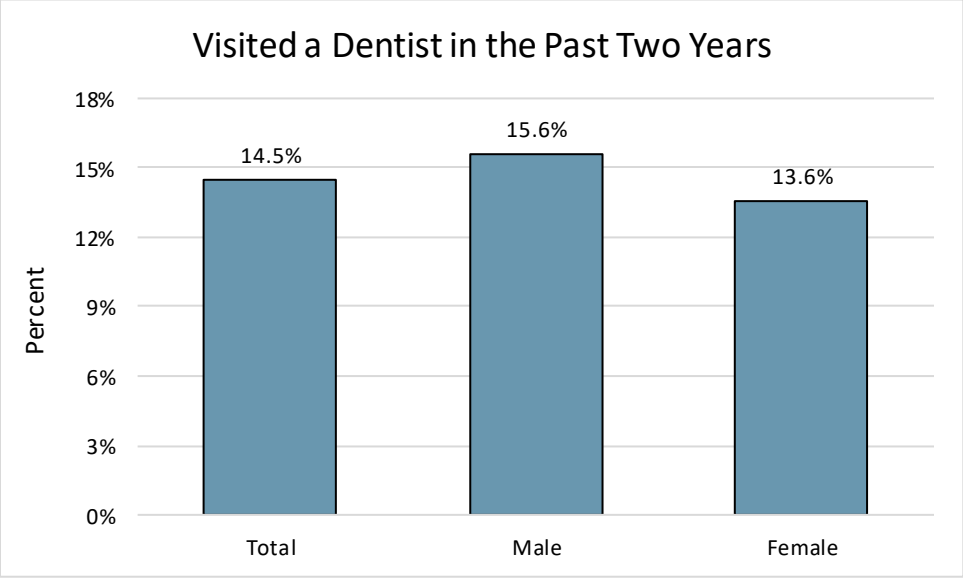
Dentist

Regular visits to the dentist are an important part of maintaining good oral health. Several of the most common oral health problems include untreated tooth decay (cavities) and gum disease. In fact, it has been reported that more than one in four adults in the United States have untreated tooth decay.[30]

The chart below represents the proportion of refugees from Somalia who reported visiting a dentist in the past two years.

Key Findings by Gender

- Almost 15% of refugees from Somalia (14.5%) reported having visited the dentist in the past two years.
- Male refugees (15.6%) were more likely than female refugees (13.6%) to report having visited the dentist in the past two years.



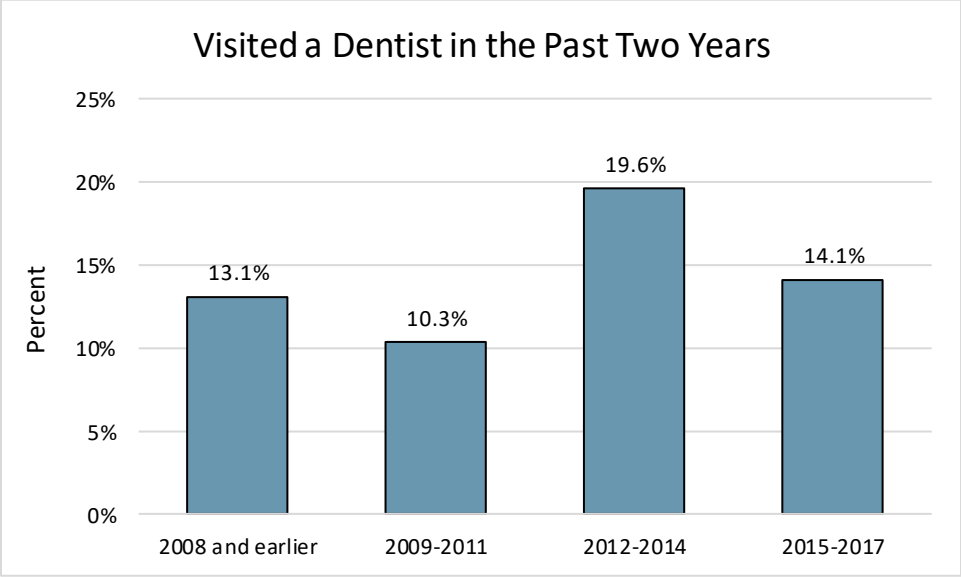
[30] Centers for Disease Control and Prevention. (2015). Dental Caries and Tooth Loss in Adults in the United States, 2011-2012. Retrieved from www.cdc.gov/nchs/data/databriefs/db197.htm

Dentist

The chart below represents the proportion of refugees from Somalia who reported visiting a dentist in the past two years.

Key Findings by Year of Arrival

- Refugees who arrived in 2012-2014 (19.6%) were most likely to report having visited the dentist in the past two years, followed by refugees who arrived in 2015-2017 (14.1%).
- Only one in ten refugees who arrived in 2009-2011 (10.3%) reported having visited a dentist in the past two years.



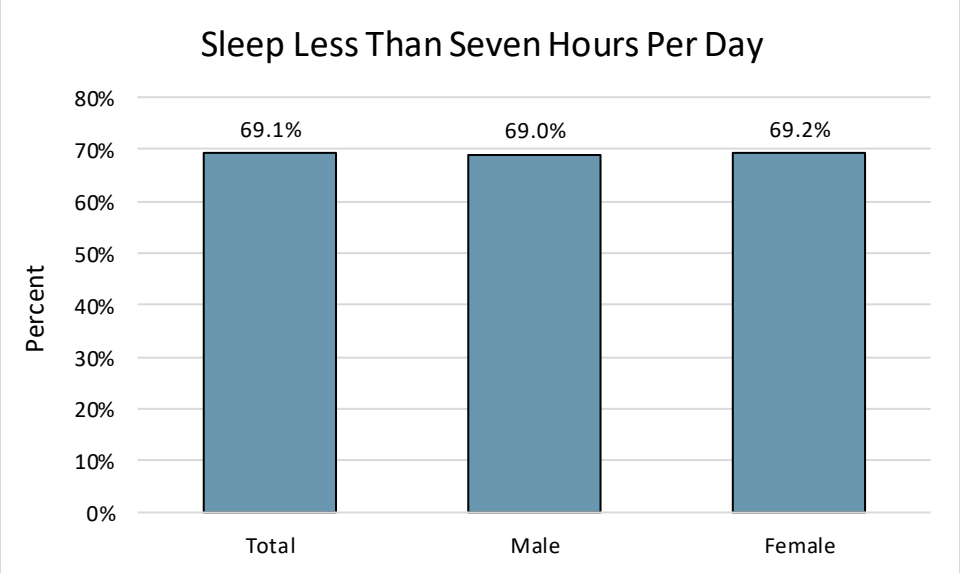
Insufficient Sleep

Insufficient sleep has been linked to numerous chronic diseases, including diabetes, obesity, depression, and cardiovascular disease.[31]

The chart below represents the proportion of refugees from Somalia who reported sleeping less than seven hours daily.

Key Findings by Gender

- Almost 70% of refugees from Somalia (69.1%) reported sleeping less than seven hours per day.
- Similar proportions of male refugees (69.0%) and female refugees (69.2%) reported sleeping less than seven hours per day.



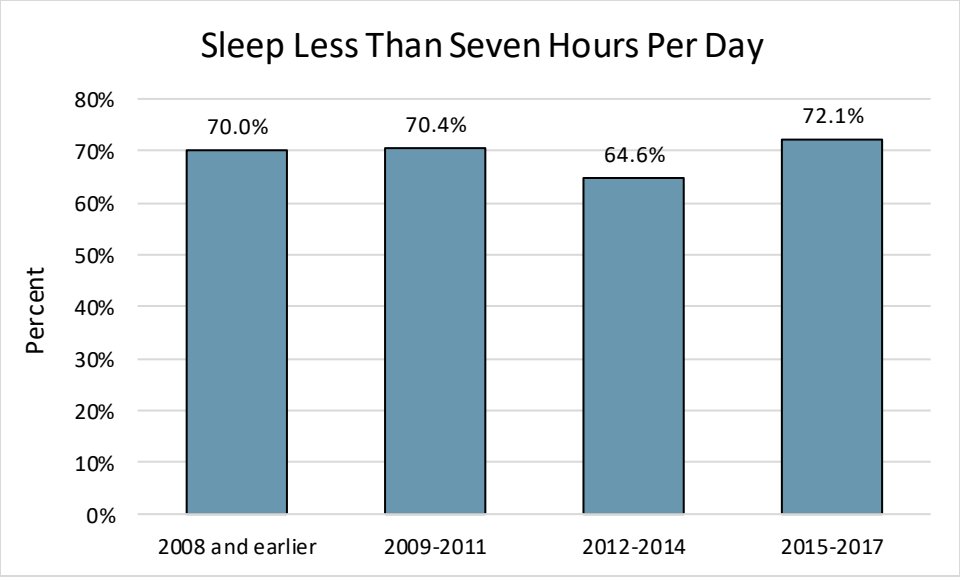
[31] Centers for Disease Control and Prevention. (2016). Sleep and sleep disorders. Retrieved from www.cdc.gov/sleep/index.html

Insufficient Sleep

The chart below represents the proportion of refugees from Somalia who reported sleeping less than seven hours daily.

Key Findings by Year of Arrival

- Refugees who arrived in 2015-2017 (72.1%) were most likely to report sleeping less than seven hours per day, followed by refugees who arrived in 2009-2011 (70.4%) and in 2008 and earlier (70.0%).
- Refugees who arrived in 2012-2014 (64.6%) were least likely to report sleeping less than seven hours daily.



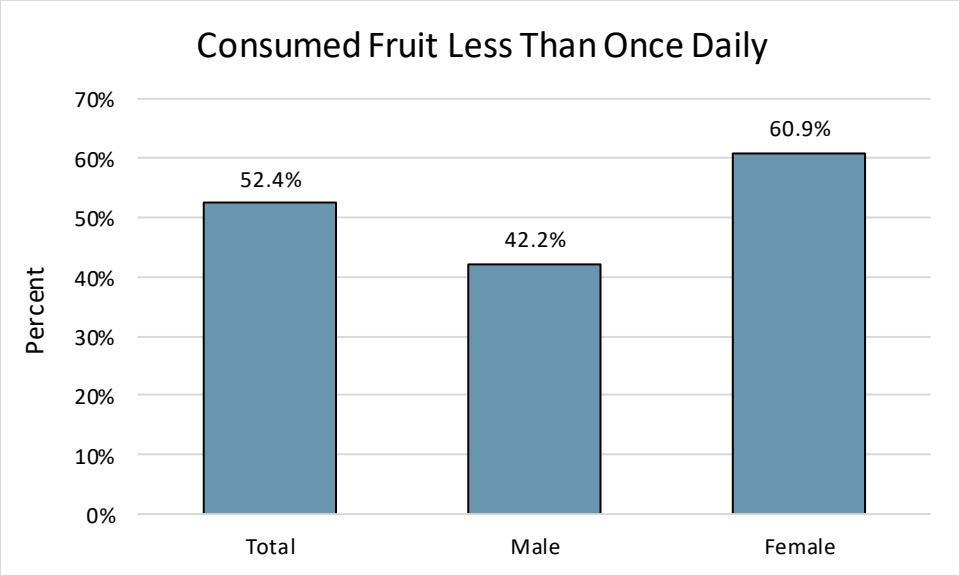
Fruit Consumption

Diets high in fruits and vegetables can reduce the risk for cancer and chronic disease.[32] Fruits and vegetables are a good source of essential vitamins and minerals. They also provide fiber, while remaining low in fat and calories. Half of one's dinner plate should consist of fruits and vegetables.

The chart below represents the proportion of refugees from Somalia who reported eating fruit less than once daily.

Key Findings by Gender

- Over half of refugees from Somalia (52.4%) reported consuming fruit less than once daily.
- Female refugees (60.9%) were 1.4 times more likely than male refugees (42.2%) to report consuming fruit less than once daily.



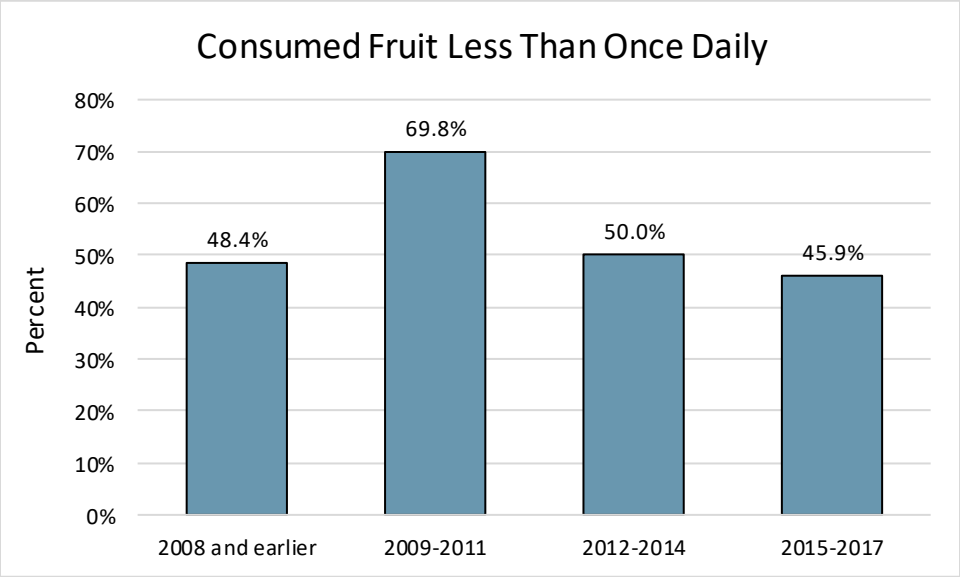
[32] Centers for Disease Control and Prevention. (2015). Adults meeting fruit and vegetable intake recommendations. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6426a1.htm

Fruit Consumption

The chart below represents the proportion of refugees from Somalia who reported eating fruit less than once daily.

Key Findings by Year of Arrival

- Refugees who arrived in 2009-2011 (69.8%) were most likely to report consuming fruit less than once daily.
- Refugees who arrived in 2015-2017 (45.9%) were least likely to report consuming fruit less than once daily, followed by refugees who arrived in 2008 and earlier (48.4%).

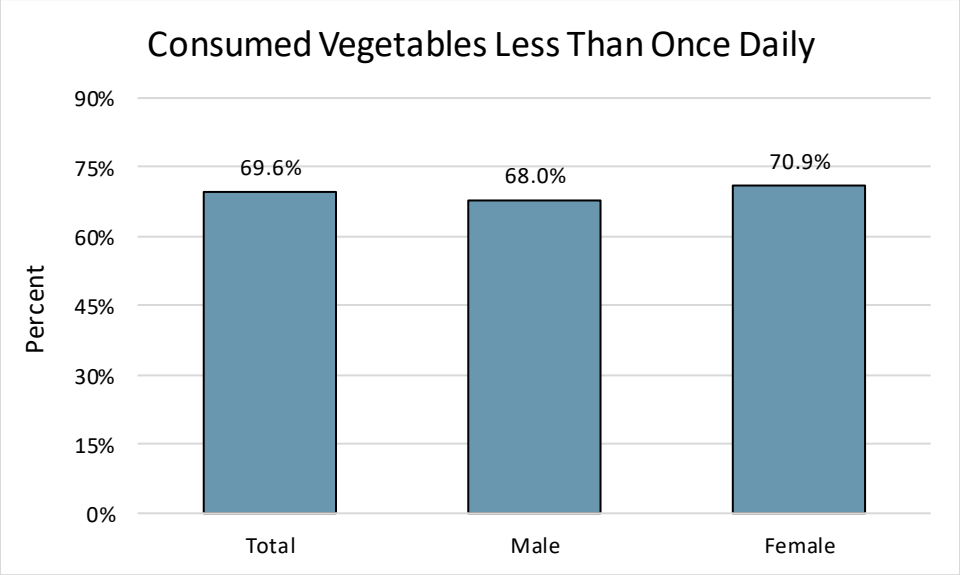


Vegetable Consumption

The chart below represents the proportion of refugees from Somalia who reported eating vegetables less than once daily.

Key Findings by Gender

- Almost 70% of refugees from Somalia reported consuming vegetables less than once daily.
- Female refugees (70.9%) were more likely than male refugees (68.0%) to report consuming vegetables less than once daily.

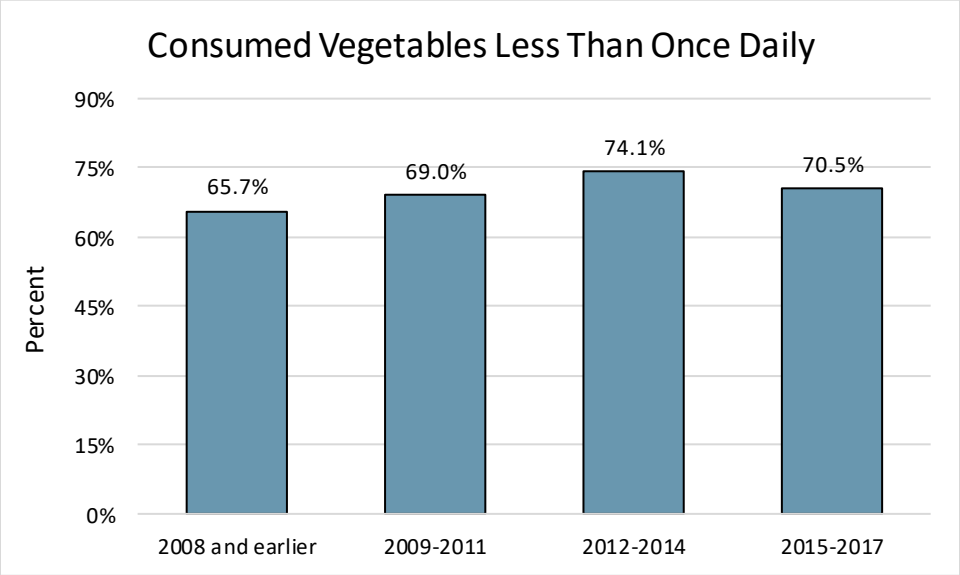


Vegetable Consumption

The chart below represents the proportion of refugees from Somalia who reported eating vegetables less than once daily.

Key Findings by Year of Arrival

- Almost three-fourths of refugees who arrived in 2012-2014 (74.1%) reported consuming vegetables less than once daily.
- Refugees who arrived in 2008 and earlier (65.7%) were least likely to report consuming vegetables less than once daily, followed by refugees who arrived in 2009-2011 (69.0%).



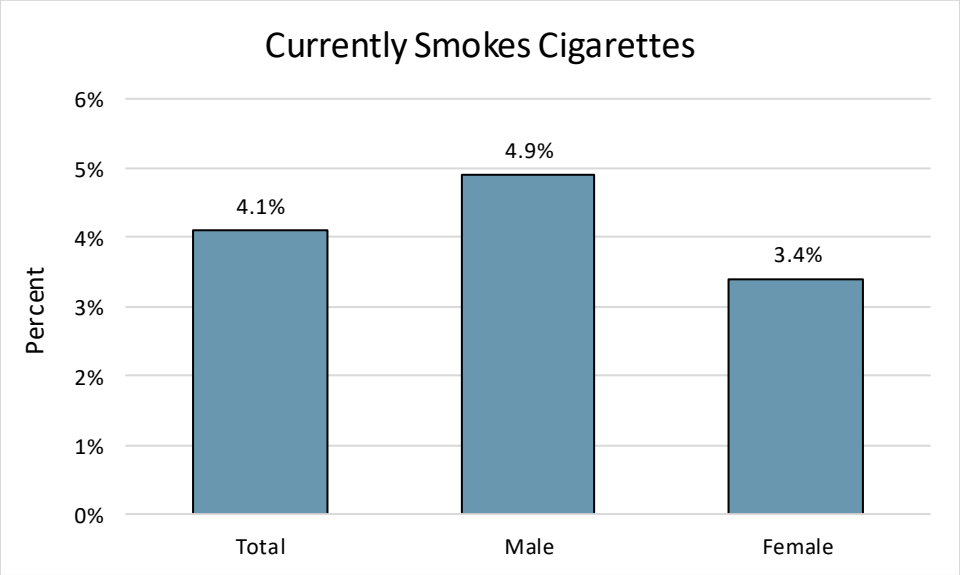
Current Cigarette Smoking

Tobacco is the leading cause of preventable death and disease in the United States. Smoking increases the risk of chronic diseases like lung disease, coronary heart disease, stroke, and various cancers.[33] Cigarette smoking causes nearly one in five deaths each year in the United States.[34]

The chart below represents the proportion of refugees from Somalia who reported currently smoking cigarettes every day or some days.

Key Findings by Gender

- Approximately four percent of refugees from Somalia (4.1%) reported being current smokers.
- Male refugees (4.9%) were 1.4 times more likely than female refugees (3.4%) to report being current smokers.



[33] Centers for Disease Control and Prevention. (2016). Health effects of cigarette smoking. Retrieved from www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/

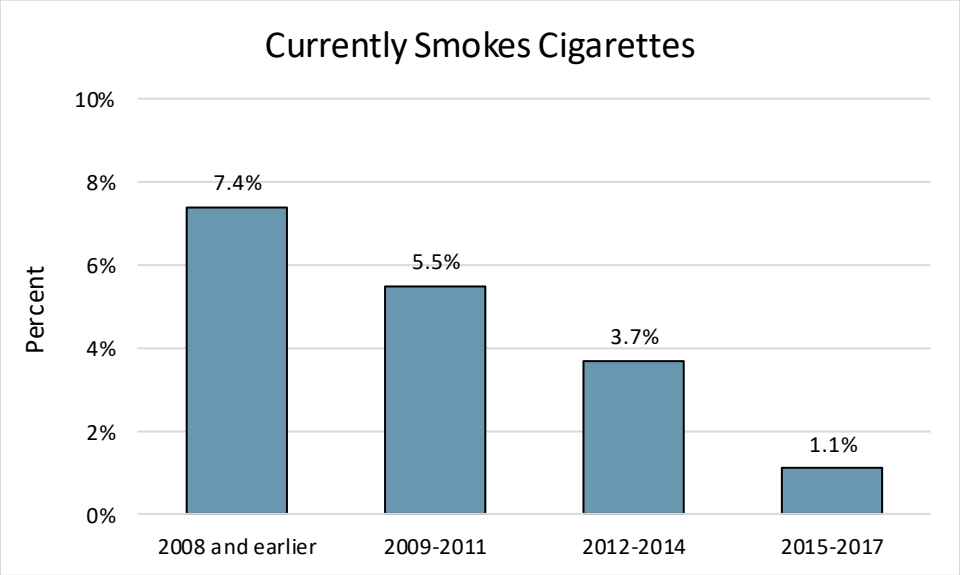
[34] Centers for Disease Control and Prevention. (2013). QuickStats: number of deaths from 10 leading causes. Retrieved from www.cdc.gov/mmwr/preview/mmwrhtml/mm6208a8.htm?s_cid=mm6208a8_w

Current Cigarette Smoking

The chart below represents the proportion of refugees from Somalia who reported currently smoking cigarettes every day or some days.

Key Findings by Year of Arrival

- The rate of refugees from Somalia who reported being current smokers increased with length of stay in the United States.
- Refugees who arrived in 2008 and earlier (7.4%) were 6.7 times more likely than refugees who arrived in 2015-2017 (1.1%) to report being current smokers.



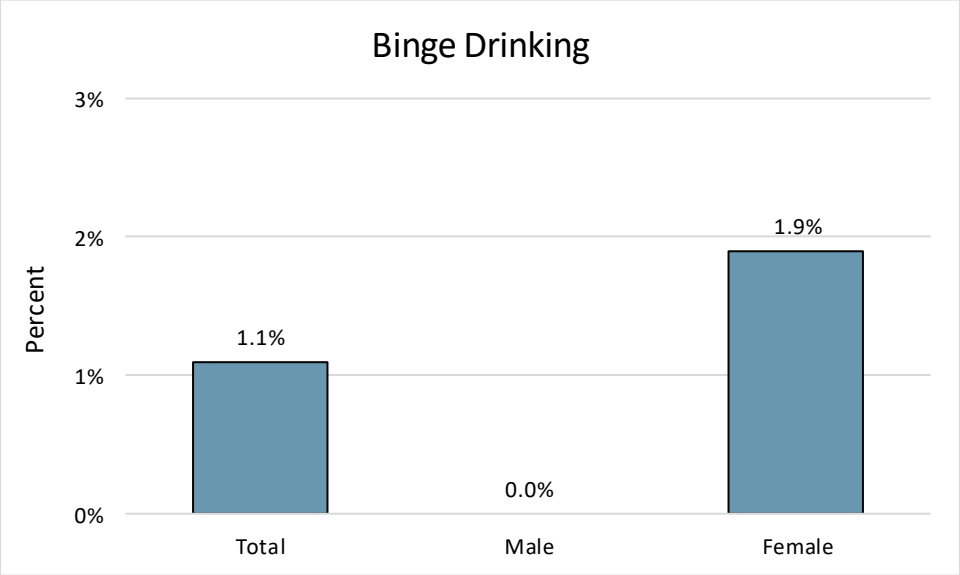
Binge Drinking

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines binge drinking as drinking five or more alcoholic beverages on any one occasion.[35]

The chart below represents the proportion of refugees from Somalia who reported having four or more drinks (for women) or five or more drinks (for men) on any one occasion in the past 30 days.

Key Findings by Gender

- Approximately one percent of refugees from Somalia (1.1%) reported binge drinking in the past month.
- Female refugees (1.9%) were more likely than male refugees (0.0%) to report binge drinking in the past month.



[35] National Institutes of Health. (2016). Drinking levels defined. Retrieved from https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking

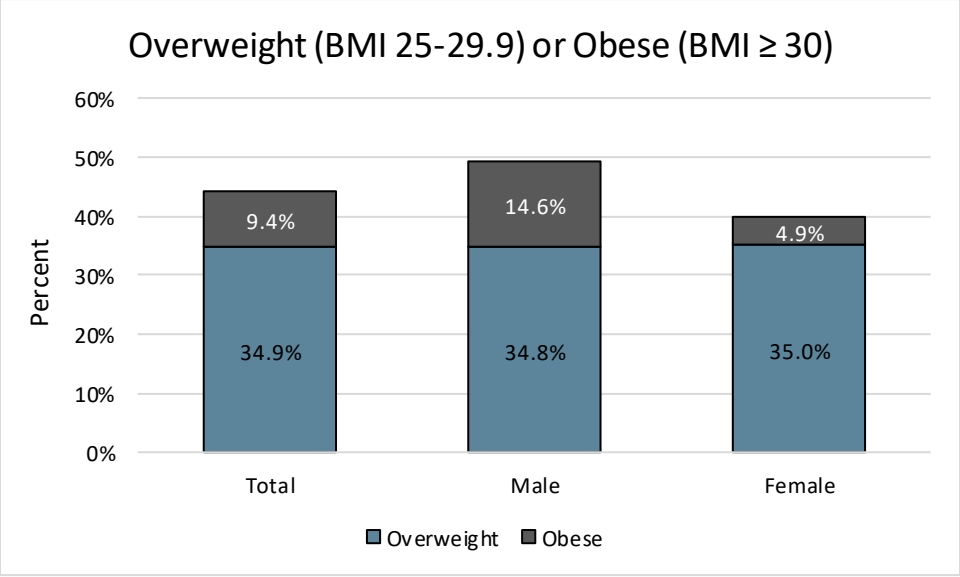
Overweight or Obese

Body Mass Index (BMI) is an estimated measure of an adult's body fat, which is determined by the ratio of one's height and weight. Higher BMIs can indicate a higher risk of heart disease, high blood pressure, type 2 diabetes, and certain cancers.[36] Individuals with a BMI of 25-29.9 are considered overweight. A Body Mass Index of 30 or higher is considered obese.

The chart below represents the proportion of refugees from Somalia with a BMI of greater than 25.

Key Findings by Gender

- Approximately 35% of refugees from Somalia (34.9%) were overweight and an additional 9.4% were obese.
- Male refugees (14.6%) were three times more likely than female refugees (4.9%) to be obese.
- Similar percentages of male refugees (34.8%) and female refugees (35.0%) were overweight.



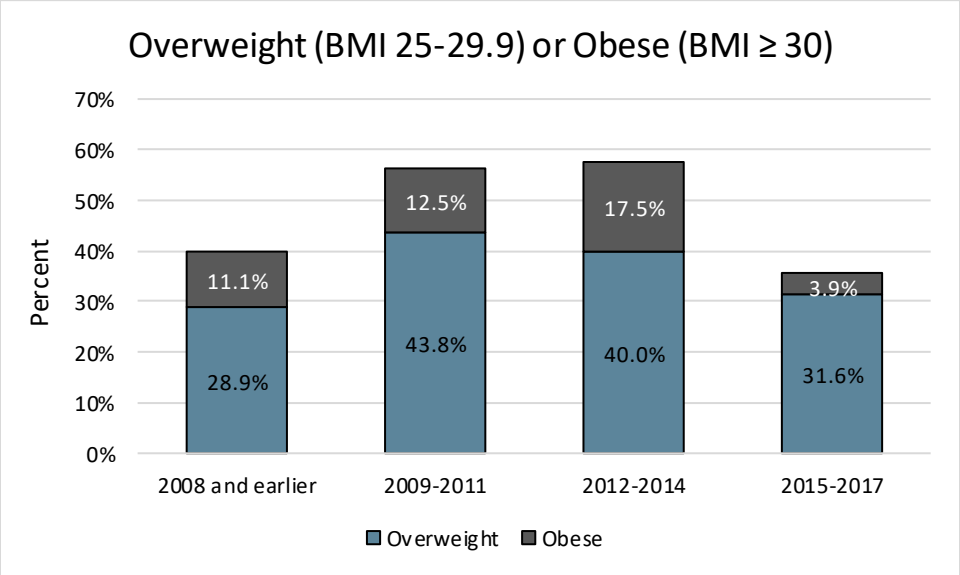
[36] National Institutes of Health. (2016). BMI Tools. Retrieved from www.nhlbi.nih.gov/health/educational/lose_wt/bmitools.htm

Overweight or Obese

The chart below represents the proportion of refugees from Somalia with a BMI of greater than 25.

Key Findings by Year of Arrival

- Refugees who arrived in 2008 and earlier (11.1%) were 2.8 times more likely than refugees who arrived in 2015-2017 (3.9%) to be obese.
- Refugees who arrived in 2009-2011 (43.8%) were most likely to be overweight, followed by refugees who arrived in 2012-2014 (40.0%).



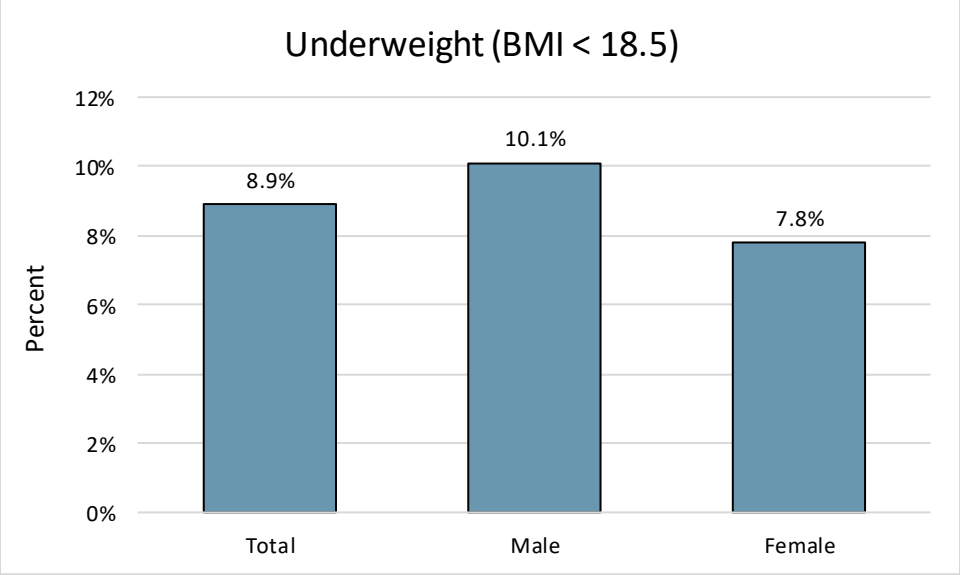
Underweight

Body Mass Index (BMI) is an estimated measure of an adult's body fat, which is determined by the ratio of one's height and weight. Individuals with a BMI lower than 18.5 are considered underweight. Being underweight can put individuals at a higher risk of not getting the amount of nutrients needed for the immune system to function properly.

The chart below represents the proportion of refugees from Somalia with a BMI lower than 18.5.

Key Findings by Gender

- Approximately nine percent of refugees from Somalia were underweight.
- Male refugees (10.1%) were 1.3 times more likely than female refugees (7.8%) to be underweight.

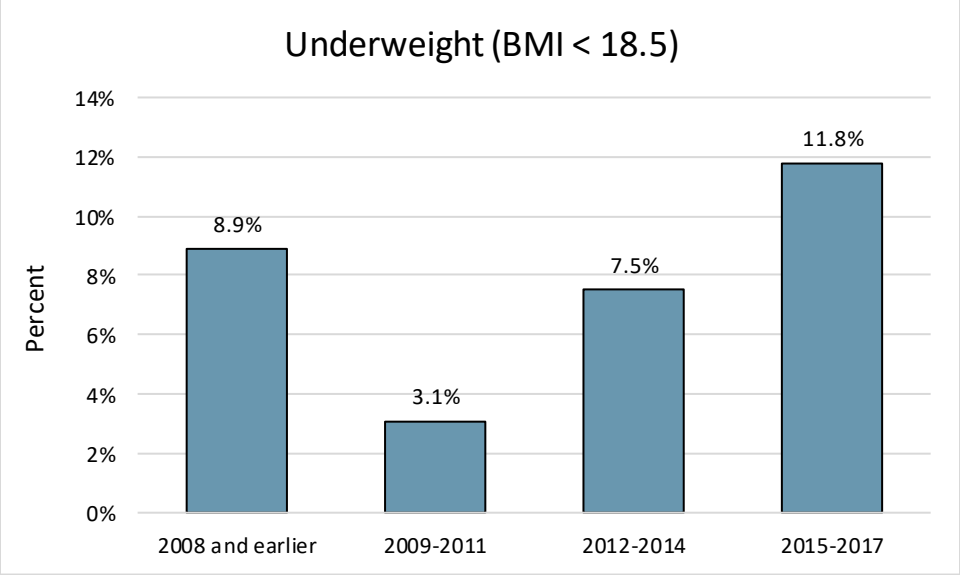


Underweight

The chart below represents the proportion of refugees from Somalia with a BMI lower than 18.5.

Key Findings by Year of Arrival

- Refugees who arrived in 2015-2017 (11.8%) were most likely to be underweight, followed by refugees who arrived in 2008 and earlier (8.9%).
- Refugees who arrived in 2009-2011 (3.1%) were least likely to be underweight.

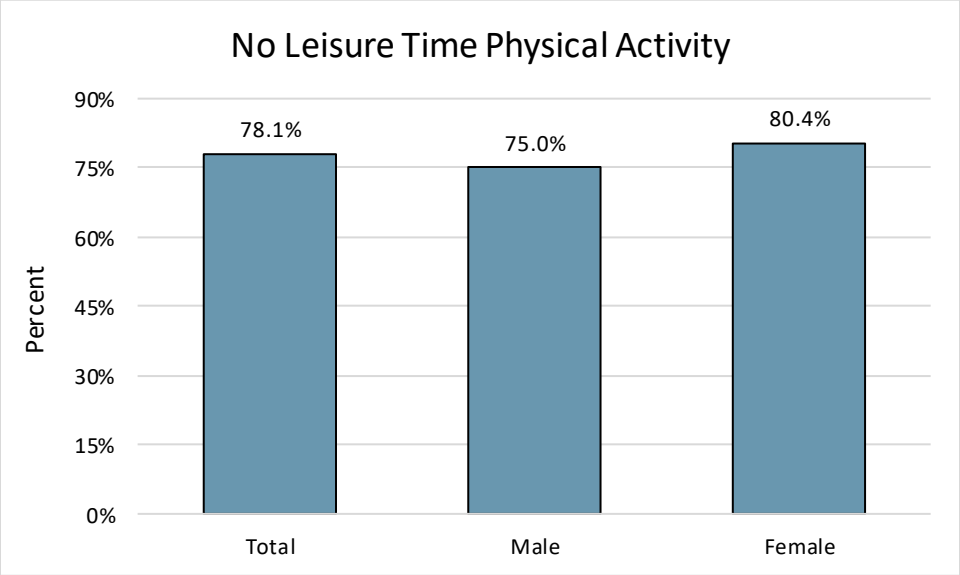


No Leisure Time Physical Activity

The chart below represents the proportion of refugees from Somalia who reported not having any physical activity outside of work.

Key Findings by Gender

- Approximately 78% of refugees from Somalia reported not having any leisure time physical activity.
- Female refugees (80.4%) were more likely than male refugees (75.0%) to report not having any leisure time physical activity.

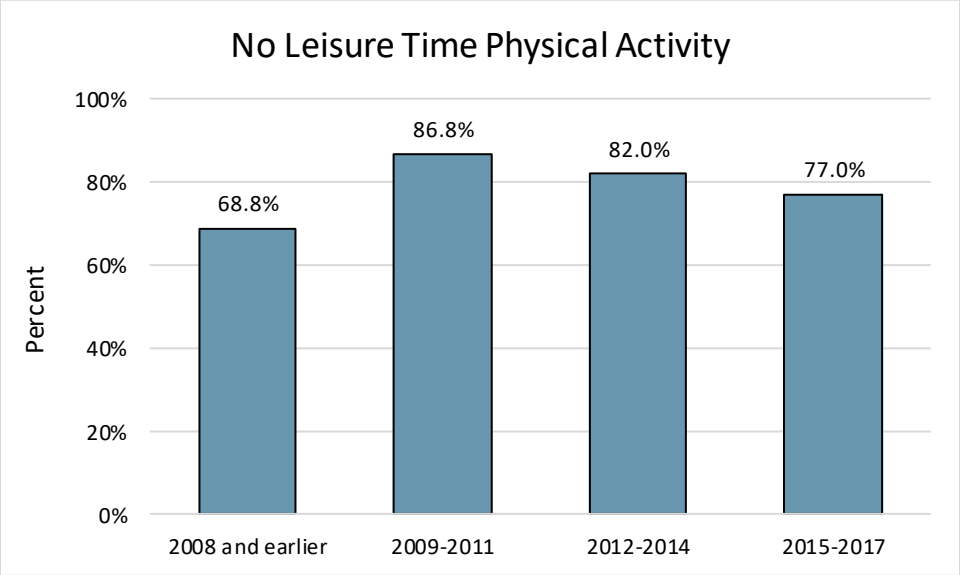


No Leisure Time Physical Activity

The chart below represents the proportion of refugees from Somalia who reported not having any physical activity outside of work.

Key Findings by Year of Arrival

- Refugees who arrived in 2009-2011 (86.8%) were most likely to report not having any leisure time physical activity, followed by refugees who arrived in 2012-2014 (82.0%).
- Refugees who arrived in 2008 and earlier (68.8%) were least likely to report not having any leisure time physical activity.



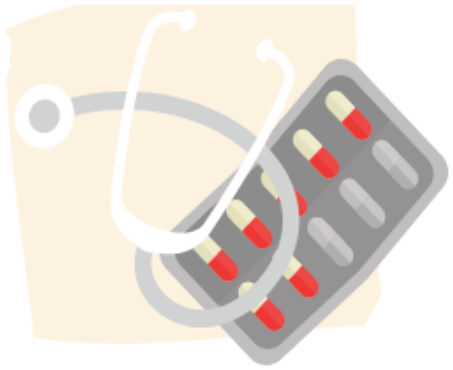
Treatment Received as Refugees

Approximately 5% of refugees from Somalia reported feeling that they were treated worse than non-refugees at work and when seeking health care.

Treated Worse at Work

Male refugees (8.1%) were 4.1 times more likely than female refugees (2.0%) to feel that they were treated worse than non-refugees at work.

Treated Worse When Seeking Health Care



Male refugees (9.4%) were 13.4 times more likely than female refugees (0.7%) to report feeling that their experience when seeking healthcare was worse than non-refugees.

Nebraska DHHS Office of Health Disparities and Health Equity
Refugee Needs Assessment 2017

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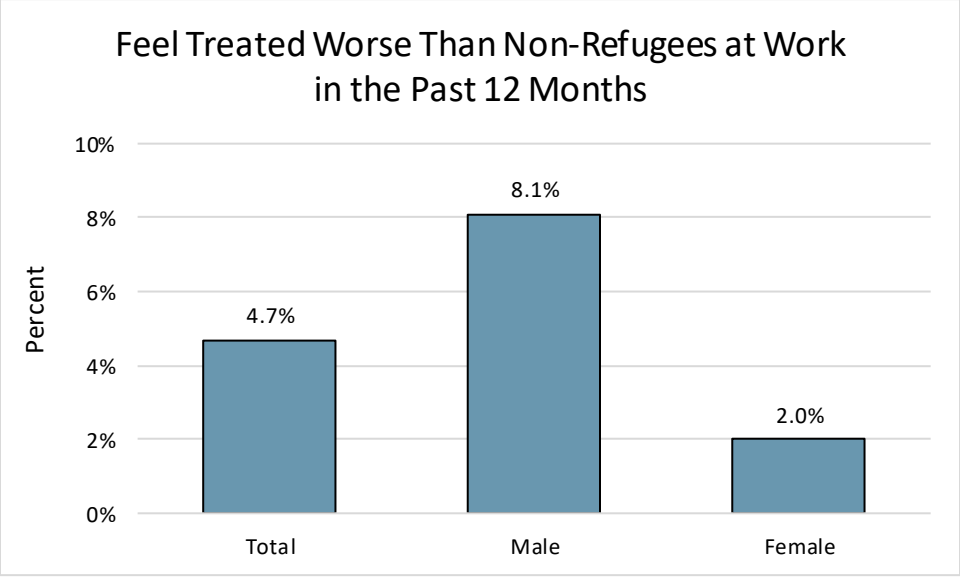
Treatment as Refugee

Treated Worse at Work

The chart below represents the proportion of refugees from Somalia who reported feeling that they were treated worse than non-refugees at work in the past 12 months.

Key Findings by Gender

- Just under five percent of refugees from Somalia reported feeling that they were treated worse than non-refugees at work in the past 12 months.
- Male refugees (8.1%) were 4.1 times more likely than female refugees (2.0%) to feel that they were treated worse than non-refugees at work in the past 12 months.

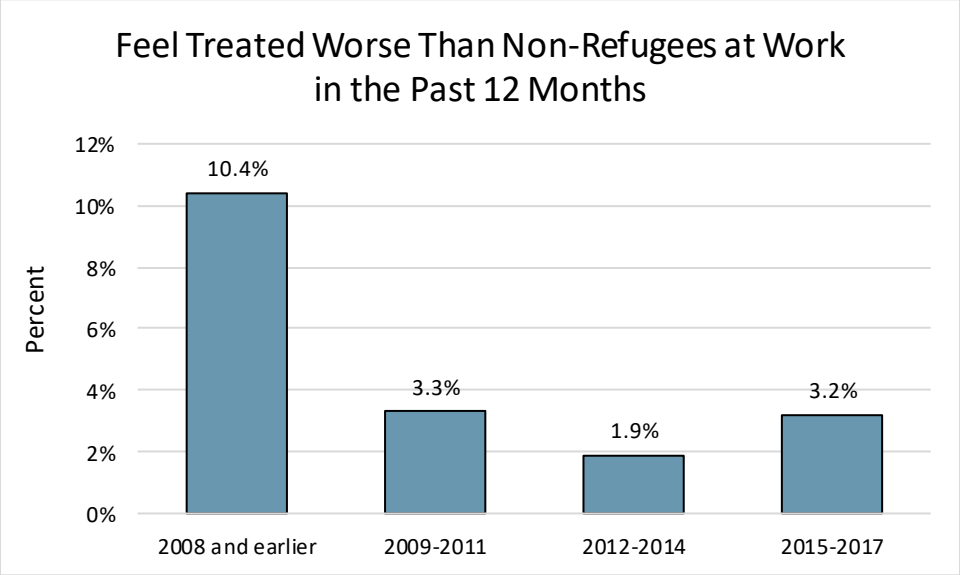


Treated Worse at Work

The chart below represents the proportion of refugees from Somalia who reported feeling that they were treated worse than non-refugees at work in the past 12 months.

Key Findings by Year of Arrival

- Refugees who arrived in 2008 and earlier (10.4%) were most likely to report feeling that they were treated worse than non-refugees at work in the past 12 months.
- Refugees who arrived in 2012-2014 (1.9%) were least likely to report feeling that they were treated worse than non-refugees at work in the past 12 months, followed by refugees who arrived in 2015-2017 (3.2%) and in 2009-2011 (3.3%).

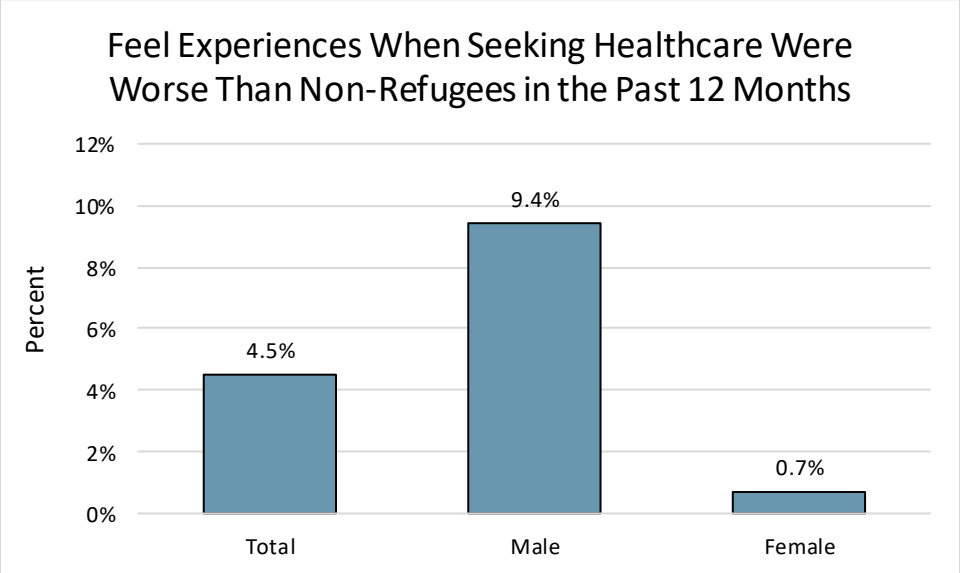


Treated Worse When Seeking Healthcare

The chart below represents the proportion of refugees from Somalia who reported feeling that they were treated worse than non-refugees when seeking healthcare in the past 12 months.

Key Findings by Gender

- Just under five percent of refugees from Somalia (4.5%) reported feeling that their experience when seeking healthcare was worse than non-refugees in the past 12 months.
- Male refugees (9.4%) were 13.4 times more likely than female refugees (0.7%) to report feeling that their experience when seeking healthcare was worse than non-refugees in the past 12 months.

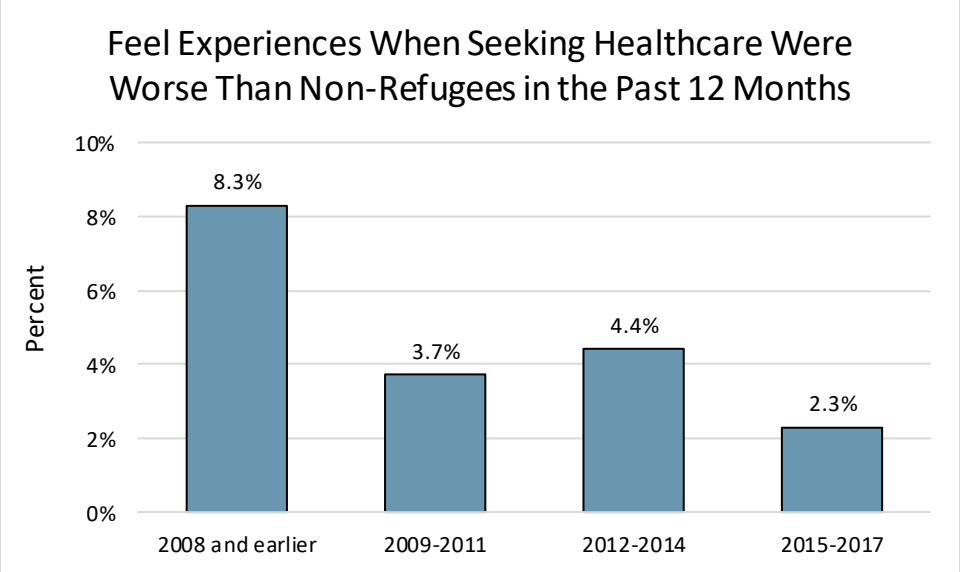


Treated Worse When Seeking Healthcare

The chart below represents the proportion of refugees from Somalia who reported feeling that they were treated worse than non-refugees when seeking healthcare in the past 12 months.

Key Findings by Year of Arrival

- Refugees who arrived in 2008 and earlier (8.3%) were 3.9 times more likely than refugees who arrived in 2015-2017 (2.3%) to report feeling that their experience when seeking healthcare was worse than that of non-refugees in the past 12 months.
- Approximately four percent of refugees who arrived in 2009-2011 (3.7%) and in 2012-2014 (4.4%) reported feeling that their experience when seeking healthcare was worse than that of non-refugees in the past 12 months.



Conclusion

The purpose of this report was to provide a snapshot of the health status and needs of the Somali Refugees in Nebraska using the data from the 2017 Nebraska Refugee Needs Assessment. The Somali refugees surveyed reported their biggest challenges as language barriers, access to health services and transportation issues. Furthermore, the Somali refugees surveyed reported their most urgent needs to be education, legal assistance and work.

The largest challenges to accessing healthcare for refugees from Somalia is the language barrier. Approximately 72% of refugees from Somalia reported language barriers as their biggest challenge in everyday life and 62% of the population reported having limited English proficiency. Additionally, 61% of refugees from Somalia reported having difficulty understanding health information from healthcare providers spoken in English. One out of every ten refugees from Somalia reported access to healthcare as their biggest challenge. The reason refugees identified healthcare as one of their biggest challenges becomes increasingly clear when looking at access indicators. Only 27% of refugees from Somalia reported having healthcare coverage and 28% reported being unable to see a doctor due to cost in the past year. As seen in this report, Somali refugees face unique challenges to reaching and maintaining a higher health status in multiple areas of their lives.

Social determinants of health can have a long and lasting impact on the health. Refugees in the United States have long suffered from social and economic disparities. This is currently seen among the Somali refugees in Nebraska. Just under 50% of refugees from Somalia did not graduate high school. Higher educational attainment is associated with higher income. For the Somali refugees, approximately 97% of this surveyed population earned less than $35,000 annually. Lastly, the rate of homeownership for the refugees surveyed was only at 3%. These clear disparities greatly impact the health of the refugees in various ways especially access to health care.

Accessing health care has a great influence on one's health status. Health status is measured by having individuals rate their health. Approximately one-fourth of refugees from Somalia perceived their health as fair or poor. This is especially bothersome as those that perceive their health status as poor or fair have higher rates of activity limitations, hospitalizations and mortality.

Health status can also be determined by medical history. High rates of chronic disease were seen across the Somali refugees as well. For example, 14% of refugees surveyed had ever been diagnosed with high blood pressure, whereas 8% had ever been diagnosed with diabetes. One possibility for the high rates is that many chronic diseases are caused by negative health behaviors. Less than half of refugees from Somalia reported having had a routine checkup in the past two years and almost 70% of refugees from Somalia (69.1%) reported sleeping less than seven hours per day.

Identifying and understanding where disparities exist among the Somali refugees in Nebraska is a step in the direction of achieving health equity. The results from the 2017 Nebraska Needs Assessment Survey show there is a need for unified support across communities, health care providers, partner organizations, and government agencies in meeting the needs of the Somali refugees in Nebraska. By acknowledging the barriers faced by this population and eliminating the duties, ensures everyone has an equal and fair opportunity to be healthy.

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