

Exploration of Health Care Needs Among Sudanese Refugee Women

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Abstract

Many Sudanese refugees that have resettled in the United States have experienced severe trauma and loss during their migration, as well as physical, social, and psychological struggles in their continued adaptation to living in a new country. This study explored the healthcare needs of Sudanese women as they transition to living in the United States. Community-Based Collaborative Action Research (CBCAR) provided a framework for the study.

Qualitative descriptive design using focus groups was utilized to explore the healthcare needs of Sudanese Women. Eighteen women participated in the study, which consisted of five educational sessions that were immediately followed by five audio-taped focus groups. The educational seminars presented topics such as parenting skills, preventative health practices, childhood illnesses, and emotional well-being. Focus groups allowed for a confidential setting in which women were able to reflect on the information presented, as well as verbalize topics that they would like to receive more education on in the future.

Three themes were identified that reflected experience of Sudanese women. These included being pulled between two worldviews in ways of parenting and communicating with children, multiple difficulties maneuvering within the US health care system, and internal struggles in meeting emotional needs in their transition to living in the United States. This study may contribute to the empowerment of Sudanese women by providing them with a greater understanding and ability to maneuver within the US healthcare system. This partnering interchange may also increase nursing knowledge in offering culturally competent care to the Sudanese community and other refugee populations that have resettled in the United States.

Introduction

Due to a civil war between northern and southern Sudan from 1983-2005, millions of Sudanese have been forced to leave their homes and find refuge in nearby countries as they apply for refugee status. During their migration to countries such as Ethiopia, Kenya, and Uganda, the Sudanese are faced with devastating struggles such as starvation and sickness. Because of this, most resettled Sudanese refugees have experienced severe trauma and loss, as well as physical, social, and psychological struggles in their continued adaptation to living in a new country (Schweitzer, Greenslade & Kagee, 2007).

Purpose and Problem

The purpose of this study was to explore the health and illness concerns of Sudanese refugee women as they transition to living in the United States. Identifying specific health issues within this population will allow nurses and healthcare staff to provide more holistic care for the Sudanese, as well as educate health professionals in becoming more culturally competent for Sudanese refugee communities.

Research Questions

Our study was guided by 3 primary research questions. These questions were as follows: 1) What are the Sudanese refugee women's major health concerns for themselves and their family? 2) What are the barriers that Sudanese refugee women face in obtaining healthcare for themselves and their family? 3) What are Sudanese refugee women's perceptions of the interactions with healthcare providers and their ability to meet their healthcare needs?

Literature Review

History and Background of Sudanese Refugees

According to section 101(a) (42) of the Immigration and Nationality Act (INA), a refugee is "a person who is unable or unwilling to return to his or her country of nationality because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion" (United States Citizenship and Immigration Services, 2010, p.1). Within the past decade, there has been a great increase in the number of refugees and displaced persons around the world. In 2008 statistics, there were "approximately 14 million refugees, and an additional 23.6 million people [were] internally displaced" (Khawaja, White, Schweitzer & Greenslade, 2008, p. 489). Majority of these immigrants are fleeing situations that involve warfare and famine in which significant trauma is experienced (Khawaja et al., 2008). According to statistics from the United Nations High Commissioner for Refugees (UNHCR), refugees are scattered throughout the world, with more than 50% from Asia and 20% from Africa. Before resettlement, refugees live in widely varying conditions, ranging from well-established camps to makeshift shelters or living in the open. Since the early 1990s over 20,000 Sudanese, most from southern Sudan, have resettled to the US, with nearly 2,500 of them resettled in the KC metropolitan area (United Nations High Commissioner for Refugees, 2010).

Covering more than one million square miles, Sudan is the largest country in Africa. According to Kemp and Rasbridge's article (2001), the suffering is "large scale, with political and religious oppression, famine, flood, locusts, and warfare endemic" (p. 110). In Sudan, the country is essentially split between two religions: the Muslim north and the Christian south. When violence

erupted between these opposing sides of the country in 1983, a civil war began that has taken over two million Sudanese lives within the past two decades. Due to war and drought, food shortages have occurred in the south leading to famines that add to the disparity of the country.

According to Schweitzer, Greenslade and Kagee (2007), nearly 5.5 million refugees have been forced to flee their homes and have either become internally displaced persons (IDP's) within the country's borders or are living in refugee camps in nearby states. Most refugees fled to neighboring states, such as Egypt, Kenya, Uganda and the Democratic Republic of Congo. After fleeing their homeland, many refugees will permanently reside in a new area within their nation, while others will apply for refugee status and be resettled in a new country. The most common countries for resettlement are Canada, United States, and Australia (Dormitorio, Sachs, Ali & Omar, 2008). During migration, the "majority of refugees reported being separated from their families, experiencing violence, witnessing murder of family or friends and being deprived of basic needs" (Schweitzer et al., 2006, p. 184).

Sudanese Cultural Values and Health Beliefs

Culture in Sudan varies greatly within each region of the country. Regarding language, the Sudanese people are diverse with each tribe having its own language and often several dialects within that language (Kemp & Rasbridge, 2001). English was the official language in Sudan until they gained independence in 1956 and it was replaced with Arabic by the northern Khartoum government (Kemp & Rasbridge, 2001). The written languages are *Dinka* and *Nuer*, but these tribal languages can only be read by those who have been through adequate schooling. Literacy rates are low among the Sudanese, and have dropped even lower during the civil war since schooling has been disrupted by warfare.

Health beliefs within the Sudanese culture are quite different between the northern Muslim and southern Christian areas of the country. For example, "almost 90% of women from northern Sudan have had genital cutting performed", whereas this practice is not as common among the Christians in southern Sudan (Kemp & Rasbridge, 2001, p. 111). The Sudanese have many alternative medical practices that are used as remedies for common sicknesses. For example, a widely used cure for migraine headaches is a chalky compound...that is rubbed over the head (Kemp & Rasbridge, 2001). Kemp's (2001) article provided multiple illustrations of the Sudanese people's remedies for a variety of illnesses, and it also states that, "even highly educated southern Sudanese may view this treatment as more effective than Western medications" (p. 112). As a result of chronic shortages of health care and medication in their homeland, it is not uncommon for

Sudanese to share over-the-counter medications and prescription drugs with one another if symptoms are similar (Kemp & Rasbridge, 2001).

A frequent finding in southern Sudan is the strong belief of the interconnectedness between health, cultural practices and spirituality. For example, “failure by a husband to meet the bridewealth obligation is believed to result in a family curse that may cause abortion or death of children in a marriage” (Onyango & Mott, 2011, p. 376). In Sudan, payment of bridewealth from the husband to the woman’s relatives is a symbolic binding of the commitment between families that play a significant role in the normal functioning of the Sudanese social structures within the society (Onyango & Mott, 2011). Interestingly, southern Sudan has “one of the highest maternal mortality ratios in the world, estimated at 2,054 per 100,000 live births” (Onyango & Mott, 2011, p. 376). This is most likely due to abortion complications and failure of the woman to access appropriate healthcare during pregnancy and childbirth.

In southern Sudan, a woman is considered the property of her husband once she is married. Sudanese women are not allowed to make important decisions in the family because all authority belongs to the males, the women essentially have “no rights or voice in South Sudan” (Onyango & Mott, 2011, p. 382). Although the culture does not support physical abuse because of the woman’s reproductive importance, a “husband can beat his wife if he discerns she is not listening to him” (Onyango & Mott, 2011, p. 382), illustrating that women have value more as a commodity rather than a person.

Because of the poor living conditions, the Sudanese people in Sudan typically do not receive any healthcare assistance unless they are severely ill, and even then, most will use traditional healers in an attempt to cure themselves. This type of healer will use herbs, cutting to release “bad blood”, and sacrificing of animals to expel evil spirits in the home (G. Tanui, personal communication, February 2, 2012).

Sudanese Transitioning to Living in the United States

In her work with refugees at Jewish Vocational Services (JVS) in Kansas City, Gladys Tanui, BSN, provided some insight into the process of transitioning refugees from their homeland to the United States. “There is no specific time line between fleeing from their country to being resettled in a new country; some refugees have been in camps for several years, some even decades, before they are resettled. They have to apply with the UNHCR (The UN Refugee Agency) through their offices in the host countries, and this process may take several years to complete due to the large number of applications” (G. Tanui, personal communication, February 2, 2012). For 2012, the

United States will only accept 72,000 refugees, leaving millions of refugees left to struggle in their host countries (G. Tanui, personal communication, February 2, 2012).

As a result of the difficult migration process, millions of Sudanese have experienced instability as they live without critical resources, such as food and health care, for as long as two decades (Willis & Nkwocha, 2006). As noted above, refugees from Sudan that are accepted for resettlement into the US are primarily from southern Sudan. These refugees are composed of various minority ethnic groups fleeing religious and political persecution, warfare, and starvation (Kemp & Rasbridge, 2001). Due to warfare and extreme poverty, nearly all Sudanese refugees had limited access to health education and treatment prior to resettlement in the United States (Willis & Nkwocha, 2006).

Sudanese fleeing their country undoubtedly faced incredible stress, as they have endured the loss of loved ones and situations of extreme violence or trauma. Such emotional traumatic experiences can “challenge their sense of empowerment, identity and meaning in life” (Schweitzer et al., 2006, p. 180). Experiencing such trauma does cause the refugee population to be more vulnerable for poor adjustment in their transition to a new country, especially when combined with psychological stress.

Although agencies do the best they can to help the transition process, refugees are generally faced with language and cultural barriers that make it difficult for them to assimilate into the American society. Also, a huge factor in a refugee’s resettlement process is the cultural transition to a Westernized fast-paced society driven by technology (Willis & Nkwocha, 2006).

In the United States, southern Sudanese are confronted with a myriad of new cultural traditions and options as they transition into the American culture (Kemp & Rasbridge, 2011), but findings suggest that Sudanese people tend to avoid high risk behaviors within their new country. The Willis and Nkwocha (2006) article identifies that “refugees from Sudan are not engaging high risk behaviors known to impact health” such as smoking cigarettes and/or drinking alcohol. Also, “refugees report consistent use of safety behaviors, for example, seat belt use in the car, [and] concern about diet in the United States” (p. 31). As far as coping during their transitional period, consistent methods have been identified as refugees use religion, social support, cognitive reframing, and thinking of the future as ways to deal with their current stressors in life (Khawaja, White, Schweitzer & Greenslade, 2008).

Sudanese Issues of Health and Illness Upon Resettlement

Refugees face many barriers in their attempt to access healthcare, along with a health workforce with a generally low awareness of issues specific to refugees (Murray & Skull, 2005). Murray and Skull (2005) addressed several “hurdles to health” that make it difficult for refugees in Australia to receive adequate health care in their new country of resettlement. These identified hurdles included: economics and unemployment, cultural difference, language difficulties, an under-trained workforce, legal barriers, and the impact of current policies.

An article by Willis and Nkwocha (2006) identifies that health has been neglected in Sudanese refugees living in the US stating, “Sudanese refugee patients in a Minnesota health clinic had to be treated for a number of pre-existing conditions” (p. 20). Willis and Nkwocha (2006) also notes that for Sudanese refugees living in Nebraska, “nearly 40% [of refugees] do not have health or dental insurance, 20% have never visited a dental or eye care professional, and 11% have never been to a doctor” (p. 19). Furthermore, preventative health measures are rarely used in the Sudanese population, as demonstrated by nearly half of the female respondents never having had a clinical breast exam or pap smear performed. Willis and Nkwocha (2006) believe that the lack of understanding of HIV and AIDS, along with participating in preventative healthcare is most likely not taken advantage of due to financial constraint and a lack of education.

Studies suggest (Schweitzer et al., 2007) that the Sudanese refugees have experienced traumatic events that “may lead to an increased risk of psychological distress” and have left this population prone to emotional distress, symptoms of post-traumatic stress, anxiety and depression (p. 283). Schweitzer’s article (2007) goes on to note that despite the hardships refugees have faced, reports of resettled refugees demonstrate that this population is extremely resilient and have high expectations for the future.

Theoretical Framework

Our study utilized the Community-Based Collaborative Action Research (CBCAR) framework which includes the tenets of participation, knowledge attainment, empowerment, and social action to create a positive change in the community (Velde, Williamson & Ogilvie, 2009). This framework allows both parties to actively participate in the study that results in knowledge attainment for both the researcher and participants. In Pavlish and Pharris’ book on CBCAR (2010), the assumptions of this research method are defined. The following is a condensed version of assumptions incorporated within this research study:

1. Communities have the best insight into their own situations, and change within a population can be both transformational and unpredictable

2. For nurses, social justice is a mandate to identify and address inequalities and threats to human rights, freedoms, and capabilities
3. The purpose of research is to address inequalities and promote human flourishing
4. Patterns of health are recognized as nurses partner with communities and study the interactions between people and their environment.
5. Dialogue centered on significance gives rise to unforeseen learning and action potential

Methods

Research Design

A qualitative descriptive design using focus groups was used to explore the healthcare needs of Sudanese Women. This research method allowed for a thematic summary of Sudanese refugee women's experiences of health and illness concerns as they transition to living in the United States (Sandelowski, 2000).

Sample and Setting

The participants of this study were twenty women between the ages of 20-67 that participated in educational sessions and focus groups. These women have been in the United States for 7-16 years, and speak Dinka, Arabic, English, or a combination of these languages. All of the women in the study originated from villages in southern Sudan and were forced out of their homeland because of religious and racial persecution. They left due to fear for their safety and the safety of their family members. Many witnessed the murdering of loved ones. All of the women in this study migrated with their children and family members across multiple international borders to reach a place of refuge where they started a new life in countries of protection and applied for refugee status.

All participants were invited to five educational sessions. The sessions covered preventative health practices, women's health throughout the lifespan, childhood illnesses, parenting, and women's emotional well-being. These sessions were held on Saturday mornings in a designated room that was located in their church (agreed upon location by participants and researchers) they attended for Sunday services. Focus groups followed these educational sessions to elicit the helpfulness of the educational topic presented and to identify further educational needs. Focus groups were conducted in the same room that was identified as a private area. Childcare was also provided in another space within the church setting. Lunch was provided between the educational

sessions and focus groups. All participants of the educational session were invited to join the focus group and were assured that their participation in the focus group was completely voluntary.

Data Collection

Data for the study was collected by means of descriptive demographics used so that the sample could be described for the study. Data collection also included observation participation (observation throughout educational sessions and focus groups), field notes (taken throughout the study), five educational sessions (sessions addressed healthcare topics chosen by the women), and audio-taped focus groups consisting of 7 to 13 women (conducted immediately after educational sessions). Prior to each of the focus groups, review of the consent for any new group participants was completed. An refugee woman was used during all study activities to translate between Dinka, Arabic, and English. All focus groups were audio-taped and transcribed into English with back translation.

Data Analysis

Qualitative content analysis was conducted on all six transcribed focus groups. In inductive content analysis, meaning units, codes, categories, and overarching themes are developed from all focus groups (Elo & Kyngas, 2007). Graneheim and Lundman (2004) identify that the goal of this type of analysis seeks to recognize the underlying meanings of the text. After the initial reading of the transcriptions, hand coding was completed to identify meaning units, and primary and secondary codes. Codes were then grouped into categories. Categories were condensed to form a specific pattern of meaning. Overarching themes were then developed that incorporated field notes and observations. Throughout the analysis and interpretation, debriefing was done with student and instructor to support the accuracy of the analysis and interpretation of all data.

Credibility and Trustworthiness

Focus groups were transcribed in English with back translation to ensure credibility, along with peer debriefing with co-investigators and student research colleagues throughout data collection and analysis and interpretation. Personal engagement in the study consisted of attending educational sessions and focus groups with the women, as well as participating in Sudanese church services. Also, personal reflective journals were kept by all members of the research team to support the trustworthiness of the findings (Lincoln & Guba, 1985).

Human Subjects Protection

Proposal for this study received approval by the university Institutional Review Board, and a verbal consent was read at the beginning of each focus group, which also explained that

participants were able to leave or withdraw at any point in the study. Participants were assured that their confidentiality was protected at all times. All identifying information was removed to conceal the identity of the women.

Findings

Preliminary findings included Sudanese women's desire for a greater understanding in accessing healthcare. The findings identified three overarching themes as Sudanese women struggle with their transition to the living in the United States. 1) The first theme identified Sudanese women's experiences of being pulled between two worldviews in ways of parenting and communicating with children. 2) Secondly, the women experienced multiple difficulties maneuvering within the United States health care system. 3) The third theme identified the internal struggles of Sudanese women experience in meeting their emotional needs in their transition to living in the United States.

Theme 1: Sudanese women experience of being pulled between two worldviews in ways of parenting and communicating with children

The first theme consisted of two major categories:

Category 1: Conflicting beliefs of appropriate ways of interacting within family and community

During the focus group with of STD education, several of the women stated that they were not comfortable talking to their daughters about sex and self-hygiene, and it was common practice for the mothers to have relatives discuss personal issues with their daughters. A mother in the study gives an example of calling a friend and saying, "okay you are my aide, my daughter is doing this, I don't know if she's sleeping with somebody and maybe something's happening, could you come and talk to her?" Issues of privacy or sexual relations are typically not discussed with parents in the Sudanese culture. As a result of not having extended family living in the US, daughters are not being educated about normal sexual development, receiving information on sexual health, and being supported in making important sexual decisions. Left to feel that her only option was for her daughter to obtain this information from the clinic, one participant shared, "...you can talk to your daughter and let her go to the doctor for what's going on for her. We don't use the other thing [mothers talking to daughters about sexual practices], in my country, you don't talk to your daughter about it".

Category 2: Difficulties in raising Sudanese children in US culture.

As a result of the educational session on parenting, the study found that raising children in the United States has proved to be difficult for both parents and children because they are being pulled between two very different worldviews. Furthermore, Sudanese children are often better adapted to US culture which makes it challenging for parents to be a role model for their children. One woman describes how language is more difficult for her than her children by saying, "We speak broken English and when we want to say something to the system, we don't get our point across. While the child is just like speaking like this." Women felt that this disconnect between cultures has caused them to become more lenient with their children and more likely to 'give in' since the culture in America is not what they are accustomed to. Not knowing what else to do, one woman shares her dilemma, "So it's not because we blaming it on America or anything, but it's a sticking [stuck] between cultures. And also we give up so quick, that's another thing. Yea, we give up really quick."

Social norms according to the Sudanese culture have also presented struggles in raising Sudanese children in America. For example, women stated that in Sudan, children were taught to not make eye contact as a sign of respect to authority, but in America, the lack of eye contact is seen as disrespectful. One Sudanese woman, who came to America as an adolescent, shared this continued conflict as she described her experience, "So, if I'm talking to American like I'm talking to you I figure out that I have to look you in the eye. But if I'm talking like, right now I'm talking to my mother, I have to talk differently."

Theme 2: Sudanese women experiencing multiple difficulties in maneuvering within the US healthcare system

The second theme consisted of two major categories:

Category 1: Sudanese perception of interactions with US healthcare providers and payment options.

Information from the women suggested that American health care providers are not spending enough time with Sudanese patients for them to understand the information they are given, as well as additional education not being readily available for their use. Also, women feel that they are expected to know more about health care than they actually do, and this is why visits to the clinic only result in confusion and a large medical bill that most Sudanese are unable to pay. One woman states,

Like in America the patient visit is like for ten minutes for every patient, but Sudanese or somebody who maybe don't...it's like...we don't have patient education...we don't know about, you know,

anything. So when they go they want to limit that in 15 minutes and we have much to talk about, sometimes hard. And especially when you have an interpreter to interpret everything is like...it's terrible because they don't want to go more than that, so it's one of the problems too.

In their experiences with healthcare providers, women feel that the providers are not aware of the Sudanese culture and health providers are not listening to their concerns. From a financial aspect, the study found that the fear of receiving large medical fees prevents many Sudanese people from seeking care, and that most Sudanese families do not have health insurance or Medicaid to cover medical bills. This concern is demonstrated by one participant stating, "...you can be sick and sometime you don't want to go because you maybe inside you have a big problem when you go to the hospital they don't give you medicine and you come back with a big bill. So I think it's something too to make people don't go to the doctor".

Category 2: Healthcare knowledge needs of Sudanese women.

Sudanese women have a genuine desire for a greater understanding in the appropriate use of medications and vaccines. One woman gave an example of how she stopped taking her blood pressure medication because she felt that she didn't need it, but then she had to be hospitalized as a result of dangerous symptoms related to her hypertension. The women also wanted further information on preventative health screens such as pap smears and mammograms, STD's, childhood illnesses, women's health throughout the lifespan, and an understanding of how infections are spread. In speaking about infection, a participant states, "Because our concept in my community whoever is infected is related to hygiene. You think you are not clean enough." The women in the focus group were committed to provide health related information to other Sudanese women in their community. This was illustrated by the women's request, to receive all educational information provided during the research project to take back to their community, to educate other women on these health topics.

Theme 3: Sudanese women's internal struggles in meeting emotional needs in their transition to living in the United States

The third theme consisted of two major categories:

Category 1: Sudanese perception of mental health and emotional coping.

In Sudan, there were few resources available regarding mental health, so Sudanese people typically turned to God and family for support and help. Our findings reflected this as one participant stated,

When we grown up back home there is no hospital. If you have mental problem there is nowhere you going to go to attend the medical [health facility] anywhere of [for] medication. So the way that you handle it is to pray to God to help you...So I think for me I understand it that way because if we were in America and you have a mental [problem] you will go to the hospital and they will help.... Us the only way that we have to help each other is the family praying and all of that.

Although mental health facilities such as ambulatory health centers are available for refugees in US, most Sudanese prefer to use prayer as a form of healing, and depend on God for help with their emotions. A Sudanese woman reiterated this by saying, "If you pray and you call God you will be okay in your mind...We believe in God and God help us." Women stated that they use their faith to cope with stress and tragedy, and it is difficult for them to consider alternatives to help in this process.

Sudanese women do not see traumatic life experiences as something that requires additional assistance to support coping skills. As one participant stated, "There are some countries like if you are stressed or traumatized, you need help. Like [people] from different [countries] they said, 'oh my brother was killed in front of me and I cannot get this image out of, you know, my mind, I need help with this'. But Sudanese we don't see these as a problem." Women explained that the view of mental health in their culture is 'someone that is crazy', so this causes Sudanese people to not want to be associated with mental health issues. The women explained that "...we define it like craziness and then when we don't think we are crazy, we don't think it applies to us." One participant gave an example of how the stress of her husband's death led to her forgetting to put her clothes on before leaving the house. It was only after this occurred that she realized how overwhelmed she was. Another woman elaborates on the Sudanese perception of mental health by saying,

We don't believe in mental problems or emotional problems. I would think like whoever just like have an emotional problem is crazy. We are women of pride. I'm proud, I don't want to just like appear

depressed or I did this or I did this because people are going to make fun of me. We are very close, we are very tight...we are strong, we don't give up, we don't get stressed, we don't cry, we don't do this. So all the time when you have mental problem or emotional problem you feel guilty. You feel like you didn't handle it right. You didn't handle the Sudanese way or the Dinka way, that's some of the problem.

Category 2: Additional stressful issues related to transition.

As a result of their inability to pay large medical fees, many Sudanese feel as if they are still living in Africa since they are unable to receive needed medical treatment. A participant states, "Lot of Sudanese they are like that, we don't go to hospital, what we going to do? Lot of refugee women and men they are here like that. You don't have any treatment, you are like in Africa." Women discussed that the financial struggle in America is almost worse than it was in Sudan, and that the financial stress of raising a large family in the United States makes their transition even more difficult.

Discussion and Conclusion

The purpose of this paper was to explore the healthcare concerns of Sudanese refugee women as they transition to living in the United States. The study was led by three primary research questions. The first research question concerning Sudanese women's major health concerns was addressed primarily in the second theme that identified multiple difficulties that Sudanese face as they maneuver within the US healthcare system. Our second research question was to identify the barriers that refugee Sudanese women face in obtaining healthcare for themselves and their family. This question was addressed by themes two and three, which concentrated on the difficulties encountered in seeking healthcare within the US healthcare and the internal struggles Sudanese women experience in meeting their emotional needs. Perception of interactions with healthcare providers, the third research question, was again addressed by theme two and three. Another major finding of this study identified the conflicts that Sudanese women face in communicating with and parenting their children and the continued pull between two worldviews. Sudanese women also expressed the internal conflicts of remaining strong in the face of multiple traumas and stress while also needing to be supported and comforted by members of their community. The women also shared how Sudanese cultural beliefs of infertility or being

divorced increases stress and isolation as a result of the negative judgment imparted by family and community members.

Many of the barriers that Sudanese women identified in this study are consistent with previous qualitative studies with refugee populations. In a study by Schweitzer, Melville, Steel, and Lacherez (2006), findings suggested that social support played a significant role in mental health outcomes for Sudanese refugees that had faced trauma during migration. This was a similar finding in our study in that Sudanese women spoke of the importance of being able to share and trust other women within their community to gain support and comfort. Another study by Schweitzer, Greenslade, and Kagee (2007) had similar findings as it identified three themes that predicted Sudanese refugee's ability to cope during pre-migration from Sudan and post-migration in their host country. The attributing characteristics were religious beliefs, social support, and personal qualities. Murray and Skull (2005) conducted a study in Australia that identified barriers refugees face as they seek health care in a new country. Findings from their study recognized cultural differences, language difficulties, a workforce not trained in refugee health, legal barriers, and issues of economics and employment as the primary obstacles refugees faced in accessing health care. The outcomes from Murray and Skull's (2005) findings were similar to the findings from our study with the Sudanese refugee population in the Kansas City metropolitan area.

The CBCAR framework was utilized in this study by assessing the Sudanese community, acquiring data from observations and focus groups, and presenting the findings to the community to implement social action. Booklets were created on all information presented during the healthcare sessions so that women could have resources to use when educating other Sudanese women within their community.

The limitations of this study included hearing the health and illness concerns of only eighteen Sudanese women living in the Midwestern US that attended the educational sessions and focus groups. The women spoke of other healthcare information they desired but because of the time frame of the research these educational sessions could not be implemented within this study. These findings cannot be generalized to all refugee populations that have transitioned to the US since their history of pre-migration and migration may be very different. This study does provide a lens into the difficulties and health and illness concerns these particular refugee women have faced during their transition to living in the US. Even with these limitations, multiple positive results have occurred during this research. One positive outcome is that this study provided insight into the culture and struggles Sudanese women face during their resettlement. Women learned how they could access preventative health care services, and many of them followed through with well-

women exams & mammograms. Also, women learned that they could utilize nurses in schools and clinics as a resource to talk to their daughters about issues of sexuality. Another benefit from this study is that women were able to verbalize the emotional stress that they have endured during their migration and transition to the United States.

This study may contribute to the empowerment of Sudanese women by providing them with a greater understanding and ability to maneuver within the US healthcare system. At the same time this partnering interchange increases nursing knowledge in offering culturally competent care to the Sudanese community and other refugee populations that have resettled in the United States. “By acknowledging the potential of refugees, health care professionals can develop interventions that empower women by maximizing their innate resources” (Baird, 2009, p.187).

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