

Healthy Eating in King County East African Communities

An Assessment of Perceptions, Preferences & Circumstances
Influencing Food Choice



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Summary

Through the Rainier Valley Eats! (RaVE) program, East African Community Services (EACS) and Public Health - Seattle & King County (PHSKC) are working to improve health by increasing knowledge of, and access to healthy food in local East African communities. We have conducted a preliminary assessment of food practices and preferences among groups of East African Seattle residents to help guide the planning of community forums on nutrition, to be organized by EACS with support from RaVE. Through a series of key informant interviews and focus groups, we received feedback from men, women, and teens of a variety of East African national and cultural backgrounds. Our discussions with participants were guided by four main questions, exploring current food practices and preferences, beliefs and understanding, and desire for future knowledge and activities. The Oromo adults we spoke with had a high level of knowledge of specific nutrition information, while the Somali women were less confident in this type of information and described food related decision-making in terms of personal experience and cultural tradition. Our interviews also revealed the variety of traditional versus “American” food preferences and practices among age groups and immigrant statuses. We further describe such differences, as well as notable similarities between groups and individuals, in this report.

EACS plans to present separate forums to specific language/ethnic communities. Based on the information we have gathered, we further recommend the following: that the events be tailored to women, but be open to all members of the community; that events focus primarily on answering questions people already have about food and their health instead of introducing large amounts of new information “from scratch”; and that the events include a casual question-and-answer style discussion with a physician as a main component. We believe these attributes will make the forums relevant, useful, and engaging to target audiences and will be of great value to the communities.

I. Introduction & Background

Rainier Valley Eats! (RaVE) is a United Way of King County (UWKC) supported coalition working to create opportunities for people of Southeast Seattle to learn about, grow, cook and eat healthy foods. Seattle Tilth and Public Health - Seattle & King County (PHSKC) coordinate the efforts of many community organizations to strengthen access to good food and nutrition in the Rainier Valley. One facet of RaVE is the mini-grant program, whereby community organizations can apply for funds to support their own “grow-share-eat” programming.

East African Community Services (EACS) supports East Africans and their families in King County and strives to help them overcome barriers to prosperity. Towards this mission, EACS and partners are using RaVE mini-grant funds to design and implement educational forums on nutrition to promote healthy eating in the East African communities they serve.

We, Elizabeth Burpee and Angela Wood, are Master’s degree students in the Community-Oriented Public Health Practice (COPHP) program at University of Washington’s School of Public Health. For our COPHP first-year practicum project, we conducted an assessment of nutrition-related interests and needs among King County East African communities, to guide the design of EACS’s RaVE-funded nutrition forums. Our hope is that the information in this assessment report will serve the organizations with whom we have worked, as well as the community in the following ways:

- Ensure the forums are successful by targeting the content to participants’ needs, strengths, and interests.
- Inform PHSKC’s future health- and nutrition-related work in these East African communities.
- Provide a basis of information from which King County East African organizations may design proposals to continue gathering information, and providing support for food-related health in their communities.

Through interviews with leaders and staff of organizations serving King County East African communities, as well as through focus groups drawn from these communities, we collected information to assess four topic areas:

1. Current food practices and preferences
2. Understanding of the relationship between diet and health
3. Barriers to healthy living
4. Interest in food-related health information and further involvement in nutrition forums

In this report, we discuss our findings and assessment of different East African communities, provide recommendations for the EACS nutrition forums by community, and discuss implications for future work with local East African communities regarding food and health.

Notes on Terminology

When we began this project, we referred to it as a “nutrition needs assessment.” However, over the course of working with community members, we learned that there is often no direct translation for the word “nutrition” in many East African languages, and when there is, it may not be understood in the same way as in English. We tried other terms like “healthy diet,” but we found discussing “health as it relates to food” to be the clearest way of discussing these topics. As such, the language of this report reflects the language used in the focus groups. We also feel that the idea of food and health is in line with RaVE’s holistic approach to well being, as opposed to a strictly western medical view that may be more associated with the term “nutrition.”

Because East Africa encompasses many overlapping cultural and ethnic groups as well as national identities, we have identified people in this report as they identified themselves to us. In some cases, this is by national origin (e.g., Ethiopian), while in others it is by ethnic or language group (e.g., Oromo). More locally gathered information on each of these groups is available through EthnoMed (<http://ethnomed.org/culture>).

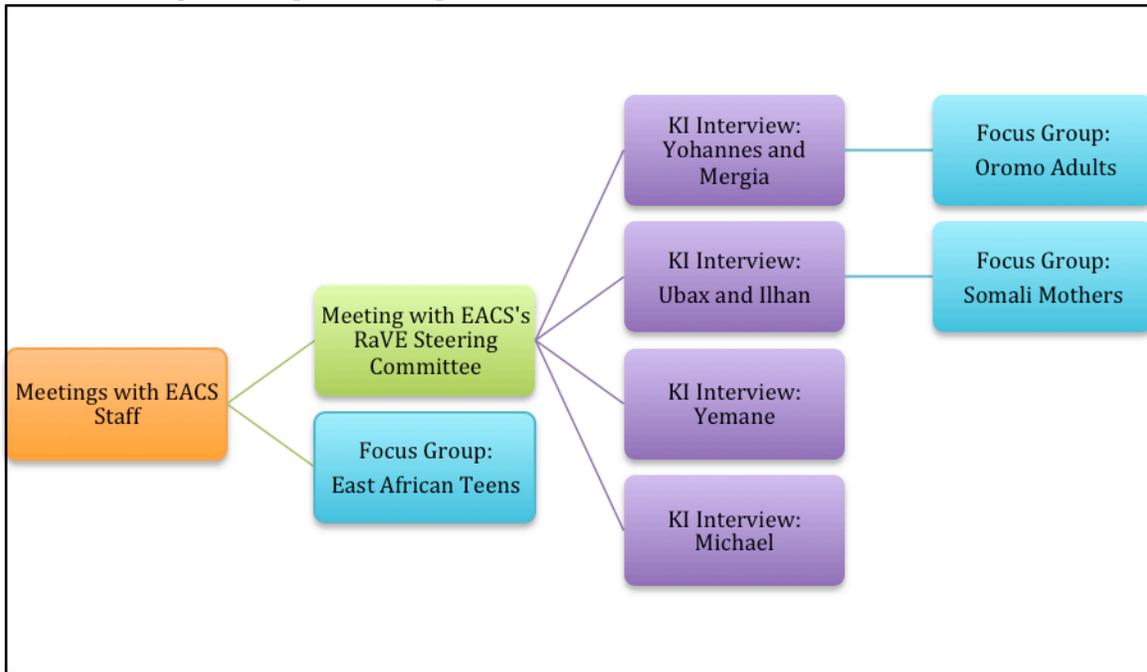
II. Methods

In designing and implementing the needs assessment, we believed that the process should be community-informed and community-led to the best extent possible. We employed this general strategy because 1) we are outsiders to East African communities, and 2) we believed it the best way to get community buy-in and accurate information. This approach is evident in both our steps to reach community leaders and members, as well as in how the focus groups were facilitated. *Figure 1* shows the sequence of steps we used to gather information from communities.

The following questions guided the needs assessment and will hereto be referred to as the “driving questions”:

1. *What are current food practices and diet preferences in the community?*
2. *What is the prevailing understanding of the relationship between diet and health?*
3. *What are barriers to healthy living present in this community?*
4. *Is the community interested in obtaining health information and/or becoming further involved in the EACS/RaVE nutrition forums?*

Figure 1. Sequence of Steps Used to Gather Information from Communities



Step 1: Meetings with EACS staff

To begin, we met with EACS staff to discuss nutrition and health in King County East African communities from their perspectives, working with a variety of individuals and families. From these conversations, we developed a draft of the driving questions, as well as draft questions to ask Key Informants (KIs), based on the driving questions.

Step 2: Meeting with EACS's RaVE Steering Committee

Next, we met with EACS's RaVE steering committee, composed of four East African male community leaders (representing the Oromo, Tigrinya and Somali communities), as well John Argerious, the EACS Resource Development Coordinator, and Diana Vinh, the Public Health Seattle-King County RaVE project lead. In this meeting, we described our desire to conduct a needs assessment, and asked for the East African steering committee members' permission to implement the assessment. Once granted permission, we asked that the East African steering committee members 1) look over our draft questions for KIs and make suggestions, and 2) put us in contact with key informants from their respective communities.

Step 3: Key Informant Interviews

We met with six KIs, referred to us by the steering committee or by other KIs, in a series of four interviews. Our KIs are all people of East African descent who have worked with and/or have extensive experience with East African communities of King County. The goal of meeting with KIs was to hear an informed perspective on a specific community's eating habits and general

understanding of health-related diseases, and to gather insight into framing and discussing the driving questions in a focus group setting. We interviewed the KIs in person at a location of their choosing, in sessions lasting from 45 minutes to one hour. At the end of each interview, we asked KIs to help us organize and facilitate a focus group. See **Table 1** for KI demographics, and **Appendix A** for sample KI interview questions.

Table 1. Characteristics of Key Informants

	Participant(s)	Ethnic group represented	Gender
KI Interview 1	Yohannes Beshi & Mergia Sonessa	Christian Oromo	Male (both)
KI Interview 2	Ubax Gardheere & Ilhan Ali	Somali	Female (both)
KI Interview 3	Yemane Gebremichael	Ethiopian	Male
KI Interview 4	Michael Neguse	Eritrean	Male

Step 4: Focus Groups

All KIs agreed to organize a focus group, but due to time constraints, we were able to conduct only three focus groups: one with Somali mothers, one with Oromo adults, and one with East African teenagers. When possible, we tried to have focus group participants be in the same age range, and be of the same gender. The Somali mother focus group reflected this homogeneity best, while the Oromo adult focus group included both genders and many ages, as was deemed most appropriate by the facilitating community leader. For the Somali mother and Oromo adult focus groups, our community contacts acted as facilitators, while we facilitated the group with East African teens, who spoke English comfortably. The facilitators were also our primary interpreters. Further details can be found in the descriptive section for each focus group. With the Somali mother and Oromo adult focus groups, we tried to maintain an observer role while taking notes and occasionally asking for clarification, but this proved difficult as will be elaborated upon in the limitations section. In addition to taking notes, we also recorded the Oromo adult focus group conversation on a digital audio recorder, with verbal consent from the participants. For the teen focus group, we shared the roles of facilitator and note-taker. See **Table 2** for a demographic breakdown of focus groups.

Table 2. Characteristics of Focus Group Participants

	Female (%)	Male (%)	Ethnic Background	Age range
Group 1 Somali Mothers	5 (100)	0 (0)	Somali	40s to 60s
Group 2 Oromo Adults	8 (57)	6 (43)	Christian, Muslim, and Waqefata Oromo from Ethiopia, Kenya, Tanzania, & Somalia	Late 20s to Early 60s
Group 3 East African Teens	2 (33)	4 (66)	5 Somali, 1 Ethiopian/Kenyan	15 years old

Step 5: Analyzing KI Interview and Focus Group Findings

We reviewed our KI interview and focus group notes individually and in discussion with each other. We came to consensus on similarities and differences between focus groups, as well as between KI interviews and their respective focus group discussions.

III. Findings by Group

Oromo Adults

Key Informant Description

Yohannes Beshi is a Christian Oromo man in his 20s who has volunteered with the Center for East African Community Affairs (CEACA) for two years, currently serving as Vice Executive Director, and previously as Program Coordinator. Mergia Sonessa is a Christian Oromo man in his 30s, born in Ethiopia, and has also been a volunteer with CEACA for two years. Before joining CEACA, Mergia worked with The Oromo Community Organization and served as an after-school tutor for Oromo children. For twenty minutes of the interview, we were joined by another CEACA volunteer, a Muslim man in his mid-20s. His difference in religion provided a point of comparison for our discussion, offering some interesting points.

Focus Group Description

We held the focus group at the CEACA, as recommended by Habtamu Abdi, an Oromo EACS RaVE steering committee member and Program Coordinator at CEACA. Habtamu, with the advice of elders in the community, organized the room so that focus group participants sat in rows facing the front of the room. Habtamu stood at the front to facilitate, and we sat behind him and off to the side with an interpreter (male), designated by Habtamu, sitting between us.

Eight adult women were present, and all sat in the front three rows. Six men were present, and sat in the last two rows, away from the women. Participants included Muslim, Christian, and Waqefata Oromo from countries including Ethiopia, Kenya, Tanzania, and Somalia. On the whole, the women participated in discussion much more often than the men, though the men did give us a warm welcome and offer some bits of information. There were a number of children present, and some participants (particularly men) informally came in and out of the room. Habtamu asked the majority of the focus group questions and also interpreted participants' responses, paraphrasing them after listening to multiple participants. The designated interpreter translated some responses, but also seemed to be playing a participatory role in the discussion. We took notes and observed, but were also fairly active in guiding the discussion, asking participants follow up questions, etc.

Responses

Question 1: What are current food practices and diet preferences in the community?

Key Informants:

- Oromos mainly eat traditional foods.
- Many Oromos are used to eating the same foods repeatedly.
- Some Oromos do eat fast food. This is dependent on whether or not they are first generation immigrants.
- Back home, white bread and light colored grains are considered better quality than dark bread and grains. Back home, everything was whole grain (hand made and minimally processed), so the indications of good quality were different than they are in the U.S., where things are processed differently.
- Oromos also purchase injera from East African grocery stores. Although this is, strictly speaking, more of a traditional food for Amharic Ethiopians than Oromo or Somali people, it is still commonly eaten here among all East African groups.
- Most Oromos eat bread for breakfast.
- Many make bread at home, but for some, especially unmarried men (like our KIs), bread is purchased from the supermarket (Safeway).
- Oromos eat much more meat in the U.S. than back home, both because it is much more available here, and because of its perceived higher value. It is a status symbol, whereas vegetables were very cheap back home. Chicken was for guests on special occasions, but here it is much more of an everyday food.
- Meat, including chicken, beef and lamb are often cooked with a lot of spices, butter and oil and can be served in soup, with rice or pasta dishes, or eaten with injera.
- Vegetables, like cabbage, potatoes, lentils, beans, and tomatoes, are also included in soup, rice and pasta dishes.
- Eating out is rare. Oromos usually pack their lunch from home if they have to eat at work or school. Many simply “don’t have taste for other foods.”
- Christian Oromos have fasting days when they don’t eat meat or dairy.
- Muslims have days when they don’t eat at all.
- Oromos typically do not like sweets as much as Americans. They feel these things are for children.
- Many people just eat too much.

Focus Group:

- People mentioned eating many traditional foods.
- Beverages are often coffee with milk, juice, and water.
- Kids who are raised here often don’t like to eat traditional foods as much, so mothers sometimes take them out to eat for pasta. Some go to McDonald’s.

- Most families eat their own food and do not go out to eat other types of food. People mentioned that this is because people want to adhere to their religious values. They are suspicious of consuming food from a restaurant where they may accidentally ingest pork.
- For breakfast, many people eat budena (the Oromo version of injera), churo (porridge), flat bread, and/or rice.
- The injera is usually made of teff and barley. Injera at restaurants is salty, but people don't often put a lot of salt in it when making it at home.
- People seemed to know about healthy foods and incorporated these into their diets. For example, people stated that protein often comes from chicken, goat meat, beans, and seafood.
- Many women cited eating a wide variety of fruits and vegetables (e.g. oranges, apples, grapes, bananas, spinach, carrots, broccoli, potatoes, tomatoes, cabbage, squash).
- People mentioned sugary foods not being healthy for kids. A number of mothers feed their children cheese and crackers, chips, fruit punch, apple juice, and low-sugar cereals.
- Some women said that they advise people not to consume fatty foods and instead to focus on green foods.

Question 2: What is the community's understanding of the relationship between diet & health?

Key Informants:

- There is no equivalent word for "nutrition" in Oromo or Amharic.
- Oromos don't use the concept of nutrition when gauging foods; they just consider "whether something is food, or if it's not." They are focused on a general concept of "good," not on healthiness. They want things that taste good.
- Many Oromos here have symptoms of diabetes and are overweight.
- Some people in Ethiopia learn about health - including diabetes, blood pressure, the importance of exercise - in school, but not everyone had access to that level of education.
- Oromos do hear from doctors that some foods are recommended and that they shouldn't be overweight. People learn these things when they have health problems, or when they hear from friends and family about health problems.
- When you talk about food, you should use explanations of cause and effect, instead of using the term "nutrition."
- For elders, health effects are going to be their primary concern.
- For younger Oromos, effects on the way they look may be the most important. People here want to be slender to be attractive, whereas back home being fat was a good thing and would get you respect.
- Even back home, though, Oromos understand that being very fat is bad.

Focus Group:

- Many women learn about nutrition through the Women, Infants, and Children (WIC) program and are advised to feed their children things like skim milk, mostly natural cereals, low-sugar peanut butter, and to avoid salty snacks. They stated that sugary things are not healthy for kids, so they choose low-sugar cereals like Kix, Chex, or Cheerios. High sugar content is not good for teeth, salty snacks can cause high blood pressure or gastritis, and fatty foods like red meat can cause obesity.
- Some people said they could tell if food was healthy for them by tasting it.
- When cooking, one woman who receives WIC benefits removes the skin from chicken and bakes it in the oven so fat will filter out of the meat and into the pan.
- When buying food, women often look at the sugar, cholesterol and vitamin content. If there is a language barrier, they bring their children with them to the grocery store for help.
- Diabetes is oftentimes called “sugar.”
- Most people do not know about nutrition when they get to the U.S., so they often learn the hard way and contract a disease rather than taking preventative measures.
- There is an understanding that some diseases are hereditary while others can be influenced by health behavior.
- Back in Africa, there were not these kinds of problems because everything was organic. Kids would run around outside and find organic berries and fruits to eat. Kids also used to drink a lot more water when they were running around outside.
- Here, people get less exercise, life is much less physically demanding, and people sweat less because there is less exposure to sun. Kids are confined to their homes and only exercise during school recess.

Question 3: What are barriers to healthy living present in this community?

Key Informants:

- There wasn't access to many sugary things back home. Here, there is access to a lot of junk food.
- Back home, there weren't very many cars, so people walked a lot.
- Oromos only get information here when they get treated for symptoms.
- Many Oromos avoid getting shots because they may contain pig products. Even Christian Oromos consider it very shameful to consume pork products.
- Many people, especially women, just have too much in their lives to manage. They have lots of kids and don't have time to exercise or eat properly. Mothers are under a lot of stress and spend a lot of time at home. Back home, exercise was not an activity people had to manage. Purposefully scheduling and doing exercise would be an adjustment here.
- Sometimes husbands control what women buy and cook, so it's not just a matter of reaching one person in the family.

Focus Group:

- Life is not as physically demanding in the U.S.
- Human behavior makes it hard for people to always do what's best for them, even when they know what they should be doing. "It's about negligence, not ignorance."
- Medical doctors do not focus on preventative measures.
- Diet recommendations seem to be changing all the time. This can confuse people.

Question 4: Is the community interested in obtaining health information and/or becoming further involved in the EACS/RaVE nutrition forums?

Key Informants:

- People trust physicians.
- The person presenting health information doesn't need to be someone from within the community. It's more important that the person be viewed as an authority.

Focus Group:

- Yes, people are interested in getting more information.
- People want to hear directly from doctors.
- People want to have information sessions on nutrition in a forum similar to the focus group.
- People expressed desire to learn more about the following:
 - Preventative measures they can take to stay healthy and avoid disease
 - What foods to avoid
 - Kinds of foods that can keep one healthy
 - Consistent recommendations regarding diet.
 - How to be healthy when pregnant, what to eat, etc.
- People are confused as to why doctors treat symptoms of some diseases rather than curing them. People can be suspicious of doctors and the medical system, thinking that doctors avoid curing diseases like Type 2 Diabetes so that the patient continues to pay into the system. People want to know why this happens.

Discussion

Commonalities and Differences between KI and Focus Group Responses

There are a number of common themes present in the KI interview and the focus group. First, it seems that many Oromo adults in King County eat mostly traditional foods, make most of their meals at home, rarely eat out (through some do, to appease their children), eat chicken often, and eat a wide variety of vegetables. Second, there is consensus that Oromo adults are usually educated on nutrition and health only once they have been diagnosed with a disease, not before.

This status quo of “learning the hard way” is seen as a problem and people voiced a desire to learn more about preventative health measures. Third, KIs and focus group participants also recognized that life is not as physically demanding in the U.S. as it is in East Africa. Many participants pointed to the sedentary U.S. lifestyle and accessibility of unhealthy foods as reasons why some health problems are more prevalent in the U.S. than back home. Finally, KIs and focus group participants expressed a desire to learn more about health and nutrition, and expressed a desire to learn directly from a physician.

Though not glaringly obvious, there were a few discrepancies between what the KIs stated about their community in comparison to focus group responses. First, KIs mentioned that traditional Oromo foods that people continue to eat often contain butter, oil, beef, and/or lamb. They also mentioned that since meat is highly valued in Ethiopia, Oromos eat it often in the U.S. due to accessibility. Though one focus group participant mentioned using olive oil, there was not, any mention of other oils, butter, beef or lamb. It is possible, however, that focus group participants were tailoring their responses to the information they believed would be relevant or appropriate for us as public health practitioners, based on what they had heard from other American health workers or health education materials.

Second, KIs stated that their community does not choose food based on healthiness, rather they choose it based on taste and know little about what makes food “healthy.” Many female focus group participants, however, had been educated on nutrition through the WIC program (or via someone who had participated) and seem to have a firm grasp on nutrition. These same women also report that they make food decisions based on this knowledge. We are uncertain as to how many Oromos receive nutrition information from WIC and believe this is worth further inquiry.

Notable Findings

The KIs and focus group participants made a number of points that we feel are worth extra emphasis. For example, there were a number of foods that were talked about in terms of “value.” The KIs said that back in Ethiopia, light colored grains and white bread are considered better quality than dark grains and bread. This may influence peoples’ openness to eating whole grains in the U.S., depending on the home country of origin. Additionally, there was some talk about Oromos overeating when living in the U.S. Since meat consumption connotes a higher status level in many East African countries, the fact that it is widely available in the U.S. has caused Oromos here to eat much more meat than when they lived in their home country. Similarly, the KIs mentioned that vegetables were not considered as valuable as meat since they were very cheap back in Ethiopia. This concept of certain foods having status “value” may be worth considering further.

Also, the KIs mentioned that unmarried Oromo men often eat out at restaurants and purchase more premade foods (e.g. bread) from the supermarket instead of making them at home.

Finally, many focus group participants, both men and women, voiced concern about how the U.S. medical system is treating disease. Though people understood that excess sugar consumption can cause Type 2 Diabetes, for example, they wondered why doctors here do not “cure” the disease, and instead prescribe medication and ask that patients continue to come back for appointments. This brought up feelings of distrust and confusion.

Recommendations for Forums with Oromo Adults

- Have a physician and nutritionist available for questions and/or a presentation.
- Allot for a large portion of the forum to be a question-and-answer session.
- Address the difference between chronic versus acute disease, especially in relation to food-related conditions and treatment of those conditions.
- Address nutrition and pregnancy.
- Target single adult men as a separate audience.
- Focus heavily on educating mothers, but also ensure that their partners are being educated and understand the importance of healthy eating and what healthy foods are.
- Recognize that many participants may already have knowledge of nutrition.
- Use measurements that focus more on eye measurements rather than U.S.-based metrics.
- Describe how different health-related diseases are caused and give people concrete preventative measures they can practice.
- Address how increased meat consumption can be harmful to one’s health.
- Provide people with information on why overeating, or unbalanced eating, is unhealthy.
- Have the group brainstorm ways to incorporate exercise into their lives in the U.S.

Somali Mothers

Key Informant Description

Ubox Gardheere is a Somali Muslim woman and has been in the United States for 16 years. Ubox is currently finishing her Master’s in Public Affairs, works at Culturally Appropriate Responsive Education, and has years of experience working with and for the King County Somali community. Ilhan Ali is also a Somali Muslim woman and has been in the United States for more than 20 years. Ilhan recently received her Bachelor’s of Science as a pre-med student and currently serves as a volunteer tutor for teenagers at EACS while planning for her future medical education. We had originally scheduled the interview with just Ubox, but she recruited Ilhan to the interview for her valuable additional perspective.

Focus Group Description

Ubax and Ilhan facilitated and interpreted a focus group with five Somali mothers at one of the participant's homes. The seating arrangement was informal, with the participants and facilitators/interpreters sitting on chairs and couches scattered around the room. Ubax, Ilhan, and Angie sat near each other, as Angie took notes and asked clarifying questions. The women's ages ranged from 40 to 60 years old, and the ages of their children ranged from 8 to 16 years (children were not present at the focus group). The questions and responses were conducted primarily in Somali and interpreted by both Ubax and Ilhan, although some of the participants directed their responses directly to Angie in English. All of the participants were Muslim, were born outside of the U.S., and spoke limited English. They represented a range in life experiences: some had spent time in other countries before settling in the U.S., some had children in Somalia, and others' children were born in the U.S. None, however, were very new mothers as all had years - and some had decades - of experience raising children and caring for a family.

Responses

Question 1: What are current food practices and diet preferences in the community?

Key Informants:

- Somali families usually stick to traditional Somali foods in the U.S., but with some differences. They usually cook for themselves and their families rather than eat out.
- A lot of ingredients are bought from ethnic stores or in bulk from Costco.
- There is a lot of sugar consumption from beverages, like tea.
- Because Somalis were not introduced to many fruits and vegetables when in their home country, they do not like them now.
- While Somalis had access to markets and fresh foods in their home country, they now buy mostly frozen vegetables and meat. They do not, however, trust canned foods.
- Due to lack of time, a lot of families "take the easy way out" and use frozen and/or microwavable food.
- A lot of women cook a big batch of food and use that to feed their family for the whole week.
- Many Somali kids receive free or reduced lunch at school.
- Snacks used to be accessible only to affluent Somalis back in their home country, but now they are available to everyone and very common.
- Many Somali families are on food stamps, but this is not something that is discussed publicly.

Focus Group:

- Common/favorite foods are: rice, pasta, injera, goat meat, milk (cow), halal meat (chicken, beef), and fish. Most of these are similar to what was eaten in Somalia before coming to the U.S.
- Some women cook both Somali and Ethiopian food.
- Kids like American foods. Some mothers cook American food at home, including pizza (cheese and vegetable), macaroni and cheese, and oatmeal. Others rarely or never cook American food, but occasionally bring kids to McDonald's or pizza restaurants. Sometimes (not every day), they buy them chips or candy.
- Moms look at the school lunch menu and let kids buy lunch when it doesn't include meat. This is in order to prevent kids from eating non-halal meats.
- Moms read labels at the store to make sure that foods don't contain pork products, but they often don't feel that they are understanding all of the ingredients and would like help with this. Many ingredients are listed even on simple items and are listed in a language other than their native language, so the mothers do not see this as a good way to decide if something is worth buying. Instead, women rely on their own experience - they have been cooking for a long time, have tried a lot of things, and know what tastes good.
- Cost is often a deciding factor if there are two brands or types of the same thing.
- Many consider any food made with ingredients bought from Safeway "American food."
- Somali tea has a lot of sugar in it.
- Spices were mentioned often, including: berber, onion, garlic, cumin, cilantro, parsley, tandoori ("but the doctor said these cause heart burn"), ginger ("helps heart burn"), cinnamon, cardamom seeds, and cloves ("numbs toothaches").
- For special occasions, people make sambusas and halua (a very sugary desert made mainly of oil, corn starch, water, and food coloring). People know this is unhealthy, but they still love it and it is considered a cultural staple. Small packages of it are sold in some stores and it is particularly popular with kids.
- Salt, oil, and sugar are added by taste - "measurement by the eye and the tongue."
- Meal times are not rigid like they are in American culture. Instead, people wait until they are really hungry and then they eat.

Question 2: What is the community's understanding of the relationship between diet & health?

Key Informants:

- Nutrition is not talked about in Somali culture.
- Many Somali Muslims believe that things are predetermined by God, leading some to state that what they do in life (e.g. eating habits) won't make a difference. Some people rarely place the blame for disease on themselves.
- Somalis do not talk about their diseases.
- Diseases such as Type 2 Diabetes are called "American Diseases."
- People want to be healthy.

Focus Group:

- The Somali word for diabetes comes from the word for sugar, so people know that they are related.
- “Back home, people used all these same things —sugar and salt and heavy ingredients— but they didn’t have these problems because they sweated and walked a lot.”
- “In Somalia, there were obese people, but they were healthy. Here, you get a little overweight and then you get all these diseases.”
- People made a number of statements about nutrition: a lot of sugar and salt are not healthy; a lot of salt causes high blood pressure; a lot of sugar is not good for your skin; meat has cholesterol; baking is better than frying. “Removing skin from chicken makes it less fatty, but it tastes better with the skin.”
- Somali food cooked at home is believed to be healthier than “outside food” from restaurants, and preferable because “you know what’s in it.”
- Some agree olive oil is preferable, but some don’t like the smell or feel there are some kinds that don’t work for cooking so use vegetable oil instead.
- People have read/heard about “belly fat” being particularly bad and Somalis having a susceptibility to this problem, even if they are skinny. Some say it’s because of all the sugar in the tea.
- Waiting to get very hungry before eating might be leading people to overeat.
- Some believed health problems (i.e. diabetes and overweight) are mostly hereditary and are not related to food.
- The idea of “healthy food” was confusing. However, when asked, all did agree that vegetables are healthier than meat. They also acknowledged that they still eat more meat than vegetables.
- Stress was cited as a main factor in bad health. (“Thinking about stressful things can give you high cholesterol.”)

Question 3: What are barriers to healthy living present in this community?

Key Informants:

- Nutrition and disease are not discussed in Somali culture.
- Cost: most good fresh food is organic and expensive and many Somali families are on food stamps. Additionally, most families are large and have lots of children to feed.
- Language barriers.
- Lack of time.
- “When one believes Allah predetermines their destiny, they may not believe that their personal choices will make a difference in their health.”
- A lot of people are prescribed pills for illness, but they often do not understand what the pills are for. There is also a lot of sharing of prescription pills when a friend or family member has a similar ailment. There is a lack of understanding that this may be dangerous.
- Medical interpreters themselves may not always know much about health.

Focus Group:

- There were a variety of reasons given for not eating more vegetables, despite knowing they were healthy:
 - The vegetables here are unfamiliar*
 - Vegetables here aren't as fresh and tasty as they were back home, so people have to add more sugar and salt to make it taste good
 - Vegetables actually caused weight gain or didn't prevent it
 - Vegetables are not filling
- People are so used to drinking Somali tea that they have to have it or they get headaches and can't function.

**Some participants had little previous experience with the types of vegetables available in American grocery stores, while others were more familiar. Our facilitator/interpreter said this variation was based on income; many fruits and vegetables had to be imported to Somalia, so only fairly wealthy people had access to them back home.*

Question 4: Is the community interested in obtaining health information and/or becoming further involved in the EACS/RaVE nutrition forums?

Key Informants:

- A lot of people go to *Daryel*, a Somali women's yoga and health program in Rainier Valley. Apparently, a program every week on Sundays has begun to feature doctors and nutritionists.
- People like to be involved and feel like they are part of something.

Focus Group:

- Participants expressed a desire to get more information, even before the question was brought up in the focus group. They feel unsure of their knowledge and want general information about health, information on whether their current habits are healthy or not, and more information on how to tell if things are halal.
- The women are very interested in talking with American doctors.
- Some participants wondered what a doctor would have to say about nutrition, as they thought of nutrition in terms of food and cooking, which seemed like a non-medical issue.
- Somali men don't typically cook, so the women said men wouldn't know anything about nutrition (and were assuming a doctor would be a man).
- Women, and especially the elderly, share any health information they get with everyone they know.
- The women don't want someone to hand them a book on nutrition and/or health. Instead, they want time to sit down with a doctor, like in the focus group, and ask questions.
- Women would particularly like information on health during pregnancy.

Discussion

Commonalities and Differences between KI and Focus Group Responses

KI and focus group respondents agreed on a number of points. First, both said that most Somalis cook and eat traditional Somali food at home, seldom eating out or cooking non-Somali foods. They agreed that the traditional diet includes vegetables and whole grains, as well as meat and dairy. Meat (red meat and poultry) is preferred to vegetables, although people have a sense that vegetables are healthful. Second, KIs and focus group participants noted that Somali mothers prefer their children to eat food cooked at home instead of purchasing food during the day. Some mothers review the school lunch menus ahead of time and have their children buy lunch if it does not contain meat. Others plan for their children to have very large breakfasts and late lunches after school, with the intent that they will not have to eat outside the home at all. Third, there was agreement that traditional Somali tea is a big source of sugar in the Somali diet, and that though people are aware that eating sugar contributes to diabetes, drinking highly sweetened tea is an entrenched custom that would be difficult to change.

There were no striking differences in responses between our KIs and focus group participants, although there was variation between individuals in the amount of American food they cooked and bought for kids outside the home. Personal preference for sweet foods and vegetables (as mentioned previously) also varied.

Notable Findings

While our focus group participants could make statements, when asked, about salt and sugar as being bad in large amounts, they did not seem confident in their knowledge. The concept of “healthy food” was, to some degree, confusing in itself, and may be a western medical view that does not align well with how these women think about food and cooking. Studies have shown that Americans tend to oversimplify nutrition information by categorizing foods and components (like fat) as “good” and “bad” generally -- a belief system that can actually be harmful to long-term health.^{*†} A culturally different way of describing and understanding food could be a great strength in this population, and care should be taken to understand and build upon the existing understanding of food; not to encourage people into an over-simplified view of some foods as “good” and others as “bad.” Further inquiry is necessary to better describe the current more nuanced understanding of food and health in this community.

* Rozin P, Ashmore M, Markwith M. Lay American Conceptions of Nutrition: Dose Insensitivity, Categorical Thinking, Contagion, and the Monotonic Mind. *Health Psychology*,

† Birth LL, Fisher JO. Development of Eating Behaviors Among Children and Adolescents. *Pediatrics*; 1998(101):539-549.

People recognize lack of exercise (particularly walking) in the U.S. as a source of the health problems they see here. Many equated sun exposure and sweating with good health.

There were a number of reasons given for eating more vegetables before coming to the U.S. Many described the vegetables back home as “fresher” and “organic,” whereas this type of produce was described as hard to get in the U.S. This resulted in vegetables here being less appealing because of taste and health concerns (fertilizers, vitamin content), and also meant that vegetables here are often seasoned with more salt and sugar. Participants’ familiarity with the produce available in the U.S. also varied widely, depending on the income level of participants and their previously ability to buy imported vegetables when living in Somalia.

The proportion of meat to vegetables in people’s diets here is different than in Somalia because meat is much more readily available and less expensive than it was back in Somalia. The presence of pork-derived ingredients in food is also a major concern for mothers as they try to decide what to buy, cook, and feed their families.

Finally, we found it difficult to engage focus group participants in conversations around snack foods. Snack foods were not mentioned as foods people usually eat until we specifically asked about chips, candy, ice cream, etc. Upon direct inquiry, some people did report consuming these things “sometimes.” It is possible that people are not considering these “foods” as they are not usually affiliated with meals or food preparation. As such, the nutrition forums may want to specifically address snack foods as having an important role in overall diet and health.

Recommendations for Forums with Somali Mothers

- Have a physician present at the forums.
- Allot a large portion of the forum for question-and-answer session.
- Focus on health as generally as possible rather than focusing just on nutrition.
- Be careful to not try to completely re-frame how women understand food/nutrition, or describe foods as “good” and “bad.” Build upon the existing understanding of food.
- Describe the benefits of eating fruits and vegetables, and provide information on where to get the freshest kinds (farmers markets, community gardening activities, CSA boxes).
- Define the term “organic,” and discuss how eating even non-organic fruits and vegetables is better than eating none.
- Discuss the pros and cons of meat. How much meat is a healthy amount? How much, compared with vegetables?
- Create a list of English words and specialized ingredients that contain pork derivatives so people can easily recognize them when shopping. Use this as an opportunity to talk about label reading: what information is there and what to watch out for (e.g. how do I know if it’s *too much* sugar?).
- Acknowledge that tea is a large source of sugar, and help people find ways to reduce sugar in other parts of their diet.

- Address nutrition and pregnancy
- Events should be held on weekends, or mothers will not be able to attend. Saturdays and Sundays are equally good.

East African Teenagers

Focus Group Description

Elizia Artis, Education and Volunteer Coordinator with EACS, invited us to hold a focus group with East African teenagers active in the African Eagles extracurricular group at Cleveland High School. The African Eagles group is comprised of teenagers of East African descent who attend Cleveland High School. On the day of the focus group, the African Eagles were preparing for an upcoming cultural event. We met with six teens (2 female, 4 male) in the hallway while others practiced a dance routine elsewhere. Five of the teens were of Somali background, and one teen had one Ethiopian parent and one Kenyan parent. Four of the teens were born in the U.S., while two of the teens moved to the U.S. when they were toddlers. All of the teenagers were 15 years old and all, save one sophomore, were in their freshman year of high school. With the teens, we put desks in a circle. Because all the teens speak fluent English, we acted as facilitators and also took notes.

Responses

Question 1: What are current food practices and diet preferences in the community?

Focus Group:

- “Not eating pork” is “the only rule” about food. Most of the teens said they abide by this very strictly.
- When asked what percentage of the time they eat traditional foods versus “American foods,” respectively, the teens cited the following proportions:
 - 75/25 (1 teen)
 - 50/50 (3 teens)
 - 25/75 (1 teen)
 - 30/70 (1 teen)
- Breakfast items mentioned include:
 - Injera with olive oil, tea, and some sugar
 - Cereal, including Cinnamon Toast Crunch, Cocoa Puffs, Reese’s Pieces, Fruity Pebbles

- Lunch at school: Most teens said that they stopped bringing their lunch from home when in middle school. Now they eat the school lunch, go out to McDonald's, order pizza, or go to the nearby "bakery" which sells sodas and things like cinnamon rolls. "It seems like they [the "bakery"] mostly have junk food."
- Snacks at school: The school provides after school snacks, including things like packaged banana muffins, apples and whole fruits, chocolate milk, and Capri Sun. The teens really like these snacks.
- Snacks at home: Cup 'o Noodles, Nutella sandwiches. Nutella is a popular food among these teens.
- Dinner dishes mentioned include:
 - Pasta with chicken, vegetables (peas, carrots), and tomato sauce
 - Homemade pizza
 - Chicken burgers
 - Tuna sandwiches
- Beverages mentioned include: A lot of water, juice, and milk; soda when going to McDonald's. One teen said they don't keep soda in her home.
- McDonald's is popular among these teens. Some go there 3-4 times a week. Some (only boys in our group) eat a variety of foods there including Big Macs, McChicken sandwiches, and french fries. Others said they only eat halal foods there, which essentially meant only fish sandwiches.
- Though the teens know that McDonald's and other fast food isn't healthy, they eat it anyway.
- The teens' parents mostly shop at Costco or Sam's Club. If they need fresh produce during the week, they go to Safeway.
- The teens do not accompany their parents to the store to interpret for them.
- One teen said her family likes to eat many different kinds of food, including Indian, Chinese, Mexican, Vietnamese Pho, and other spicy foods.
- Some said they sometimes prepare food for younger family members (specific examples given were scrambled eggs and tuna salad).
- Two of the boys mentioned that since getting into sports, they are exercising, going to the weight room, and eating more proteins like steak and eggs.
- The teens often choose food based on what they want to eat and taste.
- They learn about nutrition and health in school, but some from their parents.
- "Healthy" is eating green foods and avoiding too much fat.
- Babies should not be skinny.

Question 2: What is the community's understanding of the relationship between diet & health?

Focus Group:

- The teens did not see “health problems related to food” in their community. They initially understood the question to mean things like “food poisoning” or “not having enough food.”
- Many teens (and some of their parents) have seen a CNN documentary on food processing. They talked a lot about being “grossed out” by what fast food is and how some food is prepared.
- “Fast food can help make you fat and get diabetes.” Sometimes the teens think about this, sometimes they don’t.
- When asked what people should know about nutrition, the teen said to read nutrition labels and look for calories and fat content. They also mentioned the importance of serving size.
- When asked how they would advise someone to be healthy, the teens said the following:
 - “Eat at Subway because it’s fresh and they make it in front of you. You can tell what’s in it.”
 - Eat things like broccoli, lettuce, pasta, rice, and potato salad
 - Exercise more

Discussion

Commonalities and Differences between Somali Mother and East African Teenager Focus Group Responses

Though we did not have a KI for the East African Teens group, due to the fact that the majority of these teens come from Somali families, we discuss the teens’ responses in regards to the Somali Mothers Focus Group responses. One major commonality is that both the Somali mothers and East African teens feel very strongly about not eating pork. While many Somali mothers state that they send their children to school with packed lunches, many of the Somali teens said that their families stopped sending them to school with lunch when they were in middle school. Instead, they now all eat food provided by the school and/or go off campus to buy their own lunches, which often consists of fast food or “junk food.” As such, the teens seem to eat more American food than their parents. It is unclear to us whether the teenagers and the mothers we talked to are representing different parental approaches, or whether some parents are unaware that their children are eating “outside” food while at school. Perhaps the mothers believed we were more interested in the details of their traditional diets, and didn’t describe “outside” food because it seemed irrelevant. When asked if their parents were aware of their eating habits, the teen said “yes,” their parents are aware.

Notable Findings

While many of these teens come from Muslim families, their meat choices are sometimes not Halal (e.g. Big Macs). This is interesting considering that the teens themselves were very serious about obeying their religious beliefs when it comes to not eating pork.

Though the teens understand the concept of food-related disease, they rarely make healthy food choices in order to prevent future disease. Instead, two of the teens mentioned that they started weight lifting and eating more protein because of their involvement in sports. Focusing on more immediate reasons for healthy eating may be a more successful way to influence teens' behavior than focusing on food-related disease prevention.

The "CNN documentary" on food processing[‡] seemed to be something with which all the teens were familiar, and some of their parents had even seen and been influenced by the documentary.

Recommendations for Forum with Parents of Somali Teens (or teens themselves)

- Discuss what foods teens may be eating while at school and/or off campus during the school day and provide suggestions for healthier options.
- Teens notice what their parents eat. It seems that the boys were particularly influenced by their father's eating behaviors. Talk about this and how important it is for parents to be good food role models.
- Focus on giving teens immediate reasons for eating healthy rather than asking them to prevent adult-onset health issues.

D. East African Seniors

Key Informant Description

Michael Neguse works as Program Coordinator for the Seattle Neighborhood Group's East African Program. Part of this work involves engaging seniors in growing their own fresh produce, teaching them how to cook, and sharing meals together twice a week. Yemane Gebremichael helps with these activities, and is also active in the community through African Diaspora of Washington, and Horn of Africa Services, run by Tsegaye Gebru. Yemane is originally from Ethiopia, and his primary languages are Amharic and Tigrinya. Michael is from

[‡] Title unknown, but possibly coverage of the documentary "Food, Inc." Students also mentioned "Fast Food Nation."

Eritrea, and speaks Amharic, Tigrinya, and Arabic. Both have extensive experience working with immigrants from all parts of East Africa.

Responses

Question 1: What are current food practices and diet preferences in the community?

Key Informants:

- Many or most of the seniors have hypertension or diabetes. Their metabolism is slowing as they age.
- People have a sudden change of diet when they come to the U.S. For example, they cook at home, but the ingredients are not good (e.g., bleached flour). As such, they start eating food that isn't fresh and end up making greasy, sugary food. They need to be taught how to get fresh food here.
- If people put Ethiopian spices in their food, they call it "Ethiopian," not "American," but the other ingredients might not be the same as back home.
- Younger people, notably teenagers, like "party foods."
- American food looks cheaper, are easier to prepare, and kids like them better.
- People are not used to reading labels.

Question 2: What is the community's understanding of the relationship between diet & health?

Key Informants:

- People know about—and are afraid of getting—diabetes, heart failure, high blood pressure, cancer.
- People know food and health are related, but they don't know enough about specific ingredients.
- People need to learn that having diabetes is not just about taking medication. You have to do that, but you also have to control blood sugar. Having peers talk about how they do this (i.e., tell their stories) is what's effective.
- People need to know that going to the doctor isn't always going to help. Sometimes the better thing to do for health is to come to the community center to learn how and where to shop, start gardening, make connections with people, and make your own healthy food.

Question 3: What are barriers to healthy living present in this community?

Key Informants:

- Seniors aren't active here. They don't walk because they don't have to anymore. They don't necessarily know it is important.
- Men in East Africa do not traditionally cook. Here, it's important to bring them into the kitchen so that they don't just go out to eat all the time. Once they learn how to cook, they love it.
- People can't afford healthy food. We teach them how to grow it themselves, and we try to grow things with which they are familiar. Some seniors don't have enough food, and they have to eat what they can get, even if they know what's healthy and what's not.
- When immigrants come here, they think they are outsiders. Sometimes they think they are going back someday, and this prevents them from getting involved with things, which is very unhealthy. We have to make people feel part of something, to get them to participate in things that bring people together AND get them healthy food.

Question 4: Is the community interested in obtaining health information and/or becoming further involved in the EACS/RaVE nutrition forums?

Key Informants:

- Michael already brings in nursing students from Seattle University to talk to the seniors about health, and they are getting access to and education about vegetables and healthy eating through this program. He did not seem to think a class-style forum would be a good fit for this population, but instead thought that having physicians talk to the community via forums was a good idea. He recommends having multiple topics and some hands-on activities to make things engaging.
- Yemane agreed that the forum organizers should bring in physicians. He recommends reaching out to places of worship to bring people in. He also expressed interest in East African community organizations taking on future work in conducting a more thorough health needs assessment, including using a door-to-door survey.

IV. Limitations

To plan the design of our focus groups, we consulted best practices literature on focus groups and also spoke with experienced practitioners. From this research, our original plan was to form focus groups with people of the same ethnic group, gender, and similar in age. Though the Somali mothers focus group fit this expectation, our Oromo adult focus group was much larger and more heterogeneous than we expected. Unlike our KIs for the Somali mother group, who

had mostly non-professional affiliations with focus group members, our main Oromo contact (Habtamu) is the leader of the CEACA, a community organization from which he recruited participants. Considering his role at the organization, it would have been more difficult, if not impossible, for him to be more selective about participants. His focus group also turned out to be more of a community meeting than a traditional focus group, with the room arranged in an audience-and-presenter format, and including everyone from children to elders. The room set-up, as well as the mixing of genders and ages, may have inhibited fully open and honest conversation. However, as we were working through a community leader, it was appropriate and necessary for us to be guided by the social expectations of the community in holding the event. Additionally, while not all of the attendees were active participants in the discussion, it did not seem that any group (e.g., women, younger people) was on the whole refraining from speaking.

In both the Somali mother and Oromo adult focus groups, we originally intended for the facilitator to conduct the focus group and ask questions in the participants' primary language, as we sat taking notes outside the circle with an interpreter. However, we did not have access to interpreters with the specialized training it would require to do this kind of simultaneous interpretation. Instead, our facilitators and interpreters worked together to translate our questions for the participants, listen to the comments that followed, and then provide us with a paraphrased English interpretation. This method presents some major limitations for our findings. For one, as participant responses were often summarized and paraphrased by our facilitators and interpreters, the facilitator and interpreters provided us only with the information they felt was useful. It is possible that we missed information, and/or that some information was interpreted differently than the respondent intended. Also, because our interpreters were sometimes also our facilitators and KIs, it was not always clear which statements were attributable directly to participants, and which were explanatory comments added by the interpreters to help us understand. In short, our focus group findings are likely biased to some extent toward the perspectives of our KIs.

Because we had very limited time and resources, our focus groups did not maintain some best practices found in the literature. For example, side conversations occurred and were not captured. Additionally, direct interpretation of participant comments was not enforced.

We also suspect that some of the focus group findings are limited in scope. For example, participants often spoke directly to facilitators, answering specific questions instead of engaging in a richer interactive discussion. Some group participants may also have been telling us facts they remembered being told about nutrition, but that they don't actually employ in decision-making on a daily basis.

Finally, our focus group findings represent only a small sample of perspectives from large King County East African communities with a wide variety of experiences, education, customs, and exposure to American food culture and nutrition information. Because of this major limitation, we do not intend for our findings to be generalized to any ethnic group. Rather, the findings should be used as a guide in beginning forum design, and to direct future needs assessments.

V. Final Discussion & Recommendations

We believe the EACS nutrition forums have great potential to positively impact the lives of many people in King County East African communities. Across the range of people with whom we spoke, we encountered appreciation of efforts to increase access to health information and genuine interest in learning more about healthy eating. Considering our findings, we agree with EACS's current plan to host different forums targeted to different language/ethnic groups, not only because it simplifies the logistics of interpreters and location, but also because it will be easier to address the different knowledge levels of the various groups. Due to the differences we found, we also recommend that the vocabulary used to discuss food and health and the content of presentations be different.

Participants in both groups were very interested in having time to speak with a physician in a group setting. We recommend keeping the formal presentation of material in the forums to a minimum, and instead allowing most of the event to be a community discussion with a doctor and nutritionist (both, if possible). This will allow the forum content and vocabulary to be directed by the community members, and to be most applicable to their lives and current needs. Involvement of EACS's RaVE Steering Committee members will provide the extremely valuable perspective of those who have personal knowledge of both American and East African food practices. RaVE staff (Diana Vinh, who is a public health nurse, and Leika Suzumura, who is a nutritionist and cooking instructor) can help with a holistic framing of the concepts of food and health, and provide specific tools and information to participants about accessing healthy food locally. This approach will also avoid the need to redefine how anyone thinks about food, which could easily result in oversimplification and be counterproductive to the effort of improving healthy behavior.

While we think it is important to have separate forums for each language/ethnic group, we do not think it is necessary to have different forums for men and women unless explicitly stated by participants or organization leaders. The format of our Oromo focus group, where all ages and genders were present, was established by elders of that community and seems like a good model for the forums, as the information will be beneficial to everyone. However, we think it will be most effective to tailor any formal presentation, as well as any printed materials, to women, since they are the ones who are most often purchasing and preparing food. This means making sure the vocabulary used matches the way women currently talk about food (e.g. in the Oromo community, this could reflect the language used in WIC materials), avoiding strictly numeric measurements (e.g. show a physical cup, if that measure is necessary in the discussion), and starting with topics about which the women already have questions. Some areas of interest we identified across adult groups include:

- Healthy proportions of meat and vegetables
- Health pros and cons of meat
- Why the common diseases in the U.S. like diabetes cannot be cured and require lifelong treatment
- Ways to get fresh, natural, good-tasting vegetables
- Why diets similar to those back one's home country seem to lead to different health problems in the U.S.
- How women can eat for a healthy pregnancy

While participants in our focus groups were most interested in speaking with a physician and did not have a strong preference for someone with knowledge of their culture, we feel it would be beneficial to have someone present who is very familiar with food availability and habits in the forum participants' home countries (e.g. East African members of EACS's RaVE Steering Committee).

Many of the questions we encountered have to do with the differences between “back home” and here. Some things seem the same, but are having different outcomes (“I eat a lot of the same things I ate at home, but here they give you diseases”), and some things are noticeably different (e.g., less appetizing vegetables), and people have questions about what to do about it. The forums are a wonderful opportunity to bring people together, answer their questions, and send them home with information tailored to their own lives.

Apart from informing the EACS nutrition forums, we hope this report proves useful for future public health work with East African communities of King County. Through this process, we have found communities to be very open to and interested in learning about nutrition, food, and health. In particular, RaVE may be interested in working with organizational leaders and families attending the nutrition forums in order to work towards increased distribution of fresh vegetables in these communities. The Oromo community in particular may be open to RaVE's farm-to-table approach as many Oromos we spoke with already incorporate many vegetables in their diet. RaVE food baskets may also be seen as a welcome alternative to wholesale produce, since many community members rely on food stamps and have little choice when buying produce. When engaging in conversation with community members, we recommend that RaVE have a good understanding of the vegetables used in common dishes and specifically mention when things are organic, as this was of interest to participants in our groups. Finally, we believe that in developing strong, honest relationships with community organizations and leaders, and in listening to what community members already know and what they want to know, public health can successfully partner with communities to promote health and prevention.

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Last but certainly not least, we would like to send a special “Thank You” to all the focus group participants. We appreciate how you welcomed us into your community and thank you for engaging in honest conversation.

VII. Appendices

APPENDIX A

Sample Interview Questions for Key Informants

(Each interview included a selection of the questions below)

1. Name/country of origin/native language/length of time in the U.S.
2. What do you eat on a daily basis?
3. What do your kids eat on a daily basis?
4. What do you feed your family on a typical day?
5. From your perspective, what are some healthy habits people in your community have?
6. What are your cultural beliefs around food?
7. How often do you think people in your community exercise? What types of physical activity to people have?
8. What comes to mind when I say the word “nutrition?”
9. What do you think people in your community understand as “nutrition?” What is the word/concept for it?
10. Are there other foods that are considered healthier than others?
11. Do you see nutrition-related problems in your community? Do you think the community sees those problems?
12. Have you ever been in a class about health? Learned about it in school? Learned it from a friend/family member?
13. What are certain foods that may make you sick? What do you think the community believes will make them sick?

14. What do you know about: obesity; diabetes; hypertension; high blood pressure; cholesterol and fat; malnutrition?
15. How do you think people in your community think about these things?
16. Is there anything that helps you to be healthy and avoid these diseases?
17. Are there things that make it difficult to be healthy in this community? What are those?
18. Do you think people have enough to eat in your community?
19. What would you like to see changed in your community to make people healthier?
20. Where do people in your community buy groceries?
21. How do you think I should learn about communities and talk to people about these things? Through focus groups? Written surveys?
22. What are some questions you think would be helpful to get information? Would you be willing to help me do this?
23. Who else do you think I should talk to?
24. How do you think the community would best learn about nutrition? Do you think they would be interested in learning this? How could we make it interesting for them?

APPENDIX B
Interview questions for adult focus groups

Ice breaker

Name, favorite food

Introductory Question

If you have kids, what kinds of things do you feed them so that they can grow and be healthy?
If you don't have kids, what would you tell a friend to eat, and not eat, to be healthy?

Transition Questions

When you look at food at the store, what do you consider, when you decide what to buy?
[facilitator note, or probe for comments related to *quality* and *ingredients*]

Key Questions

What traditional foods do you and your family eat often?

What American foods do you eat? Do your kids, if you have them, eat more American foods than you do?

How should foods be prepared, so that they're healthy to eat?

What do you know about how food is related to diseases?
[facilitator note, or probe for mentions of specific diseases: *heart disease, diabetes, hypertension, or obesity*
And ingredients, like *sugar* and *salt*]

What gets in the way of eating or cooking healthy food you'd like to have?

Ending Question

Are you interested in learning about food, health, or nutrition?

Would you like to help get health information to people in your community in some way? Do you have any advice for us as we try to get people interested in these topics?

APPENDIX C
Interview questions for East African teenagers focus group

1. Icebreaker: Please say your name and your favorite food

2. What do you eat?

Prompts:

- What traditional foods do you eat?
- What American foods do you eat?
- What do you eat at home?
- What do you eat when you're not at home?
- Do the adults you live with know you eat these things?
- What are people in your house eating?

3. What have you learned about nutrition?

Prompts:

- How do you think the food you eat affects you?
- Do you know what kinds of diseases are related to food?