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Research paper

'The perfect size': perceptions of and influences on body image and body size in young Somali women living in Liverpool – a qualitative study

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What is known on this subject

- Somalis now living in the west are less active than they were in Somalia, and have a high prevalence of obesity.
- Obesity is influenced by body image, which is in turn influenced by cultural and environmental factors.
- Research into body image has been undertaken with young Asian women in the UK, but not with Somalis.

What this paper adds

- Young Somali women negotiated UK and Somali cultures, endeavouring to extract positive elements from both.
- Environmental barriers affect opportunities for Somalis living in the inner city to make healthy lifestyle choices.
- Public health practitioners could harness the skills and enthusiasm of young Somali women to address obesity in the Somali community.

ABSTRACT

Obesity has been identified as a problem in the Somali community in Liverpool, and is affected by body image and environment. This research used qualitative methods to explore perceptions of and influences on body image and body size among young Somali women living in Liverpool. Initial discussions with Somali health workers informed a series of focus groups, which were held in local community centres. A total of 13 young Somali women were recruited for the focus groups using a snowballing technique. Themes that emerged from these groups formed the basis for further focus groups with the original participants to check the validity of the analysis and to generate possible solutions for the specific issues uncovered. The study found that young women negotiated UK and Somali cultures, endeavouring to extract positive aspects of Somali culture relating to body size and diet. However, they felt constrained by older Somalis' cultural attitude that favours a larger body

size, and by Somali men's more traditional attitude towards diet. Young Somali women wished to be healthy, but also faced environmental barriers in engaging with both exercise and healthy eating, particularly in a deprived inner-city area. Both cultural pressures and environmental barriers are likely to increase as women grow older and have children. This research highlights the need to address cultural norms in an obesity-targeted health promotion strategy. The findings suggest that public health practitioners should harness the skills and enthusiasm of young women in addressing obesity in the Somali community. The wider public health community should facilitate an environment that enables women and their children to lead healthy lifestyles. Further research is needed to examine the influence of Somali men on dietary practices.

Keywords: body image, body size, cultural broker, obesity, Somali diet, Somali women

Introduction

Both local and international research indicates that adult Somalis now living in the west are likely to be overweight (Mohamoud, 2005; Guerin *et al*, 2007). The reasons given for this include changes in diet, a more sedentary lifestyle, and the cultural acceptability of a larger body size (Garine and Pollock, 1995). Obesity is a risk factor for diabetes, cardiovascular disease and hypertension, and tackling obesity has been identified as a national priority in the UK (Department of Health, 2008). The contrast between slim young Somali women and overweight older women has been highlighted by Somali health workers (Elmi, personal communication, 2008) and noted by GPs in Liverpool. Discussion with Somali community members has indicated that obesity is recognised as a problem, and that young women would be keen to participate in research to increase understanding of this issue. Haq (2003) and Carroll *et al* (2007) have previously shown this issue to be of concern to Somalis in the USA. Recent local research indicates that women have a key role in cooking and food preparation, and that young Somalis are now eating more western foods (Salah, 2004). Young Somali women in Liverpool are influenced by both traditional Somali culture and UK culture, and will play a key role in their own and their families' future health.

Obesity: a major public health problem

The Foresight Report (Foresight, 2007) estimated that if current trends in obesity continue, more than 50% of the adult population in the UK will be obese by 2050. The UK government's obesity strategy, *Healthy Weight, Healthy Lives*, emphasised the need for research to 'deepen our understanding of the causes and consequences of the rise in excess weight' (Department of Health, 2008, executive summary p. xv). Morbidity due to obesity includes hypertension, type 2 diabetes, cardiovascular disease and liver disease (Landman and Cruickshank, 2001). Research indicates that people of African origin are at additional risk from these conditions, although the reasons for this are still unclear (Cooper *et al*, 1997; Khan and Beevers, 2005). Treloar *et al* (1999) examined cultural and social influences on obesity in a multicentre international study, and concluded that health promotion which concentrates on the individual without examining wider cultural and socio-economic influences may not be effective. Bhopal (2007) has highlighted the need for public health strategies to ensure that the needs of minority ethnic groups are being met. Nevertheless, recent obesity strategies, for example that of Liverpool Primary Care Trust (2008), have tended to adopt a 'one size fits all' approach.

Cultural and environmental influences on body image and size

Grogan (2008, p. 3) defined body image as 'a person's perceptions, thoughts and feelings about his or her body.' Body image has a central role in determining body size, and Grogan has emphasised the importance of understanding differences between sub-cultural groups and their attitudes towards size when addressing issues such as obesity. Local research has indicated that most Somalis perceive being overweight (as medically defined) as healthy, and that a 'healthy' diet is a Somali diet, that is, eating meat with fat and cooking with ghee (Salah, 2004; Maxwell *et al*, 2006). Wardle *et al* (1993) explored issues of body image and size with young Asian women in the UK using pictorial silhouettes, but did not explore attitudes to obesity or body size in later life. No research has been published on this topic for the Somali community in the UK, where young, second-generation women are growing up in a society shaped by western preferences for slimness (Grogan, 2008). Treloar *et al* (1999) found that body size is also influenced by lifestyle, availability of food, environment and physical activity. Research indicates that Somali refugee women living in the west are less active than they were in Somalia (Guerin *et al*,

2003) and have a high prevalence of obesity (Burns, 2004).

The Liverpool Somali community

This community has its origins in the colonial relationship between Britain and Somalia. Many Somalis arrived as seamen after the Second World War and brought their families with them (Stokes, 2000). With the advent of civil war in 1991, Somalis fled to join their relatives worldwide (Guerin *et al*, 2003). Refugees come from different clans and tribes and diverse social backgrounds. Some have previously led a nomadic life, while others are professionals, many having qualified abroad (Harris, 2004). Although exact numbers are disputed due to a lack of accurate data (Information Centre About Asylum and Refugees, 2007), their numbers are estimated locally to be in the range 5000–6000 (Icarus, 2004). Most young Liverpool Somalis are now growing up in Toxteth, one of the most deprived areas in Liverpool (Liverpool Primary Care Trust Public Health Intelligence Team, 2008). Although in Somalia the men are traditionally head of the household, many households in Liverpool are all female due to the casualties of war. Women have a key role in managing the family (Whittaker *et al*, 2005) and in shopping and cooking (Maxwell *et al*, 2006). It was therefore appropriate to investigate how Somali women perceived themselves and the factors that contributed to obesity.

Research design

Aim

The study aimed to explore young Somali women's perceptions of and influences on body image and body size.

Ethical opinion

This study was approved by Cheshire Research Ethics Committee and Liverpool John Moores University Research Ethics Committee.

Methods

This was a qualitative study based on focus groups, which allow individuals to explore issues that are important to them and to generate their own ideas (Kitzinger, 1995). Whittaker *et al* (2005) used repeated focus groups in their research on the psychological well-being of young Somali women, and suggested that this method increases reliability by feeding back initial themes to participants and involving them more deeply in the research. In addition, Somalis have a strong oral tradition in which important issues are often discussed in a group setting (Samatar, 2009).

Culley *et al* (2007a, p. 103), in their research with British South Asians, found that focus groups are particularly effective in enabling researchers to understand 'group norms and values.' They recommend the involvement of focus group facilitators as partners in research, exchanging knowledge and ideas with the principal researcher (Culley *et al,* 2007a, b). In the present study, a Somali woman with previous experience in health research, Samsam Salah (SS), acted as a co-researcher. She played a crucial role in building trust within the community and recruiting participants to the study.

Participants

A purposive sampling strategy was used, based on discussions with local Somali health workers. This strategy is appropriate for groups that are difficult to reach, and has been used successfully by Flynn and Flynn (2008) in their research with the Manchester Somali community. SS recruited women, using a snowballing technique (Browne, 2005), through a combination of word of mouth and visiting community groups. She had successfully used this form of recruiting in previous research into Somali diet in Liverpool (Maxwell *et al*, 2006).

A total of 13 Somali women, aged 18–28 years, who had lived in the UK for at least five years and who spoke both English and Somali, agreed to take part in the study. All of the participants had a number of GCSEs (range 4–11, average 7), and almost all of them were in higher education. Their UK dress size ranged from 8 to 16, although most were size 10–12. Only one of the participants had children.

Procedures

Initial discussions about concerns in the local Somali community were held with female Somali health workers. These discussions shaped the topic guide (see Box 1) and identified lines of enquiry to be pursued in the focus groups, for example, the traditional Somali practice of eating a large amount and resting indoors after childbirth.

Two focus groups were planned with the expectation of repeating them with all of the participants. However, not all of the difficulties involved in recruiting young women and organising the focus groups had been anticipated. This was due to their busy work, study and social lives, with social events often being planned at short notice. Consequently, the methodology was altered and three smaller groups were held

Box 1 Summary of topics for initial focus groups

Topic 1: Body size and body image
Using a silhouette scale, participants were asked to compare ideal body shape with perceived actual body shape. This was used as a springboard to discussion of influences on body size and image, such as Somali traditions, family, media and advertising.

Topic 2: Healthy physical body and health awareness
Participants were asked what makes a healthy physical body. They were asked to discuss whether the notion of a 'healthy body' is different in the UK and Somalia, and how this influences their size.

Topic 3: Diet and exercise, including costs and availability
Participants were encouraged to express their views about what constitutes a healthy diet. This was used as a springboard to discussion of the role of food and constraints on healthy eating. Participants were also asked about attitudes to exercise in maintaining a healthy body and an acceptable body size. This was used to generate discussion, including consideration of access to facilities and barriers to exercising.

Participants were encouraged to think about all of the topics in relation both to their present lives and to the future, with reference to the silhouettes.

(with 4, 4 and 5 women, respectively), and two further groups (with 5 and 3 women, respectively) were conducted with eight of the original participants

Initial focus groups

The three initial focus groups, each lasting for 60–90 minutes, were conducted by Katy Gardner (KG) and SS in two local Somali women's centres. The centres, which were well known to participants, were chosen to ensure that the participants felt at ease. Appropriate refreshments consisting of fruit, biscuits and tea were provided. The nature of the study was explained, and verbal and written consent was obtained, including permission for audio taping. The participants were identified only by numbers. As they had been living in the UK for some years, language and literacy were not anticipated to be a major problem. However, SS, who is bilingual, ensured that the participants fully understood the nature of the research before they gave consent. The demographics of the participants were requested, including dress size. Visual body silhouette prompts (see Figure 1) were used to create an informal atmosphere and initiate discussion. Liburd *et al* (1999) have used silhouette prompts successfully to explore body size and body image in black women with diabetes. Focus groups were conducted using a topic guide (see Box 1).

KG introduced the topics for the focus groups, which were conducted in English, although SS was available to clarify any ambiguous meanings. At the end of each group the participants were debriefed, the issues raised were clarified, and any misinformation about health issues was corrected. Each participant received a pack containing information about healthy eating, local primary care trust food workers, and self-help groups for eating disorders. SS noted topics and nuances during the focus groups (e.g. in one group the participants broke into Somali during a heated discussion about access to women-only swimming sessions). The researchers held a debriefing session immediately after each focus group to gather SS's impressions and to reflect on the emerging themes.

Further focus groups

Two further focus groups were convened to explore the emerging themes and to check that the researcher's analysis was correct. These groups also discussed possible solutions to the problems that had been identified.

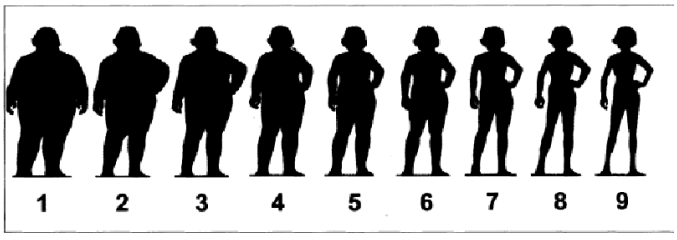

Figure 1 Body size silhouettes (where largest = 1 and smallest = 9). Source: Liburd *et al* (1999).

Analysis

Realistic and desired body sizes from the silhouette exercise were recorded (see Box 2). The focus group proceedings were transcribed by KG and subjected to thematic content analysis in accordance with Green and Thorogood (2004), who have provided a comprehensive overview of this process. Initial focus group transcripts were laid out on the floor and coded using different coloured pens. These codes were grouped into categories and then further grouped into emerging themes. Krueger and Casey (2000) have highlighted the importance of noting the frequency and emotional intensity of participants' comments, and this was carried out as part of the debriefing meetings after each group. Emerging themes were compared repeatedly across transcripts. Notes taken by the researchers were reviewed in conjunction with the transcripts. Emerging themes were checked and discussed with SS, who read the transcripts independently. Dissenting views were noted and the analysis was modified accordingly as discussed by Frankland and Bloor (1999). Further focus groups were analysed similarly. The aim was to reach a consensus of themes between participants and researchers, as Culley *et al* (2007a) have suggested. Green and Thorogood (2004, p. 191) have emphasised the importance of member checking in establishing credibility. Feedback to key informants and the repeated focus groups gave the participants an opportunity to discuss and modify the themes. Following the recommendations of Lincoln and Guba (1985), the methods and results are described in detail, allowing the reader to draw their own conclusions.

Reflections on researchers' roles

KG is a white GP who has had many years' experience of working with the Somali community, both as a GP and as a researcher (Aweis *et al*, 2001). Oakley (2005) has discussed how power can be a problem in community research. Although KG might have been perceived as a powerful outsider, due to her professional status, working with a Somali co-researcher and using repeated focus groups helped to empower the participants to speak out, and minimised the social and professional gaps. SS, although slightly older than the participants, is a trusted community member with previous local research experience (Salah, 2004; Maxwell *et al*, 2006).

Findings

The findings are presented in terms of the major themes identified, which were as follows:

- silhouettes
- the perfect size, the healthy size
- 'eat, eat, eat'
- rice and meat: making the Somali diet more healthy
- access to healthy food and exercise.

Silhouettes

The silhouette exercise provoked laughter and animated discussion, much of it in Somali, that focused on what sizes women were choosing, what their preferred sizes were, and whether these were realistic. All of the participants except one wished to be a smaller

Box 2 Silhouette exercise with focus group participants (n = 13)

Now:
What size do you see yourself as realistically on the silhouette chart?
All participants: silhouette numbers 6–8

What is your ideal size?
11 participants wanted to be smaller: silhouette numbers 7–9
1 participant wanted to be the same size
1 participant in Focus Group 1 wanted to be larger

In 20 years' time:
What will your size be realistically?
12 participants saw themselves as larger: silhouette numbers 3–6

What would be your ideal size?
12 participants wanted to be smaller: silhouette numbers 6–8
1 participant in Focus Group 1 as above wanted to be larger

size (see Box 2). They wished to retain their current size in the future, but perceived themselves realistically as getting larger when they got married and had children.

The perfect size, the healthy size

The focus group participants (P) had all been through the UK education system and were aware of the dangers of obesity and the importance of a healthy lifestyle. For them the perfect size was the healthy size, as one participant put it, 'slim but toned' (P6), and another 'The perfect size for a Somali woman is not too skinny and not overweight with fat hanging off, but with a bit of meat on you so you look good' (P5).

All of the participants emphasised the influence of the media and celebrity culture on young women, and the pressure, as SS mentioned in preliminary discussions, to be like 'slave models.' Several participants talked about fitting into society and the pressure to be a 'size zero' (P4): for example, 'Shops have certain sizes like 8 and 10. It really puts you down if you don't fit in to them' (P2).

The participants spoke about the difficulty of fitting into tight fashionable jeans. P4 explained that 'It's your natural ass. You can't lose it. It's an African thing.'

All of the participants were aware of the dangers of extreme slimness, but felt that their religion would protect them from extreme dieting:

> 'If it is harming your body you are not allowed to do it in our religion. It is like alcohol and cigarettes, they kill you in the long run so basically you're killing yourself, and that is not allowed in our religion.'
>
> (P4)

Most of the participants agreed that traditional Somali culture favours a larger body size, and that this would have a positive effect on young women in combating extreme diets or the desire for excessive slimness. However, the effect was often negative, as participants were caught between the pressure from western society to be slim and the pressure from older Somalis to be larger. One participant expressed it in the following way: 'You want to be that size, the perfect size or the healthy size, but you can't, you really can't choose ... it weighs down on one side and it weighs down on the other' (P13).

All of the participants faced pressure from older Somalis who preferred women to have 'a bit of weight' (P6) and wanted 'proper meat on their girls' (P5). One of them talked about her sister's experience: 'Her friends comment ''you have lost weight, you look so much better'', but the older generation, my mum's friends, say ''she is getting ill, there is something wrong with her''' (P1).

This pressure was especially upsetting for one young woman, who was very slim and was the only participant who wanted to be larger. She complained that 'The old people, they are offended by the way I am because I am skinny. They say ''Why is she so skinny? Doesn't she eat?''' (P3).

P10 spoke for the majority of participants who experienced this pressure when they visited their families in Somalia, where slimness is still often associated with ill health: 'Back in Somalia people love overweight women with a big size, and if you're skinny they think you are unhealthy.'

SS reflected on her own experience, describing the rapid change from feeling healthy in Somalia to feeling overweight in the UK: 'As soon as the plane lands I say, ''Oh, what about my size!''

However, most of the participants felt that perceptions of what constitutes a healthy size are changing in the UK Somali community as young women grow up assimilating both western culture and western health messages: 'The older generation like their women fatter and [with] more meat. With this generation it is different' (P4).

Eat, eat, eat

A major influence on body size was the custom of eating more after having a baby. Traditionally, a Somali woman rested at home for 40 days after having a baby, while relatives brought her food. Although the participants felt that this custom was changing due to societal pressures and also for financial reasons, they still experienced cultural pressure to rest and eat after having a baby. As one of them stated, 'Especially when you've got your mum! She feeds you. Twenty-four seven she will be in your face with food. She will be ''eat, eat, eat'' with meat and bread and all that' (P9).

Another participant described attempts to resist these pressures:

> 'Many people say when you give birth you have to eat a lot of nutritious food: Somali nutritious food. It's not what we know here and what's in health books, it's other things that are part of our culture. But if you don't eat that and you control yourself you can stay that ideal weight.'
>
> (P12)

The participants felt strongly that healthcare professionals, such as health visitors, have a key role in supporting healthy practices among women with young children, and that Somali community members should be encouraged to become healthcare professionals, as they would have cultural insight and be trusted. As one participant explained, 'Sometimes people don't want to say anything in case they feel you won't understand. But if it is someone from your own culture you will think ''Oh yes''' (P11).

Rice and meat: making the Somali diet more healthy

Most of the participants described the dilemma of being caught between traditional Somali cooking at home, often with oil and ghee, and the easy availability of fast food nearby. However, two of the participants were typical in feeling that Somali culture would increasingly influence them after marriage:

> 'Culture is a very strong thing, which is why young girls, although they were before influenced by the Western society, as soon as they get married they change.'
>
> (P1)

> 'It's culture. It's where we came from and what we eat, what is cooked at home and how we cook. Throughout the years we have to eat that food. No matter what!'
>
> (P12)

All of the participants were aware of the importance of a healthy diet, and many of them described efforts to improve the Somali diet by using more vegetables and cooking with less oil. The following was typical of their positive approach:

> 'Somali food can meet all your dietary requirements if you cook it the correct way. For example, if you are careful with the oil and add many vegetables you can get your five a day out of it.'
>
> (P5)

Most of the participants felt that they could make changes to the traditional diet and still enjoy it, as two of them illustrated:

> 'I think I will always eat rice and meat, but in a healthy kind of way.'
>
> (P2)

> 'You could make small changes to make a big difference. You can still have the food you like. It's a win-win situation!'
>
> (P10)

Although the participants did not feel that men had a direct influence on their size, men's attitude to diet was perceived by all of the participants as a major barrier to healthy eating, thus contributing indirectly to their size once they were married. They felt strongly that men have a more traditional attitude to food, preferring meat and rice to be cooked in the traditional way with plenty of oil. The idea of attempting to influence men generated lively debate: 'If there is no meat then it means you will not really be feeding him. It means ... *die* ... starve to death!' (P3).

The participants discussed attempting to steer men towards different foods, including fish. However, all of them felt that this approach would meet with resistance: 'You are not going to give them a tuna salad. You are going to give them proper food. That's what they consider proper food: rice and meat' (P1).

Several of the participants described attempts to influence men's diet. A married participant made her husband sandwiches with tuna and salad which he ate because no other food was offered. The participants felt that women should be supported in challenging men's diet. This would involve engaging with men and 'seeing their point of view' (P3). They felt that further research could involve Somali men. However, they sounded a note of caution that any approach would take time: 'They will say ''Healthy eating, ridiculous!'' It will take them some time to adapt' (P7).

Access to healthy food and exercise

The participants led busy lives, juggling work, studying and looking after the home in many cases. One of them spoke for the majority who wished to lead a healthier lifestyle but felt constrained by their environment:

> 'If you make healthy eating easier for people they will eat it, but if everything is expensive and you can't go to the gym because it's either too far or it's not available ... if you make things easier for them they will do it.'
>
> (P1)

The cheapness and proximity of takeaways by comparison with healthy food outlets was a major influence on most of the participants. As one of them explained, 'There are a lot of takeaways around. You get into the habit of just ordering' (P5).

Most of the focus group participants thought that healthy foods were more expensive than unhealthy foods, although a few felt capable of budgeting for healthy choices. Although cost was not currently a major factor for one participant, she expressed her concerns that it would be when she was buying food for a young family:

> 'I used to get fish and chips, a whole meal for less than £1. But a little bit of vegetables in the supermarket cost £1.70 or £2. That makes it difficult to be healthy because the food they like is much cheaper than the food they don't like.'
>
> (P1)

The participants recognised that provision of healthy food outlets as the local area is regenerated could be a useful opportunity. They discussed the possibility of local people opening healthy takeaways and greengrocers, but recognised that this may not be easy: 'It would be great. I am not trying to be negative, but it will take years to get something like that happening' (P7).

The participants also discussed the value of having role models in the community. Two of the participants'

mothers have improved their diet, and were recognised as cooking Somali food healthily. One woman described the changes that her mother had made: 'We used to buy crisps and biscuits. Nowadays mum does different shopping' (P7).

Almost all of the participants felt that the lack of availability of women-only gyms was a major barrier to regular exercise, and felt that the local facilities were not adequate for Muslim women. As one woman said, 'The facilities are there, but there's not a lot of facilities, one gym and how many in the Somali community?' (P6).

Another woman expressed the view of most participants that women-only sessions could be easily provided: 'It is just a few hours. It is not as if you are building a new building' (P1).

Almost all of the participants enjoyed swimming. However, animated discussion took place about women-only swimming sessions. The participants emphasised that the presence of older women made young women feel intimidated: 'They feel this boundary. You can't cross that boundary, so only women over thirty go' (P12).

The outlook for women exercising with young children was even more bleak. One woman worried that 'they are not seeing daylight' (P1), and this view was echoed by the majority of the participants: 'After you have a child you think, especially with this weather, ''Oh no, I will just stay at home.'' You get into the habit of sitting at home' (P9).

The participants emphasised the need to encourage women with young children to exercise. The following quote reflected other participants' views: 'There should be a place available for your kids as well so you don't have to worry about where they are ... if there was a gym with kids' playground or activities' (P7).

Although a few of the participants felt that they would go out with their children, the safety of outdoor spaces was an issue for most. Prior to the final focus group a Somali girl had been attacked by a dog, and one participant described the local park as 'dodgy' (P7).

The participants felt that the relatively small size of the Liverpool Somali community was a disadvantage, as there can be safety in numbers. As one of them stated, 'In Birmingham they have this big park. There is a large Asian community and they go together. The women are overweight, they walk and the children play' (P1).

Discussion

The perfect size: caught between cultures

Turner (1995) and Grogan (2008) have argued that body image is strongly influenced by socio-cultural issues, and that different body sizes have been considered desirable and undesirable by different societies at different times. Obesity is related to body image, and Prentice (2000), in his review of urban obesity in the Gambia, suggested that for some rural societies with seasonal food shortages, a larger size may have had a protective role. Preferences for a larger size, associated with health and wealth in their country or setting of origin, often persist in migrant populations that move from a rural environment to an urban one. This has been demonstrated by Prentice (2000) and by Rguibi and Belahsen (2006) in their studies of recently urbanised Moroccan women. The participants in the present study frequently referred to the influence of culture on the way that they perceived themselves. They reflected on the tension between different cultural values, caught between the western pressure to be slim and the pressure from older Somalis to be larger. Helman (2007, p. 3) has described this as 'biculturalism', a feature of recent migrant communities where 'the traditional culture of the first generation coexists with the different cultures acquired by their children and grandchildren.' Pressure from older Somalis for young women to be larger has been demonstrated in previous research with migrant Somali communities in the USA (Haq, 2003) and in the UK (Chowbey *et al*, 2008). Salah (2004), in her recent study of Somali women of all ages in Liverpool, found that most of them perceived a healthy size as a large size.

However, the present study has shown that young Somali women in Liverpool are thinking differently about body size, demonstrating an awareness of what constitutes a medically healthy body size and a wish to influence their size. Unfortunately, the generally perceived norm in the UK is also changing. Johnson *et al* (2008), in a study of population surveys, found that fewer respondents identified themselves as overweight in 2007 by comparison with 1999, while the average population weight had increased. While attempting to resist cultural pressure from older Somalis, the young Somali women in the present study are also at risk of following this trend towards the host country's norms as they experience lack of access to healthy food and exercise.

On the other hand, the participants also expressed concerns about the influence of western notions of slimness on younger Somalis growing up today. The relentless nature of celebrity culture and media pressure on young women have been discussed by Grogan (2008) and Orbach (2009), and have been found to influence body size and shape in black women with diabetes (Liburd *et al*, 1999). The interplay of western values with traditional culture has been highlighted by MacLachan (2004), who documented an increase in the incidence of eating disorders in developing countries. Chowbey *et al* (2008) found that eating disorders occurred, albeit rarely, in BME communities, including the Somali community in Sheffield. However, although most of the participants in this study wanted to be a smaller size, they felt that they were protected from extreme dieting by a combination of Somali culture and religion. Although Nishina *et al* (2006) reported that female African American adolescents experienced less body dissatisfaction than their white counterparts, and related this finding to culture, a meta-analysis by Grabe and Hyde (2006) of 98 studies of body dissatisfaction found that this effect was small, indicating that BME women may be more at risk of body dissatisfaction than was previously thought to be the case.

Diet: 'small changes to make a big difference'

Gilbert and Khokhar (2008) have documented how migrant BME groups living in Europe combined aspects of traditional diet with less healthy aspects of western diet. Guerin *et al* (2003) and Carroll (2007) have shown that increasing obesity in Somali refugee women living in New Zealand and the USA is related to both inactivity and dietary change.

However, our study findings show that in Liverpool the traditional Somali diet is still dominated by meat and rice. The perception of meat and rice as 'proper food' was also found in a recent study by McEwen *et al* (2009) of dietary habits of Somalis in London. In the present study, the participants struggled to maintain the best of the traditional Somali diet, while trying to make it healthier. They acted as brokers negotiating between cultures, a notion introduced by Szasz (1994) and described by Whittaker *et al* (2005) in their research with young Somali women in Sheffield. These strategies were also evident among Indians and Pakistanis interviewed by Mullen *et al* (2006) during a study of dietary practices and oral health in BME communities in the UK. Burns (2004) studied the dietary habits of recent Somali immigrants living in Australia, and concluded that supporting the Somali diet, incorporating the use of local vegetables and encouraging the use of healthy cooking methods may protect Somalis against obesity and the chronic diseases that are associated with migration to the west. In the present study the participants suggested encouraging local food champions and food workers to support young women. This need for support and for community education about healthy eating was documented recently in UK research by McEwen *et al* (2009) and also by Lawrence *et al* (2007), who examined the factors that affect dietary choices of young BME women, including Somalis. Prior to the 1990s, researchers tended to view health beliefs and practices in BME communities as problematic**.** However, Greenhalgh *et al* (1998), who studied Bangladeshi diabetics in the UK, have argued that an asset-based approach to health promotion that utilises the skills of local communities is more helpful. This was consistent with our experience of working with young Somali women in Liverpool, who displayed knowledge of what constitutes a healthy diet, as well as a willingness to make positive changes. This reservoir of motivation could be harnessed by the local primary care trust as part of its approach to combating obesity (Liverpool Primary Care Trust, 2008).

Despite the role of women as dietary gatekeepers, as described by Webb (2008) and reflected by local research (Salah, 2004), the present study found that men had an important influence on the family diet. The study participants felt that Somali men would be resistant to changes that women are attempting to make with regard to switching to a healthy diet, and they highlighted the need for research and community education with and for men. Although diet has been studied with Somali women (Burns, 2004), and more recently with mixed participants (McEwen *et al*, 2009), the authors could find no recent research that has explored these issues specifically with men.

'If you make things easier for them they will do it': creating the context for health improvement

The busy lives of second-generation BME individuals, who are juggling work and families, as potential barriers to a healthy lifestyle have been documented elsewhere (Mullen *et al*, 2006). Lawrence *et al* (2007) found that lack of time for cooking was a contributing factor in young women from BME communities adopting less healthy aspects of western diet, including fast foods. In this study, the easy accessibility of fast food outlets emerged as a temptation to participants, in addition to lack of time. The participants all lived in Toxteth, one of the most deprived areas of Liverpool (Liverpool Primary Care Trust, 2008). Treloar *et al* (1999) demonstrated the importance of the effect of the social and economic environment on health behaviour. The need for access to cheap, convenient

options for a healthy lifestyle featured strongly in the discourse of the participants in the present study.

Lack of women-only sports and exercise sessions was highlighted by Asian women in the 1999 UK Health and Lifestyle Survey (National Institute for Clinical Excellence, 1999). Guerin *et al* (2003) found that this was a major problem for migrant Somali women in New Zealand, and it has been documented among Somalis in the UK by McEwen *et al* (2007). The study participants felt that it continues to be a barrier for Muslim women in Liverpool today, and at the conclusion of this research the local gym that had been used by participants closed due to shortage of funds. The participants' lack of confidence in the safety of parks and outdoor spaces reflects the experience of mothers interviewed by McGarvey *et al* (2006) in their study of maternal beliefs as part of a childhood obesity prevention programme in the USA.

Both Guerin *et al* (2003) and McGarvey *et al* (2006) emphasised the need to understand cultural beliefs and traditions when planning health promotion programmes, and current thinking highlights the importance of creating environments in which change is more likely to occur (Thaler and Sunstein, 2008). Toxteth is undergoing a process of regeneration, and the issues raised in the present study should be considered during this process, including the encouragement of enterprises that provide healthy food, as suggested by the Liverpool City-Region Health is Wealth Commission (2008). As most Somali communities are based in poor inner-city areas (Flynn and Flynn, 2008), these findings are also relevant to Somalis living in other areas of the UK.

Limitations

The numbers of focus group participants were small. Culley *et al* (2007a, b) described difficulties in recruiting participants from communities that are hard to reach, even when the researchers are known to the community, as was the case in the present study. However, the researchers believe that the small numbers became an advantage in terms of obtaining participants' viewpoints in more depth. Flynn and Flynn (2008), in a study of the Somali community in Manchester, have documented difficulties in working with larger groups, particularly if the participants all talk at once.

This was a small study conducted in a specific community. However, Green (1999, p. 421), commenting on previous research by Gardner and Chapple (1999), explained that 'the generalisability of a small study does not derive from the representativeness of the sample', but from the concepts arising from it that may be relevant to other settings.

Conclusion

This study found that young Somali women were negotiating between two cultures. The participants were attempting to extract the best elements from both cultures, but faced substantial cultural and environmental barriers. Women wished to be healthy and to maintain their ideal size, but might not succeed. An asset-based approach to health promotion and attention to an enabling environment will increase their chances. Further research is needed to examine the influence of Somali men on dietary practices. The findings of this study reflect the conclusions of Treloar *et al* (1999), that socio-cultural influences on diet and body image should be considered in health promotion and social marketing strategies. Greenhalgh *et al* (1998) and Landman and Cruickshank (2001) have argued that culturally competent health promotion involves understanding the experiences of diverse communities and building on their assets. During initial discussions in the present study, a heath worker expressed the importance of word of mouth in the Somali community: 'If you educate one young girl you will educate a whole generation.' MacLachlan (2006) emphasised the importance of forging relationships between researchers and communities. Conducting this study in a participatory manner with a commitment to feedback should ensure that the participants' views and potential solutions are widely disseminated in the future.

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CONFLICTS OF INTEREST

None.

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