FACT SHEET

Somalis in Minnesota

Increasing the cultural competence of health care providers serving diverse populations

In order to provide equitable and effective health care, clinicians need to be able to function effectively within the context of the cultural beliefs, behaviors, and needs of consumers and their communities. According to the 2002 Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, racial and ethnic minorities tend to receive lower quality health care than non-minorities even when access to insurance and income is provided. Failing to support and foster culturally competent health care for racial and ethnic minorities can increase costs for individuals and society through increased hospitalizations and complications.

In 1992, large numbers of Somali refugees began arriving in the US after the devastation of civil war in the African country of Somalia. An estimated 50,000 or more Somalis now live in Minnesota. Minnesota has the largest Somali population in the US.

Social Structure. Family and clan groups define the social structure in Somalia, with membership in a clan determined by the father's lineage. Families traditionally live in multi-generational households. Under Islamic law, a man may have as many as four wives if he can support them equally, and under law, he is bound to support his children. Somalis have three-part names. The first name is often the name of a grandparent, the second name is the name of the child's father, and the third name is the name of the child's paternal grandfather. Somalis are identified by their first and second names, which can be confusing to Americans who are used to using the first and last name. Women do not change their name after marriage.

In a Somali home, the father is the decision-maker and wage earner for the family, and represents the family outside the home. When a father is absent, that role is passed on to an older male relative or adult son. In a Somali household, women have considerable influence and her status is enhanced by the number of children she has. Traditionally, Somali women marry and have children early—birth control practices are not widely used. Somalis commonly have large families. The women are responsible for care of the children and preparing their food. Children are valued highly in Somali culture and spanking is considered an acceptable practice.

Diet. Traditional staples of the Somali diet are rice, bananas, and the meat of sheep, goats, and cattle, with little fresh fruit or vegetables. All meat is ritually slaughtered according to Islamic law. Twin Cities' stores sell Halal, a specially prepared meat. Traditional Somali bread is similar to pita bread. Coffee and teas are preferred Somali drinks.

Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

Stratis Health works with the health care community as a quality improvement expert, educational consultant, convenor, facilitator, and data resource.

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According to custom, food is eaten with the right hand. Somali men and women eat separately.

Qat, (also spelled khat, chat, kat) a mild stimulant used by some Somali men is derived from fresh leaves of the catha edulis tree. In the US, the federal designation of Qat was recently changed to a restricted drug due to concerns for potential abuse.

Religion. The majority of Somalis are Sunni Muslims. For Somalis, Islamic religious teachings provide meaning for living, dying, health, child rearing, and family life. In Islam, prayer is performed five times a day: at dawn, noon, mid-afternoon, sunset, and in the evening. Prayer can take place at home, at school, in the workplace, outdoors, or in a mosque. Hands, face, and feet are washed before prayer. Islam forbids eating pork, drinking alcohol, and touching or being near dogs. Ramadan is observed as the most important Islamic holiday, a month long holiday during which people refrain from taking medications, and eating and drinking during daylight hours, with the exception of pregnant women, the very ill, and young children.

Traditionally, men and women do not touch members of the opposite sex outside the family, such as shaking hands. According to Islamic tradition, women are expected to cover their bodies, including their hair. Most Somali women do not wear a full-face veil. In Islamic tradition, the right hand is considered the correct and polite hand to use for daily tasks such as eating, writing, and greeting people. If a child shows a left-handed preference, parents train the child to use the right hand. The Somali language is spoken universally by most Somali people, with Arabic, the language of Islam, a common second language.

Medical Care. Major medical conditions in Somalia and among recent immigrants to the US are malnutrition, iron deficiency anemia, Vitamin A deficiency, and scurvy. Common infectious diseases are diarrheal disease, measles, malaria, and acute respiratory illness. At least 47 percent of recent arrivals to the US are affected by intestinal parasites. In 1997, Somalia's HIV infection rate was .25 percent—well below that of other African nations.

Depression and anxiety are common to Somali refugees, who may have lost family members or were separated from them. An estimated 30 percent of Somali refugees have been victims of torture; they have experienced horrific events and may be suffering posttraumatic stress. There is no word for stress in the Somali language.

Health prevention is practiced primarily through prayer and living a life according to Islam. Many Somalis believe that an individual cannot prevent illness, as the ultimate decision is in God's hands. They believe that illness may be caused by a communicable disease, by God, by spirit possession, or by the "evil eye." Mental illness is often believed to be caused by spirit possession or as a punishment from God. Traditional spiritual healers use religious rituals for healing. Patients often wear amulets, believed to have medicinal value and to keep evil spirits away. Often, Somalis will not take medications such as anti-tubercular agents if they feel healthy. Most Somali patients agree to surgery and blood drawing. Health care decision making may involve the entire family, with a male family member acting as the family spokesperson. The father is expected to give consent for medical procedures and surgery.

Viewed as a rite of passage and required for marriage, circumcision is universally performed on both Somali males and females. Uncircumcised people are traditionally viewed as unclean. Female circumcision is performed before adolescence, and involves several different procedures in which varying amounts of genitalia are removed, after which the area is sewn together. Circumcision creates many health problems for women, including chronic pain, urinary tract infections, menstrual problems, and increased pregnancy risks. Before a child is born, a Somali mother's circumcision site must be cut open to allow passage of the infant. After delivery, the area is again sewn together. Female circumcision in the US has become a complex and emotionally charged issue. Most Somalis in the US believe the practice to be obsolete, and it is not a requirement of Islam. US law forbids circumcision of a female child.

Take advantage of the following tips to help you provide the most appropriate, culturally competent care for your Somali patients:

- Ask your Somali patients about their symptoms. They may describe pain by saying they hurt all over.
- Ask about dietary restrictions and use of herbal medications.
- Be aware of unexpressed depression, anxiety, and post traumatic stress common to Somali refugees who have experienced torture.
- Be aware of female circumcision as a sensitive issue for Somali women. Keep lines of communication open.
- Use trained medical interpreters, not family members, when possible. Never use children as interpreters.

- Establish a child's care plan with the assistance of the father and mother.
- Consider changing medication schedules during Ramadan, when Somalis may be fasting during the day.
- Repeat information and offer reassurance frequently during long procedures.
- Provide information on American health care practices.
- Establish a relationship with the family before care begins.
- Be receptive to family suggestions. Building respect is essential.
- Provide educational materials orally or in a video to accommodate limited English proficiency.
- Use the right hand to give food or medications; the left hand is considered impolite.
- Ask permission before touching a patient to offer comfort.
- Provide a location and opportunities for prayer (at dawn, noon, mid-afternoon, sunset, and evening). Do not interrupt prayer. Somalis believe the divine is present during prayer.
- Do not use finger gestures to get attention. It is viewed as disrespectful.
- Consider establishing a walk-in clinic for Somali patients rather than scheduling appointments.

Death and Dying. Somalis view dying as salvation and part of the life cycle. When a Somali person is terminally ill, it is considered uncaring for a health care provider to tell the dying person. The family tells the patient. When death is impending, a special portion of the Koran, called yasin, is read at the bedside. After death, a sheik prepares the body. In Minnesota, the Islamic Care Center handles all arrangements if a family requests it to do so.

Sources

Conversations with Huda Farrah, MSc, an educator, researcher, cultural competency trainer, mentor, coach, host and producer of TV and radio shows, and leader in public health and early childhood education.

Children's Hospitals and Clinics of Minnesota, http://www.childrensmn.org, viewed May 10, 2007

Stratis Health has a long record of success in reducing health disparities among communities of color and underserved populations. Our efforts to reduce health disparities include increasing the cultural competence and effectiveness of providers serving culturally diverse populations, improving health literacy in the community, and working with specific populations on targeted clinical conditions.

Culture is essential in assessing a person's health and well-being. Understanding a patient's practice of cultural norms can allow providers to quickly build rapport and ensure effective patient-provider communication. Efforts to reduce health disparities must be holistic, addressing the physical, emotional, and spiritual health of individuals and families. Also important is making connections with community members and recognizing conditions in the community.

Get to know your patients on an individual level. Not all patients from diverse populations conform to commonly known culture-specific behaviors, beliefs, and actions. Generalizations in this material may not apply to your patients.

WWW.CULTURECARECONNECTION.ORG

Culture Care Connection is an online learning and resource center dedicated to supporting Minnesota's health care organizations in their ongoing efforts to provide culturally competent care.

Funding to support Culture Care Connection has been provided by UCare.

Contact us for assistance with your quality improvement and patient safety needs related to reducing health care disparities.

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