

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.

According to 2010 American Community Survey data, Minnesota still has the largest Somali population in the nation. The survey estimates the national population at 85,700 and the Minnesota population at more than 32,000, with the majority of Somalis living in Minneapolis and St. Paul. However, these numbers are greatly disputed by the Somali community and by Donald Yamamoto, principal deputy for the State Department's Africa Bureau, who estimates the national number to be significantly greater than 100,000. Large numbers of Somalis also reside in Ohio, Washington, and California. The majority of Somali refugees first began arriving in the U.S. in the 1990s, when civil war devastated Somalia, a country located on the far eastern tip of Africa, bordering Ethiopia.^{1,2}



Social Structure. The majority of Somali refugees first began arriving in the U.S. in the 1990s, when civil war devastated Somalia, a country located on the far eastern tip of Africa, bordering Ethiopia. Somalis in Minnesota are younger than the general population. The median age of the Somali population is about 25 years, compared with the median age of the general population, at 37 years.

Somali 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 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.



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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In a Somali home, the father is the wage earner and decision-maker 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. Women have considerable influence in the home and their status is enhanced by the number of children they have. Traditionally, Somali women marry and have children early—birth control practices are not widely used. Somalis commonly have large families. Women are responsible for the children, who are valued highly in Somali culture. Spanking is considered an acceptable practice.

According to Islamic tradition, men and women do not touch members of the opposite sex outside the family, such as shaking hands. Women must cover their bodies, including their hair, although most Somali women do not wear a full-face veil. 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 often train the child to use the right hand. The Somali language is universally spoken, with Arabic, the language of Islam, a common second language.

Qat (also khat, chat, kat), a mild stimulant derived from fresh leaves of the *catha edulis* tree, is regularly used by Somali men. In the U.S., however, Qat has been designated a restricted drug due to concerns for potential abuse.

Diet. Traditional staples of the Somali diet are rice, bananas, and the meat of sheep, goats, and cattle. All meat is ritually slaughtered according to Islamic law. Twin Cities' stores sell Halal, a specially prepared meat. Islam forbids eating pork and drinking alcohol. Traditional Somali bread is similar to pita bread. Somalis eat little fresh fruit and vegetables. Coffee and teas are preferred drinks. According to custom, food is eaten with the right hand and Somali men and women eat separately.

Religion. Most Somalis are Sunni Muslims. 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, school, work, outdoors, or in a mosque. Hands, face, and feet are washed before prayer. Islam forbids touching or being near dogs. Ramadan is observed as the most important Islamic holiday. It is a month long holiday during which people refrain from taking medication, and eating and drinking during daylight hours—with the exception of pregnant women, the very ill, and young children.

Medical Care. Major medical conditions in Somalia and among recent immigrants are malnutrition, iron deficiency anemia, Vitamin A deficiency, and scurvy. Common infectious diseases are diarrheal disease, measles, malaria, and acute respiratory illness. Nearly 47 percent of recent arrivals are affected by intestinal parasites. According to the UNAIDS project, in 2007, Somalia's HIV infection rate was well below that of other African nations.

Depression is common among Somali refugees, who may have lost family members or endured horrible events during the war. An estimated 30 percent of refugees have been tortured and may be suffering from post-traumatic stress disorder.

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. 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 to keep away evil spirits. Often, Somalis will not take medications such as anti-tubercular agents if they feel healthy. 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 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, the circumcision site is cut open to allow passage of the infant. After delivery, the area is again sewn together. Female circumcision is a complex and emotionally charged issue in the U.S. It is not a requirement of Islam and most Somalis in the U.S. believe the practice to be obsolete. U.S. law forbids circumcision of a female child.

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. When death is pending, the family

tells the patient and a special section 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 at the family's request.^{3,4,5}

Use these tips to help provide the most appropriate, culturally competent care for your Somali patients:

- + Talk with Somali leaders in your community to better understand the health needs and preferences of your Somali Muslim patients.
- + Establish a relationship with the family before care begins. Be receptive to suggestions, as building respect is essential.
- + Use trained medical interpreters. Never use children or other family members as interpreters.
- + Ask permission before touching a patient to offer comfort.
- + Use the right hand to give food or medications; the left hand is considered impolite.
- + Ask your patients about Muslim-based dietary restrictions. Muslims do not eat pork. Be aware of resistance to vaccines that contain porcine gelatin, an animal protein.
- + Be aware of unexpressed depression, anxiety, and post-traumatic stress common to Somali refugees who have experienced torture and lost family members in war.
- + Be aware of the sensitive issue of female circumcision in this population. Keep lines of communication open.
- + Repeat information and offer reassurance frequently during long procedures.
- + Involve the parents when establishing a child's care plan.
- + Provide educational materials orally or in a video to accommodate limited English proficiency.
- + Consider establishing a walk-in clinic for Somali patients rather than scheduling appointments.
- + Provide a location and opportunities for prayer (at dawn, noon, mid-afternoon, sunset, and evening). Do not interrupt prayer. Muslims believe the divine is present during prayer.

Sources:

¹American Community Survey, <http://www.geolytics.com/USCensus,Census2010ACS,Categories.asp>, viewed October 10, 2011

²MPR News, <http://minnesota.publicradio.org/display/web/2010/12/14/american-community-survey-initial-findings/>, viewed October 10, 2011

³Promoting Cultural Sensitivity: Somali Guide, Centers for Disease Control and Prevention, <http://www.cdc.gov/tb/publications/guidestoolkits/EthnographicGuides/Somalia/chapters/chapter1.pdf>, viewed October 10, 2011

⁴Conversations 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, December 18, 2006

⁵Children'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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