Somali Muslims AND HEALTH CARE

WHO THEY ARE

Somalis are a group of new immigrants to the United States primarily from Somalia, which is in the northeastern corner of Africa. Somalia's neighbors are Djibouti, Ethiopia, and Kenya and its long coastline is on the Red Sea and the Indian Ocean. As a result of civil war which preceded the ousting of the Somali government in 1991, **Somali citizens fled to neighboring countries and to other parts of the world to escape the widespread consequences of the war, namely, hunger, rape, and death. Most Somali refugees have lived in camps in northern Kenya. Minneapolis/St. Paul is the "Somali capital" of the United States.**

CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES[1]

Almost all Somalis speak the same Somali language and share the same culture and Sunni Islamic religious tradition. Saudi Arabia, the heartland of Islam, being situated rather close to Somalia's northern border, Somali culture and the Islamic faith have blended together for the past fourteen hundred years. Somalis were colonized by the Italians and the British and attained independence in 1960. Despite this fact, they generally have limited experience with multi-cultural and multi-ethnic situations.

The majority of Somali refugees come from rural Somalia and may not possess urban work experience. They have less formal education and literacy, hence less knowledge of English. Nonetheless, **many Somalis are multi-lingual given their historic links with neighboring and foreign countries.** Along with loss of extended family and community, they suffered from exposure to physical and emotional trauma having lived many years in refugee camps. **Many of these experiences are risk factors for poverty and illness.**

[1]Please see Introduction for a caveat against stereotyping members of any group at all.

CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES (CONTINUED)

Somali Muslim identity prescribes certain practices. For example, Somalis **pray** five times a day after ritually washing and cleansing themselves. They fast during the sacred month of Ramadan from sunrise to sunset. **They are forbidden to eat pork and drink alcohol. Pre-marital sex is not acceptable.** Casual physical contact, such as touch, is forbidden between Somali men and women who are not family. Men shake hands with men only and women shake hands only with women. **Separation of genders is noticeable especially during prayers in a mosque. Since the last three generations or so in Somalia, women** have generally been wearing *hijab* (**headcover**).

Similar to Muslims worldwide, Somalis greet each other with "Salaamu alaykum" (pronounced "Sir-laa-moo aa-lie-koom") which is Arabic for "Peace be with you" or "God bless you."

Somalis bury their dead the same day or **within twenty-four hours. Autopsy is not acceptable**, except for criminal investigation. **Post-mortem organ donation is not generally known to the Somali community and hence not encouraged, but blood transfusion is not taboo in Somali culture.**

Males are circumcised. Practices such as clitorodectomy, cutting, and infibulation are non-Islamic but common to most religions and cultures in northeastern Africa, especially Somalia.

Somalis tend to accept illness and death as coming from God. Their attitude is "For every disease sent by Allah (Arabic for "God"), he also sends a cure, except the one that kills you." **They vigorously try to find a cure for any illness that afflicts them.** They will seek out a cure sent by Allah. They routinely try to find a second opinion and sometimes resort to alternative healers. If they are cured, they take it as God's will. If not, that is also seen as part of God's plan. **Somalis are more accepting of death once it occurs.** This may be interpreted as fatalism.

Somalis have strong family ties. Children are considered a gift from Allah. Senior members stay with the family until death, usually with their daughters. **Elders remain active members of the family as long as**

CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES (CONTINUED)

they can and are treated with great respect. They are addressed as "Aunt" or "Uncle" even if they are strangers.

Somali society has a clan and family structure. The clan, with its multiple subdivisions, is an important traditional social unit in Somalia. It is patrilineal and, until recently, mostly exogamous (marriage only outside one's clan). **Clans continue to play a vital role in Somali culture and politics.** Clan conflict fragmented Somali society starting in the 20th century. This fragmentation may be continuing in some way among Somali Americans.

Somalis are usually accompanied by many family members when they go to a health care facility.

Somalis have recourse to traditional healers who may be using rituals, herbs, cauterization, and practicing medical procedures, including surgery and bone-setting. **A "Sheikh" or "Imam" (religious leader) reciting the Qur'an over a patient is generally believed to be far more effective than any herbal or medical procedures.**

Somalis have an implicit belief in the healing power of Black Seed which is called in Somali "Habad Sowda" or "Habad al-barakah." This herbal remedy has been used for millennia to treat a variety of conditions related to respiratory health, including the common cold; skin, stomach, and intestinal disorders; kidney and liver dysfunction; circulatory and immune system support; and to maintain and improve overall health and a sense of well-being. Black Seed is said to be a remedy recommended by the Prophet Muhammad himself. **It is believed to heal every ailment but death.**

CHALLENGES TO HEALTH CARE[2]

Many Somalis do not speak English, so they need interpreter services. Gestures and body language of non-Somalis can at times be misinterpreted. For example, when somebody uses the index finger to beckon a Somali to come nearer, he or she may feel put down. In Somali culture, such a gesture is never made to another human being, and certainly not to one's social equal.

[2]Please see Introduction for elements which are of common concern to all five new immigrant groups of the HCWR series.

CHALLENGES TO HEALTH CARE (CONTINUED)

Somalis may be embarrassed when sensitive or potentially offensive questions are asked during assessment. Somali interpreters may not even translate such questions. **Concerns about confidentiality may often lead Somali patients to withhold information.**

Somalis often lack basic literacy, health education, and prior experience with western medicine. They experience difficulties with the following:

- routine procedures in clinics and hospitals, such as comprehensive and time-consuming admission procedures and paperwork,
- long waiting room times,
- staggered appointments,
- excessive, comprehensive, and invasive tests which are seemingly unrelated to patient symptoms, and
- the health insurance system, including confusing rules and restrictions.

Punctuality is not a high priority for Somalis.

Somalis prefer same-gender health care providers.

Given the remarkably high percentage of women who have undergone clitorodectomy, cutting, and infibulation, pelvic exam and labor can pose challenges to health care providers.

Based on their experience of health care in Somalia, Somalis are accustomed to seek medical help only when there are symptoms. **They are not accustomed to preventive care. Historically their health care priorities have been primarily related to survival.**

Somalis prefer short term treatments, maximum comfort (pain relief), and full discussion of risks and benefits of procedures with sufficient time to consult with influential family members.

Trauma experienced by Somalis during the civil war and refugee camp periods may pose obstacles for

CHALLENGES TO HEALTH CARE (CONTINUED)

them to reveal aspects of their medical history.

Chronic pain and Post Traumatic Stress Disorder are common in the Somali population. In most cases treatments are unsuccessful due in part to inaccuracy in diagnosis and interpretation of their symptoms by health care professionals. Anxiety lowers their threshold of pain endurance. **Somatization Disorder is common among Somali refugees.** It may be masked by poor communication and cultural barriers.

For Somalis, health care is holistic. Mind, body, and spirituality are all interlinked. Contrary to the western biomedical model of health, a holistic approach towards health care gives due consideration to economic, social, environmental, religious, and cultural factors impacting patients' lives.

Lack of adherence to treatment is common among Somalis and can pose a challenge when treating chronic conditions.

BEST PRACTICES FOR HEALTH CARE PROFESSIONALS

For effective delivery of health care with first generation Somalis, **face-to-face interpreter services are a must.** Many Somalis, particularly seniors, are unable to effectively use phone interpreter services.

In order to establish rapport, trust, and confidence, **it is desirable that providers equip themselves with some basic knowledge of phrases and words in Somali.** Using these can break the ice.

Hello.	= *Ma nabad baa?* (lit. Is it peace?)
Hello. (response)	= *Wa nabad.* (It is peace.)
How are you?	= *Iska waran?* Pronounced: Iska warran?
Good morning.	= *Subax wanaagsan.* Pronounced: Subah wanaksin.
Good afternoon.	= *Galab wanaagsan.*
Good evening.	= *Habeen wanaagsan.* Pronounced: Habayn wanaksin.
Goodbye.	= *Jaaw.* Pronounced: Chow.
What's your name?	= *Magacaa?* Pronounced: Maga-a?
Thank you.	= *Mahadsanid.* Pronounced: Mahatsenit.
Don't be afraid.	= *Ha cabsan.* Pronounced: Ha absan.

BEST PRACTICES FOR HEALTH CARE PROFESSIONALS (CONTINUED)

Health care providers need to **show respect and acceptance of differences** in Somali food habits and restrictions, dress codes, involvement of family members in patient care, and religious practices, such as prayer and fasting. **Health facilities would do well to include a prayer room which is culturally appropriate.** For example, a room for ritual washing of face, hands, and feet prior to prayer, copies of the Qur'an, and prayer rugs need to be available. In facilities where such provision is not made, Somalis try to make do with wash basins and the absence of a quiet place for daily prayer. This could lead to awkward situations such as water splashed around a wash basin in a public restroom.

Especially in communities where the Somali population is significantly large, a health care facility which makes such provision is showing hospitality to this immigrant group.

Since religious belief is central to Somali culture, it seems especially important to provide culturally and religiously appropriate spiritual care. **For example, a copy of the Qur'an** in Arabic should be made available when a Somali patient is terminal. A Muslim person reading the "Yassin," namely, Qur'anic verses which are especially comforting to the family, is believed to facilitate a peaceful death.

Time taken to **discuss diagnosis and treatment plans with the Somali patient** is time well spent. The same goes for efforts made to **involve family members in health care decisions** by asking the family, for example, about their preferences regarding end-of-life needs. Somalis can arrive at decisions more easily when offered convincing arguments based on sound evidence. One might ask the patient, "Are there any doctors in your family? Would you like me to talk with them?" There may well be physicians in the family who could help clarify situations for decision making. **The oldest blood relative, namely, father, brother, or son, may be the ultimate decision maker. Older Somali females also enjoy decision making status.**

When a Somali patient is terminally ill, it is appropriate to say, "There is nothing more that we can do for you. You are in the hands of Allah," rather than "You are going to die." It is similarly **preferable to employ the phrase "return to God" instead of "death."**