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Somali Elder Care: A Guide for Healthcare in the West

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Somali Elder Care: A Guide for Healthcare in the West

by

Meyran Ali Omar

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Table of Contents

Chapter	Page
1. Introduction	3
Background	3
My Experiences	4
2. Literature Review	8
Understanding Refugee Experiences	8
Somali's and Healthcare	9
Somali's and Mental Health	12
Change of Cultural Dynamics	13
Somali's and Diabetes	15
3. Methods	17
Future Directions and Recommendations	17
References	19
Appendix	21

Chapter 1: Introduction

Background

With the influx of refugees to the United States and other countries, one population can be seen in almost every country across the globe, it is the Somali's. Somali's come from a part of Eastern Africa known in modern times as the "Horn Africa" and is bordered by Ethiopia, Kenya, and Djibouti. In ancient times it was referred to by the Egyptians as the Land of Punt (Land of the Gods), by the Greeks as Terra Aromatica (Land of Aromatic Plants), and by the Romans as Regio Cinnamafore (Land of Cinnamon) as they thought the land produced cinnamon. (Abdullahi, 2001).

The Somali's are uniquely homogenous as they speak and write one language, have one religion (Islam), and are nomadic unlike most of Africa (Ganzglass, 1980). Much of the Somali's history was passed down through oral traditions and poetry and it was not until 1972 that the written language of the Somali's was created (Ganzglass, 1980). Other parts of their history can be seen in ancient writings of the Greeks and Romans, Arabs and Persians, and the ancient Egyptians as they valued a resinous substance that is mainly produced in Somali known as frankincense and myrrh (Luuban and Uunsi in the Somali language) (Ganzglass, 1980).

The Somali's are a pastoralist society even though they have a long history of maritime traditions. This nomadic lifestyle is centered on a ceaseless search for water and grazing land for their animals. (Ganzglass, 1980).

For the past 25 years the country of Somalia has been torn apart by civil war and clan rivalry and has had no central Government until 2012. From 1979, due to the Ethiopian

conflict, until 2012 when the permanent Federal Government of Somalia was established, Somali elderly, women, and children have fled the conflict as refugees and have been relocated all over the globe (Aldi, 2014; Ganzglass, 1980).

My Experiences

As a Somali woman that has had shared experiences with the rest of the Somali people as well as shared experiences in the academic setting with many different people from different parts of the globe, I have gained many insights from these experiences and interactions that I would like to share with others. Concepts of aging among the Somali's have changed with the process of immigration. As soon as they arrived to countries around the globe, many of the traditional roles were challenged and in some cases changed altogether. Abdi (2012) states that: "In fact, Somalis are the largest African refugee population in the U.S. today, accounting for 5.5 percent of all refugees admitted between 1983 and 2000, but 25.4 percent of those admitted between 2001 and 2005" (p. 94).

Imagine a pastoralist society that was built around the raising of animals and children with many customs and practices that would seem strange or even abhorrent to modern cultures. Elder men were the problem solvers and relationship counselors that were responsible for educating and deciding matters between families, clans, and tribes. Elder men were the transmitters of religion, Islam, from generation to generation. Elder men taught the younger men how to raise animals such as goats, cows, and camels.

Elder women were the kin keepers and the transmitters of the language to the youth. Elder women were also the midwives to the young women when it was their time to have children. A women's role started upon maturation and she was taught how to make the food,

take care of the house, raise children, and prepare herself for marriage. This role was cultivated through her adult years into her elder years where she passed on the culture, language, and traditions to the women younger than her. According to Boyle and Ali (2009) “Refugees often have experiences that set them apart from voluntary migrants. By definition, the circumstances that lead to a refugee experience disrupt the ‘home country’ in some way – personal and societal upheavals go hand in hand” (p, 47). Upon arrival to the host countries, the woman became the provider of the family in most cases as most of the men struggled to learn a new language and find work for their families. This change in social dynamics had a profound effect upon Somali communities and mostly upon the aging Somali population. Boyle and Ali (2009) state that: “In the cultural realm, American values and beliefs may be embraced (or rejected) with differing levels of enthusiasm by different subgroups within a migrant community” (p. 49). The elder Somali man’s role as the counselor was challenged almost immediately upon arrival in the host countries. Religion, language, and culture were very different from what they were accustomed to back home and they struggled to adjust to the new environment. Also the empowerment of women in most host countries as the providers of the family diminished the role of the men and elder identity of the wise counselor.

My internship at a Somali Senior Center in 2014 really opened my eyes to the struggles and social factors that have been effecting the Somali elder community here in Minnesota. Abdi (2012) argues about this settlement in Minnesota: “that this community is reaping some of the benefits associated with migration while also becoming entrenched in inner-city, segregated urban America and is thus not enjoying full citizenship” (pp. 90-91).

Most lost their homes, businesses, and loved ones in the war. Then they arrive into the US and into the Minnesota snow and experience a culture shock. They find a new culture different from the one they were accustomed. The food is different, markets are different, customs are different, language is different, religion is different, and the way they dress is different. They feel helpless and anxious at this new way of life. They came from a culture that one language was spoken, one religion, and one set of customs. Imagine being honored in your culture for being “wise”, being called on to solve problems, and passing on customs to younger generations and then coming to a place where all of that has no meaning any more. All the respect is gone. The youth blame the elders for the problems back home and the youth and elder divide has grown wider. Many are illiterate in their first language which makes learning English a challenge. Imagine being able to hear but being “deaf” because you do not understand the language. They have televisions, yet they do not understand. They go to the doctors that are using technology they are unfamiliar with. They get told through interpreters they have diseases they have never heard before. They were only aware of Tuberculosis, Malaria, Jaundice, and Cholera. Now they have diabetes, cholesterol, high blood pressure, kidney failure, liver problems, heart problems, different types of cancer, heartburn and gas. This has caused them to have to take many medications. They see their peers dying around them and they fear their own mortality in a land that is not their own. If someone dies they are supposed to be buried within 24 hours which sometimes does not happen according to religious customs. Some of the residence that come to the Adult Day Center come from different tribal backgrounds than others. Political things that happened back in Somalia sometimes spill over into the daycare and one group blames the other for killing the other

back home. Most of the Somali Seniors are un-happy, angry, and frustrated and it was important that I helped build trust to get them access to the services that they so desperately needed. The following paper looks at the struggles and accomplishments of the aging Somali's in their host countries and some practical advice for social workers and health care workers when providing services to the aging Somali refugee population. This project will include a Gerontology curriculum for healthcare workers and the aging Somali refugee populations which they serve.

Chapter 2: Literature Review

Understanding Refugee Experiences

The refugee population that preceded the Somali's to the United States and to the state of Minnesota are commonly referred to as Hmong (Free men). Many arrived in the United States after the 1975 takeover of Laos by communists (Lor & George, 2014). The Hmong shared many of the same struggles that newly arrived Somali refugees face. Many of the Hmong had illiteracy in their first language which caused many problems for the public education system of the United States. Just like the Somali refugees; language barriers, cultural differences, and lack of knowledge of Western medicine created many obstacles for the refugees (Lor & George, 2014). Just like the Somalis, Hmong refugees felt like they were torn between two cultures. Many have traditional ideas of medicine where elders would administer different homeopathic remedies and chanting of religious incantations that would be used to cure the patient. This role was usually by an elder that was trained in this "medicine man" role. Hmong, elder refugees helped to inform the practice of practitioners when the large influx of Somali refugees started arriving in the early 1990s to Minnesota. One difference between the Somali refugees and the Hmong refugees is the acquisition of the English language. Somali refugees succeeded in acquiring the language at greater rates than the Hmong refugees, although second and third generation refugees are equal across both groups (Deckys & Springer, 2013; Lor & George, 2014).

The refugee population that came after the Somali's would be the Afghan refugees that started arriving in the 1970s and 1980s to the United States, but only started arriving to Minnesota since 2001 with the ongoing war in Afghanistan. Just like the Somali's, Afghani's

are 99% Muslim and share many of the same religious requirements of Islam (Morioka-Douglas, Sacks, & Yeo, 2004). Unlike the Somali's who speak one language, Afghani's speak many different languages and dialects of the 49 languages represented in their country. Many of the customary family living arrangements of the Afghani's and the Somali's is shared as it is based off of a tribal and clan based structure. This presented a challenge for the refugees upon arrival in the United States as most of them started to live in apartments which was much different than the socially acculturated family environment back home (Morioka-Douglas et al., 2004). Somali's and Afghani's revere their elders as the wise leaders that need to be taken care of in older age. Usually according to both customs, the oldest son would be the one responsible for taking care of the parents when they get older (Abdullahi, 2001; Morioka-Douglas et al., 2004). Both refugee groups seemed to have higher than normal rates of mental health problems, which can be expected from the war torn zones that each refugee group escaped from (Abdullahi, 2001; Morioka-Douglas et al., 2004). Some of the traditional healing practices are shared between the Afghani's and Somali's due to the influence of Islam. Daily hygiene and treatment of illness with incantations of religious text and prayer are a common practice. The status of women is slightly different in Afghani culture when compared to Somali culture. Both revere women, but Afghani's are stricter in implication of religious separation of the sexes, which can make access to healthcare a challenge (Abdallahi, 2001; Morioka-Douglas et al., 2004).

Somali's and Healthcare

One qualitative descriptive study, Deckys and Springer (2013) took a look at elderly Somali Bantu people who had been brought to the United States from 2003 through 2006.

Unfortunately, the study was limited as it looked at an ethnic minority inside of the Somali culture. The Somali Bantu were distinguished and separated socially from the native Somali people based on their physical characteristics of curly hair, dark skin, and cultural disadvantage; as the Bantu were slaves in Africa (Deckys & Springer, 2013). Another limitation to the research was the disadvantage of the Bantu Somali's access to education. Since the Somali language was an oral tradition, there was no written language before 1972, many of the ethnic minorities and smaller clans did not have access to education. Many were illiterate and were socially separated in Somali society. From a historically preliterate society with no written language, the elderly Somali Bantu struggled to learn English four to seven years after their arrival in the U.S. (Deckys & Springer, 2013). Also access to healthcare was much different in the refugee camps than the United States. The elderly Bantu Somali were faced with an unfamiliar healthcare system, insurance forms, appointment schedules, transportation, undiagnosed mental illnesses, and language barriers. The purpose and goal of the study was to discover and describe the barriers to healthcare by the elderly Somali Bantu people. The researchers utilized Community-Based Participatory Research (CBPR), CBPR is based on the principles of collaboration, equitability, and community partnership. Researchers worked with community members to define community concerns, implement research, and disseminate and apply findings (Deckys & Springer, 2013). Findings showed that themes that described factors impacting the elderly Somali Bantu's adjustment to the healthcare system included: using interpreters, understanding difficulties about healthcare providers and systems, taking medications, finding transportation, having no money, reporting bad dreams,

sadness, and memories of Somalia; incorporating beliefs and rituals into their healthcare and receiving care for female problems (Deckys & Springer, 2013).

One study, Lagacé, Charmarkeh, and Grandena (2012) took a look at the elderly Somali Canadians in Ottawa. The goal of the study was precisely to understand how male and female Somali seniors living in Canada perceive and experience aging from a cross-cultural perspective.

Nevertheless, the growing body of studies on the Somali community in Canada, the experience of aging and of being old from the perspective of male and female Somali seniors has not been fully explored. Furthermore, understanding how the first generation of Somali migrants in Canada transition towards old age is particularly important and relevant: this group of Somalis is indeed the first to age within Canadian borders and will transmit its—most likely hybrid—vision of aging to the younger generation. (Lagacé et al., 2012, p. 410)

Traditional Sub-Saharan societies are rather gerontocratic and seniors can maintain their authority through the practice of initiation rites, esoterism, and oral transmission of knowledge and traditions. Likewise, the tendency for the older generation to live with their children still remains strong. Although seniors in Sub-Saharan Africa are still considered as important pillars of the community, their experience, knowledge and wisdom are more and more challenged by younger generations. Such threats to traditional social ties can be partly explained by the impact of modernization, globalization and formal education (Lagacé et al., 2012). In general, when asked what “aging” means to them, Somali elder women tend to hold a more positive than negative perception of the process. From the beginning of the group discussion, the large majority of women around the table spontaneously mentioned that aging is a “blessing” and that they are “grateful to be alive” (p. 417). Moreover, for most of these women, aging is described as an enriching process from a psychological and spiritual

perspective: it is a process through which a person gains more and more “experience”, more “knowledge”; consequently, elders also have more “wisdom” than their younger counterparts (p. 418). As in the case of women, Somali men emphasized the physical decline that underlies the aging process but also mentioned the gain in terms of wisdom and experience. Health problems related to age were closely associated for men to “not being able to earn your income” and “not being able to make decisions for people”, or, in other words, to a loss of social status (Lagacé et al., 2012).

Somali's and Mental Health

Researchers found a high prevalence rate of Somali's in Minnesota with Post Traumatic Stress Disorder (PTSD), depression, and Psychosis based on factors of wartime conflict (Kroll, Yusuf, & Fujiwara, 2009). The study showed that most of the psychosis episodes were in younger Somali males while depression and PTSD happened mostly in the elderly Somali population (Kroll et al., 2009). This may be due in part because younger Somali males are more likely to use an amphetamine like substance called Khat. Most Somali's do not look at the use of chewing on khat leaves as a drug and at one time it was a custom that after the afternoon prayer they would sit down and chew the leaves and drink tea and talk about politics. According to Guerin, Guerin, Diiriye, and Yates (2004) they give some practical advice to mental health practitioners:

Practitioners need to consider the possibility of Khat use particularly among male Somali clients and the possibilities of withdrawal effects due to its being difficult to access. These issues should alert clinicians that although the vast majority of Somali practice Islam, there is the possibility of alcohol or other drug abuse (including Khat) among this community. (p. 61)

The descriptions of trauma when given were tragically stereotyped in the sense that once a home was attacked, slaughter of the men, robbery of family possessions, and gang rape of the women inevitably ensued.

The decision to classify a person as either depressed or having PTSD was problematic, since in almost every case of PTSD, depression was present, and most depressed patients, especially women, had strong components of anxiety and PTSD. Patients presenting with prominent depressive and PTSD symptoms were placed in a combined “depression/PTSD” category. (Kroll et al., 2009, p. 484)

The study population was divided into broad age cohorts because the chronological age at which trauma occurred appeared to greatly affect the type of trauma experienced and the psychological response to it (Kroll et al., 2009). The clinical presentation of the older men, roughly of age 50 years and beyond, is vastly different. Psychosis is rare; a mixture of depression and PTSD predominate. The older men were extensively traumatized. They were shot and beaten, and then forced to look on while their male relatives were killed and their wives and daughters raped and sometimes murdered. Some will describe the events during an interview; most will bury their faces in their hands, weep, and say they cannot talk about it (Kroll et al., 2009). Many of these experiences will have implications not just on mental health, but also the physical health of the Somali refugee.

Change of Cultural Dynamics

Health Care workers must understand the cultural and gender norms of the Somali population. Abdi (2011) states that: “Political instability exacerbates already entrenched gender inequalities in patriarchal societies” (p. 3). From the time that both boys and girls reach adolescence, they are separated into gender roles that have been dictated by culture and social expectations (Abdullahi, 2001). Somali women are the leaders of the family and run the

household affairs. Because of religious guidelines, women do social activities together separate of men. Abdi (2014) states that: “Older women’s depictions of Somali gender relations are close to those of men, possibly because most women over age fifty-five are either divorced or widowed and thus do not themselves confront issues of income redistribution with men” (p. 470). One such cultural practice that confuses most elder Somali refugees and the healthcare workers is the issue of the hand shake. Most Somalis do not have contact with the opposite sex that is not their spouse which raises an uncomfortable feeling when a person that is non-Somali extends their hand for a handshake. The elder Somali does not want to be rude but at the same time does not want to forsake their religious convictions. What happens is that some will extend the hand and some will not extend the hand. A general rule of thumb is that if they extend the hand first then you extend the hand. If they do not, then verbally welcome them. Somali men are the providers of the family and when they become elders they are the problem solvers of family issues and the wise leaders. They spend much of their time in gatherings discussing politics with one another (Ganzglass, 1980). In the new culture of the United States and in Minnesota, on the whole, many of these customs are still observed, but in different venues. Somali Senior women are attending exercise classes at facilities that are observant of females only. They spend much of their time shopping with friends and family. They also spend much of their time attending to the home. Some still live by themselves, but many live with children in their homes. Somali Senior men have transferred the political discussions to the local Starbucks coffee houses and can be seen there throughout the day. Their role of the family fixer has become diminished with the new culture and many struggle with depression and loneliness issues that are stemmed from this

diminished role. When receiving care from a doctor or health care worker elder Somali's prefer to receive care from the same sex, so man for a man and a woman for woman. This also includes interpreter services and other non-medical personnel. After understanding these cultural dynamics health care workers can develop a guide to providing the best care for the Somali elder population.

Somali's and Diabetes

There is a growing concern among the elderly Somali refugee community about diabetes. Many environmental changes and lifestyle changes have compounded the problem and made it prevalent in this disenfranchised community. The study based on the work of physicians, researchers, and others have pointed to the increasing prevalence of type II diabetes in the Somali immigrant population. Type II diabetes, the most common type of diabetes, usually develops in adulthood and usually affects those who are overweight, have low physical activity, or are genetically predisposed to the disease (Tehrani, 2010). Physicians such as Dr. Mehmood Khan, a consultant in the Mayo Clinic's Division of Endocrinology, have claimed that "a growing number of Somali immigrants are developing [Type 2 diabetes] within 5 years, and some as quickly as 6 months, after their arrival in this country" (p. 5). The author states:

Throughout the course of my research, I was hindered by a lack of data on diabetes prevalence in the Somali population both in Somalia and in Minnesota. In Somalia, data is unavailable, mainly, because of the political instability which leaves relevant domestic and international institutions without the means to gather information. In the United States, the shortage of data is in part due to the lack of specificity in ethnic categories used by researchers. (Tehrani, 2010, p. 7)

Researchers decided to address the concern of an oral based culture and how to effectively educate about diabetes by guiding elder Somali clients with DVD's and educating them about

diabetes. The aim of the DVD guide is to give knowledge-based information about type 2 diabetes for Somali clients in their own language (Ismail, 2011). Religion and culture has been the strength of Somalis for centuries. It also became a factor preventing the use of the available and conventional health care system. Somalis prefer and seek out traditional homeopathic means of healing when it comes to health and wellness (Ismail, 2011). Islam plays a major role in the lives of many Somali immigrants, influencing their views of illness and recovery. It is a common belief that ultimately every illness occurs under God's will, even though some diseases are thought to be caused by bad spirits and the “Evil Eye” or witchcraft. Prayers, herbs and other forms of prevention are a part of the healing for all (Ismail, 2011). The perception of health by Somalis is reflected by their values and beliefs. For example, based on Somali culture, obesity is considered to be healthy, prosperity and wealthy symbol. Since Somali's have an oral tradition, producing a DVD in the mother tongue and in a simpler medical terminology will help scaffold the diabetes information to the elder Somali refugee communities (Ismail, 2011).

Chapter 3: Methods

Future Directions and Recommendations

One of the reasons for compiling this information on the struggles of the Somali elder refugees is to show the pattern of difficulty that has been common among refugees that have come before and after the Somali's arrived and practical recommendations on how to address some of the issues in elder care. One way to address these concerns is to understand that Somali's are not a homogenous group even though they share many things in common such as religion, language, and culture (Abdullahi, 2001). Also, religion plays a large role in the daily life of the Somali elders and many struggle with identity and culture shock that is very pervasive and enduring (Lagacé et al., 2012). As the Somali elder refugees encounter a health care system they are unfamiliar with and diagnosis that are strange to them, health care workers will have to understand some of the background and culture of the patients which are entrusted to their care. Dietary customs which are outlined according to religious doctrine are a concern for many of the elder Somali population. As they do not eat pork or drink alcohol, many of their medicines contain byproducts of these ingredients which causes concern. Also if the elder Somali is incapacitated by a stroke for example and can't speak, then how can they voice their concerns of dietary restrictions or if a female health care worker wants to shower or take to the restroom a male elder Somali? By understanding other refugee groups that came before and after the Somali elder refugees we can see some important correlates start to emerge. A health care system that is unfamiliar and unprepared to care and treat refugees from different countries, cultures, and beliefs is in need of some awareness and training about the elder refugees in their care. I am proposing a guide that can be used by

health care workers to understand the cultural dynamic norms that face their clients when trying to access the health care system. At the Macro level; it would be a goal of the author to provide this guidebook to the United Nations High Commissioner for Refugees (UNHCR) which in turn will make it available to Federal Governments in host countries in which refugees reside. At the meso level; State and local health agencies as well as Universities will be provided this guidebook by uploading finished copies of this paper along with the guidebook to academia.edu and Google Scholar as well as submit to journals for publishing. Finally at the micro level; nursing homes, care facilities, non-profit NGO's, and health care workers will be provided the guidebook. This way the healthcare workers will understand and be able to respect their client's culture, beliefs, and customs so they can give them the quality care that they need. I hope that this guidebook will be published to serve the Somali elder refugee population and give healthcare workers the tools they need to do their jobs more effectively.

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Appendix

SOMALI REFUGEES AND HEALTH CARE

A Guide Book for Health Care Professionals

Culture, Customs,
and Clans

Meyran Omar – BS, CNA



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This guidebook was compiled by graduate student Meyran Omar for inclusion in her starred paper for the degree of MS in Gerontology.

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Table of Contents

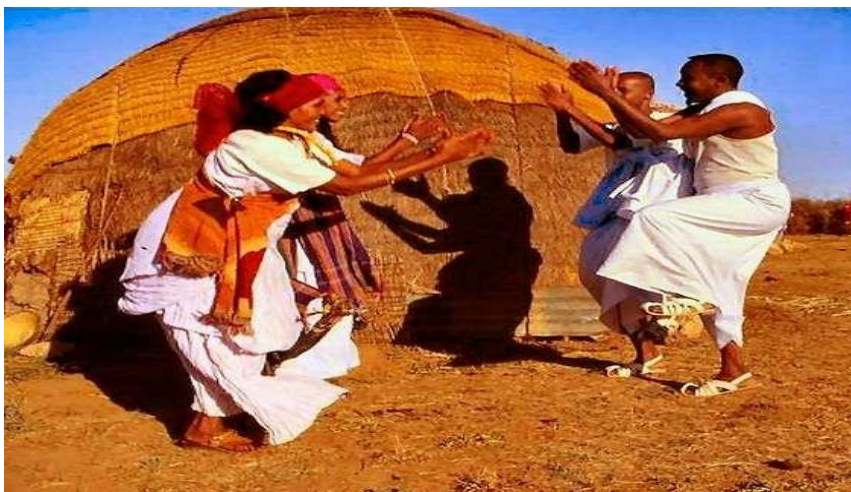
Somali Background	24
East Africa	24
The People	25
Accessing Healthcare.....	26
Mental Health	26
Gender Issues.....	27
Religion.....	28
End of Life Care	29
Bridging the Gaps	30
Case Scenarios	31-32
Common Diseases	33-34
Somali Cuisine and Tradition	35
Somali Food.....	35
Somali Dress	36
Conclusion	37

Somali Background



East Africa

Somali's come from a part of Eastern Africa known in modern times as the "Horn of Africa" and is bordered by Ethiopia, Kenya, and Djibouti (Abdullahi, 2001). Somalia has two bodies of water surrounding the peninsula, Gulf of Aden to the north and the Indian Ocean to the East and South. Somalia is five times the size of Alabama and slightly smaller than the state of Texas. Somalia's climate is principally desert. There are moderate temperatures in the north and hot temperatures in the south. The rainy season in the north is December to February and in the South, May to October. In between the rainy season there are periods of high humidity because of irregular rainfall and heat. Natural resources include; uranium, iron ore, tin, gypsum, bauxite, copper, salt, natural gas, and oil. Over 70 % of the land is agricultural and used for the grazing of goats, camels, and other animals. (CIA, 2015).



The People

The Somali's are uniquely homogenous as they speak and write one language, have one religion (Islam), and are nomadic unlike most of Africa.

The Somali's are a pastoralist society even though they have a long history of maritime traditions. This nomadic lifestyle is centered on a ceaseless search for water and grazing land for their animals. (Ganzglass, 1980).

Somali's ethnically are made up of 85% Somali and 15% Bantu and non-Somali's including about 30,000 Arabs. Somali's also speak some Arabic and because of colonization may speak some English, French, Italian, or Swahili. Somali is rated number eight in the world in birth rate with approximately 40.45 births per 1,000 people. It is rated number nine in the world in death rate with approximately 13.62 deaths per 1,000 people. Somalia is also ranked number three in infant mortality with approximately 98.3 deaths per 1,000 people. Somalia is also ranked number 4 in the world for fertility rate with approximately 6 children born per woman (CIA, 2015).

For the past 25 years the country of Somalia has been torn apart by civil war and clan rivalry and has had no central Government until 2012. From 1979, due to the Ethiopian conflict, until 2012 when the permanent Federal Government of Somalia was established, Somali elderly, women, and children have fled the conflict as refugees and have been relocated all over the globe (Ganzglass, 1980 and Abdi, 2014).

Accessing Health Care



Mental Health

Mental health professionals are becoming increasingly utilized in the Somali community in the US and around the globe. Understanding some underlying factors and cultural norms can help mental health care professionals diagnose and treat accordingly. Due to the civil war, many mental health issues are of concern. Civil war trauma has caused cases of depression, anxiety, and phobias to become prevalent. Kroll, Yusuf, and Fujiwara (2009) said; “They were shot and beaten, and then forced to look on while their male relatives were killed and their wives and daughters raped and sometimes murdered.” A few other issues compound the mental health issue. Culturally it is taboo to have mental health issues, so many go undiagnosed and are left untreated. Many will hide from family and friends. Also, Khat, an amphetamine type substance is chewed in leaf form by many Somali’s and is considered culturally normal, but is become increasingly undesirable. Khat may cause episodes of psychosis. Psychosis and Bipolar disorder may be self-diagnosed as possession by spirit or devil and treated by recitation of religious text of the Quran.



Gender Issues

From the time that Somali's reach puberty all through adulthood the opposite sex is separated with rare occasions of free mixing of the sexes (Lewis, 2015). While this is allowed with immediate family members, people outside of the family circle are only allowed to mix in public gatherings. This may cause some uncomfortable situations for the health care worker and of course their Somali clients. One of the most contested issues is the greeting of the handshake. While this is the preferable form of greeting in the US and Western countries, most of the world does not utilize this form of greeting. Somali's greet with a saying, "May the peace of God be upon you." They may embrace male and male or female and female and opposite sex contact only happens if they are related by blood (Abdullahi, 2001) The general rule of thumb is that if they extend the hand, then extend yours, as they may be too shy to hurt your feelings to refuse the hand shake. Also, in the health care setting they may prefer interpreters, nurses, and doctoral staff of the same gender although that may not be feasible. As the Somali's age many times they may have a PCA that provides some of their care. They usually prefer relatives or Somali's from their culture that understand the social norms and needs of the elder Somali patient. Religion plays a big role in dictating gender roles. While traditionally the Somali man was the provider and the Somali woman was the keeper of the children and the house, that role has somewhat changed due to the Somali woman being the provider as the Somali male struggles to adapt and find a job to provide for his family. Abdi (2014) states that: "Older women's depictions of Somali gender relations are close to those of men, possibly because most women over age fifty-five are either divorced or widowed and thus do not themselves confront issues of income redistribution with men" (470). Elder men were the transmitters of religion and the problem solvers. A women's role started upon maturation and she was taught how to make the food, take care of the house, raise children, and prepare herself for marriage. This role was cultivated through her adult years into her elder years where she passed on the culture, language, and traditions to the women younger than her (Abdullahi, 2001).



Religion

Somali's are 99% Muslim and the majority follow Sunni Islam (CIA, 2015). Much of the traditions and culture of the Somali's is derived from the teachings of Islam which arrived to Somalia during the lifetime of the Prophet Muhammad. Islam is a religion that is followed by about 1.2 - 2 billion people today (Hakim, 2001). Islam is the name of the religion derived from two Arabic words; [*Silm*] which means submission, and [*Salaam*] which means peace. Anyone who submits their will to the One true God and gains peace is known as a Muslim. Islam is the third of the three largest monotheistic religions, in addition to Judaism and Christianity (Hakim, 2001). There are five basic beliefs or pillars in Islam. The first is the testimony of faith; "I bear witness that there is only One God and He only deserves worship, and I bear witness that Muhammad is a messenger of God." The second one is prayer; a Muslim prays 5 times a day except during the month of Ramadan when the amount of praying is increased. The months of the Islamic calendar follow the moon like the Jews, instead of the sun like the Gregorian calendar that is used by Christians. The third pillar is to fast during Ramadan; a Muslim abstains from food, drink, and sexual relations from sunrise to sunset for the whole month. The fourth pillar is charity; a Muslim gives a portion of their excess wealth to the poor. Finally, the fifth pillar is to perform pilgrimage to Makkah; a Muslim is to do this at least once if they are financially able (Hakim, 2001). Islam is a theocentric religion, or God centered religion, and keeping worship solely for the One true God is the most important rule. Somali's and Muslims in general refrain from praying in a place that has images, statues, or symbols of other religions. Nutrition wise, Muslims may eat most of the foods and drinks that are available except pork, alcohol, or any meat that another God had been mentioned over. This can be problematic when some medications have inert ingredients that may contain these byproducts. Since religion plays a large role in the Somali's lives and their family's lives, it is imperative for health care professionals to understand the basics of the religion and the driving force behind much of the culture of the Somalis.



End of Life Care

In the Somali culture, nursing homes and palliative care facilities are non-existent and are a new challenge for health care professionals. It is not only Somali's, who are Muslim, but many other faiths also have challenges to the end of life care. One main principle guides Muslims in making decisions in end of life care and that is the principle of sanctity of life (Clarfield, 2003). Every moment of life is sacred and must be preserved at all cost except for capital punishment, idolatry, or adultery which can be carried out by a governmental authority. Muslims except death as an integral part of life and they learn to accept its inevitability at an early age (Clarfield, 2003). Also, there are certain death rights that a non-Muslim doctor, nurse, or chaplain will be unable to perform. The four main ones are; repeating the declaration of faith, supplication in Arabic for the dying, Quran recitation, and preparation of the body for burial (Muslim Spiritual Care Services, 2015). As the Muslim is in the last stages of life differences of opinions about religious interpretation may arise. For example the use of a feeding tube would fall under the sanctity of life principle as well as would treatment for pneumonia as it is not considered a terminal illness. (Clarfield, 2003). In Sunni Islam intubation would be favored unless breathing had started to slow down in the last stages of life, in which case life support may be removed if so desired according to advanced care directive or family decision. In Shia Islam there is a slightly different opinion and it is more closely shared with Judaism; that is withdrawing or withholding care are not morally equivalent (Clarfield, 2003). Basically this principle states that once intubation has begun that it cannot be stopped to hasten death. Both Islam and Judaism have a similar outlook on the autopsy and discourage its practice unless it is ordered by the State for investigation. After death the Muslim's eyes are closed and the complete body is covered except if the Muslim dies performing Hajj or Umrah (Pilgrimage) then the Muslim's head and face should not be covered (Stacey, 2012). Next, the body is prepared for washing and burial, this is usually performed by the same gender, except in the case of husband and wife. The washing of the body is followed by the community funeral prayer and then the escorting of the body to the grave. This should be done as soon as possible (Stacey, 2012).



Bridging the Gaps

“Aqoon La’ani Waa Iftiin La’aani” –
Without knowledge is without light. – [Somali Proverb]

With a little understanding of culture and belief of the Somali people, Health Care professionals can minimize cultural misunderstandings and increase the quality of care to the Somali refugee population.

Below are some common health concerns and some case scenarios that highlights some of the areas where medical mishaps may occur. Somali’s have a different type of healthcare than the system that is employed in most Western countries. Most Somali’s practice some form of homeopathic medicines to cure simple sicknesses.



Case Scenario 1 – A Somali woman between 50-60 years of age comes to the doctor complaining of menstrual bleeding. Many doctors try to diagnose for cancer, by biopsy or other diagnostic tools when faced with this scenario and most of the time the results are negative. Doctors are left without an explanation. Different climate, no modern drug use, and other factors increase the normal menstrual cycle (Spitzer, 2011).



Case Scenario 2 – A Somali woman comes to the doctor complaining of a headache. The nurse notices a slight yellowish red tint to the woman's nails and skin and informs the doctor that her patient may have Jaundice. Somali men and women utilize a plant called henna to dye the hair, beard, or decorate the fingers and hands (women only). This usually starts out a bright orange or red color and over time fades to a yellowish brown color (Guerin, 2006).



Case Scenario 3 – An elder Somali gentleman comes into the clinic. When asked his age he states that he is 50 years old. The older gentleman looks much older than 50 and the nurse and doctor discuss whether they should do certain screenings for cancer based on his symptoms. “Refugees might not know their birthdays for many reasons: Record keeping is spotty or nonexistent in nations ravaged by war, natural disaster, or government repression. Some regions don't follow the Gregorian calendar. Some cultures don't observe birthdays” (Sacchetti, 2009). Health care professionals need to be aware that some Somali’s may be much older, or much younger than what their birthdates state; especially if their birthdate starts with 01/01/ year.



Case Scenario 4. – A Somali male is transported to hospital by ambulance as he is found unresponsive and unable to speak. The doctor examines the young Somali, but finds no signs of trauma, no health irregularities, and is baffled why the young man can’t speak and seems catatonic. The doctor orders a blood test to test hormone levels and possible drugs in the system. The results return positive for cathinone or Khat (Kroll, Yusuf, & Fujiwara, 2009).

Common Diseases



Diabetes - Somali's started getting type II diabetes when arriving to the Western countries. The change of environment has contributed to the increase prevalence as well as a diet whose staple is either pasta or rice along with a meat. Diabetic medications should be monitored as most Somali patients will choose which medicines they feel like taking and resort to natural homeopathic self-medicating (Tehrani, 2010).



Dementia and Stroke - Elder Somali's are at a high risk for dementia and stroke, which sometimes does not get diagnosed as there is a language barrier. Most Elder Somali's have a combination of risk factors that increase the prevalence. Diabetes, Cholesterol, and High Blood Pressure are the most common. Education programs about stroke and dementia to the Somali community are imperative (Hughes, 2008)



Heart Disease - Due to a diet that is rich in carbohydrates, lots of meats, and fried foods. Along with lack of exercise and cooler climates have contributed to Somali's risk for heart disease (Hughes, 2008).



Osteoporosis and Scoliosis – Somali women in general have a greater risk for osteoporosis than men. Low vitamin D intake due to the change of climate and lack of sunlight in the cooler climates have contributed to its prevalence. Supplements such as calcium and vitamin D may help to reduce the risk of osteoporosis. Also scoliosis is a disease that is becoming prevalent even to mothers that have had previous healthy children (Sabry, 1995).

Somali Cuisine and Tradition

Somali's eat everything with their right hand as the religion explains that all good things come from the right. Also, the left hand is used when cleaning while using the bathroom or removing filth from the body.



Breakfast – Breakfast consists of a type of pancake or crepe served with goat butter or sesame oil. Sometimes porridge or oatmeal. Tea or tea with milk and different types of fresh juices.

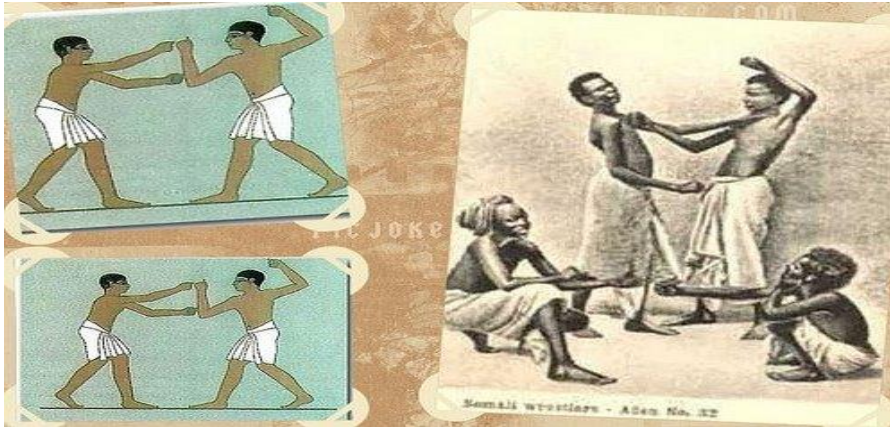


Lunch and Dinner - Diet usually consists of a staple main course of either rice or pasta for lunch or dinner. Both lunch and dinner usually have a meat; chicken, goat, steak, or fish. Salad and vegetables accompany the meal. No meal is eaten without the banana or soup.



Appetizers and Dessert - Some fried foods are served as appetizers such as fried meat triangles known as *Sambusa*, fried potato and egg called *Nafaqo*, fried beans and spices called *Bajijo*, Fried bread called *Bur* or *Mandasi*, and a type of donut called *Shushumo*. For dessert they have an orange jello-like substance called *Xalwo* and different cookies and pastries borrowed from other cultures.

Traditional Dress – Some reports claim that the traditional Somali dress dates back to the time of the Queens and Kings of Egypt. There are many similarities between both male and female dress and in ancient Egyptian hieroglyphs it is hard to distinguish between the Egyptian and the Somali.



Male: For the male the traditional dress consisted of a waist cloth called *Hoosgunti* for the lower half of the body and a cloth belt called *Suun*. The upper half has two pieces of white cloth called *Labo Qayd*. (Abdullahi, 2001).



Female: Traditional female dress depends on the occasion. For example, for a wedding would be different than for dance or social gathering. One piece of cloth is tied or knotted on the right or left shoulder and then wrapped around the upper torso and then wrapping around the waist called *Guntiino*. A belt and tassel made of thread and camel hair is wrapped around the waist and chest called *Boqor*. Sometimes for a wedding the women will dance and wear a piece of cloth called *Dirac* that is sheer and light as only women are at this occasion. (Abdullahi, 2001).



Conclusion

Many different people from different cultures, beliefs, and customs are accessing the Health Care System of the West. Health care workers, counselors, and other professionals provide services to these patients and need to understand the importance of respecting, educating, and learning about others in order to provide the best quality of care.

Although this is not an all-encompassing guide to the cultures, customs, beliefs and traditions of the Somali people. The author has put forth this guide to bridge the gaps in the health care system and give health care professionals the tools that they need in order to provide the quality of care that all of us should receive regardless of our differences, our backgrounds, or our cultures.

Some final recommendations for health care professionals while dealing with Somali clients or any client from a different culture than their own:

- Remember each patient is different, don't make generalizations.
- Be aware of religious and gender-based issues that can be evident by the clients' uncomfortable expression or resistance to certain care.
- Don't take personally if rejected.
- Consult someone who is familiar with the culture if you feel there is a cultural misunderstanding.
- Be aware of possible miscommunication if the clients' first language is different than yours.
- This is meant to be a guide to help understand some of the issues that health care professionals may face when Somali's are accessing the health care system.

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Index

Somali Background, 1-2	Bridging the Gaps, 7
Accessing Healthcare, 3	Case Scenarios, 8-9
Mental Health, 3	Common Diseases, 10-11
Gender Issues, 4	Somali Food and Dress, 12-13
Religion, 5	Conclusion, 14
End of Life Care, 6	References, 15-17