Communiversity

Medical Needs and Healthcare Services for the Somali Community in the Twin Cities

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EXECUTIVE SUMMARY

BACKGROUND TO THE PROJECT: This University of Minnesota Center for Urban and Regional Affairs (CURA) project is the outcome of research undertaken by Ifrah Y. Mohamed and Abdul Wahats Warsame, with assistance from Dr. Saeed Fahia, and Dr. Ken Root. The project was submitted for CURA support by Dr.Saeed Fahia, Executive Director of the Confederation of the Somali Community in Minnesota at the request of Abdul Wahab Warsame. CURA provided support for a University of Minnesota student to participate and Ifrah Y. Mohamed was the selected student. Support for Mr. Warsame to be the supervisor was provided by .

This project extends an earlier CURA publication (Robillos, 2001: **Somali Community Needs Assessment Project**) by focusing on the health of Twin City Somali residents. The tasks of the project were twofold: [1] the first task was to summarize the health status and healthcare needs of Twin City Somalis, with data collected from focus group participants covering a broad age range of Somalis, including those living in the Cedar-Riverside area as well as those living in the suburbs. Many focus groups used English, but in some instances a focus group would use the Somali language exclusively. Data were collected from 12 sex-segregated groups ranging from 6-12 participants, with 48 female and 70 male participants. The initial basic question asked of participants was "what are some medical health problems that you and your family are facing?" And [2], our second task was to create a bibliography on the health of Somalis once they leave Somalia, a stand-alone segment at the end of our report.

RECENT HISTORY OF SOMALIA: Our report covers a bit of recent history of Somalia because cultural traditions, foods, and behavior patterns in Somalia varied significantly from patterns here in the U.S. Further, the Civil War, forced departure from Somalia, and family separations, inflicted trauma or depression for many individuals, an indication that social determinants influence health.

EXISTING TWIN CITY LITERATURE: We were impressed with the fact that a good deal of literature on the health needs of Somalis has been initiated by University of Minnesota faculty from a variety of disciplines, including various departments in medicine, and from nursing, psychology, and social work. Other local foundations and research centers—such as Wilder Research, and the Minnesota Department of Health—have also made significant contributions. That literature indicated that [1] perceived barriers to healthcare were different for immigrants than for non-immigrants, [2] immigrants may bring with them (carry) diseases that are not common in the U.S., as well as patient views about whether those diseases are curable, [3] Somali immigrants may have more adjustment difficulties than other ethnic groups because of their education, limited experience with preventative healthcare, and lack of familiarity with an adequate healthcare infrastructure, and [4] new healthcare issues, including smoking and second-hand smoke are confronting Somalis living in the United States.

FOCUS GROUP DATA: Our findings indicate that our participants identified numerous and important medical problems for themselves and their families; a spectrum of health problems that we thought was high. For women, these included coronary heart disease, diabetes, and high blood pressure, while men identified cancer as a common medical condition common to each of the six male focus groups, but also reporting coronary heart disease, diabetes, high blood pressure, and PTSD, as well as Sickle cell anemia and arthritis. Focus group participants often discussed the limited exercise Somalis had in the U.S. compared to their life in Somalia, with many focus group participants judging the lack of exercise to the be cause of many of their health issues. Participants also discussed [1] the lack of trust (and misunderstanding) between the patient and the non-Somali medical doctor, [2] the dependence of Somalis on emergency room use, and therefore the absence of a primary-care physician, [3] the failure of Somali patients to understand the importance in taking medications regularly, and [4] the lack of familiarity that Somalis have with the side-effects of certain drugs. Cultural differences were crucial in understanding what the Somali patient understood, or accepted (i.e. traditional herbs might be more effective than any other treatment). In Somalia, mental illness was not acknowledged, and remains the situation here in the U.S. as well.

Focus group participants also acknowledged that there was a need for proper training of medical interpreters, a need for sex education, the need to know about healthy eating habits (wellness), a need for mental health workers to have a better understanding of the Somali culture, and Somali resident concerns with specific diseases, such as autism, Vitamin D deficiency, and diabetes.

SUMMARY RECOMMENDATIONS:

- Among focus group participants and their families, there appeared a large number of serious illnesses, which demands a need for Somali residents to increase their understanding of the U.S. healthcare system. This might be facilitated with:
    - [a] presentations to adults at the Brian Coyle Center by U.S. medical personnel, researchers, or Somali leaders;
    - [b] school presentations to students, so they can understand it themselves, and (as needed) assist in explaining the information to their parents; and
    - [c] additional (and specialized) training for Somali interpreters.
- Continue to assist medical professionals understand Somali cultural beliefs related to all aspects of health and healthcare practices.
- Create innovative approaches to decrease informal networking of friends and family as “medical advisors” and self-diagnosis among Somali residents.
- Encourage University of Minnesota researchers, the Minnesota Department of Health, and other research centers to continue the important research on health and healthcare issues within the Somali community.

INTRODUCTION AND BACKGROUND TO THE PROJECT: This University of Minnesota Center for Urban and Regional Affairs (CURA) project is the outcome of research undertaken by Ifrah Mohamed and Abdul Warsame, with assistance from Dr. Saeed Fahia, and Dr. Ken Root. The project stems from familiarity of an earlier CURA publication (Robillos, 2001: **Somali Community Needs Assessment Project**) that summarized the needs of the Twin City Somali community, but ignored medical and healthcare issues. One of the authors of this report (Abdul Warsame) became aware of the Robillos publication, and since he serves as a Somali interpreter for medical and dental practitioners, he is very aware of Somali healthcare needs for specific individuals, and suggested that if those needs were typical of the larger community, they [1] should be publicized, and [2] used as a basis to advocate for improved services to meet the needs of Somali residents.

Discussion of the topic with Dr. Saeed Fahia, Executive Director of the Confederation of the Somali Community in Minnesota (CSCM), culminated in a request to CURA for a community-based research program, and the involvement of a student research assistant who would have interests in research, medical issues, or the well-being of the Somali people. Preference for a female graduate student, fluent in English and one or more of the following languages: Somali, Ahmaric, or Oromo was requested. Dr. Fahia and Mr. Warsame interviewed candidates and selected Ms. Ifrah Mohamed, a graduate student in Social Work at the University of Minnesota.

At the time of the application to CURA it appeared as though there was little or no interest in healthcare issues confronting the large Twin City metro-area Somali

community. It was only later that the authors became aware of recent research—some completed, some ongoing—that focused on the same or a related topic. These research projects include: [1] The Wilder Research report: **The unequal distribution of health in the Twin Cities** (October, 2010), prepared by Craig Helmstetter, Susan Brower, and Andi Egbert of the Wilder Research staff, and supported by the Blue Cross and Blue Shield of Minnesota Foundation; [2] **African-born women's and children's exposure to secondhand smoke** (2009), also a Wilder Research report, and funded by ClearWay; Minnesota; [3] **Eliminating Health Disparities Initiative: Mobilizing Community Assets for Action** (2003), completed by the Minnesota Department of Health; and [4] another publication from the Minnesota Department of Health: **Autism and the Somali Community – Report of Study Fact Sheet** (2010). In addition, [5] Dr. Osman Ahmed has presented worthwhile information about healthcare issues related to cultural differences in the approach to diagnosis, treatment, and patient response on the East Africa Health Project website (http://www.eahpro.org). Earlier publications printed in **Minnesota Medicine** by [6] DuBois (1998), [7] Fritz, and Hedemark (1998), and [8] Garrett, Teichel, and Ohmans (1998), as well as the [9] Halcon, et. al. article from the **Journal of Adolescent Health** (2004) were also very useful. [10] Information was also obtained about an on-going research project titled "Community Based Participatory Research to Understand Social Determinants of Health and Health Disparities Among the East African Immigrant Community at the Cedar Riverside Neighborhood of Minneapolis" which is directed by Jennifer Blevins and Amano Dube from the Brian Coyle Center and Terry Lum and Elizabeth Lightfoot from the U of M School of Social Work. The Blevins, Dube, Lum, and Lightfoot project is sponsored by the Minnesota

Department of Health and focuses on minimizing the health disparities within the State, with expected completion of an initial report in the summer of 2011. [11] While the **Report to the 2003 Minnesota Legislature on the Eliminating Health Disparities Initiative** (EHDI) does not focus on Somalis, African Americans are one major racial/ethnic group that is the thrust of EHDI.

PREPARATION FOR RESEARCH: The authors read the Robillos report, read the CURA prepared Methods and Resources Packet, and the CURA Community-Based Research Program Orientation Packet, and participated in the orientation program. The authors, along with Fahia and Root, met with Jeff Corn from CURA and discussed the team-submitted work plan, focusing primarily on research ethics and procedures. The proposed work plan stated the following regarding the first task:

> Data collection. We want Somali residents in sex-segregated small groups (6-12) to discuss their health needs, and the healthcare services they need. Health includes physical / bodily AND emotional / mental health. Healthcare services includes the difficulties obtaining services, problems paying for the services, and difficulty obtaining insurance or having insurance cover the services. Residents are to be encouraged to talk about their own needs, as well as family members. We want the health / healthcare needs to cover babies and young children, school-age children, teens, adults, and the elderly. We are collecting data from adults, so they will have to speak for young children, etc. If possible it would be desirable to have a session with female teens, and another with male teenagers. Is it desirable to have a session with elderly residents? We want to cover the views of Somalis who live in central-city as well as those in the suburbs, those with low-incomes as well as those with large incomes, etc. so our data reflect as broad a representative picture of health and healthcare needs as possible.

A second task—that of a bibliography on Somali health and healthcare needs—was also planned. This stand-alone section of the report would focus on what we know of the health of the Somali people once they leave Somalia. The healthcare bibliography was to

be international, referencing English, Somali, Ahmaric, or Oromo sources, and insofar as time and resources allow, be as complete as possible. The student selected to participate in the research project, Ms. Ifrah Mohamed, completed the healthcare bibliography.

PLAN OF THIS REPORT: In addition to the **Introduction and Background to the Project**, and the **Preparation for Research**, there are five sections to this report. We start with a **Recent History of the Somali People**—in part to give the non-Somali reader an understanding of why the emigration from Somali exists—but also for the reader to understand that some of the health issues, particularly mental health issues, were created or compounded by the Civil War, and the departure from family that remained in Somalia. Additional sections summarize the R**elevant Twin City Literature and Existing Data**, P**resentation of the Focus Group Data**, a S**ummary of the Project and Recommendations**, and last, the **Healthcare Bibliography**.

RECENT HISTORY OF THE SOMALI PEOPLE: The recent history of Somalia starts in the latter half of the 19th century with the onset of seventy years of colonization. This history is still being written after thirty years of independence and a civil war of 20 years. Somalia has witnessed 120 years of history defined by violent periods and droughts interspersed with happier times of reorganization and nation building. At the end of this period Somalis lost both their will to stay in their country and the capacity to sustain their nationhood. The civil war years saw the exodus of more than a tenth of Somalia's 10 million inhabitants, with forty thousand resettling in the State of Minnesota.

Richard Burton[1], in his famous book *First Foot Steps in East Africa* captures the laidback way European colonization was introduced to Somalia. The British, Italians and French arrived to the shores of Somalia under the banner of discovery and trade but within a short time, the colonial masters were in control of large chunks of East Africa. Within two decades of Burton's famous expedition to East Africa, Somalia found itself broken into five pieces: a British protectorate in the north, an Italian colony in the South, a French Colony in the far North West; a part embedded in the British colony of Kenya; and a segment annexed by Ethiopia through collusion with the British.

Two parts of inhabited territories, the Italian colony and the British protectorate, came together in 1960 to form the Somali Republic. But this was not destined to last; by 1991, after 30 years of independence Somalia was broken asunder yet again by what the international community has termed i*rredentism*. Somalis viewed the collapse as a result of conspiracy to thwart their natural right for self-determination to unify all Somalis. In their attempt to bring all Somalis under Greater Somalia, Somalis fought two wars with Ethiopia and supported liberation militias in all of the missing Somali territories.

However, two liberation movements withdraw early on in the struggle and Somalis felt they could live with the result. The Somali inspired liberation movements in Djibouti and Kenya became dormant after ten years of struggle but for different reasons. The French colony became the independent Nation of Djibouti, run by Somalis and Afars. While Kenya, a relatively pluralistic country by African standards, was able to give Somalis of the Kenya's Northern Frontier District (NFD) enough freedoms to mollify their quest for re-unification with their brethren in Somalia. Ethiopia, on the other hand, was another matter. It is a place where people have endured under the domination of a medieval king

[1] Burton, R.F. First Footsteps in East Africa. http://www.fullbooks.com/First-footsteps-in-East-Africa1.html

in the 1960's and 1970's and under socialist dictators thereafter. Somalis, like other Ethiopians, did not have the right to exercise their political, civil, or human rights. Unlike other Ethiopians, Somalis also felt discriminated. Thus, the Ogadeni National Liberation Front, the main Somali movement, still grinds on to free Somalis from its perception of Ethiopian tyranny.

Somalis were euphoric at the unification of the Somaliland protectorate and the Italian colony under the banner of a five-star flag in 1960. But in spite of the euphoria and good will among the citizenry, the integration of two colonial systems was a challenge. For example, it took almost 12 years for successive Somali governments to designate the Somali language as the medium of instruction in schools. Building the infrastructure in a resource poor country was another challenge, particularly so when it came to management and know-how.

Somalia's efforts at nation building were short-circuited by its desire to build a large army that was capable of defeating its enemies. The Soviet Union and other communist countries assisted Somalia in establishing a humongous army relative to the country's needs and size. There were times when 65% of the national budget was spent on the military. But most unfortunate was when, on October 21, 1969, (with support from the Soviet Union) the military overthrew the democratic civil government in a coup d'état. This happened immediately after the assassination of Dr. Abdirashid Ali Sharmarke, the second President of Somalia. The military government that was installed, under the leadership of Mohamed Siad Barre, ruled the country with an iron grip, built a lot of institutions, but in the end, after 22 years, collapsed under the weight of its hubris.

As Somalia fielded a liberation war on Ethiopia, Ethiopia responded in kind and waged a proxy clan-war on Somalia. Ethiopia nurtured the grievances Somali clans felt for the military regime, gave them sanctuary and the means to fight, and mounted an insurgency against Somalia. The dictatorship, under the strong hand of Siad Barre, fought with all it had, using tanks, airplanes, foot soldiers, imprisonments, torture, and summary executions. The militias who had both legitimate and parochial grievances against the military regime won at the end. With names like: Somali Salvation Democratic Front, Somali National Movement, United Somali Congress, Somali Patriotic Movement, and the Somali National Front, they waged a fierce war and divvied up the country between themselves while at the same time vying for ascendancy against each other.

Since 1991, the war has been transformed from a war against a dictatorial regime to one between successive warmongers. At the beginning the civil war was between clans; then warlords who fought each other evolved from the clans; then religious groups who battle each over doctrinal issues emerged and are currently fighting each other to death.

However, many Somalis in succeeding waves opted out of the civil war. They began leaving the country to escape the hunger, rape, and death that had become widespread. Over one million people fled to neighboring countries such as Ethiopia, Kenya, Djibouti, Yemen, Burundi, and Uganda. Most stayed in large refugee camps, like Dadaab and Ifo in Kenya, that were set up to accommodate East Africans, including Somalis. Resettlement programs have enabled families to move to Europe (Germany, Switzerland, Finland, and England) and the United States. Forty percent of all Somalis in the US live

in Minnesota. Most live in Minneapolis/St. Paul, with smaller populations in outer Minnesota.

From the beginning, (in 1992) the Somalis who resettled in Minnesota have prospered greatly. Their major aim in coming to the US was to find safety and opportunities (economic and educational) for themselves and their children. And they did find safety and opportunities in Minnesota. Young Somalis, in the thousands, go to Minnesota universities and colleges, while adults have found gainful employment and opportunities to operate small businesses. However, older Somalis, like all world refugees, dream of going back to Somalia. While the majority of Somali children--except for a few who have joined gangs or have been lured back to fight the Ethiopians--knowing nothing of their old country, are happy with the opportunities they have. For the adults there is no end to their mental agony because the war now pits two matched groups against each other and it is unlikely they'll ever go back home. Al-Shabab, literally the youth, a militant religious group, is in a fight to the death with the Transitional Federal Government (TFG) supported by Al Sunna and Al-Isalah, two moderate religious groups joined with the international community.

However, it's not only the fighting that is keeping Somalia unstable. The hardest thing to overcome is the lack of expertise and the will to stop the war. Somalia cannot overcome its nightmare because the educated have left the country. Corruption and politics also play a role in fostering the instability, too. According to Mohamed Nor[2] and Katherine

[2] Nor, S. M. and Houreld, K. *Somalis mark 20 years of war after government fell*. Lasqorey.org, January 27, 2011.

Houreld "Corruption, clan politics and regional rivalries fuel the conflict. Somalia's U.N.-backed administration doesn't account for the cash it's given by foreign donors, and then begs them for more." There is no end in sight yet to Somali civil war.

RELEVANT TWIN CITY LITERATURE AND EXISTING DATA: As noted earlier, one of the recent reports on health of Twin City residents was the Blue Cross and Blue Shield of Minnesota Foundation commissioned **The Unequal Distribution of Health in the Twin Cities**. While the Blue Cross-Blue Shield Report was not primarily focusing on Somalis, nor based on data from local Somali residents, there is ample content in the Report that blends well with the health concerns of this project. The focus of the Blue Cross-Blue Shield Report was to determine whether health inequities existed in the Twin City area as much as were found elsewhere in the United States. The conclusion of the Report was that the metro Minneapolis-St. Paul area reflected the same strong relationship between health and the variables of race, income, and geographical city residence that are prevalent elsewhere in the United States. What was surprising to the Blue Cross-Blue Shield authors was that the "immigrant advantage" existed for some immigrants, i.e. health outcomes were better than would be expected from socioeconomic characteristics alone. While Somali residents were not identified specifically, the "immigrant advantage" could apply, because as recent arrivals, they would retain a better diet, be more physically active, and have the advantage of strong cultural beliefs and customs that would support good health.

Other facets of the Blue Cross-Blue Shield Report emphasize the importance of social determinants influencing health inequities. For example, residents in high income/low

poverty areas of the Twin Cities have a longer life expectancy than residents in low income/high poverty area—by eight-years. And, "the relationship between an area's income and mortality is so striking that, on average, every $10,000 increase in an area's median income appears to buy its residents another year of life" (p. 7). According to some health care models, half of all health is determined by social determinants—including, for example, education, income, diet, exercise, access to care, social support, and pollution.

As noted in Table 1, health outcomes vary by race. Table 2 reflects the leading causes of death within the 7-county Twin City area, and provides the breakdown using foreign-born Blacks as one category. While there are large numbers of foreign-born Twin City residents from Eitrea, Ethiopia, Ghana, Kenya, Liberia, Nigeria, and Somalia, the largest number are Somali (www.demography.state.mn.us/documents/Immigrants2009.csv). Table 2 reflects a higher death rate from cancer and AIDS/HIV for foreign-born Blacks and a lower percentage of deaths due to heart disease and Alzheimer's.

TABLE 1
Adult Obesity and Diabetes Rates for Hennepin County Residents by Race*

Health outcome	White	Of Color
Adult obesity rate (2006)	18.5%	22.2%
Adult diabetes rate (2006)	5.2%	10.2%

*Table 1 is a condensed version of Table 6 (p. 15) in the Blue Cross-Blue Shield Report.

TABLE 2
Leading Causes of Death in the Twin Cities 7-County Region by Racial and Ethnicity, 2005-2007*

	Hispanic	Am. Indian	Black (U.S. born)	Black (Foreign born)	SE Asian	Asian	White (non-Hispanic)	Total

Total number of deaths	594	361	2,172	250	646	372	45,411	49,894
Cancer	21.4%	16.9%	22.4	32.0%	25.2%	21.0%	25.6%	25.3%
Heart Disease	10.4%	14.4%	15.6	7.2%	10.7%	12.6%	17.5%	17.1%
Stroke	6.4%	5.3%	4.3	6.4%	10.7%	7.0%	5.8%	5.8%
Diabetes	3.9%	5.3%	4.7	4.4%	4.2%	1.9%	2.9%	3.0%
Alzheimer's	.3%	.3%	1.1	0.0%	1.2%	1.9%	3.2%	3.0%
AIDS/HIV	1.2%	1.4%	1.5	3.6%	.2%	0.0%	.1%	.2%

*Condensed version of Table A1 (p. 40) in the Blue Cross-Blue Shield Report.

Similar to the focus on Somali healthcare needs that we had, the Garrett, Treichel, and Ohmans article (1998) focused on a comparison of perceived barriers to healthcare for Twin City immigrant and non-immigrants with a sample of healthcare professionals. The professionals involved included medical social workers and public nursing staff—those who would have exposure to both immigrant and nonimmigrant populations. Differences between these two categories along several dimensions were considered, including healthcare needs, potential logistical barriers, potential cultural barriers, and perceived availability of services. Table 3 serves as a summary table of the survey results. Table 3 shows that among 15 different health areas grouped by organ systems (i.e. mental health, respiratory, blood/cancer, etc.) only two were significant, with infectious diseases for immigrants and alcohol and chemical abuse for non-immigrants. Of five potential logistical barriers (transportation, insurance, etc), only the trained interpreters were significant for immigrants. In contrast to potential logistical barriers, seven of the 11 potential cultural barriers were more significant for immigrants, while many of the perceived services were deemed less available to immigrants.

In the Garrett, Treichel, and Ohmans article (1998:53) tuberculosis and parasitic diseases were noted as the most prevalent of the infectious diseases among immigrants. According to Fritz and Hedemark (1998:46) a Somali community health worker made the following comment on TB:

> Some Somalis consider TB a 'bad' disease and think it is incurable. Many Somali patients find it hard to admit that they have TB, and they may deny it when asked. A better approach when initially interviewing a Somali patient may be to ask about symptoms of TB disease rather than identifying it by name.

Screening for infectious diseases is one area of the overseas medical examination required for all refugees and immigrants, as summarized in the Fritz and Hedemark (1998) article for Somali refugee arrivals. Malaria among Somali refugees is not uncommon, but more prevalent for those from southern regions of Somalia, and those who were in refugee camps in Kenya, according to Fritz and Hedemark (1998: 45). Parasitic diseases among Somalis stem from the use of contaminated water sources.

Fritz and Hedemark (1998:46) provide further suggestions for improving health options for Somali patients:

> When instructing the patient about future appointments, be specific about when to come back and why the return visit is important. Reinforce these instructions about return visits frequently. Transportation can be a deterrent to follow-up visits, so transportation options should be discussed. Be specific when giving directions for follow-up visits, medication regimens, and disease outcomes to ensure that the Somali refugee has a good understanding of the course of treatment.

TABLE 3
Statistically Significant Differences Perceived by Healthcare Professionals Between Immigrant and Nonimmigrants in the Twin Cities (1998 Data)*

Healthcare Needs	Potential Logistical	Potential Cultural Barriers	Perceived Availability of Services

	Barriers		
Infectious Diseases	Language/trained interpreters	Gender issues	Counseling
Alcohol/chemical Abuse		Intrusive/invasive procedures	Dental
		Beliefs about diseases	Skin problems
		Nonrecognition of medical need by provider or patient	Family planning
		Stigma or shame over Health condition	General medical
		Lack of acknowledgment of Family systems	Home care
		Providers seen as alien/distant	Pain management
			Hospice

*Condensed version of Tables 1-4 in Garrett, Treichel, and Ohmans, 1998.

An article by DuBois (1998) titled "A community health assessment of a culturally diverse housing project in St. Paul" was also useful, in part because it compared a sample of Somali residents with sample of other ethnic group residents (Vietnam, U.S., Ethiopia, Liberia, Cuba, Sudan, Egypt, Eritrea, German, Sri Lanka, and Nigeria) of one St. Paul high-rise apartment complex. DuBois found that while most residents did not report problems with making a medical appointment, reading medical labels, or understanding their medical insurance, Somalis were an exception, and half of the Somalis surveyed reported problems with those health concerns. Most residents (93%) reported they had health insurance, primarily because they were receiving some type of public assistance. Fewer residents had dental insurance (82%), and Somalis were noted as visiting a dentist least frequently (only 20% visited a dentist at least once a year), and some Somali residents reported that they had never visited a dentist. The article concluded that Somalis are confronted with linguistic, financial, and cultural barriers to a greater degree

than other recent refugee groups, and a targeted health education program is needed to assist them with their medical needs.

Halcon, et. al. (2004:24) and colleagues summarized data collected from Twin City Somali and Oromo youth, noting:

> Cultural barriers and stigma are a major problem for immigrants and contribute to their reluctance to pursue Western mental health services on either a group or individual level despite self-identified needs.

In the Jaranson, et. al. (2004) paper on trauma experienced by Twin City Oromos and Somalis, only six of over 1100 respondents reported that they did not have traumatic experiences.

Information from the East African Health Project (EAHP) [http://www.eahpro.org] was also useful, particularly in noting the previous experiences Somali refugees had had when they lived in Somalia. The EAHP power-point material provided the following experiences with healthcare in Somalia:

- Little preventive care.
- Chronic diseases would often be undetected or untreated.
- Self-diagnosis and treatment or pharmacist advice and treatment were common.
- Traditional healers were often consulted before medical care was sought.
- Medical doctors were primarily males.
- Medical personnel asked few questions, and used few tests.
- Payment for services was easy to understand.

According to the EAHP material, there are several barriers to medical care. One of these is language, where the word fever has variable meaning. Most Somalis interpret a fever

to mean pain or warmth at the site of pain. Many Somalis equate malaria with a real fever and if they have a fever they will often report that they have malaria. Refugees have multiple stressors that can be overwhelming, including family separation, isolation, housing issues, limited education, few skills, and restricted employment options. According to the EAHP power-point, "Chronic depression causes decreased attention, concentration and memory disturbances that make obtaining an accurate medical history more difficult".

The report on **African-born women's and children's exposure to secondhand smoke** (2009:2) noted that Somali women were exposed to shisha smoke significantly more often on a daily and weekly basis than were other African-born women. Also noted was that smoking had increased since immigrating to the United States, particularly for women and youth, which is attributed to peer pressure, the desire to "be American," and the media-portrayed glamour of smoking.

One of the issues confronting Somali healthcare focuses on what appears to be an elevation in Autism Spectrum Disorder (ASD) among Somali children. This issue is discussed in a Minnesota Department of Health Report of Study Fact Sheet on Autism and the Somali Community (http://www.health.state.mn.us/ommh/projects/autism/reportfs090331.cfm) which was **not** an attempt to identify possible causes or risk factors for ASD, but did find (p. 2) that of children, ages 3 and 4, who participated in the Minneapolis Public Schools ASD programs, a significantly higher number were Somali compared with children of other races or ethnic backgrounds. The higher participation rate in ASD school-based

programs may mean (1) that there is a higher rate of autism among Somali children, (2) there is better outreach to Somali families compared to other children, (3) non-Somali children that are identified as having ASD use services outside of the school system, or (4) other unexplained reasons account for the results.

At issue is whether the measles-mumps-rubella (MMR) vaccine and preservatives play a role in children developing autism. According to a report on Autism and childhood vaccines (http://www.health.com/health/library/mdp/),,ue4907,00.html?pkw=outbrain-ha) "Researchers in Europe, Canada, and the United States looked closely at this issue...the timing of the vaccine and the vaccine itself and have found no link between the vaccines and autism. A Tom Lyden Fox9 news item noted that the U.S. Centers for Disease Control (CDC) and the National Institutes of Health (NIH) will launch a study of Somali children in the Twin Cities to determine whether the estimated one-in-28 Somali school children diagnosed with autism is a real outbreak or a statistical fluke (http://www.myfoxtwincities.com/dpp/news/autism-fraud-wakefield-mn-somali-community). Lerner (2011) confirmed that Autism Speaks, a scientific and advocacy organization will assist in funding the CDC-NIH autism study.

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PRESENTATION OF THE FOCUS GROUP DATA: As a research team, we proposed that a summary of each focus group might contain the following items:

[1] Date/ place of meeting.
[2] Number of participants (excluding leader) and demographic characteristics.
[3] Major themes of health needs (was there general agreement on these needs? any exceptions, diversions?)
[4] Other health care needs that were identified?
[5] What were the difficulties obtaining healthcare? Were any solutions proposed?

Summaries of focus group meetings were prepared by the researchers (Warsame and Mohammed), based on the primary question that was asked: "What are some medical health problems that you and your family are facing?" Discussion of the reasons for those problems followed individual reporting of personal and family medical problems within each focus group.

There were a total of 12 focus groups, six were convened by Abdi Warsame, and six were initiated by Ifrah Mohammed. While many of the focus groups were completed in English, others were exclusively completed using Somali. While the size of the focus groups varied from 6-12, there were at least six participants in each group, for a total of 48 female and 70 male Somali Twin City residents. Some of the meetings were at the Brian Coyle Community Center, located in the Cedar-Riverside area where large

numbers of Somali live, while others were held on the campus of the University of Minnesota or the St. Paul Technical College, or at adult daycare sites. Among female respondents, three of the sessions had participants who were between 20-28, and another with participants who were professional women between 25 and 37. Two other female focus groups had respondents between 50 and 80. Male respondents varied in age between 18 and 80.

The outstanding feature of the results was that the extent of health conditions or problems appears very high (at least to this non-medical research team). For example, among female participants, coronary heart disease, diabetes, high blood pressure, and high cholesterol needs were reported by at least one participant **in each focus group**—including three female focus groups where the age ranged from 20-24, 20-25, and 20-28—although several of the younger women reported that they did not have health problems. Cancer (all forms--whether specified and generally presented as "cancer") was the only medical condition common to all the male focus groups, but male participants reported coronary heart disease, diabetes, high blood pressure, and PTSD in five of the six focus groups. In contrast to the reasonably high number of PTSD cases among men, only one focus group reported PTSD among the female participants or their families.

Cancer was another illness that varied between female and male focus groups. Among women, only one focus group reported cancer as an illness for a participant or the participant's family, but as noted among male focus groups, some form of cancer (specified as skin, throat, mouth and lungs, or "cancer") was reported as prevalent in each focus group. Gender differences in various medical problems also surfaced among the

"not often noted" end of the continuum. Aids, anemia, ADHD, acid reflux, and epilepsy were health problems noted only once in the female focus groups, but males noted none of those health conditions. On the other hand, male focus groups reported Sickle cell anemia in four different focus groups, brain tumors in two groups, and Hepatitis B and C in two different focus group participant families. Arthritis was fairly common, reported in four male focus groups and among three female participant group families.

Even extrapolating to all the families of the focus group participants, the results reflect only a small sample of the Twin City Somali population, and in no sense do we imagine that the sample is large enough to be representative of the Twin City Somali population. Focus group participants essentially comprise a convenience sample comprised of volunteers. One could account for the high incidence of coronary heart disease and high cholesterol on the basis of focus groups among the elderly. While there were elderly participants, and in two instances focus groups held at adult daycare facilities, many participants were younger, and most female participants were younger (under 30).

Other plausible factors need to be considered to account for the range of health conditions and problems presented. One plausible factor discussed here relates to social and cultural differences. The social conditions reflect behavioral factors, while the cultural conditions refer to values and beliefs instilled in the individuals and passed on to their children. For example, arthritis, joint pain, and swollen legs discussed in the men's groups might well be influenced by a change in activity. In Somalia, people were active, and frequently walked, while here in the U.S. their activity is severely limited. Abdul Warsame explained it this way:

Somali immigrants and Somali-Americans comprise one of the largest ethnic communities in Minnesota struggling to maintain adequate health. They are not maintaining an active healthy life style due to lack of nutrition, limited physical activity and most importantly, education. This lack of understanding and education results in many compromising and fatal conditions, such as hypertension, type 2 diabetes, high cholesterol, and heart disease. All of these conditions are unfortunately extremely common in the Somali community, through no fault of the Somalis themselves. The Somali people have not been given the proper education to prepare nutritional daily balanced meals. The typical Somali diet is mainly made of pasta, rice and white bread, all of which are loaded with carbohydrates. Foods high in carbohydrates must be burned off, or they will be stored away as sugar and fat leading to the diseases previously mentioned. Burning off carbohydrates was easily done back in Somalia because people lived a very active life style walking from place to place. Now, assimilating with the American lifestyle, daily exercise has become long forgotten by Twin City Somali residents, and it is costing them dearly. Because of the quality of food they are consuming, and the distortion of appropriate portions along with bad weather and isolation, their lack of understanding has caused them to sit home, eat, snack, and unknowingly gain more weight and diseases.

Furthermore, the Somali people had very natural, organic, and more nutritious food when they were living in Somalia. When coming to America many Somalis were led to believe that food in the United States made by modern factories and industries was healthful, only later to discover that the food has harmful artificial chemicals. This misunderstanding has led many Somalis to distrust all beneficial food necessary for a healthy life, and they are passing these unhealthy habits on to their children. Twin City Somali residents are at an extreme disadvantage and desperately need help, guidance, and education.

A: Behavioral changes between residence in Somalia and the United States that could influence health needs:

[1] Focus group participants often discussed the limited exercise that Somali people were now getting, compared to life in Somalia. Many Somali participants deemed the lack of exercise to be the cause of many of their health issues.

[2] There is both misunderstanding, and distrust, between the non-Somali medical doctor and the Somali patient. Some of this relates to the patient's lack of understanding English, some of it relates to the difficulty in comprehending the American healthcare

system, and some of it relates to the fact that many (most?) Somalis do not get regular medical check-ups; rather they go to the doctor when they are in pain. When in pain, Somalis tend to use emergency clinics, and thus do not have a primary-care physician. Even if they have a primary-care doctor, Somali women move from clinic to clinic because they were unable to get an appointment when they wanted to see the doctor.

[3] Some younger Somali women thought that many individuals were over-medicated. This may be because of poor communication between the patient and the doctor, or it could be related to miscommunication due to poor interpretation, and it could also be the result of sharing pills, or consulting with friends. The phrase "Somali patients have other doctors" reflects the informal network of "advice" from friends and family members who are not medical practitioners.

[4] Somalis are not used to having the medical advancements available in the United States. Thus, they may not take their medications regularly. Or, they fail to believe in the diagnosis (such as Type I or Type II diabetes) and then don't follow-up on the treatment. Somalis are not used to keeping timetables, or are not familiar with the side-effects associated with certain drugs.

B: Cultural differences between Somalia and the United States that could influence health needs:

[1] Belief patterns remain among Somali adults, including the view that Somali mothers do not want their children to have certain shots because of the view that the shots will cause autism.

[2] Some focus group participants reported that they (or a family member) did not want medical treatment because they believed traditional herbs were the most effective.

[3] Some Somalis have a mistrust of health care professionals.

[4] In Somalia, mental illness was not acknowledged, and that remains the situation here in the U.S. as well. If an individual or family member perceives there is something "strange" in their or a family member's behavior, treatment at an early stage is not sought because of the fear of stigma. Thus, early counseling for mental health or depression—or for that matter, any mental health counseling at all—is not sought.

[5] Some focus groups discussed the confusion between cultural and religious practices when seeking health treatment, i.e. is an illness the will of Allah or an illness to be cured?

[6] Confidentiality at a medical clinic is a concern among females, because any sexual problem (HIV, AIDS, or sexually transmitted disease) would generate embarrassment, and trust in interpreters to maintain confidentiality is suspect. As a result, most Somali women don't want interpreters when there is a serious health issue.

In terms of changes in healthcare, the following suggestions were made by focus group participants:

[1] Interpreters need to be properly trained (knowledgeable about medical terminology, well-educated, and aware of/adhere to the principle of confidentiality).

[2] There is a need for a sex education course, since there are high rates of abortions. "Young women don't know how to protect themselves". STDs are increasing in the Somali community and people should be educated about these diseases so they are able to protect themselves.

[3] Because mental health is such a taboo among Somalis, patients will not tell their doctors about how they feel, or they are not willing to tell the interpreter about their issues.

[4] The Somali people need to know about the importance of exercise, nutrition, balanced diet, and healthy eating habits (wellness).

[5] The Somali community will be better served when there are mental health workers that understand the Somali culture. There is a strong need for Somali professional medical personnel, but short of that, non-Somali medical professionals need to be more culturally sensitive with Somali patients.

[6] Access to Medicaid exists for some Somali people, but if you don't have that access, healthcare is difficult to obtain. Access to healthcare is therefore limited to many Somalis; it is not affordable.

[7] Surgery is a feared topic among the Somali people.

[8] Concerns about specific diseases such as autism, Vitamin D deficiency, ADHD, cancer, high blood pressure, and diabetes are huge issues for Somalis.

[9] Healthcare providers should make sure that patients with diabetes, high blood pressure, etc. truly understand their illness and treatment procedures, and if the patient doesn't understand (or can't comprehend), then members of the patient's family should be brought into the picture and informed. The patient may need a support group.

Summary of the Project and Recommendations: A review of relevant Twin City health reports on Somali residents indicates that social-cultural differences are important in a patient's health treatment expectations and appropriate procedure follow-through. Language barriers further limit the Somali patient's comprehension and confidence in the U.S. healthcare system. Clearly race, religion, cultural differences, and language indicate that Twin City Somali residents have healthcare needs and barriers that differ from the typical resident.

Somalis residing in the Twin City metro area also have had exposure to a larger number of diseases (i.e. Tuberculois, Malaria, Parasitic Diseases, and HIV/AIDS) and experienced trauma to a greater degree than most other residents. Entrenchment in Somali culture and language also limit reading English and understanding medical instructions, thus maximizing health-issue problems.

For Somalis, in addition to a carry-over of a lack of understanding health and healthcare issues are fresh problems stemming from life in a new society—increased smoking (particularly among women and youth), 2nd-hand smoke, Autism Spectrum Disorder, and limited understanding of the importance of maintaining a wellness approach.

Recommendations stemming from the relevant Twin City literature and focus group data collected in this project include the following:

- Among focus group participants and their families, there appeared a large number of serious illnesses, which demands a need for Somali residents to increase their understanding of the U.S. healthcare system. This might be facilitated with:
  - [a] presentations to adults at the Brian Coyle Center by U.S. medical personnel, researchers, or Somali leaders;
  - [b] school presentations to students, so they can understand it themselves, and (as needed) assist in explaining the information to their parents; and
  - [c] additional (and specialized) training for Somali interpreters.

- Continue to assist medical professionals understand Somali cultural beliefs related to all aspects of health and healthcare practices.

- Create innovative approaches to decrease informal networking of friends and family as "medical advisors" and self-diagnosis among Somali residents.

- Encourage University of Minnesota researchers, the Minnesota Department of Health, and other research centers to continue the important research on health and healthcare issues within the Somali community.

- Support the Minnesota Department of Health in carrying-out the Eliminating Health Disparities Initiative.

HEALTHCARE BIBLIOGRAPHY: There has been a limited amount of research that examines the prevalence of mental illness among Somali refugees (Bentley & Owens, 2008). Research has suggested that refugees are at risk for the development of a variety of psychological disturbances including depression, anxiety, and posttraumatic stress disorder (PSTD). Thus, it is important for the field of mental health to understand how the experiences of refugees, particularly those that are amenable to change, relate to mental health problems (Ellis, MacDonald, Lincoln, & Cabral, 2008). In general, mental health data on Somali populations are sparse. Part of this is due to the absence of culturally validated appropriate assessment instruments and methodological challenges (Bhui, Craig, Mohamud, Warfa, Stansfeld, Thronicroft, Curtis, & McCrone, 2006). In addition, preventing sickness is a foreign concept for Somalis (DeShaw & DeShaw, 2006). DeShaw & DeShaw discuss the Somali belief that sickness is Allah's will, which does not lead them to make an effort toward seeking health care. Furthermore, there is a lack of trust in the U.S. healthcare system, a shortage of Somali healthcare providers, and low levels of education among many Somali patients. Encounters with American health care professionals who do not know how to identify and treat depression and PSTD in Somali patients may discourage Somalis from seeking any health care (DeShaw & DeShaw).

Within the research available, perspectives of learning are significant in understanding the trauma related to post traumatic stress disorder (PTSD) derived from the experience of war-torn countries. One cannot imagine the constant distress that can traumatize an

individual who has encountered horrific life-altering conditions. A number of studies found that refugee survivors of war trauma and torture experience a range of physical and psychological problems, such as PTSD, other anxiety disorders, and depression (Halcon, et. al., 2004). In another study completed in the Netherlands, asylum seekers had experienced more post-migration stress, with Somali and Afghan asylum seekers experiencing the most traumatic events (Gerritsen, Bramsen, Deville, Willigen, Hovens, & Van der Ploeg, 2006).

Ellis, Lincoln, MacDonald, & Cabral (2008) suggest that there is a strong relationship between discrimination and poorer mental health outcomes, including depression and psychological distress among youth (Fisher, Wallace, & Fenton, 2000). Significant factors focused on "praying" and "reading" were among those that left young refugees with emotional confusion. Halcon, et. al. (2004) reports that even though most refugees have faced turmoil before arriving in the United States, they are still able to cope well. Halcon, et. al. suggest a need to develop age-appropriate strategies to promote the health of refugee youth to facilitate their successful adaptation to adult life in the United States.

In the Halcon, et. al. (2004) cross cultural comparison of Oromo and Somali refugee youth, several factors illustrate contributions to their ability to cope in a new country and the stressors that follow. Factors associated with frustration among young refugees center around linguistics due to the need to adapt to English. This cultural perspective focuses on two dimensions, interactive and structural (Caffarella and Merriam, 2000). The interactive dimension focuses on the learner and how s/he responds to the learning

environment. The structure dimension takes into account the factors that influence learning, such as race, class, gender, sexual orientation, and socioeconomic status. The authors did an incredible job in providing examples of the two dimensional structure and how it relates to one's learning environment.

Concentrating on learning environments, the article titled: *Mental Health Service Utilization of Somali Adolescents: Religion, Community, and School as Gateways to Healing* (Ellis, et. al., 2010) suggest that their findings demonstrate an enormous gap between the need for, and access to, services for Somali refugees. Regardless if resources are available, the reality of accessing benefits, such as youth programs and mental care, seem farfetched. The study also points out that other available resources--such as religious leaders and school personnel-- were accessed more frequently (Ellis, Lincoln, Charney, Ford-Paz, Benson, and Strunin). Recommendations include alternative health care approaches utilizing family values, bargaining, and educational approaches to acculturation (Scuglik, Alacon, Lapeyre, Williams, & Logan, 2007).

School has proven to be one form of self-expression for those who have identified a sense of belonging; it has shown great impact amongst those who take advantage of their opportunity at free, public education. A greater sense of school belonging was associated with lower depression and higher self-efficacy regardless of past exposure to adversities (Kia-Keating & Ellis, 2007). These findings also suggest that experiences in the school must be improved in order to develop "a school based mental health program for refugees" (Kia-Keating & Ellis, p. 29). This form of treatment is highly needed since

those Somalis that need care do not perceive themselves as ill (Wallin, Lofvander, & Ahlstrom, 2007). Wallin, Lofvander, & Ahlstrom, in their article *Diabetes: A cross cultural interview study of immigrants from Somalia,* make the point that diabetic Somalis don't consider themselves as having a medical condition and are reluctant to care for themselves in a medically prescribed way. Many diabetics have reported difficulties in managing everyday life skills, which resulted from a lack of understanding on the part of family and friends and adhering to a strict diet.

Religion has played a major role in the health of patients and their beliefs and practices according to Wallin, et. al. (2007). Many diabetic Somalis fast during the celebration of Ramadan but report that no health changes have resulted from their limited diet during the fast; in fact, one participant experienced improved health (Wallin, et. al., p. 309). Medical providers advised against the practice of fasting for diabetics. However, for the purpose of this study, those who insisted on performing the practice during Ramadan, were given an anti-diabetes drug although there is "no medical agreement as to whether it is safe for a person with diabetes to fast" (Wallin, et. al., p. 311).

Closely related to the values of religion, are the important characteristics of cultural identity. Receiving post-migration medical treatment is based on whether you have a healthy relationship with your health provider. Frequent geographical movements are seen as stressful and undesirable, disrupting family life, child development and are detrimental to well-being (Warfa, Bhui, Craig, Curtis, Mohamud, Stansfeld, McCrone, & Thornicroft, 2006). The process of helping with this transition of migration and

accessing treatment is exchanging cultural information. This is crucial in establishing a long-term clinical relationship, a culturally sensitive diagnosis and successful treatment (Groen, 2009). Once an individual (ideally the medical provider) understands the importance of your background and culture, hopefully s/he will become more sensitive to your needs and the services that are needed for successful treatment. Allowing the patient to open up through self-representation, allows for the opportunity of change (Groen, p. 461). However arriving at that point of change takes considerable self-awareness and optimism.

Few Somali see war related trauma as a direct cause of their problems but instead cite preoccupation with reunifying their families or other resettlement stressors as direct causes (Guerin, Guerin, Diiriye, & Yates, 2004). If "war related trauma" isn't related, how can we explain the causes of early PTSD, mental health disorders, and other diseases effecting this population of individuals? Those Somali who seek medical help and admit that there are mental health disorders effecting their people, had previously relied solely on "traditional treatments, especially the common use of the Koran readings for dealing with both physical and mental health problems" (Guerin, et. al., p. 63).

Refugee migration, resettlement, and readjustment into a host country places refugees at risk for a number of physical health concerns and psychological difficulties (Palinkas et. al., 2003). Relocation is more difficult and health consequences greater when associated with civil conflict and homeland violence (Berman, Giron, & Marroquin, 2006; Pavlish, Noor, & Brandt, 2010). The civil war in Somali resulted in massive resettlement of

Somali refugees. The largest diaspora of Somali refugees in the United States currently reside in Minnesota (Pavlish, Noor, & Brandt, 2010). Estimates of how many Somali immigrants live in the United States range from a low of 30,000 to as high as 150,000, depending on where the data were derived from (Kusow, 2006). Since migrating, Somali men and women have experienced dissimilarities, with Somali women and their healthcare providers reporting multiple frustrations that often diminished perceived quality of health care (Pavilish, Noor, & Brandt). Giuliani, Mire, Jama, DuBois, Oryce, Fahia, & Enrlich (2008) report that 36 percent of Somali men had no health insurance. These findings could be closely related to the dissimilarities that Somali females report. Also, tobacco has become an issue for Somalis, with female smokers posing specific challenges to prevention and intervention efforts (Gouliani, et. al., p. S457).

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