



MOVING TOWARDS **CULTURALLY COMPETENT CARE** FOR SOMALI/SOMALI BANTU POPULATION

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&

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Greetings

- ❑ Subah-Wanagsan~Good morning in Somali
- ❑ Habari-ya asubuy~Good morning in Swahili
- ❑ Iska-Waran~ How are you? In Somali
- ❑ Habari yako~How are you? In Swahili

Learning Objectives

- ❑ **Section 1: 30 minutes**
 - Describe brief overview of the history of Somali/Somali Bantu Population
 - Brief Epidemiology profile
- ❑ **Section 2 : 30 minutes**
 - Identify common beliefs and cultural practices of the Somali/Somali Bantu Population
- ❑ **Section 3 : 30 minutes**
 - Discuss additional insights and information from community members
- ❑ **Section 4 :**
 - List of additional resources & References

SECTION 1A

History

History Overview

□ Geography:

- East, Horn of Africa

□ The People:

- 85% Somali
- 5% Somali Bantu
- 10% Arab/Other

□ Culture:

- Nomadic
- Oral & artistic traditions
- Poets

□ Government:

- Sheikh Sharif Sheikh Ahmad (2009)

□ Language:

- Multiple Dialects (Mai Mai** and Somali)

□ Religion:

- Islam
 - Ramadan
 - Greetings
 - Specific Diets
 - Naming-3 parts
 - Gender Role

□ Identity validation:

- Tribal stratification system of social relationship

□ Civil War:

- 1991
- The rest of the country is in peace. Just southern part is at war since 1991



Who is this Group?

□ Somali

- Ethnic
- 85% of the population
- Very tribalistic culture
- Started coming to America in the 70s
- Many dialects



□ Somali Bantu

- Roots in West Africa
- 5% of the population
- Lived in certain area
- Started coming to USA in 2003(12,000 refugees)
- Speak **ONLY** Mai Mai



Life in Somalia

□ Somali

- Mixture of rural and urban
- Tribalistic culture
- Dominant group
- Family structure
 - Patriarchal
 - Family unit
 - Care for extended family
- Practice Polygamy
- Used hospitals more to see health provider
- Asked for full medical history for proper diagnosis
- Culture of no appointment
- Male/female roles
- Medications always prescribed
- Civil War
 - Displacement

□ Somali Bantu

- Rural settings
- Agricultural
- Hard physical work
- Discrimination-limited access to education
- Family structure
 - Patriarchal
 - Family unit
 - Care for extended family
- Practice Polygamy
- Used hospitals more to see health provide
- Asked for full medical history for proper diagnoses
- Culture of no appointment
- Male/female roles
- Medications always prescribed
- Civil war broke out
 - Displacement

Ramifications of the Civil War



Refugee Camps



Life in Refugee Camps

Dadaab, Ifo Kakuma, Liboi, Thika, Haruru, Utanga

■ **Somali Bantu/Somali**

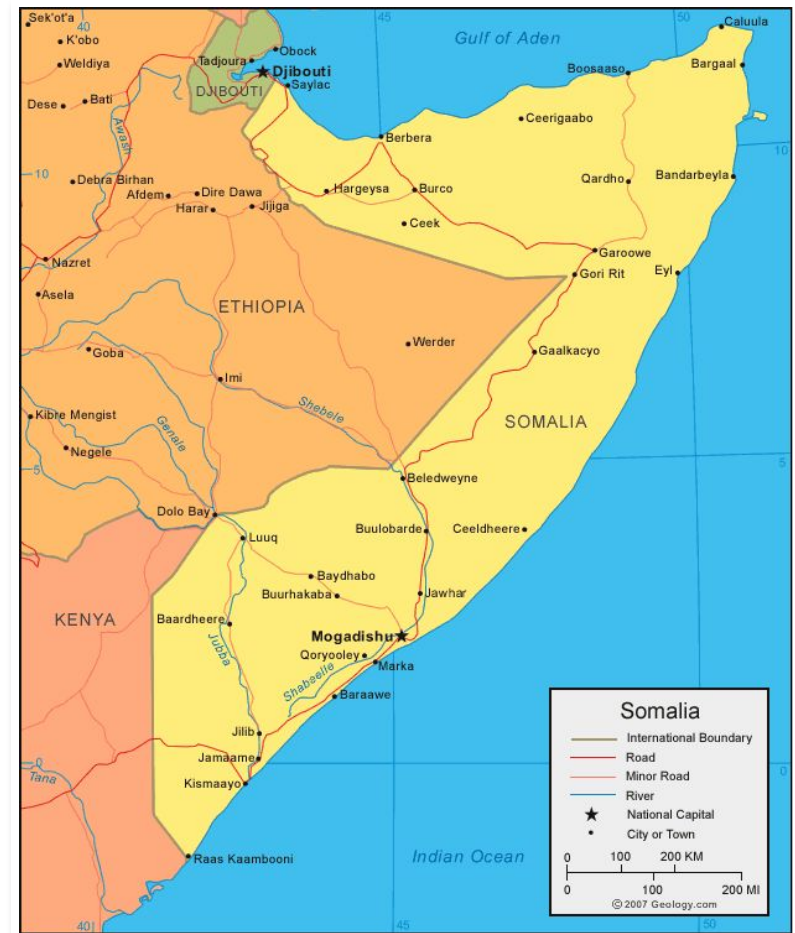
- No Education
- No healthcare facilities
- Breakfast & dinner
- Little or no preventive care.
- Chronic diseases undetected/untreated.
- Self diagnosis and treatment.
- Traditional healers consulted before seeking medical care
- Now Ashley will go over the Epidemiology profile

SECTION 1 B. EPIDEMIOLOGY & HEALTH PROFILE

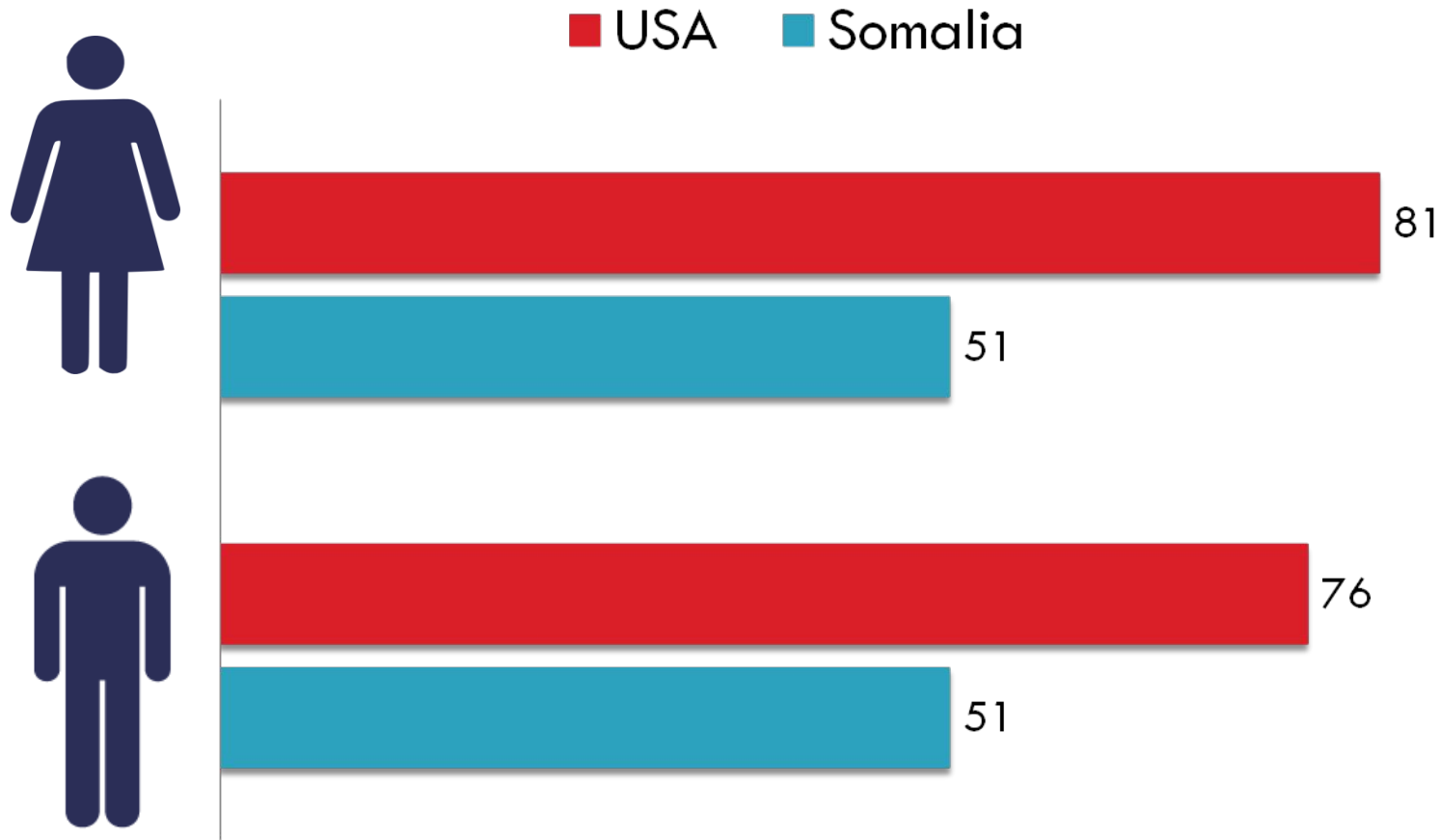
Ashley Borin, MPH- CDC/CSTE Epidemiology Fellow

Somalia- Country Stats-2010

Country Characteristic	Somalia	US
Total Population	9,133,000	314,659,000
Surface Area (Km ²)	637,000	9,629,091
% GDP Health	2.6	16.2
Mortality Rate (15-60 years) M/F	382/350	134/78

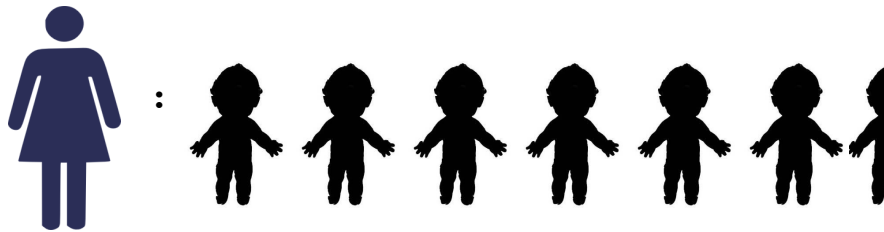


2010 Life Expectancy- years

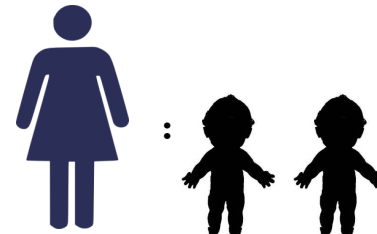


Maternal Health & Mortality

□ Fertility Rate:



Somalia: 6.3



USA: 2

□ Maternal Mortality Rate: 1 200/100,000 births

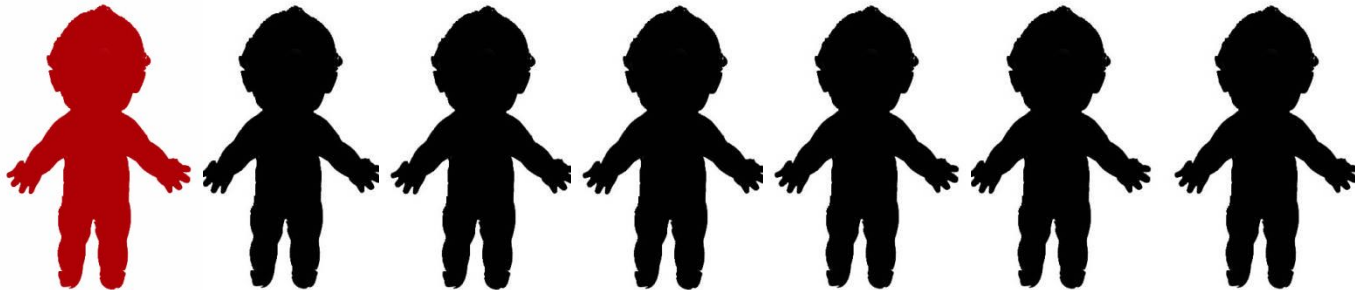
□ US 24/100,000

□ Causes include: hemorrhage, infection, high blood pressure, unsafe abortion, ↓hospital delivery, birth attendants

□ Female Genital Mutilation (FGM)- 98%

Infant/Child Mortality

- Infant Mortality Rate: 108/1000 live births
 - US Rate: 7/1000



1 in 7 children will die before their 5th birthday

Leading Causes of Death-2011

High-income Countries

1. Heart disease
2. Stroke
3. Cancer (lung, colon/rectal, breast, and stomach)
4. Lower respiratory infections
5. COPD
6. Alzheimer Disease
7. Diabetes

Low-income Countries

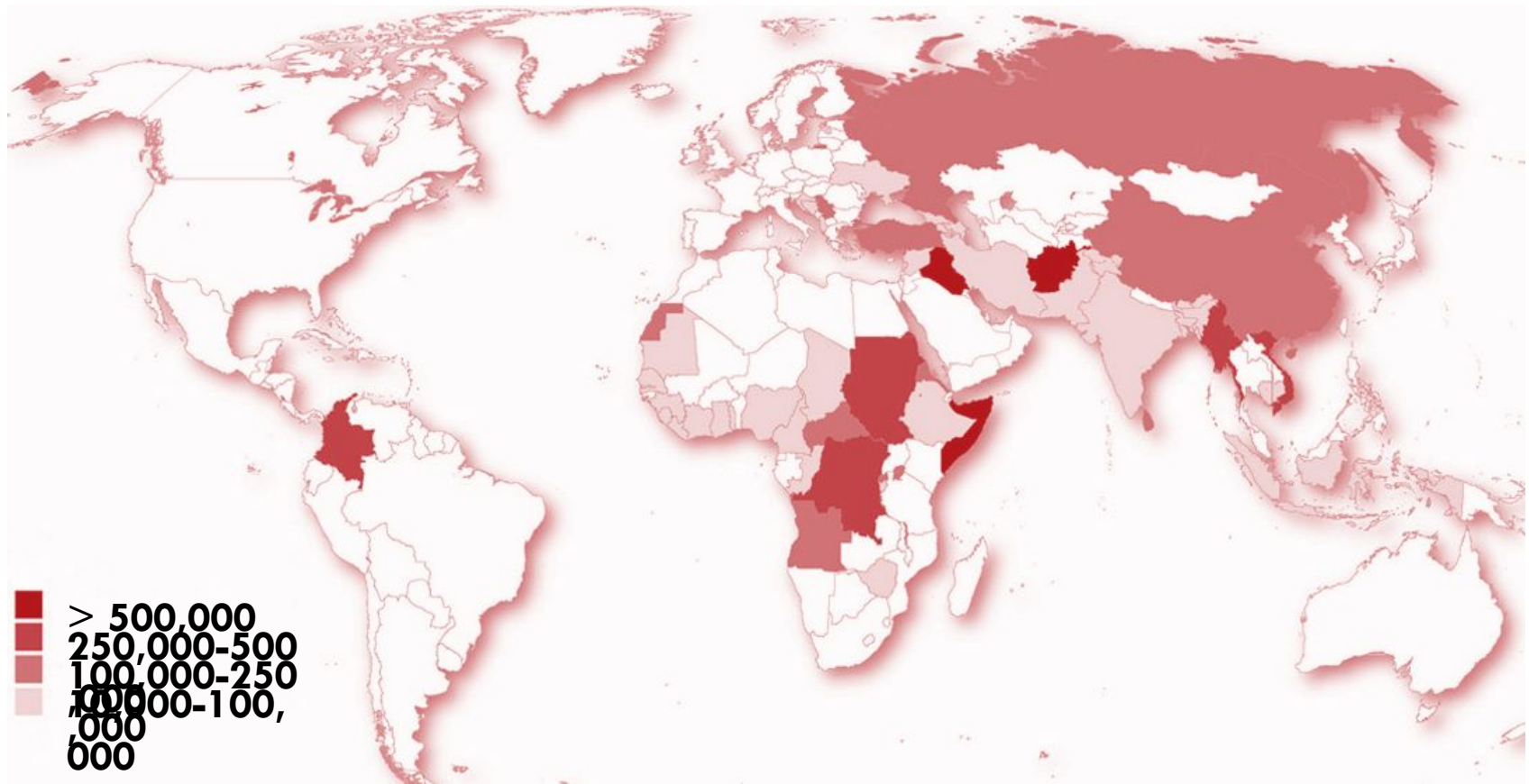
1. Lower respiratory infections
2. Diarrheal disease
3. HIV/AIDS
4. Heart Disease
5. Malaria
6. Stroke
7. TB
8. Prematurity and low birth weight
9. Birth asphyxia and trauma
10. Neonatal infections

Communicable Disease-Somalia

- Tuberculosis
- HIV/AIDS
- Vaccine Preventable Diseases
- Malaria
- Intestinal parasites
- Hepatitis B



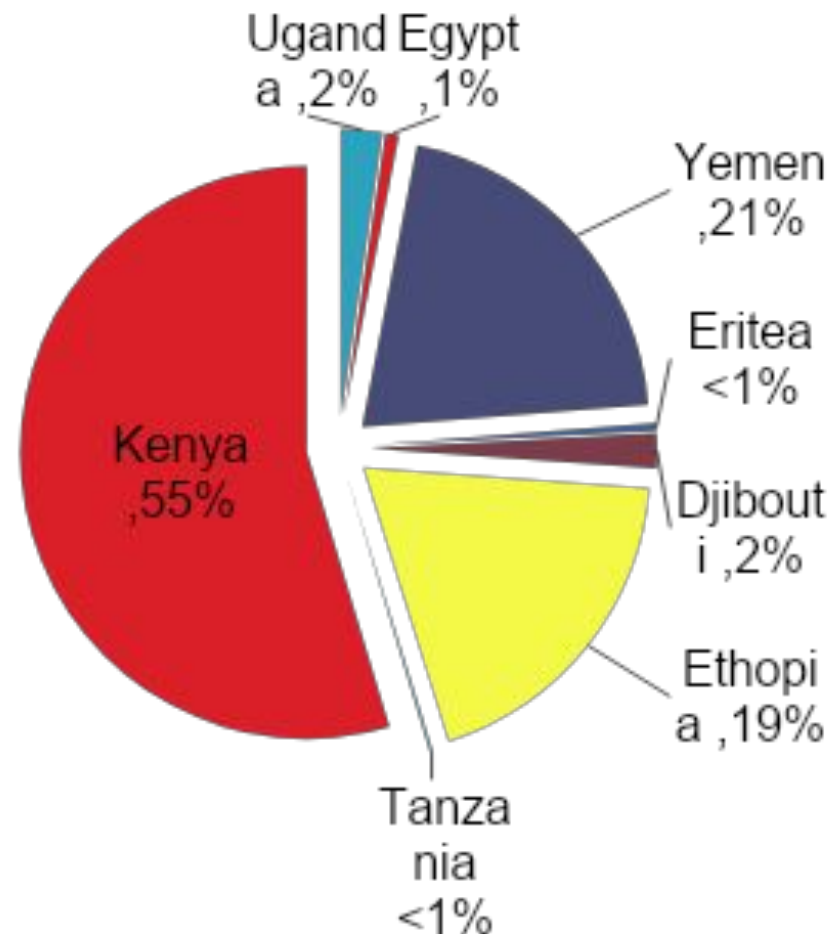
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Over 700,000 refugees from Somalia in 2011

Source: www.UNHCR.org

Somali Refugee Settling Regions



Distribution -2009

- Camps: 30%
 - 60% sub-Saharan Africa
- Urban: 58%
- Rural: 18%

Refugee Camps-2011

- Kenya
 - Home to >500,000 refugees
 - Dadaab- 3 camps (4 total)
 - Capacity 90,000
 - ↑ settlement around major cities
- Ethiopia
 - ~200,000 refugees
 - 23,000 arrivals each month
 - 67% Somali
 - 6 additional camps opened since 2006
- Djibouti
 - ~15,000 refugees
 - Reopened additional camp-2011



Health in Refugee Camps

- ↑ disease and death due to:
 - Limited access to water
 - Gender-based violence
 - Overcrowding
 - Famine
 - Poor hygiene
 - Health care access



Reproductive health

- ~20% of refugees are women of reproductive age
 - 1/10 pregnant
 - Most home delivery

- Initiatives to reduce maternal mortality and morbidity (2008)
 - ↑ birthing facilities
 - ↑ female midwives/doctors
 - Reproductive health education-C-sections, family planning
 - Incentives for hospital delivery (soap and basin)



Child Malnutrition

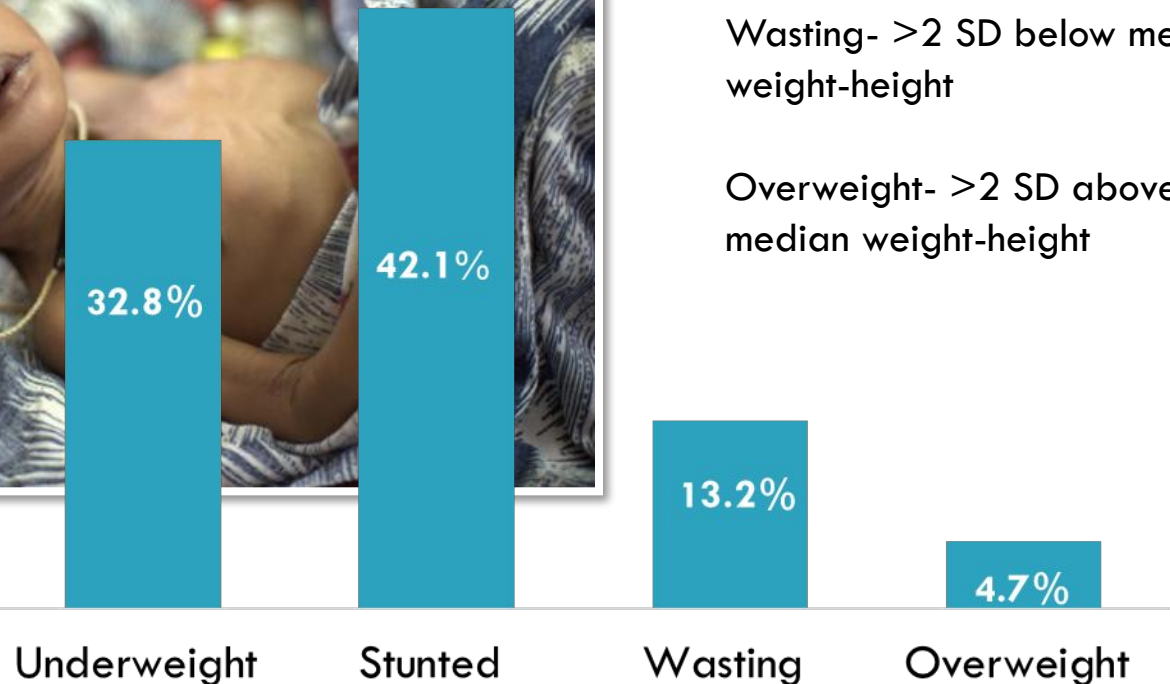


Underweight: >2 SD below median weight-age

Stunted: >2 SD below median height-age

Wasting- >2 SD below median weight-height

Overweight- >2 SD above median weight-height



Cholera

- Frequent outbreaks in refugee camps
- Causes:
 - Dehydration
 - Death
- Interventions:
 - Promotion of hygiene practices
 - ↑ chlorine levels
 - Oral rehydration

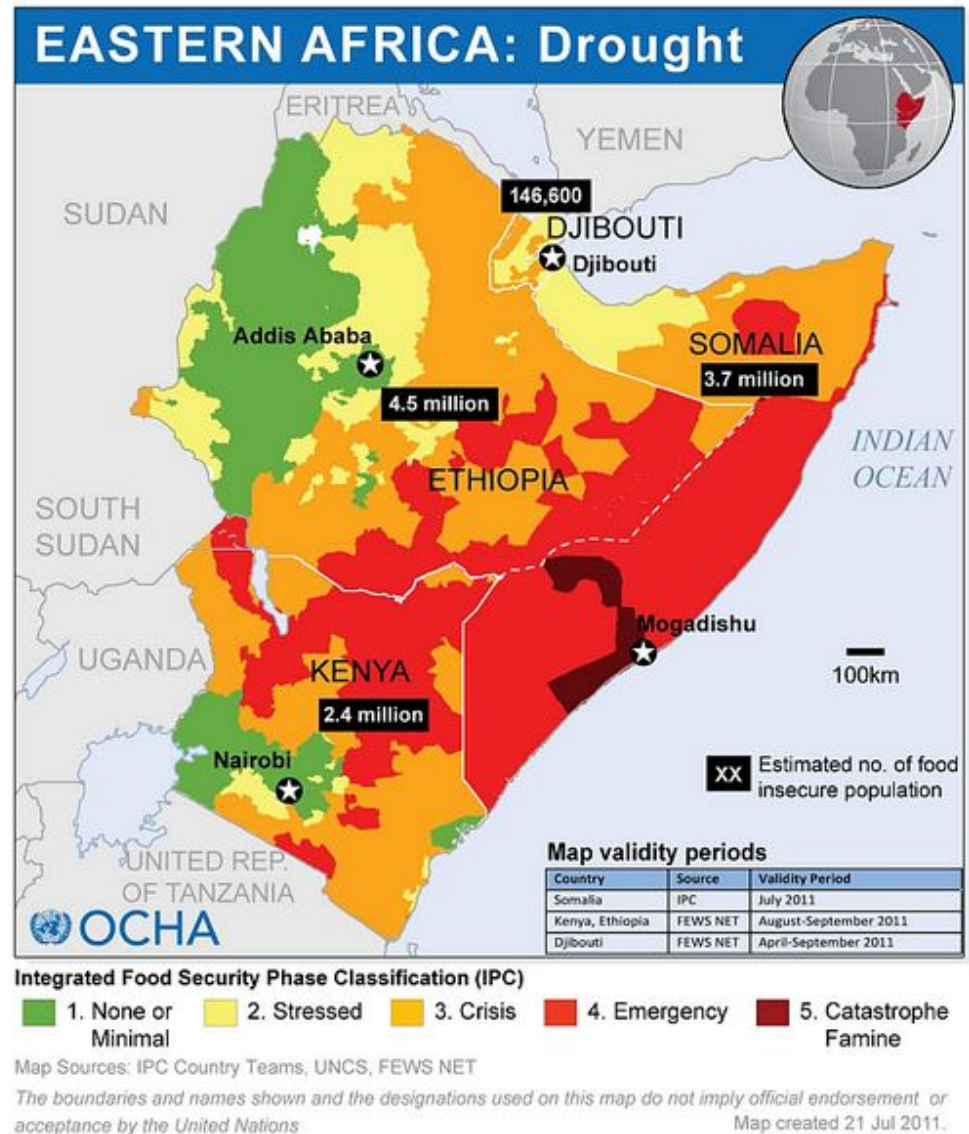


Source: www.WHO.int/countries/somalia;

<http://www.guardian.co.uk/global-development/2011/nov/17/cholera-outbreak-dadaab-refugee-complex>

Drought of 2011

- Worst in 60 years
- 3.7 million people facing starvation
- Malnutrition rate 50% (in some areas)
- Livestock death
 - 55% jobs
 - 80% export
 - 40% GDP

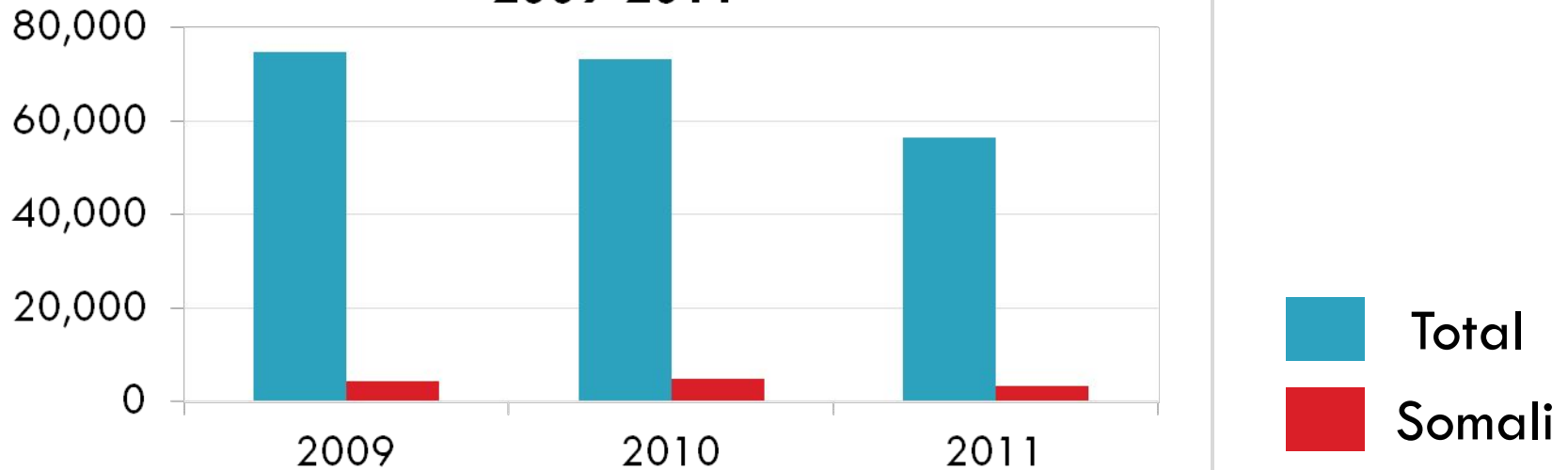


Refugee Resettlement

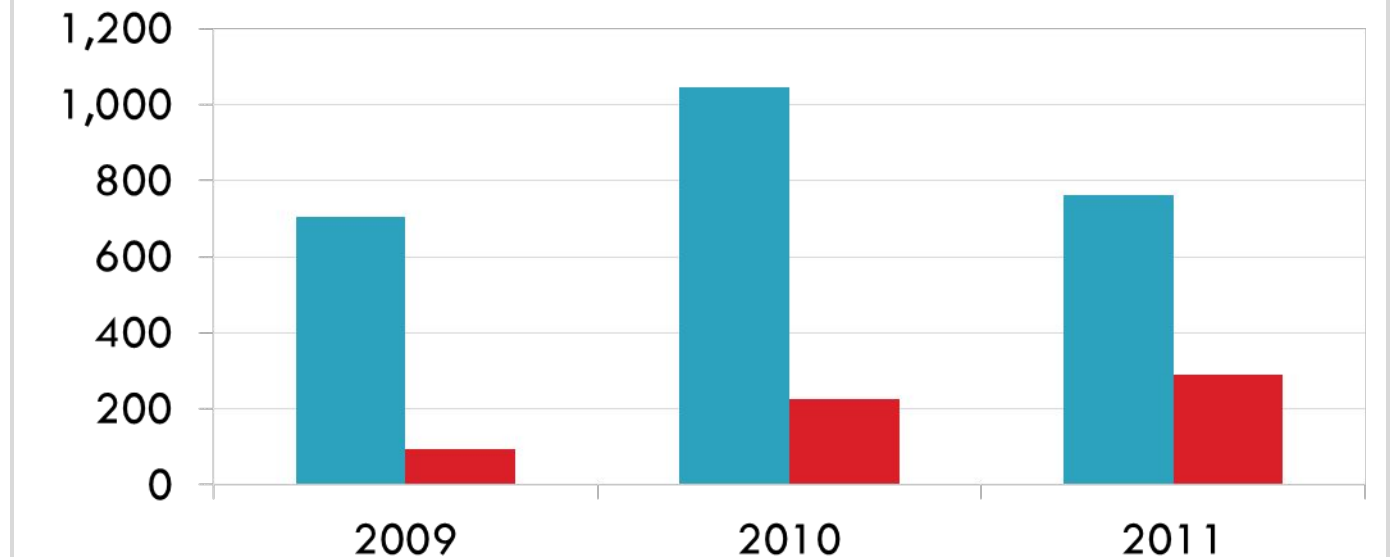
- 31% of refugees resettled-2009
 - ~15x higher than in 2002
 - 80,000 US
- Eligible refugees receive:
 - Single dose treatment for intestinal helminths
 - Treatment for Schistosomiasis
 - Malaria therapy



Resettled Refugees in United States- 2009-2011



Resettled Refugee in Oregon- 2009-2011



Analysis of Refugee-Associated Disease Prevalence and Utilization- 1994-1998

Jay Kravitz, MD, MPH- Staff Scientist, Global Health Center; Assistant Professor, Dept. of Public Health and Preventive Medicine, OHSU

David Balmer, MD, MPH-Medical Director for Quality Assurance, Willamette Valley Physicians Health Authority

Patricia Kullberg, MD, MPH-Former Medical Director, Multnomah County Health Dept.

Study Objectives

- Describe most commonly diagnosed conditions identified during screening and follow-up clinic visits
- Identify ethno-specific conditions warranting special attention
- Identify where services might be enhanced

Study Population



- July 1994-Oct 1998
- Cohort: 6,709 refugee patients
- Data pulled Multnomah County primary care (PC) clinics (18 settings)
- First 7 months of PC interaction

Utilization

- ~10.7 visits/person
 - Utilization 400% greater than typical patient
 - All expenses covered
- ~6% from Horn of Africa (N=434)
 - Others: Caribbean, W. Europe, SE Asia

Results

Health Condition	Prevalence
TB	Latent 47%*; Active 0.7%
Skin condition	Scabies 8%; fungal 11%
Anemia	9%
HepB	3.7%
Intestinal parasites	14%

* Rates for all refugee groups

- Rates of Anemia highest in Horn of Africa groups

Results- cont

Health Condition	Prevalence
Type II Diabetes (40-60 yrs)	11.1%
Hypertension	9.8%
Dental Carries	41%

- Highest rates of type II diabetes among all groups
- Mental Health Conditions
 - Low rates of mental health
 - Under-reported?

Conclusions and Limitations

- ❑ In general, common diseases were common among refugee groups (exception: mental health)
- ❑ Limitations
 - ▢ Descriptive analysis only
 - ▢ Selection bias- “healthier immigrant effect”
 - ▢ Missclassification- collapse of ICD-9 codes
 - ▢ Only 3 diagnoses recorded
- ❑ Strengths
 - ▢ First look at the health of refugees served in Multco clinics
 - ▢ Identified that region-specific screening was not necessary

Special Thanks to:



James Gaudino, MD, MS, MPH, FACPM

Jay Kravitz, MD, MPH

David Balmer, MD, MPH

Patricia Kullberg, MD, MPH

SECTION 2

Community Norms

Views Regarding Healthcare

Medicine Model	World Health View	Approach to Healthcare
Cartesian European Euro-American	Allopathic A system of medicine that embraces all methods of proven treatments	•Repair by surgery •Treatment with drugs •Replacement of defective parts
Body and Forces of Nature African African-American Native American Hispanic Arab	Naturopathic Medical philosophy that believes there is a direct connection between the body and forces of nature.	•Acceptance (to the will of a supernatural entity. Like God or Allah) •Utilize treatments provided by nature such as herbal remedies. •Use of traditional healers
Whole Body Approach Asian Asian-American Polynesian Native American	Homeopathic Medical philosophy in which the person, not the disease, is treated. A healthy body is in a state of balance.	•Hot/cold theory •Traditional healers •Acupuncture

Source. www.healthstream.com

Role of religion and Health care beliefs

- All social norms, attitudes, customs, and gender role stem from Islamic traditions
- The five pillars of Islam:
 - Shahadah: witnessing of professing of faith
 - Salat: prayer five times a day
 - Zakah: Wealth (almsgiving)
 - Sawm: Fasting the month of Ramadan
 - Hajj: Pilgrimage to Makkah

Cultural Background

- ❑ **Operating definitions**
 - Illness-pain in the entire body
 - Mental health issues-Either crazy or not crazy
 - Health provider-Physician
- ❑ **Communication style**
 - Oral communication is preferred
- ❑ **Causality of health problems**
- ❑ **Treatments**

Causality of Health Problems

- By God or Allah
- Spirit Possession
- Evil Eye
- Curses
- Witchcraft
- Jinis
- Going to health care facility is for sick people
- When you are not sick, seeking preventive care is not part of the culture

Treatments of Health Problems

- Allah
- Koran
- Fire burning- “Disease and fire do not stay together in the same place” Somali proverb
- Religious healing
- Herbal medication

Social Values

- Independence
- Democracy
- Individualism
- Egalitarianism
- Generosity
- The Family-Family takes precedence over individual
- Family male member-as the head of family for medical decisions
- Touching is common in conversations

Health Care considerations

- Medications-if you do not prescribe a medication to your patient, explain why not
- Respect- establish a relationship with the Somali family before care begins
- Diseases- teach your patients about diet and exercise

Suggestions for health care providers

- Professionally trained interpreters-Consistently
- History and culture of patients country of origin
- Role of religion in health
- Cultural beliefs regarding causes and treatments of diseases
- Always check with your patients about their preferred language
- Kindly communicate with patients/clients why they need to be on time

Moving Towards Culturally Competent Health Care Practices

Somali/Somali Bantu Population

Toolkit

Respect	Greeting	Name	Birthdate	Modesty	Religion	Food	Decision Making	Family Members	Super natural Beliefs	Diseases	Mental Health	Medications	Medical Interpreters
Treat your Somali/Somali Bantu clients with Respect & Dignity. In healthcare, cultural competence means treating patients from different cultural backgrounds, as well as the elderly and indigent, in accordance with their unique cultural needs, beliefs and risk factors.	Remember that some Somali/Somali Bantu maintain Islamic traditional norms about handshaking - limiting physical contact to persons of the same sex. <u>Try using common cultural greetings, such as:</u> <i>IkaWaran (How are you in Somali).</i> <i>Habari yako (how are you in Swahili)</i> <i>Galab-Wanagsan- (Good afternoon in Somali)</i>	Ask your patients by what name they prefer to be addressed. All Somali names have three parts. The first name is the given name, the second name is the name of the child's father, and the third name is the name of the child's paternal grandfather. All children in a family have the same second and third names. Women do not change their name with marriage.	Be careful, many Somalis/Somali Bantus have the same birthdate, 01/01 plus the year. Regardless of whether you know your real birthdate or not, this is standardized birthdate that is given to most Somali/Somali Bantu refugees.	It is important to keep the Somali/Somali Bantu patient's body covered. Women cover all but the face, hands, and feet. Men cover the chest to the knees. This stems from the religion obligation of female and male dress codes. Hijab-is the Islamic female head covering	Somali/Somali Bantu people value their connection with God. All social customs, attitudes, values, and gender roles derive from Islamic tradition. Ramadan occurs each year, which is when Muslims fast from sunrise to sunset. Suggest that patients take their medications at night. Islam forbids pork, alcohol, or anything with pork or alcohol in it, including gelatin medications made of pork derivatives.	Islam forbids pork, alcohol, or anything with pork or alcohol in it, including gelatin medications made of pork derivatives. The Somali/Somali Bantu food is meal and Basmati rice driven. Drinking sweet tea is the common culture. Daily Meals are Breakfast, Lunch (which the largest meal) and Dinner. The general view is that overweight and obesity are signs of success, good health and happiness.	Health care decision usually involves the entire family. A male family member might act as the family spokesperson	Family takes precedence over individual	Evil Eye- which can be given to someone by the purposeful or accidental gaze from an envious or admiring eye. Fire-burning- Burning the sick part of the body with a special stick. Jini-Causes psychologic problems Herbal Medication Female circumcision	Diseases and medical conditions are caused by Allah. Some diseases are believed to be caused by people or spirits such as evil eye (excess praises) and curses	Do not typically speak of emotions. It is important to develop trust with Somali/Somali Bantu patients before speaking of mental health issues. The perception is: one is crazy or one is not crazy. Mental health problems are believed to be from Allah, evil eye, Jini/evil spirits), or curses from others and parents. For treatments of mental health issues, religious leaders and traditional healers are sought.	Be aware that Somalis/Somali Bantu expect prescriptions for medications when they go to a clinic. They prefer non generic prescriptions. Islam forbids pork, alcohol, or anything with pork or alcohol in it, including gelatin medications made of pork derivatives.	Use professionally trained interpreters. For trust building, use only one interpreter consistently Linguistic competency means being able to converse in a limited-English speaking patient/client's native tongue or having access to a qualified interpreter.

References

- <http://www.cdc.gov/tb/publications/guidestoolkits/EthnographicGuides/Somalia/chapters/chapter2.pdf>
- Lyn Morland, Bridging Refugee Youth & children's Services. Somali Bantu Refugees' Cultural Considerations for Social Services Providers
- Providing culturally-appropriate health care in Minnesota: Somali

References

- Ethnomed: <http://ethnomed.org>
 - Somali/Somali Bantu Cultural Profile
 - Somali Clinical Topics
 - Breastfeeding Support for Somali Mothers
 - Many more, i.e. hepatitis, depression, TB...
 - Somali Patient Education Handouts
 - Links to community organizations in WA

References

- CultureClues™

- <http://depts.washington.edu/pfes/CultureClues.htm>

- Prenatal Care of Patient with Female Circumcision:
Planning for Labor and Delivery (ppt)

- <http://www.fmdrl.org/index.cfm?event=c.getAttachment&riid=2151>

Articles

- Carroll, J., Epstein, R., Fiscella, K., Volpe, E., Diaz, K., Omar, S. Knowledge and beliefs about health promotion and preventive health care among Somali women in the United States. *Health Care for Women International*. 2007;28:360–380. doi:10.1080/07399330601179935
- Carroll, J., Epstein, R., Fiscella, K., Gipson, T., Volpe, E., Jean-Pierre, P. Caring for Somali women: implications for clinician-patient communication. *Patient Education and Counseling*. 2007;66:337–345. doi:10.1016/j.pec.2007.01.008
- Herrel, N., Olevitch, L., DuBois, D. K., Terry, P., Thorp, D., Kind, E., Said, A. Somali refugee women speak out about their needs for care during pregnancy and delivery. *Journal of Midwifery and Womens Health*. 2004;49:345–349. doi:10.1016/j.jmwh.2004.02.008
- Chalmers, B., Omer-Hashi, K. 432 Somali women's birth experiences in Canada after earlier female genital mutilation. *Birth*. 2000;27:227–234.

OHSU Library

- ❑ OHSU Resources for Oregon Health Professionals
 - ❑ www.ohsu.edu/xd/education/library/orhp.cfm
 - ❑ Free access to databases: PubMed, DynaMed, STAT!Ref, National Guideline Clearinghouse, DailyMed, EBSCO Medline, Ethnomed, MedlinePlus, NOAH, NIH SeniorHealth, and Caphis
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