Providing Culturally Appropriate Reproductive Health and Family Planning Services to Somali Immigrants and Refugees

A REFERENCE GUIDE

As of January 1, 2010 Minnesota International Health Volunteers (MIHV) changed its name to WellShare International. Please visit our new website: www.WellShareInternational.org
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Thank you to the Somali Child Spacing Program Advisory Committee and WellShare International staff for their assistance in developing this reference guide, their insight into the wishes and concerns of the Somali community, and their contributions to this document.

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INTRODUCTION

WellShare International

WellShare International works to improve the lives of women, children and their communities around the world. As a nonprofit organization based in Minneapolis, Minnesota, WellShare International operates community-based health programs in the United States and abroad.

Since its founding in 1979, WellShare International has designed, implemented and evaluated health projects in Africa, Asia, Latin America and the United States. It currently has international projects in Tanzania and Uganda, focusing on child survival, reproductive health, malaria control, and HIV/AIDS.

In 1997, WellShare International began to apply its global health experience to international communities in the United States, working to address health disparities in refugee and immigrant communities.

Somali Child Spacing Program

Since 2004, the Somali Child Spacing Program has been providing culturally sensitive reproductive health information and resources to the Somali community and the health care providers that serve them. To date, the program has:

- Conducted qualitative research to ensure program approaches are culturally appropriate and meet the needs of the community
- Distributed over 22,800 reproductive health educational materials to the Somali community and health care providers
- Reached an estimated 25,000 Somali immigrants and refugees with culturally sensitive information about family planning
- Trained nearly 1,200 health care providers and health professionals about Somali cultural and religious beliefs around reproductive health

Reference Guide

Since the beginning of WellShare International’s Somali Child Spacing Program, focus groups, advisory committee members and health care professionals have provided recommendations on how best to provide reproductive health and family planning services to the Somali community in the Twin Cities. These recommendations have resulted in the WellShare International Somali Health Calendar, Somali Decisions About Child Spacing booklet and video, Somali CycleBeads video and instructional insert, My Body: Human Reproductive Anatomy booklet, Our Health message campaign for Somali TV, in-service trainings, and multiple community education forums.
Health care providers and Somali community members encouraged WellShare International to create an easy-to-use reference guide for health professionals in order to improve cultural sensitivity, as well as improve the appropriateness of the care they provide. This reference guide opens with an introduction to concepts in culturally competent health care. It then provides background information on the Somali population in general and the Somali community in Minnesota. The guide also provides specific information on Somali reproductive health trends and beliefs, Somali adolescent reproductive health, greetings and gestures, and additional resources.

Disclaimer: This guide is meant to be an introduction to the Somali community. It is a compilation of lessons learned from WellShare International experience and research, including community input and review by the Somali Child Spacing Program Advisory Committee. Although there are many similarities in Somali lifestyle choices, religion, values and cultural beliefs, the Somali community is not homogenous. This guide does not attempt to characterize all Somali individuals as having similar beliefs.
Definition of cultural competency

The concept of cultural competency has gained a lot of attention over the last few years by policy makers, public health workers, and administrators as an approach to reduce ethnic health disparities. Potential underlying reasons for health disparities include the variation in patients’ beliefs, values, preferences, and behaviors that are influenced by their culture, the lack of preparation on part of the health care system and the lack of expertise on the part of providers.

There is not a single definition of cultural competency, but in general, it is described as a set of skills, attitudes, and knowledge that enhance cross-cultural communication and effective interaction with others. In the healthcare field, specifically, it is characterized by the ability of systems to tailor delivery of care to meet patients’ social, cultural, and linguistic needs. Health professionals can become more culturally competent by recognizing the impact that social and cultural factors have on patients’ beliefs and behaviors, and becoming aware of tools that enable them to address these factors. For instance, there is strong evidence that cultural competency trainings and interventions positively affect providers’ attitudes and skills.

In 2001, the U.S. Department of Health and Human Services’ Office of Minority Health issued national standards for culturally and linguistically appropriate services (CLAS) in health care. Their goal is that all patients “receive equitable and effective treatment in a culturally and linguistically appropriate manner.” A more extensive OMH definition of cultural competency is as follows:

A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

While these definitions help establish a common understanding of cultural competency, each community uniquely defines what cultural competency looks like on a daily basis. Some members of the Somali community may desire to have health care providers understand and respect their Somali culture, while other community members may want to fit into the U.S. system without any modifications.
Based on WellShare International’s research and discussions with Somali community members about what a culturally sensitive encounter would entail, the following key themes emerged:

■ Recognizing the importance of privacy, family members, and their support network

■ Matching the gender of the health care provider and the patient, when possible, especially when discussing sensitive topics such as breast cancer and family planning

■ Acknowledging the role of religion in health

■ Using some Somali words – either in a greeting or through bilingual materials

■ Having a Somali speaker and cultural liaison (such as a community health worker) to assist with communication between the provider and the patient

■ Acknowledging that some topics (e.g. sexuality and reproductive health) are often sensitive and in some cases taboo

The following pages aim to provide insight into Somali cultural beliefs and act as a first step towards improved cultural competency and understanding between health care providers and the Somali community.
BACKGROUND ON THE SOMALI COMMUNITY

Demographic overview

**Location:** Eastern Africa, bordering the Gulf of Aden and the Indian Ocean, east of Ethiopia

**Area:** Slightly smaller than Texas

**Population:** 9,558,666 (July 2008 est.)

**Capital:** Mogadishu

**Languages:** Somali (official), Arabic, Italian, English

**Religions:** Sunni Muslim

**Brief history of Somalia:** Somalia gained independence in 1960 from Britain and Italy. General Mohamed Siad Barre assumed power during a coup in 1969 and governed until his government was ousted in early 1991. Civil war broke out in 1991, mainly due to clan allegiances, land disputes, and competition for resources. United Nations humanitarian groups came to Somalia in 1992 to help alleviate the effects of natural disasters (famine, flood, and drought) and restore order; however, when they withdrew in 1995 for security reasons order still had not been restored. The Transitional Federal Government, established in 2004, is working towards writing a new constitution and creating a new representative government for elections in 2009. Since 2006, the transitional government has faced violent resistance from the Council of Islamic Courts (now disbanded) and other Islamic militant groups wanting to overthrow the transitional government.

**Climate:** Principally desert, December to February — northeast monsoon, moderate temperatures in north and very hot in south; May to October — southwest monsoon, scorching heat in the north and hot in the south, irregular rainfall, hot humid periods between monsoons

**Terrain:** Mostly flat with undulating plateau rising to hills in the north

**Natural hazards:** Recurring droughts; frequent dust storms over the eastern plains in the summer; floods during rainy season

**Environment:** Deforestation; overgrazing; soil erosion; desertification; famine; use of contaminated water contributes to health problems

**Infant mortality rate:** 111 deaths/1,000 live births (2008 est.) – 117 deaths/1,000 live births (Population Reference Bureau [PRB] 2008 estimate)

**Life expectancy at birth:** Total population: 49 years (2008 est.)
  - Male: 47 years (2008 est.)
  - Female: 51 years (2008 est.)

**Total fertility rate:** 6.6 children born/woman (2008 est.) – 6.7 children born/woman (PRB 2008 estimate)

**Literacy:** Total population: 38% (2001 est.)
  - Male: 50% (2001 est.)
  - Female: 26% (2001 est.)
Social structure

The traditional social structure in Somalia is based on extended family and clan groups. As a result, Somalis typically take great pride in their heritage and lineage and view the family as the ultimate source of personal security and identity. Somalis also tend to favor large families, with seven or more children common in a traditional Somali household. The average number of Somali children per family in Minnesota is 2.7. (This topic is expanded upon in the Reproductive Health Trends and Beliefs section.) The ongoing civil war in Somalia has had devastating effects on Somali families; as a result, many Somalis in Minnesota represent only small fragments of a once rich family network. Because many women were separated from their husbands during the civil war due to death, injury, or immigration reasons, approximately half of Somali families in Minnesota consist of mothers raising children on their own. Only about one in four Somali children in Minneapolis live with both parents. As the Somali community in Minnesota grows, these family relationships and clan affiliations are being reestablished.

Religion

The vast majority of Somalis worldwide (81% - 99%) are Sunni Muslim. Islam plays an important role in every aspect of Somali culture, making it difficult to distinguish between religion and culture. Muslims believe in a single God, “Allah,” who is the supreme power and in Muhammad as his most recent and greatest prophet. Islamic teachings are primarily drawn from the Quran (Koran), the Muslim holy book. Muslims follow the Five Pillars of Islam:

- Shahadah: the witnessing or profession of faith
- Salat: praying five times a day
- Zakat: wealth-cleansing or almsgiving (giving away 2.5% of assets and investments)
- Sawm (Ramadan): fasting during this holy month
- Hajj: making a pilgrimage to Mecca once in a lifetime if he/she can afford it

Other religious beliefs:

- Do no harm to others
- The importance of family and children
- Respect for elders
- Eating pork and drinking alcohol are forbidden
- Observance of prayers on Friday, the holy day (Yom al-Jumah)

Major religious holidays:

- Ramadan – one month of fasting from sun up to sun down (occurs during the ninth month of the Islamic calendar, which follows a lunar cycle)
- Eid al Fitr – “Breaking of the Fast” celebrates the end of Ramadan
- Eid al Adha – “Feast of Sacrifice” at the end of the Hajj, approx. 70 days after Ramadan
- Islamic New Year
- Birth of the Prophet Muhammad
- Ascension of the Prophet Muhammad
Gender Roles

Islam assigns men and elders (both male and female) to positions of high respect and gives them ultimate responsibility for family strength and unity as well as public affairs. Women are traditionally respected for their work in the home and are ultimately responsible for home management. In the Somali culture, women are valued for their “purity” and “piety”, and assume higher social status when they marry and have children. In the United States as a whole and in the state of Minnesota, these traditional roles are becoming less clearly defined as women and men alike take on the new roles necessary to survive in a foreign country (and as they are influenced by a more liberal American culture). One cultural note is that men and women do not usually change their last name when they get married. Everyone maintains a three part name: their given name (first name), father’s name, and paternal grandfather’s name. For example: Fatuma Ali Mohamed. Fatuma is the given name (first name), Ali is her father’s name, and Mohamed is her paternal grandfather’s name. Although some Somalis are modifying this tradition, most Somalis will not change their name when they get married. This explains why last names may not match between mother, father, and children.
Health care in Somalia

In Somalia, health care typically consists of both traditional healing and curative Western medicine. Traditional healing consists of three parts: 13, 17

- Religious treatment (i.e., reciting from the Quran)
- Traditional medicine (i.e., spiritual song and dance)
- Traditional practical treatment (i.e., fire burning, herbal remedies, massage, and bone setting)

For many people living in rural Somalia, the only accessible health care providers are traditional healers and midwives. Curative medicine is primarily practiced by trained nurses and doctors in urban clinics and hospitals owned and operated by the Somali government.

In Somalia, an individual typically does not seek curative care until he or she is significantly ill and has already tried traditional methods. Women typically do not seek clinical assistance unless they are seriously ill or in labor. Patients almost universally receive antibiotics or other forms of medication at such visits. Both the traditional and Western systems of healing in Somalia focus on the treatment of symptoms or disease versus prevention of the disease. 11 During hospitalization in Somalia, all health care services and prescription medications are free. 13, 18

Coming from a curative model of care presents a challenge to the relationship between Somali patients and health professionals in the United States, who come from a preventive model of care. Somalis may resist taking medicine when they are not experiencing symptoms or may quickly discontinue use at the onset of side effects to which they are not accustomed. Somalis who are recent arrivals to the United States are sometimes unfamiliar with the concepts of scheduled appointments, health insurance, follow-up visits, routine check-ups, and doctors’ visits that do not result in being given prescription medications. 11, 13 Table 1 summarizes the main differences between the health care systems in Somalia and the U.S.

<table>
<thead>
<tr>
<th>Table 1: Differences between Somali and U.S. health care systems 13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SOMALI HEALTH CARE SYSTEM</strong></td>
</tr>
<tr>
<td>Government owned/managed system</td>
</tr>
<tr>
<td>Centralized system</td>
</tr>
<tr>
<td>Focus on curative medicine</td>
</tr>
<tr>
<td>On-the-spot diagnosis &amp; treatment</td>
</tr>
<tr>
<td>Few diagnostic tests</td>
</tr>
<tr>
<td>Questions pertain to current illness</td>
</tr>
<tr>
<td>Medications usually prescribed</td>
</tr>
<tr>
<td>Prescriptions free while in hospital</td>
</tr>
<tr>
<td>Payment for services: low cost/free</td>
</tr>
<tr>
<td>No appointment necessary</td>
</tr>
<tr>
<td>Predictable waiting times</td>
</tr>
<tr>
<td>No forms to fill out: oral culture</td>
</tr>
<tr>
<td>No insurance needed</td>
</tr>
<tr>
<td>Spirituality acknowledged</td>
</tr>
</tbody>
</table>
Somali refugees first arrived to Minnesota in 1993 as a result of civil war in Somalia. Somalis have continued to arrive in Minnesota every year since 1993 either as their primary placement or due to secondary relocation.

Minnesota is home to the largest Somali population in the United States, with estimates ranging from 25,000 (MN State Demographic Center) to over 60,000 (community estimates). By triangulating data sources, WellShare International estimates that the number of Somalis in Minnesota is approximately 37,000. The number of “primary” refugees (foreign-born persons whose designated state of resettlement is Minnesota) is available through the state health department, but there is no system in place to account for “secondary” refugees (foreign-born persons whose designated state for resettlement is not Minnesota but who choose to move to Minnesota after arrival in the United States).

In 2000, 35% of all Somali primary refugees entering the U.S. resettled in Minnesota. Somalis were the fastest growing refugee group in Minnesota, constituting 54% of all primary refugee arrivals to the state in 2000. In recent years, the percentage of primary refugee arrivals to Minnesota, coming from Somalia, has varied from 32% (2004), 43% (2005), 68% (2006), and 40% (2007). As a result of this population influx, more Somalis now live in Minnesota than anywhere else outside of East Africa. Every year, the U.S. State Department determines the number and countries of origin for all refugees arriving in the United States.

**Statistics:**

- 60% of Somali speakers in the state live in Minneapolis
- There are also large numbers of Somalis living in Eden Prairie, Mankato, Marshall, Owatonna, Rochester, St. Cloud, and St. Paul
- Somali students make up the third largest group of non-English speaking students in Minneapolis schools. Longitudinal trends show that the number of Somali students is rapidly increasing in both urban and rural school districts.
- Approximately 12% - 25% of the Somali population in Minnesota is under 18 years of age
- Approximately 77% - 85% of the Somali population in Minnesota is between the ages of 18 and 40

**Table 2: Somali Refugee arrivals to the U.S. in 2007**

<table>
<thead>
<tr>
<th>AGE CATEGORY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5 years</td>
<td>7.9%</td>
</tr>
<tr>
<td>5-17 years</td>
<td>31.5%</td>
</tr>
<tr>
<td>18-64 years</td>
<td>65.6%</td>
</tr>
<tr>
<td>≥ 65 years</td>
<td>3%</td>
</tr>
</tbody>
</table>

*Note: Totals may exceed 100% due to overlapping age categories*
Community Strengths
The Somali population comes to Minnesota with strengths that contribute to the local community including:

Family oriented
Allegiance to one’s family — both immediate and extended family members — is strong in the Somali community. Members take care of each other and preserve the family’s social network. These close bonds have a ripple effect on health-seeking behaviors. For example, if a woman seeks prenatal care, her cousin might also seek prenatal care when she becomes pregnant.

Resilient
During the civil war, many Somalis lost family members, relatives, neighbors, and friends. Despite surviving a civil war and living in refugee camps, many Somalis have established themselves in the U.S. Well-educated Somali professionals face obstacles when they move to the U.S., especially since academic degrees and certificates earned in Somalia and overseas are not always accepted when applying for positions in the U.S. For example, doctors working in Somalia need to go through testing and an additional residency in the U.S. before they can practice here. Despite these obstacles, many professionals persevere and adjust to work and life in the U.S.

Entrepreneurs
Many Somali families have started their own businesses including restaurants, clothing stores, cell phone stores, bookstores, barber shops, cafes, travel agencies, grocery stores, and social service organizations. There are now established Somali shopping areas that provide space for socializing, education, and information sharing which foster a sense of community and provide strong community resources.

Community Concerns
The Somali community has concerns, like other refugee communities, about moving and adjusting to life in the United States. Main concerns, in no particular order, include:

- Finding a job
- Maintaining housing
- Figuring out how to pay bills
- Worry for family members back home and in other countries
- Navigating new surroundings (e.g., bus system)
- Mental health issues (e.g., managing culture shock and post-traumatic stress symptoms)
- Violence among youth
- Adjusting to a new health system (e.g., insurance cards, appointments, referrals)
- Reservations about using interpreters (e.g., concerns about confidentiality)
- Uncertainty about how to raise children to keep their culture in the U.S.

Some of these concerns may take priority over health needs and seeking health care services, especially among new arrivals.
Health needs

When Somalis initially arrive in the U.S. they may still experience ill health as a result of malaria, parasites, or other diseases that are prevalent in Africa. As the Somali community adjusts to life in Minnesota, however, they may begin to experience new health problems that did not exist in their home country, including chronic diseases such as diabetes, cardiovascular disease, obesity, vitamin D and calcium deficiencies, and new stresses. As previously mentioned, preventive care is new to this population since they come from a curative care model of health. As a result, the concept of health screenings (e.g., blood pressure checks, mammograms, pap test) is new to many individuals.

In Somalia, people were more physically active than they are here. Many people moved from a community where they walked everywhere to more crowded urban areas with minimal access to walking paths, and colder weather than they experienced in Somalia. An WellShare International community survey of nearly 300 Somali individuals found that only 18% of men and women met the Centers for Disease Control (CDC) recommendation that adults should engage in moderate physical activity five or more days a week. Also, 20% of women and 37% of men met the CDC recommendation to engage in three or more days per week of vigorous activity. This study found that people were not physically active due to lack of time and money, not feeling comfortable exercising in front of the opposite sex (for female respondents), and having no-one to exercise with.24

The typical Somali diet — high in starch, goat meat, and fried foods and low in vegetable and fruit consumption — does not meet recommendations from the U.S. Department of Agriculture.24 The local community has seen an increase in diabetes and obesity over the past several years, most likely as a result of the change in diet as well as a decrease in physical activity (D. Pryce, personal communication).

Barriers to accessing health care in the U.S.

Somalis encounter many barriers to appropriate and adequate health care in the U.S. These barriers are rooted in the complex differences between Somali and U.S. culture and health systems. Examples of barriers to health care include:

Provider-centered barriers

- Cultural differences: different perceptions of death and disease and definitions of “invasive procedures”25-27
- Social differences: different beliefs about age, gender, class, social structure, and communication dynamics; importance of family networks and support; different understanding of the interaction between lifestyle and health (e.g. poverty)26-28
- Religious differences: unfamiliar with the role of religion in health26-28
- Language differences: a lack of high quality interpreter programs was indentified as a major barrier in the provision of health care to immigrants and refugees in the Twin Cities29
- Concern about confidentiality, especially with interpreters
- Providers’ unfamiliarity with the traditional practice of female circumcision: providers in the United States are often unfamiliar with female circumcision and may lack the necessary knowledge to care for the circumcision during childbearing
- Frustration with the general lack of emotional support given by providers and lack of respect by clinic staff as well as front-line staff such as receptionists
- Perception by the Somali community that there is a great deal of misunderstanding about Somali culture on the part of the health providers
Environmental barriers

- Lack of knowledge about where to go for services
- Patients’ unfamiliarity with the U.S. health care insurance system
- Difficulty obtaining transportation to appointments
- Lack of childcare during appointments
- Limited or inconvenient hours at clinics
- Lack of educational resources in the community’s primary language and at the appropriate literacy level
- Low literacy rates: Upon first arrival, Somalis may lack the skills necessary to navigate the complex health care system in the US, especially the paperwork involved in many health services such as lengthy applications or bills from insurance companies
- Lack of other resources: economic, social, and educational

Recommendations to address barriers to accessing health care

The following list of recommendations attempts to address the barriers above. This list is not exhaustive.

Organizational level

- Diversify the organization’s leadership team to be representative of the patient population served (e.g., hire Somali practitioners and clinic staff at clinics that serve large Somali populations)
- Engage community leaders to help advise the organization
- Employ cultural liaisons, such as community health workers, to connect the Somali community with the health care system
- Educate all clinic staff (e.g., doctors, nurses, reception staff, volunteers, educators, administration) on cross-cultural communication skills

Structural level

- Develop or obtain culturally and linguistically appropriate health education materials
- If possible, adjust clinic hours to meet the needs of the community (e.g., evening or weekend clinic hours, or devoting half a day to a Somali clinic)
- Provide quality interpreter services; ensure that interpreters are knowledgeable about the topic being discussed with the patient
- If possible, provide comprehensive services (e.g., mental health services, employment and housing assistance, health insurance support) on site or be able to refer patients to comprehensive services
- Allow health care providers and staff to attend cultural competency trainings
- Match patient and provider genders as much as possible

Individual level

- Attend cultural competency trainings
- Learn more about the Somali culture through online resources, books, and community leaders
- Don’t be afraid to ask questions about Somali culture
- Allow extra time for questions and explanations during appointments
Historical social norms

Many Somalis are familiar with family planning from the campaigns conducted in Somalia by the Somali Ministry of Health, the Curriculum Development Center, the Women’s Education Center, the Somali Women’s Organization and the Somali Family Health Care Association (SFHCA). SFHCA was a non-governmental organization funded by USAID to work on family planning efforts and the eradication of female circumcision.

Somalia has a high fertility rate in part because the infant mortality rate is high and children contribute to the family’s livelihood (e.g. farmers, nomadic herders). In addition, there is an extensive social support network available when raising children in Somalia. The tradition of having many children is changing as couples move to the United States. Many families cite economic hardship as one of the primary reasons for keeping their family size smaller in the U.S. Living expenses and transportation costs are also much more expensive in the U.S. than in Somalia. In addition, couples are trying to learn English, obtain an education, and many are working more than one job. While these steps are necessary to achieve vocational and personal finance goals, these obligations limit time spent with their children. In addition, without extended family nearby to care for the children, couples have to seek out childcare, which can be very expensive.

When conducting reproductive health programs with the Somali community it is important to know that it is more culturally acceptable to use the phrase child spacing instead of family planning. As described in more detail below, family planning is largely interpreted as limiting the size of one’s family, which is religiously unacceptable. The terms “child spacing methods”, “family planning methods” and “contraceptive methods” will however be used interchangeably in the following sections.

Female Circumcision

Female circumcision, also known as female genital mutilation or female genital cutting, is a cultural practice, not a religious practice. While female circumcision is found among various religions, the practice actually predates both Christianity and Islam. Female circumcision is performed in many communities as a coming-of-age ritual. This procedure is also described by some as a violation of human rights since female circumcision has no health benefits and causes negative side effects. The practice is perpetuated by both men and women, although women tend to organize and conduct the procedure. Reasons for the continuation of female circumcision include the belief that: 30

- Men will only marry circumcised women
- A woman is only “clean” if she is circumcised (e.g., the “dirty” parts are removed)
- Female circumcision guarantees a woman’s virginity and fidelity
- The practice heightens male sexual pleasure
- A girl or woman must undergo the procedure in order to be accepted in the community, otherwise she will be marginalized

There are four types of female circumcision. Type I is clitoridectomy, which is partial or total removal of the clitoris. Type II is excision, which is the partial or total removal of the
clitoris and the labia minora. Type III is infibulation, which is a “narrowing of the vaginal opening through the creation of a covering seal … formed by cutting and repositioning the inner, and sometimes outer, labia, with or without removal of the clitoris.” Type III is the most severe form of female circumcision. Type IV includes all other harmful procedures to the female genitalia for non-medical purposes (e.g. pricking, piercing, scraping). The vast majority of women in Somalia (98%) are circumcised; 80% have had a Type III circumcision. Having a Type III circumcision makes it difficult for women to use the vaginal ring and female contraceptive barrier methods. Statistics for the percent of Somali women in the U.S. and MN who are circumcised is unknown, although community feedback suggests that female circumcision is less common among girls born in the U.S.

Unaltered external female genitalia
Type I female circumcision
Type II female circumcision
Type III female circumcision

Contraceptive usage and demographic trends
The most recent statistics on contraceptive use in the Somali population come from the Population Reference Bureau’s 2008 World Population Data Sheet. The document notes that among 18-45 year old married women, just 15% use any contraceptive method and only 1% use modern methods.

WellShare International conducted six focus groups in 2004 about child spacing in the Twin Cities Somali community. While the sample is not representative of the larger Somali community, 46% of focus group participants were using a form of birth control (e.g., pills, IUD, injection, male condoms).

Myths and fears about contraceptives
Focus groups conducted by WellShare International with the local Somali population demonstrate that there is a high prevalence of misinformation and fears about modern contraceptive methods. Some focus group participants believe that modern contraceptive methods cause infertility or birth defects, such as physical or mental handicaps. There are also fears about side effects, such as irregular bleeding, mood changes, weight gain, and discomfort. The largest concern is whether modern contraceptive methods are permissible in Islam, especially since the side effects are sometimes interpreted as “causing harm”. Religious opposition to and support for family planning methods are discussed below and outlined in Table 3.
<table>
<thead>
<tr>
<th>Islamic Opposition to Family Planning</th>
<th>Islamic Support for Family Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children are a gift from Allah. The Quran says children are “the decoration of life.”</td>
<td>Islam is a religion of moderation and scholars point to the principles of “liberty” or “permissibility” in Islam — that is, everything is lawful unless explicitly stated otherwise in the Quran or hadiths (Sunnah).</td>
</tr>
<tr>
<td>The number of children one has is in the hands of Allah, and anything that interferes with His will is haram (a sin).</td>
<td>The Quran emphasizes that Allah does not wish to burden believers. This suggests that the well-being of children is more important than simply having a large family. It also supports the use of child spacing to avoid health risks posed to mothers and children by frequent pregnancies.</td>
</tr>
<tr>
<td>Any practice that prevents pregnancy is infanticide, which is repeatedly condemned and prohibited in the Quran.</td>
<td>Verses in the Quran discuss the importance of maintaining family harmony; if a family has too many children, tranquility in domestic life could be compromised.</td>
</tr>
<tr>
<td>It is a Muslim’s duty to perpetuate the nation of Islam (Umma). Advocates believe that a large Muslim population is ordained by religion, and that failure to achieve it deviates from the right path.</td>
<td>The Prophet Muhammad practiced and encouraged a form of family planning, al’azl (withdrawal or coitus interruptus). By extension, many Somalis find natural family planning methods acceptable (e.g., Standard Days Method, exclusive breastfeeding, withdrawal). Some believe that barrier methods are also acceptable (e.g., condom) but hormonal methods are not as well-received because they interfere with a woman’s natural state/system and may cause side effects, which is sometimes viewed as undue harm.</td>
</tr>
<tr>
<td>Family planning contradicts the Islamic belief of tawakkul (reliance on Allah) and rizq (provision by Allah). It is believed that a Muslim must trust that Allah will provide for however many children one has.</td>
<td>Some scholars believe that modern methods are allowed by analogy, e.g., the Prophet Muhammad used what was available to him in his time, so Muslims today can use what is available to them now.</td>
</tr>
<tr>
<td>Belief in not doing harm to oneself or others. Sterilization (tubal ligation, vasectomy) is widely unacceptable in Islam because sterilization does “permanent harm” to a person</td>
<td>The Quran states that a child should be breastfed for two years, which gives greater acceptance for exclusive breastfeeding (lactation amenorrhea method)</td>
</tr>
<tr>
<td>Contraception is only a means – its results are still in the hands of Allah.</td>
<td></td>
</tr>
</tbody>
</table>
Preferred contraceptive methods

Natural, non-hormonal contraceptive methods are preferred by many Somali women and men as a way to address the concerns listed above. The most popular methods include Standard Days Method (CycleBeads), a natural family planning, calendar-based method that helps a woman track her fertile and non-fertile days; the copper IUD and male condoms. The vaginal ring and patch are not preferred by most Somali women. The ring is difficult to use for circumcised women and the patch is not favored due to religious reasons. Muslims conduct water-washing rituals before prayers or handling the Quran. This includes removing rings on your hands so that water touches every part of your skin. While washing your arms is an optional washing practice, the patch would prevent water from touching all parts of your arms; therefore, most Somali women prefer an alternative method.

WellShare International conducted a pilot study with forty-three Somali women about using CycleBeads. During follow-up visits women were very pleased with the method. Individuals who discontinued use did so because they no longer needed a contraceptive method, not because they were unhappy with the method or found it difficult to use. Out of the twenty-three follow-up visits, one woman became pregnant, which is a 4.3% pregnancy rate.34 This is consistent with rates found in research on correct use of CycleBeads (5% pregnancy rate).35 As a natural, non-hormonal method, CycleBeads are an acceptable contraceptive method.

Religious and cultural influences

It is often difficult to distinguish between religion and culture in the Somali community; however, both play a pivotal role in Somali views and decisions about family planning. Below are examples of Islamic opposition to and support for family planning.

Recommendations to promote reproductive health and family planning

- WellShare International’s Somali Child Spacing Program has been well-received by the Somali community because it promotes child spacing (family planning) from a health benefit perspective for the whole family.
- When describing the benefits of child spacing, begin with the benefits to the mother and follow with benefits to the father, child, family, and finally the larger community.36
- Child spacing is beneficial for the mother because it gives her time to regain her strength before becoming pregnant again. The mother is also able to fully provide nutrition and care for the child before having another baby.
- Child spacing is good for the father because it gives him more time to spend with his family, achieve his education goals, learn English, and become financially stable.
- Child spacing is good for the children because the first child will have more time to get the nutrition and care they need before a new baby comes. In this way, children will have more time to grow up healthy and help care for the other children. Children also benefit from more time with their mother and father.
- Child spacing is beneficial for the family because parents will be able to raise quality children in a tranquil environment.
- Child spacing is good for the community because if families have fewer children and raise them well then the children will be good citizens and contributors to the community rather than a burden.
Recommendations for counseling Somalis about contraceptive methods

- When providing reproductive health counseling, here are some questions you can ask:
- Do you have any children? How many children do you have?
- Are you hoping to become pregnant in the near future?
- How much time would you like between pregnancies?
- It is important to remember that there is usually no answer to the questions “What is your ideal family size?” or “How many children do you want?” because many Somalis believe the answer is determined by Allah.

If the client seems comfortable with the above questions, continue with:

- In your culture, do you have ways you can achieve the spacing you want between children?
- Would you like to know other ways to space your children?

When counseling a patient on different contraceptive methods, allow extra time to explain the methods and let the patient ask questions. Remember that there usually is a greater learning curve when Somali patients switch from the Somali curative model of care to the U.S. preventive model of care. Taking medicine when there are no symptoms or when they are not sick may be a new concept that needs extra explanation. Special emphasis should be placed on when to take the medicine, potential side effects, benefits, and who to contact with any questions. Health providers should encourage a follow-up appointment with the patient to allow time for additional questions, ensure continuity of method use, or determine a better suited method for the patient.
In 2007, WellShare International conducted key informant interviews with health educators and Somali youth, parents, and community leaders to:

- Better understand Somali cultural norms in discussing sexuality and reproductive health (SRH) at the household and community level
- Examine how Somali adolescents learn about sexuality and reproductive health (SRH)
- Identify assets and barriers in the Somali community for facilitating a dialogue with adolescents about SRH
- Identify strategies to successfully reach Somali adolescents with SRH information

This research forms the basis for the following section of the reference guide. A summary of results can be found on WellShare International’s website.

**Influences on knowledge and values**

Many things have an impact on Somali adolescent knowledge and values around sexuality and reproductive health (SRH), including:

- What parents say and don’t say
- Religion
- Culture
- Level of acculturation
- Media
- Friends

**Sources of information**

WellShare International’s research shows that there are discrepancies between where youth are currently receiving information and where youth prefer to receive information. There is also a disconnect between where Somali youth say they receive sexuality and reproductive health (SRH) information and where parents think their kids are getting SRH information (see Table 4). Although parents are one of the preferred sources of information for youth, many adults were not educated on the subject of SRH by their parents and therefore cannot provide the information their children desire. Low literacy levels may also impact a parent’s ability to participate in educational opportunities for their children.

**Knowledge levels**

Most health educators participating in key informant interviews indicated that Somali youth seem to be less knowledgeable about sexuality and reproductive health than their mainstream counterparts considering the basic anatomy questions Somali students ask. Health educators also pointed out that newcomers tend to have greater educational needs than more acculturated youth. As one female health educator said, “Compared to the mainstream, Somalis know very little, and compared to other newcomers, Somalis seem comparable or less knowledgeable. So they are at the very bottom rung of knowledge and understanding about sex and reproductive health.”
On the other hand, one health educator indicated that some Somali students were asking very graphic, detailed questions, which she felt implied they were engaging in risky sexual behavior.\textsuperscript{37}

**Cultural considerations**

Sexuality and reproductive health (SRH) is not typically openly discussed in the Somali community. It is often viewed as shameful, especially for women to discuss. When it is discussed, it is meant to be a private conversation between same gender individuals. One health educator described the situation as, “Somalis have strong, good beliefs around sexuality. But maybe some of their curiosity is suppressed – like it is not culturally acceptable to ask questions about this subject, so they try to avoid expressing interest in it.”\textsuperscript{37}

Religion is an underlying influence behind socio-cultural norms related to SRH. Islam strongly dictates that one should not have sex before marriage because sex outside of marriage is considered a sin. Many believe that discussing SRH before one is married implies sexual activity. While some individuals believe that Islam prohibits discussion about SRH, many people believe that it is acceptable to discuss SRH in specific circumstances or if an individual meets the criteria below:

- Married people
- Same gender
- Health reasons (e.g., STD prevention)
- Private settings

**Community support for educating youth about reproductive health**

There is strong community support for educating youth about sexuality and reproductive health and for discussing sexuality and reproductive health in the Somali community. As one male community leader explains, “It [SRH] is an important issue in the Somali community, like every other community. And I don’t think it is readily discussed in the community for various reasons. I feel there is an urgent need in educating the Somali community in terms of openly discussing and emphasizing it.”\textsuperscript{37}

Recommendations for health and sexuality classes with Somali students include:

- Separate students by gender for sensitive topics (e.g., anatomy, contraceptives). It is acceptable to have students together for classes that are not considered sensitive (e.g., decision making, assertiveness skills, dating)
- If it is not possible to separate students by gender for a class on a sensitive topic, then separate students by gender for small group activities.
- Obtain bilingual materials
- Translate letters for parents into Somali
- When sending letters or information to parents, include the English copy with the Somali translation. This way, if there is confusion about translated words they will have the English version to refer to for clarification.
- Parent communication is key
- Talk about Somali values: support for abstinence messages; concern about STDs, teen pregnancy, and media messages; strong community support to educate youth
- Do not include both parents and youth in the same class or program activities, parents should have their own class
Be sensitive to take-home activities that involve parents recounting their dating and adolescent experiences. Most Somali parents did not date when they were younger. Most marriages and relationships were arranged by their parents.

Values-based, abstinence-first approach that focuses on protecting health and fertility will likely be an acceptable program model to the Somali community.

The use of a healthy youth development model would address both youth’s needs and be culturally acceptable.

Modify activities in accordance with Somali culture and religion when possible.

Use cultural references and personal experiences.

When possible, time SRH units so they do not happen during Ramadan. It is not completely forbidden to talk about sexuality and reproductive health during Ramadan, but when individuals are fasting they try to avoid talking about unnecessary topics, which includes sexuality and reproductive health.

Refer to community resources, including religious leaders (imams), with questions or to request guest speakers.

In the Twin Cities, three resources on Somali culture include WellShare International (WellShare International), the Brian Coyle Community Center (Pillsbury United Communities) and the Confederation of Somali Community in Minnesota.

If you are not sure, don’t be afraid to ask.

Try to learn a few words in Somali.

Don’t change too much content — Somali youth have the right to the same information as everyone else.
### GREETINGS AND GESTURES

<table>
<thead>
<tr>
<th>English</th>
<th>Somali</th>
<th>Pronunciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome</td>
<td>Soo dhawoow</td>
<td>soh dah-woh</td>
</tr>
<tr>
<td>Good morning</td>
<td>Subax(h) Wanaagsan</td>
<td>soo-bahh wah-nahk-sahn</td>
</tr>
<tr>
<td>Good evening</td>
<td>Habeen Wanaagsan</td>
<td>ha-been wah-nahk-sahn</td>
</tr>
<tr>
<td>How can I help you?</td>
<td>Maxaan kuu qabtaa?</td>
<td>mah-hhan koo kahb-tah</td>
</tr>
<tr>
<td>How are you?</td>
<td>See tahay</td>
<td>say tah-high</td>
</tr>
<tr>
<td>Fine</td>
<td>Fiican</td>
<td>fee-ahn</td>
</tr>
<tr>
<td>Okay</td>
<td>Haye</td>
<td>high-ee-ay</td>
</tr>
<tr>
<td>Bad</td>
<td>Xun</td>
<td>hhoon</td>
</tr>
<tr>
<td>Yes</td>
<td>Haa</td>
<td>hah</td>
</tr>
<tr>
<td>No</td>
<td>Maya</td>
<td>ma-yah</td>
</tr>
<tr>
<td>Wait</td>
<td>Sug</td>
<td>soog</td>
</tr>
<tr>
<td>Thank you</td>
<td>Mahadsanid</td>
<td>mah-had-sah-need</td>
</tr>
<tr>
<td>You’re welcome</td>
<td>Adaa Mudan</td>
<td>ah-dah moo-dahn</td>
</tr>
</tbody>
</table>

In Muslim culture, shaking hands is often restricted to individuals of the same gender – men and women do not usually shake hands. If you are unsure about whether or not to shake hands, it is often best to ask if you may shake their hand or wait for the other person to extend their hand.

It is inappropriate to motion for someone to follow you or come towards you by using your pointer finger and bending it towards you, which is common in American culture. Using your pointer finger is how you call an animal, not a human. Instead, face the palm of your hand away from your body and bend your four fingers down repeatedly or face the palm of your hand towards you and bend two or more fingers down repeatedly.

The Somali language has a ‘throaty’ sound when spoken. In addition, the language is often spoken at a louder level than English. As a result, non-Somali speakers sometimes think that Somali speakers are arguing when in fact they may be having a normal conversation. It is better to ask about the conversation than to assume what is happening.
<table>
<thead>
<tr>
<th>Organizations</th>
<th>Description</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross Cultural Health Care Program</td>
<td>Lists cultural competency tools</td>
<td><a href="http://www.xculture.org/">http://www.xculture.org/</a></td>
</tr>
<tr>
<td>Cultural Orientation Resource Center</td>
<td>Provides a basic introduction to the people, history, and culture of Somalia in their booklet</td>
<td><a href="http://www.cal.org/co">http://www.cal.org/co</a></td>
</tr>
<tr>
<td>“The Somalis: Their history and culture.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CulturedMed</td>
<td>Lists available cross cultural training resources</td>
<td><a href="https://culturedmed.sunyit.edu">https://culturedmed.sunyit.edu</a></td>
</tr>
<tr>
<td>DiversityRx</td>
<td>Provides models and strategies to overcome linguistic and cultural barriers</td>
<td><a href="http://www.diversiryrx.org">http://www.diversiryrx.org</a></td>
</tr>
<tr>
<td>East Africa Health Project</td>
<td>Non-profit education, outreach, and advocacy organization in Minnesota</td>
<td><a href="http://www.eahpro.org">http://www.eahpro.org</a></td>
</tr>
<tr>
<td>EthnoMed</td>
<td>Provides patient education materials in various languages, plus medical and cultural information on immigrant and refugee groups</td>
<td><a href="http://ethnomed.org/">http://ethnomed.org/</a></td>
</tr>
<tr>
<td>IslamiCity.com</td>
<td>Contains information for people seeking knowledge and understanding of Islam, including a prayer time search feature</td>
<td><a href="http://www.islamicity.com">http://www.islamicity.com</a></td>
</tr>
<tr>
<td>Islamic Medical Association of North America</td>
<td>Contains educational materials on caring for Muslim patients</td>
<td><a href="http://www.imana.org">http://www.imana.org</a></td>
</tr>
<tr>
<td>Minnesota International Health Volunteers</td>
<td>Provides cultural trainings and bilingual health education materials</td>
<td><a href="http://www.mihv.org">http://www.mihv.org</a></td>
</tr>
<tr>
<td>National Center for Cultural Competence</td>
<td>Lists cultural competency resources, tools, assessments, and promising practices</td>
<td><a href="http://www11.georgetown.edu/research/gucchd/nccc/">http://www11.georgetown.edu/research/gucchd/nccc/</a></td>
</tr>
<tr>
<td>National Council on Interpreting in Health Care</td>
<td>Contains resources and guidelines for culturally competent health care interpreting</td>
<td><a href="http://www.ncihc.org">http://www.ncihc.org</a></td>
</tr>
<tr>
<td>North Carolina AHEC Digital Library: Minority Health Special Collection</td>
<td>Provides links to organizations, clinic tools, patient education materials, plus information on health disparities and refugee health</td>
<td><a href="http://library.ncahec.net/scMain.cfm?scid=44">http://library.ncahec.net/scMain.cfm?scid=44</a></td>
</tr>
<tr>
<td>Somali Medical Association of North America: List of providers</td>
<td>Lists Somali doctors, dentists, chiropractors, resident doctors, medical students, researchers, and health professionals*</td>
<td>Main website: <a href="http://www.somalimedicalassociationnorthamerica.com">http://www.somalimedicalassociationnorthamerica.com</a></td>
</tr>
<tr>
<td></td>
<td>*This is not an exhaustive list because professionals need to personally sign up</td>
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<tr>
<td></td>
<td>List of professionals: <a href="http://www.somalimedicalassociationnorthamerica.com/untitled1.html">http://www.somalimedicalassociationnorthamerica.com/untitled1.html</a></td>
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</tr>
<tr>
<td>Organizations (continued)</td>
<td>Description</td>
<td>Website</td>
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<tr>
<td>U.S. Department of Health and Human Services, the Office of Minority Health: National Standards on Culturally and Linguistically Appropriate Services (CLAS)</td>
<td>Contains recommendations for national standards to make practices more culturally and linguistically accessible</td>
<td><a href="http://www.omhrc.gov/clas">http://www.omhrc.gov/clas</a></td>
</tr>
<tr>
<td>University of Michigan Health System Program for Multicultural Health</td>
<td>Provides information and resources from the Muslim Patient Care Committee on cultural competency with Muslim Patients</td>
<td><a href="http://www.med.umich.edu/multicultural/ccp/index.htm">http://www.med.umich.edu/multicultural/ccp/index.htm</a></td>
</tr>
<tr>
<td>University of Washington Medical Center Cultural Clues</td>
<td>Provides a tip sheet on working with the Somali population</td>
<td><a href="http://depts.washington.edu/pfes/CultureClues.htm">http://depts.washington.edu/pfes/CultureClues.htm</a></td>
</tr>
</tbody>
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<thead>
<tr>
<th>Tools</th>
<th>Description</th>
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</tr>
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<tbody>
<tr>
<td>Speaking Together Toolkit</td>
<td>Provides advice to hospitals on improving quality and accessibility of language services.</td>
<td><a href="http://www.rwjf.org/qualityequality/product.jsp?id=29653">http://www.rwjf.org/qualityequality/product.jsp?id=29653</a></td>
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<thead>
<tr>
<th>Somali Mosques</th>
<th>Address</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Twin Cities, MN)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abubakar as-Saddique Islamic Center &amp; Mosque</td>
<td>2824 13th Ave S Minneapolis, MN 55407</td>
<td>Tel: 612-872-4009 Website: <a href="http://www.abuubakar.org">www.abuubakar.org</a> <a href="mailto:aaic@abuubakar.org">aaic@abuubakar.org</a></td>
</tr>
<tr>
<td>Dar Al-Hijrah Islamic Center</td>
<td>504 Cedar Ave S Minneapolis, MN 55454</td>
<td>Tel: 612-339-4235 Fax: 612-332-9250 Website: <a href="http://www.daralhijrah.com">www.daralhijrah.com</a> <a href="mailto:info@daralhijrah.com">info@daralhijrah.com</a></td>
</tr>
<tr>
<td>Dar Al-Farooq Mosque</td>
<td>983 17th Ave SE Minneapolis, MN 55414</td>
<td>Tel: 612-331-1234 Fax: 612-331-8888 Website: <a href="http://www.daralfoorq.org">www.daralfoorq.org</a> <a href="mailto:mailing@daralfoorq.org">mailing@daralfoorq.org</a></td>
</tr>
<tr>
<td>Masjid Dawah (Minnesota Dawah Institute)</td>
<td>478 University Ave St. Paul, MN 55103</td>
<td>Tel: 651-224-6722 Fax: 651-224-2726 Website: <a href="http://www.mndawah.net">www.mndawah.net</a> <a href="mailto:info@mndawah.net">info@mndawah.net</a></td>
</tr>
<tr>
<td>Masjid Omar Ibn-Alkhattab (24 Mall)</td>
<td>912 E 24th St Minneapolis, MN 55403</td>
<td>Tel: 612-423-6746 <a href="mailto:abuusaalix@hotmail.com">abuusaalix@hotmail.com</a></td>
</tr>
<tr>
<td>Umatul Islam Center</td>
<td>3015 2nd Ave S Minneapolis, MN 55408</td>
<td>Tel: 612-825-1678 <a href="mailto:univer.124@hotmail.com">univer.124@hotmail.com</a></td>
</tr>
</tbody>
</table>
REFERENCES


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