THE TANDEM PROJECT
http://www.tandemproject.com.

UNITED NATIONS, HUMAN RIGHTS,
FREEDOM OF RELIGION OR BELIEF

The Tandem Project is a UN NGO in Special Consultative Status with the Economic and Social Council of the United Nations

Separation of Religion or Belief and State

SOMALIA TO MINNEAPOLIS:

FOREIGN WAYS & WAR SCARS TEST HOSPITAL

Article in the Sunday New York Times, *Foreign Ways and War Scars Test Hospital* by Denise Grady, 29 March, 2009. This is an article on Somalia and Minneapolis. It demonstrates the challenge of a model local-national-international integrated approach to freedom of religion or belief, in a city with a rapidly developing cultural complexity.

March 29, 2009

Somalia to Minneapolis - Foreign Ways and War Scars Test Hospital

By DENISE GRADY

MINNEAPOLIS — The man from Somalia sat nervously in an examining room at Hennepin County Medical Center, gingerly brushing his fingertips against the left side of his head.

"You're having surgery to remove shrapnel from your skull," Dr. Steven Hillson told him, pausing to let a Somali interpreter dressed in a black head scarf and a floor-length skirt translate.

The patient, Abdulqadir Jiirow, 31, nodded and explained that the shrapnel had been there since 1991, when he was 14 and civil war broke out in Somalia and an artillery shell smashed into his home. It had not bothered him much until recently, when he began to work at a meat-packing plant and the helmet and goggles needed for the job pressed on it painfully.

Mr. Jiirow said he worked in a small town several hours away and shared an apartment with other Somalis, while his wife and child lived in Minneapolis. He saw them on weekends.

"It's still astonishing," the doctor, shaking his head, said after Mr. Jiirow left. " 'Someone sent artillery into my home.' But it's common."

Hennepin County Medical Center, a sprawling complex in downtown Minneapolis near the Metrodome, offers an extraordinary vantage point on the ways immigrants are testing the American medical establishment. The new arrivals — many fleeing repression, war, genocide or grinding poverty — bring distinctive patterns of illness and injury and cultural beliefs about life, death, sickness and health.

In a city where Swedes and Norwegians once had separate hospitals, Hennepin spends $3 million a year on interpreters fluent in 50 languages to communicate effectively with its foreign-born patients.

Many arrive with health problems seldom seen in this country — vitamin deficiencies, intestinal parasites and infectious diseases like tuberculosis, for instance — and unusually high levels of emotional trauma and stress. Over time, as they pick up Western habits, some develop Western ailments, too, like obesity, diabetes and heart disease, and yet they often question the unfamiliar lifelong treatments these chronic diseases need.

Some also resist conventional medical wisdom or practices, forcing change on the hospital. The objections of Somali women to having babies delivered by male doctors has led Hennepin, gradually, to develop an obstetrical staff made up almost entirely of women.

Doctors here say that for many of these newcomers, the most common health problems, and the hardest to treat, lie at the blurry line between body and mind, where emotional scars from troubled pasts may surface as physical illness, pain and depression.

“Being an immigrant, it will be a chronic illness for the rest of your life,” said Dr. Veronica Svetaz, a physician from Argentina who works at one of Hennepin’s neighborhood clinics. “You don’t belong anywhere anymore.”

From Far-Flung Countries

Like many American cities, Minneapolis has seen a tremendous influx of Hispanics, many of them here illegally from Ecuador and Mexico. Hispanics, both legal and illegal, make up the biggest immigrant group in the state, as well as in the nation.

But since the late 1970s, this once lily-white city on the prairie, frozen solid half the year, has also been taking in waves of legal refugees from more far-flung parts of the world: Vietnam, Cambodia, Laos, Russia, Bosnia and Herzegovina, Liberia, Ethiopia, Somalia, Myanmar and other countries.

So many people came here from war zones that a nonprofit group opened the nation's first Center for Victims of Torture in Minneapolis in 1987. Statewide, the number of foreign-born people more than doubled in the 1990s and is nearly a quarter million now. They make up 5 percent of the population.

The influx from Somalia has been especially large. A million people fled the country when civil war broke out. Many spent years in squalid, disease-ridden refugee camps or shantytowns in Ethiopia or Kenya.

The lucky ones, granted refugee status, started arriving in the United States in the mid-1990s. Many were relocated to Minneapolis by the State Department because of the city's strong social services and its many civic groups that help newcomers. There are an estimated 35,000 to 40,000 Somalis in Minnesota, most in Minneapolis, more than in any other American city. But the exact number is not known because refugees are not tracked when they move from state to state. Some officials and Somalis themselves think the figure is much higher than the state estimates, perhaps even double.

"Nobody can count us," said Dr. Osman Harare, a physician and public health official in Somalia who became a patient advocate and interpreter at Hennepin. "We are nomads."

The community is thriving, though it is not without troubles. The F.B.I. has been investigating whether young Somali men in Minneapolis have been recruited to commit acts of terrorism in Somalia, and health officials have been looking into reports of unusually high rates of autism in the children of Somali immigrants.

A 446-bed public hospital, Hennepin has a tradition of turning no one away, and it has become the first stop for many immigrants who need a doctor.

No questions are asked about immigration status. About 20 percent of the center's patients were born in other countries, and they account for $100 million of its $500 million yearly expenses for patient care. Hennepin's interpreters are called on to help patients more than 130,000 times a year. The greatest demand by far is for Spanish, followed by Somali.

One of the challenges in treating immigrants is money. Hennepin has $45 million a year in costs that are not reimbursed, and though immigrants by no means account for all of it, they are "a major contributor," said Mike Harristhal, the hospital's vice president for public policy and strategy.

Most Somalis are in this country legally and qualify for various government health insurance programs. For people here illegally, it is a whole other story. They used to be eligible for Medicaid, but are not anymore, except for emergencies or if they are pregnant or under 18. Hennepin has sliding-scale fees for the indigent, but some cannot afford even those prices.

Minnesota has its share of people who oppose immigration and resent footing the bills for foreigners, and Mr. Harristhal acknowledged that the melting-pot atmosphere at Hennepin drives some potential customers away. But the hospital is a renowned trauma center; even those who turn up their noses at the clientele accept that for someone in a car accident, there is no better place to be.

Complex Needs at the Clinic

Much of Hennepin's work with immigrants takes place in a stretch of examining rooms and offices on the seventh floor, which has become an international health clinic with certain days set aside for various ethnic groups.

On a Tuesday afternoon last fall, a 62-year-old woman from Somalia made her first visit to the clinic. Initially, she was exuberant, speaking so rapidly that an interpreter could barely keep up.

"I love this big government hospital, the same government that welcomed me here after the war and the sadness of Somalia," she said, beaming at Deborah Boehm, a nurse practitioner. "Your face welcomes me."

The patient's broad smile showed gaps in her teeth. She wore a traditional Muslim head scarf, a floor-length skirt in bright blue and purple, flip-flops and a gauzy, pale aqua shawl over a sweatshirt. Her fingernails were tinted orange with henna.

She had a dozen bottles of pills from other clinics in the Twin Cities, and a long list of ailments: arthritis, digestive trouble, allergies, insomnia and, worst of all, pain. Twice in recent months she had gone to the emergency room for terrible aches in her legs and burning pain in her side.

Ms. Boehm said she would order a blood test to measure vitamin D, because deficiencies are common in Somalis and are a frequent cause of aches and pains. (Aching all over is not uncommon among Somalis, and older people sometimes tell doctors they feel as if camels or horses have been walking on them all night.)

The body uses sunlight to make vitamin D, and dark-skinned people make less than whites. Somali women are especially prone to deficiencies because their traditional clothing covers so much of their skin.

The patient said she sometimes could not recall how many of her children were still alive. The forgetfulness had begun when she left Africa and all the problems there.

Ms. Boehm, 56, with short, curly hair and glasses, looked at the patient intently as she took notes and said, "Haa," the Somali word for yes. "Tell me about the problems."

The woman's face crumpled. She rocked in her seat, choked out a few words, then bit her hand and wiped her eyes with her shawl.

The translation, "Don't remind me," was unneeded.

Ms. Boehm calmly changed the subject to matters of digestion and a local supermarket that sold camel's milk.

Later, Ms. Boehm predicted that much of her new patient's physical trouble would turn out to have emotional roots in Somalia. Anguish morphing into physical pain and depression is something Ms. Boehm has seen time and again in treating Somali refugees.

Ms. Boehm began working with Somali women at the clinic in 1997, and her job quickly became complicated.

"I began to hear about the pain," Ms. Boehm said. "I couldn't find any reason for it. They would say it felt like fire or electricity, descriptions I wasn't familiar with. I did X-rays, lab tests, ordered physical therapy. Somehow, I just couldn't get it to go away. After 6 to 12 months I said, 'We have to look at the mental health piece.' "

At her urging, the clinic brought in a psychologist, and Ms. Boehm said, "I aggressively worked on getting these women into therapy."

Dr. Mary Bradmiller, the psychologist, said the rates of depression and post traumatic stress disorder were high. Most of her Somali patients are mothers with "tremendous psychosocial stress, domestic violence, child protection issues, war trauma, nightmares, flashbacks and separation from their families," Dr. Bradmiller said.

A study of 1,134 Somali and Eritrean refugees in the United States in 2004 found that 25 percent of the men and 47 percent of the women had been tortured, rates that the researchers considered shockingly high. The torture of women frequently involves rape.

Survivors often resist psychological help and deny their problems. Somali culture, like many others, stigmatizes mental illness. In Somalia, mental troubles are often attributed to spirit possession, and psychotherapy barely exists. “They might have talked to a sheik or an imam or a female healer,” Dr. Bradmiller said.

She has deliberately kept an office in the medical clinic, a familiar place to patients, so they do not feel as if they are going to a mental hospital. The director of care for the Somalis, Dr. Douglas Pryce, and Ms. Boehm urge certain patients to see Dr. Bradmiller and sometimes even walk them down the hall to make sure they go.

“They never come for therapy unless there’s a strong recommendation from a medical person they trust,” Dr. Bradmiller said.

Still, it has not been easy. Early on, she noticed insulted looks on patients’ faces when her role was being explained and found out that some interpreters were calling her the “crazy doctor.” Other interpreters laughed at what patients said.

Indeed, Dr. Bradmiller said, some therapists have left the clinic because of their struggles with interpreters. Now, she introduces herself as a “talk therapist” and chooses interpreters carefully.

“Some patients have completely checked out,” Dr. Bradmiller said. “The older children are bringing up the younger ones, and the mother doesn’t leave the house.”

If patients reach the point of talking about what happened to them in Somalia or at the refugee camps, it has to be handled carefully to prevent their being traumatized all over again, Dr. Bradmiller said.

The patients’ stories may also bring back the interpreters’ horrific memories, so Dr. Bradmiller has tried to find the interpreters who are the least vulnerable.

“I try not to digest what is being said so it doesn’t affect me,” said one, Abdi Rahmansali. “I try my best, but I’m a human being. I do get affected. Sometimes, no matter how hard you try, you feel your hair standing up.”

Dr. Bradmiller estimated that about only 10 percent of her patients saw the connection between their physical and emotional pain.

But for those who do, she said, the changes can be striking.

“They go to school, they cook, they put on makeup and colorful clothes, they start talking to you in English,” she said. “When life becomes more interesting than therapy, it’s time for therapy to be done.”

Home Health in Question

On an afternoon in late September, Dr. Pryce and Dr. Harare, the interpreter and patient advocate, emerged from an examining room looking tired but wryly triumphant.

They had just finished negotiating, politely but persistently, with a patient who — just as politely but persistently — had refused to allow any blood tests because it was the holy month of Ramadan and he feared that having blood drawn might be a sin.

Finally, they telephoned an imam, who declared there was no sin. The blood was drawn.

Dr. Pryce says one of the great joys of working in a hospital like Hennepin is finding ways to bridge such cultural divides — and knowing that his patients are better off because of it. But the cultural challenges can cut both ways, he said, and lately one issue has begun to grate on him and Ms. Boehm.

Somali patients have been asking them to fill out forms stating that they need personal-care assistants. Some do not need the help, Dr. Pryce said, but are being egged on by Somali-run health care agencies that want to collect insurance payments for the services.

Somalis in Minneapolis, often entrepreneurial and business minded, have opened the agencies to take advantage of relatively generous rules in Minnesota that were originally meant to help keep the elderly and chronically ill out of nursing homes.

Tricia Alvarado, director of home care for the Minnesota Visiting Nurse Agency, which evaluates requests for home help, agreed that there had been an explosion of Somali agencies, with 100 or so opening in just the last three years. Many are run by people without any medical training. And Ms. Alvarado confirmed that the agencies were putting a hard sell on potential clients.

“ ‘Diabetes?’ ” Dr. Pryce said, relaying what he said was a typical conversation between a sick Somali and a Somali-run agency. “ ‘You need a personal-care assistant. Here’s a form. Give it to your doctor.’ ”

Dr. Pryce turns down requests that he thinks are unwarranted, but patients argue and sometimes even act sicker than they really are.

The whole thing leaves him “hopping mad,” Dr. Pryce said. “I want to be a good steward of our resources, the tax money we’re all paying.”

The same thing happened with Russian immigrants in the 1990s, he said, even though state regulations were stricter then.

The current situation with the Somalis is part of a larger problem in Minnesota: the number of clients, and the costs of personal care, more than doubled from 2002 to 2008, and the number of agencies more than tripled. A report in January by the state legislative auditor said, “Personal care services remain unacceptably vulnerable to fraud and abuse”; the state is drawing up plans to tighten its control of the services.

“I love the Somali people and their culture,” Dr. Pryce said. “I like taking care of them. It’s rewarding and interesting. They don’t drink, they don’t smoke much, they’re living the American dream, they need our help. Then you have this other side that’s really painful, this contentious issue of who gets what.”

The Tandem Project a non-governmental organization (NGO) founded in 1986 to build understanding, tolerance, and respect for diversity of religion or belief, and to prevent discrimination in matters relating to freedom of religion or belief. The Tandem Project has sponsored multiple conferences, curricula, reference material and programs on Article 18 of the International Covenant on Civil and Political Rights- Everyone shall have the right to freedom of thought, conscience and religion – and the 1981 United Nations Declaration on the Elimination of All Forms of Intolerance and Discrimination Based on Religion or Belief.

** In 1968 the United Nations deferred work on a legally-binding treaty on religious intolerance as too complex and sensitive and passed a non-binding declaration in its place. The Tandem Project believes until a core legally-binding human rights Convention on Freedom of Religion or Belief is adopted international human rights law will be incomplete. It may be time to begin to consider reinstating the 1968 Working Group to better organize and bring all matters relating to freedom of religion or belief under one banner, a core international human rights legally-binding treaty.*