STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Cultural Wellness Perspectives on Mental Health and Disability: Supporting Immigrants and Refugees in Iowa

The purpose of this handout is to accompany a competency-based training held on 7/17/2023. Resources were either created by or gathered by Lutheran Services in Iowa for the purposes of this training and are not a product of Iowa Medicaid. This information was gathered to assist direct support professionals and agencies to serve and support refugees in Iowa.

Resources to assist with serving refugee populations:

LSI Handouts – Diet and Food Practice Guides (linked below):

- Bhutan - Diet and Food Practices of Nepali-speaking Bhutanese Refugees
- Burma/Myanmar – Diet and Nutrition of Burmese Refugees
- Burundi – Diet and Food Practices of Burundian Refugees
- Democratic Republic of Congo – Diet and Food Practices of Congolese Refugees
- Ethiopia – Diet and Food Practices of Ethiopian Refugees
- Iraq – Diet and Food Practices of Iraqi Refugees
- Syria – Diet and Food Practices of Syrian Refugees

Tips to Consider in your Work with Refugees

Working with Interpreters – Best Practices

Psychological Treatment of Ethnic Minority Populations

SOUTH SUDANESE REFUGEES
FOOD AND CULTURAL PRACTICE

South Sudan is the youngest country in Africa that gained its independence on July 9th 2011, from North Sudan after 22 years of civil war. South Sudan is bordered by five countries, North Sudan, Ethiopia, Kenya, Uganda, Democratic Republic of the Congo, and Central Africa Republic. Throughout history South Sudan has been home to many ethnic groups (tribes) for centuries. According to the Worldometer reported in 2021, the current population is around 11.06 million. The South Sudan people are also known as Nilotic, meaning related to the Nile River or to the Nile region in Africa. Nilotic people spoke many languages, believed in different rituals and religions before the Europeans and Islamic groups colonized Sudan. European people converted native South Sudanese people to Christianity from the traditional beliefs and rituals. Islamic people converted North Sudanese to Islamic beliefs again from the traditional beliefs and rituals.

History

The history starts with Nubia, meaning land of Black. Nubia was seized by Britain and Egypt and after 135 years of ruling by Anglo- Egyptian government and 56 years of ruling by the British government (Strnad, 2002, p. 431). Nubia was granted independence in 1956 and renamed Sudan. Due to different religious beliefs, power struggle, and unjust resource distributions practiced with the northern government, the southern militias rebelled to northern government policy. The retaliation escalated to racial tension and generated social gaps between Christian's from the South and Islamic from the North. In terms of the power imbalance, Northern government (Islamic) perceived and claimed superiority over the Southern government (Christianity) and forced social policies that provoked the Southern citizens to continue to rebel. In 1983, the Northern government promoted Sharia Law as part of its overall policy to the Islamic belief to all people in Sudan. The South region that has been dominated by Christian and Animists retaliated by forming the Sudan People Liberation Army (SPLA) (Frontline/World, 2005). The conflict between South and North Sudan had roughly claimed two million lives and displaced four million people to the neighboring countries. As a result of years of conflicts South Sudanese people gained their independence July 9th, 2011 and resettled back into their region. They were able to continue their culture's practices, such as herding their livestock and engaging in ancient rituals and their belief in Christianity.

South Sudanese Belief/Religions

In South Sudan, the majority of the people believe in Christianity, while nineteen percent still follow traditional beliefs (Animism) and six percent identify as Muslim. Religions in South Sudan

form the foundation s of life and contribute to the improvement of social bonds within communities. In social aspects during the civil war in the country, South Sudanese viewed religion as the unifying factor to help them to overcome the struggle (Sawe, 2017). "South Sudan respects and upholds the freedom of the religion" (Sawe, 2017, para .1).

Food and Diet

South Sudanese refugees have a specific diet. They mostly consume sorghum and maize. They include yams, potatoes, and vegetables, legumes (beans, lentils, and peanuts). Meat (goat, mutton, chicken and fish) in their diet also. Fresh vegetables are grown for the rainy seasons plus other crops. In South Sudanese's traditions, they rarely slaughter animals for meat. They raise their animals for marriages and other bargaining trades. Their main sources of protein are fish and consume plenty of milk. Lunch and dinner are the most common meals. Breakfast is on occasion: such as finger millet porridge with yogurt; Fenugreek porridge (Madeeda hilba), Black tea and tea mixed with milk and eaten with bread. South Sudanese are not savvy on snacking, but Men do gather around during the evening hours to drink tea. The main spices and herbs of South Sudanese cuisine cannot survive without these five main ingredients such as Coriander (Kuzbara), Cumin (Shamar), Black pepper (Filfil), Cinnamon (Girfa), and Cardamom (Habbahan). These spices are considered to be the most important spices in both South Sudan and North Sudan cooking.

There are strict gender roles. South Sudanese Women are usually expected to prepare the food and Men wait to eat. A South Sudanese Father's role is to work and provide the Family's basic needs. South Sudanese value relationships, Family meals together and assisting one another when help is needed. Children help their Families, girls assist their Mothers in the kitchen and boys serve a similar role as Father.

Refugee Diet

South Sudanese that are settled in Des Moines, some had lived in Kenya, Kakuma refugee camps and Ethiopia, Pugnido refugee camp, etc. According to interviews with individuals at the local South Sudanese' church events and Prospect Park, they spent five to twenty years in camps before they were relocated to the United States. The main diet that they recalled was maize, sorghum, oil, lentils, and beans that the High Commissioner for Refugees (UNHCR) had provided. The diet choices were limited and lack of job opportunities in refugee camps had constricted incomes. The World Food Program stated (2017) the Kakuma camp refugee's nutrition situation is serious and inadequate diets in refugee camps remains concerning.

Resettlement and diet changes

Despite an improvement in the nutrition and awareness of healthy food, the South Sudanese refugees who are settled in the Des Moines area are heavily reliant on mixed diets. They serve varieties of dishes, which are similar to their traditional dishes. Their recipes include (molokhia) eggplants, chevon, chicken, and fish etc. And different spices and herbs; that they can purchase from our local J&K African store in Des Moines. The store sells a variety of South Sudanese stuff, such as clothes, foods, and jewelry.

In addition, there are plenty of choices that individuals South Sudanese can choose from. Also, few shop at the groceries stores like Walmart, Sam Club, and Target in the Des Moines area. Although some may not be fluent in English, they get help from their children that are fluent in English. Additionally, some use common sense and purchase things they are familiar with and omit certain things. South Sudanese refugee families exclude shellfish seafood in their menu, namely such as crab meat, lobster, and cockle etc. Native South Sudanese do not favor pork in their diet; pigs are seen as unclean animals. The younger generations or generations born in the United States seem to have a different view and are willing to try anything including pork.

Food security/ insecurity:

Some South Sudanese refugee families receive government assistance, such as food stamps, WIC and other benefits. Unsurprisingly, South Sudanese refugee families in Des Moines still enacted the mindset of having several children. Some families range from four to seven children. Although both parents are working, their incomes would not sustain such a large family. Additionally, South Sudanese kinship is important. Families living together with their grandchildren, cousins and extended relatives is common. Also, South Sudanese refugee families have family members in their home country that they support. The financial constraint in South Sudanese refugee families consequently interfere with family' functions. The prolonged Civil War that has been occurring in their home country positions every South Sudanese family into food insecurity, including those who are relocated in the Des Moines area.

Physical Activity:

South Sudanese refugee families that came to Des Moines as adults are foreigners to American lifestyle. They are unfamiliar with the gym or weight room. They continue doing similar routes they are familiar with, such as walking or working around their houses and spending time with friends. Since some adults are illiterate in English, they hold occupations that require a physical demand such as factory jobs and custodian jobs. Some South Sudanese adults have relatives or friends to assist with transportations but still take public buses that require individuals to walk. Also, the diet they are consuming is healthy and they rarely eat fast food. They continue to prepare their traditional food.

Concern on Diet:

South Sudanese youth that came or were born in Des Moines often prefer American foods and few struggle with their weight. The high calories consumption and lack of physical activity has prevalence to the high cholesterol and higher blood sugar. As one South Sudanese stated, "The children do not listen to their parents and they are making irrational choices." Particularly, the young adults are indicated more rejecting the food their parents cooked and rather have processed foods. Also, these young adults are engaging in delinquency behaviors like alcohol, drugs, and neighborhood gangs. Consuming unhealthy foods is contributing to health concerns (Interview, 6 people, Des Moines, July 20, 2021). The obesity among South Sudanese youths is alarming but some are overweight according to the interviewees. The prevalence of diabetes and related risk factors among South Sudanese refugee adults no data is available.

Mental health: prospect work

Mental health among South Sudanese families is concerning. According to Adaku et. Al (2016) study, the mental health among South Sudanese refugees had risen due to the existing warfare in their country. The South Sudanese refugee families in Des Moines are devastated as those still in their home country. Many South Sudanese refugee families have past trauma, specifically those who came as adults. The precarious news of the current Civil War and hearing of losing loved ones or relatives triggering their past experiences. As a result, secondary trauma stress plays a crucial role in some behaviors that exist in South Sudanese refugee families. Sadly, South Sudanese families sparsely acknowledge mental health for whatsoever. Families may be aware of the love one struggles mentally, but nothing much they can do about it. Their culture and society perceived mental health as a lack of being punished. The stigma emanated from lived experiences in the past and rooted into dysfunctional families.

According to my interactions with some South Sudanese refugee adults who settled in Des Moines, Iowa, some had mentioned, "It is challenging in many ways to settle in a new environment, the language barrier, culture and other social morality. Adults like ourselves, we cannot even connect with our children and express our feelings in the way they can understand. Language barrier is negatively hurting families, children are wild as some of the adults. They learn English and blend into the American culture without making moral choices." (Interview, 3 people, Des Moines, March 12 , 2020). Those characteristics could be initially a culture shock to many South Sudanese refugee adults, while in American culture, family matters are solved in the form of individualism.

Medicines and treatment practice

Traditional medicine has remained as the most reasonable source of treatment of several diseases and microbial infection through centuries. The elders and most knowledgeable persons collected different herbs, and plants to treat different infections. The traditional medicines include leaves, roots, and neem leafs (Azadirachta indica) that have been used to treat various symptoms, such as malaria, fever and jaundice and other mores.

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DIET AND FOOD PRACTICES OF ERITREAN REFUGEES

Eritrean refugee context

Eritrea is an East African country in the Horn of Africa. It is about the size of the state of Mississippi. Sudan, Ethiopia, Djibouti, and the Red Sea border Eritrea. For thirty years, Eritrea fought for independence from Ethiopia. The Eritrea-Ethiopia border remains disputed. Groups of Eritreans have fled the country due to ongoing conflict with Ethiopia and living conditions in Eritrea.

The Tigrinya are the majority ethnic group. They often live in urban settings and are educated. Many of the Tigrinya refugees flee Eritrea to avoid harsh compulsory conscription into the Eritrean army. The Kunama are a minority ethnic group in Eritrea. They are marginalized and live in rural areas near the Ethiopian border. Many Kunama refugees flee Eritrea to escape persecution by the government. Third country resettlement for Eritrean refugees living in refugee camps is the only option. Anyone returning to Eritrea faces persecution and local integration is impossible due to the political tensions between Eritrea and Ethiopia (COR).

Religion and food

The most prevalent religions in Eritrea are Christianity, Islam, and indigenous religions. Tigrinya are mostly members of the Eritrean Orthodox (Coptic) Church. Of the Kunama refugees processed for resettlement, the majority are Catholic or Protestant. A minority of Kunama are Muslim. Some Kunama from rural regions practice an indigenous monotheistic religion and follow other religions that are not well understood or studied. Educated Kunama and those from more metropolitan areas are typically Christian (COR).

Many Eritreans who are Muslim or Orthodox (Coptic) Christian do not eat pork or pork products. Regardless of religious affiliation, the majority of Kunama do not eat pork or pork products (COR). Muslim Eritreans may follow halal, specific dietary guides in the Qur'an. The Qur'an also discourages drinking alcohol and smoking.

Fasting is also an important spiritual practice for many Eritreans. Fasting practices vary among Christian denominations. In Orthodox Christianity, a specific sect of Christianity, fasting is a common spiritual practice. Generally, fasting in this religious tradition means abstaining from food and drink until a certain time of day. A fast in the Orthodox tradition is typically broken some time in the afternoon (McGaugin). A vegan diet may be followed during this fast. Some Orthodox Christians may eat fish during a fast (McGuagin). Much of how often a person fasts and what they will or will not eat is highly specific to that individual.

Ramadan is the main fasting period in Islam. For the month of Ramadan, a person does not eat while the sun is up. A person will only eat before sunrise or after sunset. Eid al-Fitr is the final day of Ramadan. People may feast on certain foods to celebrate the end of Ramadan.

Nutrition pre-resettlement

Eritrean refugees living in camps receive monthly rations from the United Nations World Food Program. They receive a monthly ration of legumes, lentils or peas, wheat cereal, vegetable oil, sugar, and salt. Many refugees report that the rations do not last the entire month. Some sell part or all of their rations for cash. This money can be used for various household expenses. The Ethiopian government prohibits camp residents from working. The only work available to Eritrean refugees is within the camp grounds. The lack of income limits access to food and other household needs (COR).

Micronutrient deficiencies are a concern for refugees living in camps. In some refugee camps in Ethiopia anemia and vitamin A deficiencies are common among long term residents. These deficiencies are associated with malnutrition and a lack of diversity in diet (Seal).

Characteristic Eritrean diet

Traditionally, Eritrean meals revolve around a carbohydrate and stews. Eritrean food is often compared to Ethiopian food because Eritrea was once a part of Ethiopia. There are a few ways that Eritrean food is distinct from Ethiopian food. One is the amount of spice used in food. Eritrean food is often thought to be less spiced than Ethiopian food. Another difference is that seafood is incorporated in Eritrean food because of the coast line (McGuigan).

Common ingredients:

Proteins:
Beef, lamb, goat, chicken, lentils, chickpeas, fava beans

Vegetables:
Green pepper, mustard greens, spinach, collard greens, tomatoes, carrots, cabbage, iceberg lettuce

Fruits:
Banana, mango, orange, papaya

Beverages:
Coffee, tea, honey wine, homemade beer

Breakfast is often served early in the morning. Pancakes, porridge, and yogurt are frequently served at breakfast. Leftovers from previous evenings may also be served at breakfast. Lunch is the main family meal of the day and the largest meal. For both lunch and dinner stewed meats, pulses, or vegetables in spiced sauces and flatbreads are served.

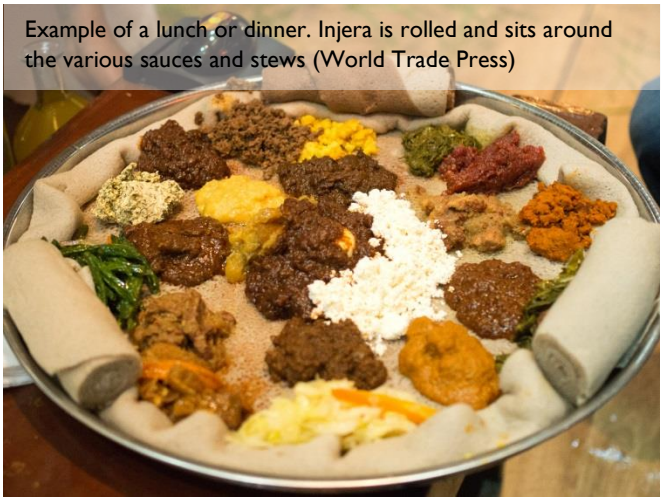
Coffee and tea may be drunk throughout the days. Sweet breads may accompany coffee or tea. Coffee and tea breaks are a time for Eritreans to socialize and have a respite from work. Homemade beer may also be drunk at mealtimes (World Trade Press).

Characteristic dishes:

- Injera: flatbread made from a grain indigenous to the Horn of Africa
- Genfo: porridge made from barley or wheat flour
- Kitfo: raw, ground beef mixed with spiced butter
- Aib: soft cheese similar to cottage cheese
- Niter kibbeh (Amharic) or kibe (Tigrinya): spiced butter used for cooking

Post-resettlement diet and health concerns

Upon resettling in the United States, many Eritrean refugees alter their diet. Ingredients commonly used in Eritrean dishes may be substituted with other ingredients. Teff, the key ingredient in injera and other bread products, is one ingredient frequently inaccessible in the U.S. A bag of teff is more expensive than other flours and grains. It is also not widely available. The grain is known to be highly nutritious. It is much higher in fiber and a more complex carbohydrate than other refined flours. Pancake mix and other more refined flours are reportedly used in place of teff (McGuigan).



Example of a lunch or dinner. Injera is rolled and sits around the various sauces and stews (World Trade Press)

Other diet changes include adding new foods and drinks. Sugar sweetened beverages like soda pop and fruit juice are popular. A group of Eritrean refugees in Seattle report to drink energy drinks in lieu of coffee and tea (McGuigan).

In an Australian study of refugees from Eritrea, Ethiopia, Somalia, and Sudan interviewees recognized diet changes and lifestyle changes since resettling in Australia. Parents said children seemed to not care for traditional foods, choosing instead more Western foods like pizza and fried chicken. Older refugees and parents believed traditional food was healthier but due to time and expenses, fast food and other Western foods were easier to feed children and the family. Children of refugees however believed that traditional foods were less healthy because of the oil and because vegetables were always cooked. Parents and children in the study believed that school played an important factor in diet changes. Both parents and children felt pressure to eat Western foods and enjoy school lunch rather than packing cultural foods (Wilson).

Chronic diseases like hypertension and diabetes are common among the elderly Eritrean population because of advancing age. There is also a rise in diabetes rates among younger generations. The Australian study found that refugees associated diet acculturation and lifestyle changes with diabetes, heart disease, and hypertension risks. One Eritrean mother in the study cited that after resettlement she and other family members are not as active because they have a car to drive places. Additionally, living in an apartment or a small house with no backyard or little green space was cited as "why people get diabetes" (Wilson).

Portion sizes are a concern and may contribute to a person being overweight or obese. Traditional Eritrean meals are served in communal plates and dishes. These plates and dishes may be continually refilled throughout the meal. Gauging portion sizes is difficult based on this eating practice (McGuigan).

Sources

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"Country Primers on Disabilities"

A Resource for Providers Working with Refugees and Immigrants with Disabilities

See more at PADDC Grantee Announces Release of Provider Resources: Country Primers on Disabilites | Pennsylvania Developmental Disabilities Council.

This resource highlights country background and resources for refugees and immigrants with disabilities in their country of origin. Specific to the countries of **Afghanistan**, **Bhutan**, **Democratic Republic of the Congo**, **Iraq**, **Mexico**, **Myanmar**, **Pakistan**, and **Syria**, these resources focus on what education and services were available to people with disabilities in that country, and the stigma associated with having a disability in that culture. The intent of the resource is to educate providers working with refugees and immigrants with disabilities.

These resources can be found on **Nationalities Service Center's website** or from the **document section of the PADDC website**.

Questions about the resources or about the grant project working to improve the lives of immigrants and refugees with disabilities can be directed to Christina Kubica, Refugee Health and INSPIRE Program Manager, at **ckubica@nscphila.org**.

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WELLNESS COUNTRY GUIDES | NPCT – GULF COAST JFCS (GULFCOASTJEWISHFAMILYANDCOMMUNITYSERVICES.ORG)

Refugee Wellness Country Guides

These guides provide practical insights and everyday applications for resettlement workers and mental health providers working with resettled refugees. They offer brief overviews of each country, highlighting current healthcare systems, common perceptions and responses to adverse mental health symptoms, and typical community support networks.

- BURMA/MYANMAR ROHINGYA and references (October 2017)
- SYRIAN ARAB REPUBLIC/SYRIA (March 2017)
- BURMA/MYANMAR (July 2016)
- DEMOCRATIC REPUBLIC OF CONGO/DRC (November 2016)
- FEDERAL REPUBLIC OF SOMALIA/SOMALIA (March 2016)

Country Condition Reports

These reports provide historical timelines, brief descriptions of common methods of torture, and synopses of current conditions and pertinent issues related to each country featured (each report has an updated timeline as of August 2015).

- AFGHANISTAN (August 2021)
- BHUTAN (July 2011)
- BURMA (May 2010)
- CENTRAL AFRICAN REPUBLIC (June 2015)
- COLOMBIA (June 2010)
- CUBA (July 2011)
- DEMOCRATIC REPUBLIC OF THE CONGO
- EL SALVADOR (May 2015)
- ERITREA (September 2013)
- HAITI (June 2013)
- HONDURAS (January 2015)
- IRAQ (July 2011)
- ISLAMIC REPUBLIC OF IRAN (August 2015)
- RUSSIA (December 2013)
- SOMALIA (February 2013)
- SOUTH SUDAN (April 2015)
- SUDAN (August 2014)
- SYRIA (March 2012)

Additional resources can be found on the Gulf Cost JFCS website:

Information Guides | NPCT - Gulf Coast JFCS (gulfcoastjewishfamilyandcommunityservices.org)

SOMALI REFUGEE MENTAL HEALTH CULTURAL PROFILE

Somali MH Profile.pdf

Author(s): Jacob A. Bentley; Christine Wilson Owens
Contributor(s): Zeba Ahmad; Somali Community Services of Seattle
Reviewer(s): Mohamed Ali Roble; Bria Chakofsky-Lewy; Lorin Boynton; Anab Abdullahi; Salma Musa
Date Authored: November 1, 2008

Methods
Medical interpreters, healthcare providers, and community respondents were recruited to other information about depression, anxiety, and posttraumatic stress disorder (PTSD) within the Somali refugee community; and to share knowledge of common Somali beliefs about mental illness, traditional treatment approaches, and advice for healthcare providers working with this population. Six interpreters and seven providers (including psychiatrists, counselor and primary care physicians) were interviewed individually, and two group discussions were held with elders from the Somali community in Seattle. A review of the existing literature, and web search, were conducted. In November 2008 a small group of Somali caseworkers, interpreters, health and mental health care providers gathered to discuss mental health care issues of concern for Somalis, including Somali youth. Notes from that meeting are incorporated here as well.

Introduction to Somali Mental Health Profile
According to the United Nations Refugee Agency, Somali refugees and asylum seekers comprise one of the fastest growing populations seeking international amnesty. As of the end of 2006, approximately 460,000 Somali individuals were displaced into the international community, representing an 18% increase in prevalence from one year prior (UNHCR, 2007). Somali refugees represented the highest number of initial claims for asylum (about 45,600) with Yemen and Kenya among the foremost destinations for Somalis seeking refuge in 2006. Over the past decade and a half, about 2 million Somali refugees have fled that country to seek asylum elsewhere (Bhui et al., 2006). Given the rising prevalence of Somalis within the overall refugee population, health care providers need to become familiar with Somali perceptions and cultural understandings of both physical and mental health conditions. Somalis need to understand the new system of health care and what services are provided in the United States.

RELATED MATERIALS IN THE REPORT

Somali Refugee Mental Health Cultural Profile – Literature Update

Somali Mental Health

Somali Depression Profile