Migration and Transnational Health Care: Connecting Finland and Somaliland

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The article connects research findings regarding key dimensions of in-Finland care for Somali patients with findings regarding treatments sought by transnational migrants in Somaliland. Finnish physicians do not possess an accurate picture of the extent to which Somali patients rely upon, or do not utilize, traditional approaches and transnational healing. Transnational networks offer an important resource for an ill Somali migrant, both practically and as a source of hope. However, Somali patients typically are silent about transnational healing experiences and Western physicians do not normally show interest in nonbiomedical resources and sources of resiliency. Western health-care providers need to approach each patient's lived world in a holistic manner with transnational imagination, appreciation, and augmentation.

In our era of global mobility, health outcomes increasingly are influenced by the interplay of transnational practices.[1] At the same time that new arrivers are adapting to life in receiving countries, they remain connected with sending countries and social relationships. Moves often result in "*multi*-placement" in addition to *dis*placement (Olwig and Sorensen, 2002, 5). With mobility comes expanded opportunities for creative mixing.

Researchers have found that the health-care practices of migrants are complex and multidimensional, including receiving-society treatments that rely on biomedical approaches; traditional remedies that newcomers bring along with them; imported medications and nutritional products; overseas advice transmitted electronically, by phone, and by traveling intermediaries (Tiilikainen, 2006, 10); the invocation of distant rituals and blessings (Tiilikainen, 2006, 9); and consulting across borders with trusted healers, including via physical return to one's country of origin. Although migrant care seekers are known to combine several of these health-care approaches,[2] researchers and providers have tended to treat each practice in isolation from the others. In particular, links between receiving-society treatment and return to the country of origin are underdeveloped in the physical and mental health-care literature (see, for instance, Murphy and Mahalingam, 2004, 169).

In this article, we aim to address the methodological challenges inherent in studies of transnational health care by connecting research findings regarding key dimensions of in-Finland care for Somali patients with findings regarding treatments sought by transnational migrants in Somaliland (northern Somalia).[3] Although a coordinated research design would be advantageous for such a comparative exploration, we will be linking research findings from independently designed projects undertaken by a political scientist and an anthropologist.[4] Emerging from this novel collaboration is a rich picture of contemporary transnational health care.[5]

Somali Transnational Migrants in Finland

Migrants from Somalia, mainly male asylum seekers, started arriving in Finland in the 1990s. Later, a higher proportion of Somali women and children came as a result of the state's family-reunification policy. At the end of 2005, 8,593 native Somali speakers lived in Finland (*Statistics Finland*, 20.9.2006). In Finland, Somalis constitute the largest group of migrants of African origin and the largest Muslim group.

Recent research has highlighted the importance of transnational migration. Transnational

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processes, including moves back and forth across borders, are "anchored in and transcend one or more nation-states" (Levitt, 2001, 14). Many migrants remain actively connected to people and institutions in their countries of origin (Yin and Koehn, 2006). Instead of breaking all ties with their country of origin, some individuals who settle in new places "are keeping their feet in both worlds" (Levitt, 2001, 3). Their transnational social fields include health-related conversations and activities. To advance understanding regarding the impact of transnational embeddedness, therefore, "scholars must conscientiously patrol the border between the culture of health and well-being as understood by migrants and the host society's culture of medicine" (Kraut, 2006, 106).

Transnational connections offer a potentially valuable resource for people in spatial transition (Portes, 2001, 189). For instance, the everyday life challenges faced by Somalis in Finland, particularly women, often are addressed by reference to transnational family networks (Tiilikainen, 2003a). While there are no firm estimates regarding the number of Somali transnational migrants who cross borders annually, a substantial number are observed to visit their place of origin, sometimes frequently, to consult healers and for other reasons (Tiilikainen, 2006, 9; Alitolppa-Niitamo, 2004, 44, 126).

At the same time that Somali transnational migrants engage in health-related practices that involve actual or virtual border crossings, they maintain interactions with medical professionals in Finland and other resettlement countries. In this article, we explore key interfaces of health-care in transnational contexts by linking research findings from two separate studies.[6] First, we consider the perspectives of Somali patients and Finnish care-providers regarding critical dimensions of health care in the receiving-society context. Then, we consider the treatments sought by transnational patients in Somaliland and their expressed reasons for seeking care in the place of origin. The concluding discussion considers how embeddedness in cross-border health-care networks serves as a special resource among transnational migrants.

In-Finland Health Care: Patients and Providers

Koehn's study explored migrant perspectives on health care received in Finland. He interviewed adult asylum seekers at five reception centres and resident foreign nationals living in Helsinki and Joensuu. Fourteen of the 93 patients in this study identified Somalia as their country of origin. The focus of this article is on the orientations and assessments of these eight males and six females.[7] Although the representativeness of this small set of study participants cannot be determined and the researcher did not specifically explore their cross-border health-care behavior, Koehn's 14 extensive interviews provide baseline insights of value in the innovative multisite comparison that constitutes the core of the collaborative analysis presented here.

Two of the fourteen interviewed patients reported that a physical exam (well-check), screening procedure, or immunization constituted the only occasion they came in contact with the Finnish health-care system. The others explained that they had sought medical treatment from reception-centre or municipal-commune medical personnel for a wide variety of reasons, including dengue fever, broken bones or knee injury (3), pregnancy (3), flu (3), tooth infection, abdominal hernia, allergies (2), migraine headache, stomach problem, tonsillitis, respiratory problem, physical complications from torture, depression, and stress (2). Five of the 14 (36 per cent) reported that they had experienced a mental-health problem in Finland. All five indicated that they suffered from depression. Four of the five mentioned loneliness and distress as serious problems, and two reported insomnia.

In this article, Koehn reports on five aspects of the interpersonal interaction of Somali patients and Finnish health-care providers. The five issues are patient (dis)satisfaction with the principal physician's care; current and future health expectations; the influence of biomedical and traditional medical beliefs and practices; patient and provider transnational competence; and mental-health treatment perspectives. Which of these factors, if any, are likely to encourage some Somalis to seek out supplementary forms of medical treatment in Somalia?

One possible explanation for seeking treatment in the country of origin is the transnational patient's dissatisfaction with the medical care secured in the receiving country, or lack of confidence

in the attending physician. Asked to identify the level of their satisfaction/dissatisfaction with the results of the care provided by their principal attending physician on a five-point Likert scale ranging from "very satisfied" to "very dissatisfied," 13 of the 14 study participants (93 per cent) indicated that they were satisfied or very satisfied and the remaining patient chose "neither satisfied nor dissatisfied" (Pohjanpaa, et al., 2003, 125-126; Degni, 2004, 102). Furthermore, all 14 interviewees reported that they were "very confident" or "confident" that the attending physician's health-care recommendations would be helpful for their health in the immediate future (the next year or so).[8] These findings raise the possibility that factors other than dissatisfaction with, or lack of confidence in, the results of physical-health care received from physicians in Finland influence the decision of some transnational migrants to seek medical attention in their country of origin.

Do some Somali migrants desire to return to their place of origin for health care out of concern that they are not currently taking sufficient care of their health in Finland or because they lack access to familiar remedies and foods? The in-Finland data collected in this study suggest that self-care constraints might be a factor for a minority of Somali migrants. Asked to evaluate the extent to which they are effectively taking care of their health in Finland, two interviewees (14 per cent) selected "only partly" and one (7 per cent) indicated "not at all." The other 11 felt that they were effectively taking care of their health in Finland. The doctors treating these individuals viewed their situation somewhat differently. Five of the nine reporting physicians judged that the patient was "only partly" effective in taking care of his/her health in Finland (the other four selected "effective").[9]

Only six study participants (43 per cent) felt (very) confident that Somali health-care practices would be helpful for their health in Finland over the next year or so.[10] Two individuals (14 per cent) were not confident or *very* unconfident that such practices would be helpful. The remaining six were not sure (neither confident nor not confident). While post-resettlement changes in outlook might explain the reported lack of confidence in traditional approaches, the interviewees' responses regarding the future personal health benefits of such approaches also might reflect individual inability to access authentic Somali practices or health supplements in Finland.

Does lack of understanding of and appreciation for Somali health-care practices on the part of Finnish providers lead some Somalis to seek treatment in the place of origin? Anne Alitolppa-Niitamo (2004, 126) illuminates the problems associated with cultural essentializing, or relying on stereotypes.[11] The diversity of medical beliefs and practices that exists among Somalis in Finland is revealed even in the small sample selected for this study. First, nine (64 per cent) of the fourteen interviewed adults indicated that they value biomedical beliefs and practices; four study participants (29 per cent) only partly valued such beliefs and practices and one patient (7 per cent) did not consider them at all valuable. When asked whether they valued the medical beliefs and practices of Somali culture, only two study participants (15 per cent) indicated that they did so without reservations while three others (23 per cent) indicated that they possessed no value. The majority of interviewed patients (N=8; 62 per cent) felt that Somali medical beliefs and practices were "partly" of value – suggesting that they valued them in some, but not all, circumstances.[12] Moreover, seven patients reported that their doctor did not value Somali health-care beliefs and practices and two others felt that their doctor only "partly" valued them; two study participants had no idea, and two reported that their physician did value Somali beliefs and practices.[13]

When asked if they actually combine biomedical and Somali cultural practices in their health-care behavior, a majority (N=8; 57 per cent) of the study participants replied that they did so in part or on occasion (Dayib, 2005, 46); six others (43 per cent) did not. It is interesting that in 8 (89 per cent) of the 9 cases where comparative data are available, the principal attending physician did not correctly identify whether their patient incorporated or did not incorporate Somali health-care practices (Alitolppa-Niitamo, 2004, 420).[14] In addition, nine (69 per cent) of the interviewed patients indicated that their doctor had never suggested an appropriate combination of biomedical and traditional health-care approaches.[15]

A related consideration involves the nature of the in-Finland

health-care encounter. If encounter participants (patients as well as providers) lack transnational competence (Koehn, 2004), the in-Finland consultation process could prove unfulfilling for the care receiver even if s/he appreciates the technical results. It is illuminating in this connection that 80 per cent of the principal attending physicians (N=5) and nurses (N=5) were rated low on transnational competence (TC) and all seven of the migrant patients for whom intersubjective evaluations are available also scored low on TC.[16]

In contrast with the physical health-care-satisfaction results discussed above, the Somali participants in this study evinced less satisfaction with the mental-health treatment they had received in Finland. Indeed, two of the three reporting interviewees stated that they were "dissatisfied" with the mental-health care they had received at a commune health centre or specialized psychiatric out-patient clinic (Gissler, et al., 2006). However, none of the interviewees who reported a mental-health problem had consulted a traditional healer in Finland – probably due, at least in part, to nonavailability. Possession healing, in particular, requires expert attention that is not available in Finland (Tiilikainen, 2003b, 63).

Transnational Health Care in Somaliland

Tiilikainen collected her data using ethnographic research methods in Somaliland, mainly in the Hargeysa area. She conducted 3.5 months of fieldwork over the summers of 2005 and 2006. Tiiliakainen's study involved observations and interviews with local healers and patients from the diaspora, including some patients observed and interviewed both in Europe and in Somaliland. Her primary data set consists of taped interviews and discussions, field notes, photographs, and videotapes involving about 30 illness cases and 15 different healers.

Health services in Somalia were weak even before the civil war. Pastoralists, in particular, had limited access to health care (Omar, 2001). Consequently, traditional healing practices have long played an important role in the overall health-care system. Traditionally, Somalis see supernatural, social, and natural agents as behind illnesses (Antoniotto, 1984; Slikkerveer, 1990). Accordingly, Somali cultural treatments deal with God and different spirits, evil eye and witchcraft, and physical and organic factors. Depending on the situation and the illness interpretation, various kinds of treatments, such as Koranic healing, spirit-possession rituals, bone setting, cupping, and herbal medicine are employed separately or in combination with biomedical care (Ahmed, 1988; Serkkola, 1994; Lewis, 1998, 107-132).

The civil war ruined Somalia's existing infrastructure, including the limited public-health services. Extreme poverty, the tremendous needs of an impoverished population, and the breakdown of governance have resulted in flourishing private entrepreneurship in the health sector. In addition to private clinics operated by medical doctors, one finds numerous clinics run by religious and other traditional healers in Somaliland. Among the clients are Somalis from the diaspora.

In particular, Somalis visit their place of origin during summer time. It is difficult to determine precisely how many transnational migrants consult traditional healers or use herbal medicine. One way to estimate the extent of the phenomenon is to examine the patient registers kept by some traditional healers. In 2003, Sheikh Mahamud Sheikh Mahamed Rage founded his clinic in Gebiley, 40 kilometers west of Hargeysa. Today, he is one of the most popular healers in Somaliland and he receives about 100 patients in a day. Since he works five days a week, he sees about 500 patients weekly.

Over the course of a year, the total number of his patients will approximate 26,000. During July and August, the most popular healers might see three to five patients from abroad per day. According to statistics gleaned from handwritten bookkeeping, Sheikh Rage consulted with 991 patients from all over the world (nearly 4 per cent of his total practice), including 558 persons from the neighboring countries of Ethiopia and Djibouti, between 4 July 2005 and 1 August 2006. His third largest group of patients were from the United Kingdom (118 persons during the chosen time period).

A smaller and fairly evenly distributed number of patients came from other countries, including the United States (39), Canada (26), and Finland (14). Telephone and e-mail contacts from abroad, medication carried across borders by a patient's relative, and healing rituals arranged in Somaliland for a person who is not present are

common, but are not recorded in the registers maintained by traditional healers.

What reasons do transnational migrants offer for seeking treatments and medications in Somaliland? Six discrete types of motivations emerge from preliminary analysis of Tiilikainen's data.

First, some Somali transnational migrants turn to healers in their country of origin if Western physicians have been unable to make a diagnosis or have not prescribed effective treatment. In some cases, for instance, an ill person abroad suffers from vague symptoms, such as pain, the etiology of which remains unclear and inexplicable. The inability of Western biomedicine to relieve this patient's symptoms raises doubts and concerns that "something" other than a medical explanation lies behind the problem(s).

In the second type of motivation, a returning person or his/her family does not trust and/or accept the diagnosis, treatment, or medication provided by a Western medical doctor. For instance, children who have been diagnosed as autistic, epileptic, schizophrenic, or depressed are sometimes brought to healers because their parents want to hear a sheikh's opinion about the diagnosis and make sure that spirits, such as jinn, are not behind the problems. Some family members even transport back to Somaliland persons who have been hospitalized in resettlement countries for mental illness.

The third category of explanations involves persons who accept the diagnosis given by a physician in the diaspora and use Western medicine, but simultaneously are searching for alternative treatment in order to restore their full health or to eliminate the need to take regular medication. Diabetic patients relying on insulin injections offer an example of this group. In some cases, camel milk plus selected herbs are experienced as an effective alternative.

In the fourth set of cases, the medication or treatment recommended by a Western physician fails to help or is too expensive. Chronic skin diseases or infertility are examples. For instance, Tiilikainen met a Somali woman who reported that she could no longer afford infertility treatments in Canada and, therefore, had sought treatment by traditional healers in Hargeysa.

In the fifth category, a person's problems, typically drug and alcohol abuse, are viewed as tied to life in the resettlement country. Families bring their ill members back to Somaliland because they believe problems can be solved easier in a familiar cultural environment where access to drugs and alcohol is difficult.[17] Somali families also remove young people who, according to parents or other custodians, have become too Westernized. They are brought to Somaliland for a long "holiday" to learn about Somali culture and Islam, sometimes against their will (also see Peutz, 2006).

The sixth group of patients are incurably ill. Western doctors give them no hope. They wish to recover miraculously or to die and be buried in Somalia. For instance, a seriously ill elderly Somali from Finland mentioned that he preferred to die in Somaliland because many relatives will attend the funeral and know his burial site.

Discussion

How are Tiilikainen's Somaliland findings related to Koehn's Finland results? First, we learn that Somalis hold diverse and complex orientations regarding traditional health-care practices and respond differentially to illness experiences. Next, we observe that uncertainty stemming from conflicting illness explanations and health-related experiences is one important factor that drives Somali migrants to search for transnational treatments. For some migrants, Somali cultural concepts, which differ from biomedical understandings, are meaningful as they weigh the seriousness of symptoms, the appropriateness and efficacy of the treatment prescribed by a Western physician, and their ability to undertake effective self-care in the country of resettlement. In particular, Western psychiatric diagnoses and mental-health treatments, including medication, are difficult to accept (also see Sainola-Rodriguez and Koehn, 2006). Both of the studies reported here uncovered lack of satisfaction with mental-health care in the North.

On the other hand, most Somali migrants appreciate and trust the advanced medical technology encountered in Finland and other industrialized countries and the technical skills demonstrated by physicians when treating physical problems such as contagious diseases and broken bones. For many Somalis, however, the body is a psychological and spiritual (as well as a physical) entity. Hence, there is a zone that is reached on-

ly by persons who are gifted with special knowledge. A Finnish (or other Western) physician is not expected to assume the role occupied by Islamic sheikhs and other specialist healers.

Increasingly, illness is a "transnational experience" (Kraut, 2006, 128). Researchers have documented that "many people in Somali communities are … seeking to find a more balanced and holistic way of managing sickness in Finnish society, a way which is not solely based on the western biomedical model" (Dayib, 2005, 47; also Tiilikainen, 2003a). However, Western health-care providers often are unaware of the alternative and supplementary treatments that their patients are using. In this integration of two separately conducted studies, we found that Finnish physicians did not possess an accurate picture of the extent to which Somali patients relied upon, or did not utilize, traditional approaches. Particularly hidden from attending physicians are the practices engaged in by transnational migrants who return to their place of origin, physically and/or virtually.

For many people in and from Somaliland, travel "is considered to be a learning process and a source of wisdom in itself" (Rousseau, et al., 1998, 386). Have traveling transnational migrants gained access to special wisdom when it comes to personal health care?

Transnational networks offer an important resource for an ill Somali migrant, both practically and as a source of hope. At times, traveling back to the place of origin itself is perceived as therapeutic. Many Somali patients benefit from some combination of biomedical and traditional healing practices as well as from transnational social support, particularly in cases of mental distress (also see Murphy and Mahalingam, 2004, 170). Of course, it is not always possible, or even desirable, that migrants travel to their countries of origin for treatment. Some aspects of traditional health care, such as Koranic healing in mosques, can be found in Finland and other Northern countries.

In any case, the healer most commonly encountered by Somali patients in the Northern resettlement country is the Western physician. What lessons can we draw from this comparative study regarding how interpersonal interactions among Somali patients and Finnish health-care professionals can be improved? Our findings suggest that mutual trust, together with sensitivity regarding each patient's unique cultural context and transnational migration paths (see Gushulak, 2005, 53), constitute key elements in a successful encounter between the Somali patient and the Finnish health-care provider. Illness explanations such as spirits, evil eye, and witchcraft fall outside the standard domain of Western doctors. Somali patients typically are silent about traditional illness explanations and transnational healing experiences and Western physicians do not normally show interest in nonbiomedical resources and sources of resiliency. Two-way information sharing among biomedicine practitioners and indigenous healers is rarely forthcoming (also see Madamombe, 2006, 11). Now that all patients, including the poor and marginalized, are physically and virtually mobile, Western health-care providers need to approach the patient's lived world in a holistic manner with transnational imagination, appreciation, and augmentation.

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Notes

1 Alejandro Portes (2001, 186) reserves the term "transnational" for activities on behalf of organized groups or networked individuals that "take place outside the pale of state regulation and control."

2 For some members of the Hmong community in St. Paul, Minnesota, for instance, "physicians have learned that the most expeditious way of getting a patient's permission for invasive procedures such as blood tests is to establish collaborative relationships with shamans. Both stand at the patient's bedside and support each other's efforts" (Kraut, 2006, 126).

3 On the history of Somaliland and the 2001 referendum vote in favor of independence, see Lacey (2006).

4 A grant from the Fulbright New Century Scholars program supported Koehn's in-Finland study of Somali patients and their principal attending care providers. For a description of the research methods used in this project, see Koehn (2006b, 27-29). Tiilikainen's ongoing study explores transnational healing practices among Somali families. Her work is part of a wider research project "Changes in the Population, Changes in Distress – Challenges for Finnish Health Care," under the Health Services Research Programme (TERTTU) of the Academy of Finland.

5 For a similarly illuminating collaboration involving a political scientist and an anthropologist who had conducted independent research projects, see Koehn and Waldron (1978).

6 We recognize that an integrated study that focused on the same individuals in both contexts offers a superior research design. In the absence of such projects, however, linking work conducted independently with the broader base of Somali migrants encountered in Finland and in Somaliland provides valuable insights regarding the full complement of processes at work in transnational health care.

7 To compare the results presented here with the larger multinational data base, consult Koehn (2006a, 2005); Sainola-Rodriguez and Koehn (2006).

8 The nine reporting doctors showed less confidence in their own recommendations (56 per cent "confident" and 44 per cent "neither confident nor not confident").

9 The attending nurse rated seven of the patients as "effective" and the other three as "partly" effective.

10 Only one of the nine reporting doctors (11 per cent) was "confident" that Somali practices would be helpful.

11 As one Somali woman explained to Fatuma Dayib (2005, 57), "the patient is the one that is ill, not his culture."

12 Tiilikainen (2003a) also found that Somali women in Finland mix traditional and new illness explanations.

13 Only three patients (25 per cent) indicated that their nurse did not value Somali health-care beliefs and practices (also see Degni, 2004, 114).

14 The principal attending nurse showed greater awareness – half (4 out of 8 available cases) of them correctly identified the extent to which their patient combined (or did not combine) biomedical and traditional practices.

15 According to the Somali patients, nurses were almost as unlikely (67 per cent) to suggest an appropriate combination of biomedical and traditional practices (also see Dayib, 2005, 42).

16 The methodology used to determine individual TC scores is described in Koehn (2005, 53-55).

17 With the exception of chewing narcotic khat leaves – a serious problem throughout Somalia.