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(In)visible embodiment: Somali perspectives of diabetes and mental health in diaspora

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(IN)VISIBLE EMBODIMENT:
SOMALI PERSPECTIVES OF DIABETES AND MENTAL HEALTH IN DIASPORA

by

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DEDICATION

For *hooyo*:

Maxaa ani iigu jira.

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(IN)VISIBLE EMBODIMENT:

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MENTAL HEALTH IN DIASPORA

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ABSTRACT

Somalis represent the largest consecutively displaced and resettled group in the United States yet, little is known about their experiences with and perceptions of illness in diaspora. In this research project I examine how Somalis' understandings of the body and embodiment shape perceptions of diabetes and mental health. In addition, I ask how are the effects of migration and diaspora embodied among Somalis in Boston? To answer these research questions, I developed a qualitative study among Somali Muslims in Boston. I utilized information from semi-structured interviews (n=6), informal interviews (n=4), and participant observation at a local mosque from March 2015 to March 2016. I argue that for Somalis, diaspora is embodied through: bodily practices based on fluid and complex body ideals and values, food ritual and practices of consumption, and chronic physical health and mental health issues resulting in culturally relevant somatic explanatory models.

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LIST OF ABBREVIATIONS

Body Mass Index	BMI
Critical Medical Anthropology	CMA
Greater Boston Muslim Health Initiative	GBMHI
Post Traumatic Stress Disorder	PTSD
United Kingdom	UK
United Nations High Commissioner for Refugees	UNHCR
United States	U.S.
Violence, Immigration, Diabetes, Depression, Abuse	VIDDA

INTRODUCTION

Illustration 1. Somali woman reading and reciting the Qur'an before Arabic class starts. Photo by author, 2015.

My first few Arabic classes at the Barakah Institute were muddled with anxiety and insecurity. For one, I was a young, white, non-Muslim woman among a group of Muslim Somali women with children. Two, my Arabic skills were elementary despite having studied Arabic several years ago in Amman, Jordan for a summer and taking classes at my undergraduate university in Kentucky. Finally, I did not know a word of Somali and quickly realized that the Arabic class was primarily taught in Somali. Several times during recitation exercises, I would write out Somali words in Arabic. I was not sure when my teacher was switching from Arabic to Somali in order to explain something to the women in my class. As she graded my assignments, she would circle these

"random" words I had inserted in the story, later realizing my confusion.

Before moving to Boston, I worked with a refugee resettlement agency in Kentucky. I had years of experience working with and teaching Muslim English learners. Most of my students and clients at the agency were Muslims from the Middle East; I had never worked with Somali women. When I moved to Boston I heard that of a rising diabetes rate among Somali Muslims and therefore decided to work with this population. I became involved at the Barakah Institute through an internship with their health team. However, my internship supervisor quickly realized that my role in creating a resource guide would not allow me to work directly with Somali Muslims. Therefore, she advised me to enroll in an Arabic class taught at the mosque in order to become involved with the Somali community in Boston. Before enrolling in the class, I met with the teacher of the class, Ayan[1]. She and my former internship supervisor suggested that I wear a veil, or *hijab*, to class to make my experience "easier" for the Somali women because they were "conservative" Muslims. I was uncomfortable with the idea of veiling because of the strong connotations it carries of being Muslim, and I was not. I feared wearing a *hijab* would make me look fake or be seen as mocking a cultural and religious practice. Despite my initial hesitations, I wanted to remain respectful and decided to wear the *hijab.*

My first attempts at wearing *hijab* were pitiful. I believed this gave my non-Muslim, or *gallo*, status away. I watched several YouTube videos on how to make the scarf look "cute," yet my biggest concern was keeping it on my head and making sure my hair was covered. Although it was a novel piece of clothing for me, I sometimes forgot

[1] For confidentially purposes, all names have been changed to pseudonyms.

that I was wearing it, only to be reminded by Muslim women in the mosque. For example, when walking to Arabic class, I often encountered a *sister*[2] in the hallway who would greet me with *salaam alaykum,* a common greeting among Muslims. This would take me by surprise. Nearly every time I fumbled for the correct response *wa alaykum salaam*; several times I simply smiled and said "hello". Later, I would criticize myself for not having the correct and appropriate response.

The initial period of becoming involved in the Arabic class consisted of me arriving early and sitting alone. Although I was told the class had a set time, it never seemed to start at the same time each day. I would often wait thirty minutes or more for class to begin. I tried, desperately, to reach out to Somali women during this time but felt rude interrupting their practice of reciting the Qur'an, a deeply spiritual practice. My ignorance of Somali and their limited English skills only exacerbated the barriers I faced making friends. I worried that the Somali women in class would think that I was Muslim and realize I was an "awful Muslim," because I was not explicitly familiar with all Muslim practices. I also worried that the women would think I was not Muslim but that I was "faking" a belief system by attending the mosque and wearing *hijab*.

In addition, my teacher Ayan seemed hesitant about my research project. She was thrilled I had Arabic knowledge, however limited, and was impressed that I wanted to learn more. She welcomed me as a student, but would avoid talking about my research. After a few weeks of waiting for her to decide if she would distribute recruitment flyers to Somali women, I began to think she had forgotten about my project entirely. Finally,

[2] This term is used among Muslims to describe a religious connection, not necessarily a blood relationship.

one day she casually mentioned that flyers were not going to work. I was shocked that she remembered, and I think it showed on my face. She smiled and explained that many Somalis are not accustomed to reading information. Instead, they primarily rely on word of mouth. Afterward, she gave me a wink. I began to realize that she was testing my commitment, my patience, and my interest in working with Somalis. Had I proven myself?

Becoming a Daughter

Over the next few weeks, Ayan began to work with me one-on-one after class. Each week, she would give me ten to fifteen words to memorize and quiz me the following week. During our one-on-one Arabic practice, she would also discuss my research interests. One week she explained that a research project on diabetes conducted in the past had upset several women in class. She explained that researchers came in to collect information from the Somali women and had only produced a small presentation and pamphlet in return; an uneven exchange of time and care. Ayan's beginning hesitations about my research and recruitment flyers began to make more sense to me. I recognized the importance of establishing valuable relationships with the women in my class and showing my intentions through time spent among them.

I began to make friends in class, including Dahabo. Dahabo's English was limited, but she was eager to explain the love and peace of Islam found in the Qur'an. Every day before class she would recite the Qur'an and tap the ground next to her, cuing me to sit down. I would listen and she would point to words as she went along while holding my hand. Each week before class, Dahabo would explain more about Islam's

peacefulness and tell me that Muslims are not violent terrorists, as shown in the media, indicating that she knew I was not Muslim and that she was very aware of the tensions surrounding Islam in the United States. In addition, Ayan began inviting me to have lunch with her after class at her house or at her husband's nearby restaurant. During these meetings, she would teach me about Islam; she thought it was essential for me to understand the religion before I conducted research.

Illustration 2. Hooyo Dahabo prays at the mosque. She's dressed in long, flowing, colorful patterns. You can see orange henna on her hands and nails. Photo by author, 2015.

After a few months, these lunches and staying to talk after class became part of my weekly routine. I found myself spending most of my day at Ayan's house, during which time several other Somali women would drop by unannounced. Ayan would serve food and/or Somali tea. Our meetings went from discussions of Islam, to discussions of food, and finally, to health. Ayan began to teach me how to cook Somali food, like sambousa, and make Somali tea. She would sometimes take me on walks to visit other Somali women, nearby mosques, Somali restaurants, and Somali stores. The line between awkward outsider and close friend had been crossed.

Ayan eventually stopped teaching Arabic class, but I continued to visit her each week. One day Ayan was in the bathroom making *wudu*, or washing, before prayer. Someone knocked on the door; Ayan told me to answer it but I was nervous to do so. When I did, there was a Somali woman I had never met before standing outside. She gave me a glance that indicated I was an unexpected presence. Ayan came into the room and put her arm around me and introduced me as *Ashley, my adopted daughter; don't worry, she's Somali, a white Somali*. Ayan explained that she was teaching me about Islam, Somali, and how to cook. I was both relieved and happy to learn that Ayan "vouched" for me and was taking a growing interest in our friendship. These interactions continued with Ayan reminding me, and others, that I was family.

Finally, other women who I began to see and visit regularly agreed. I began to call them *hooyo*, the Somali word for "mother". After moving to Boston and attempting to make friends, I had found a family of multiple Somali moms who fed me, taught me, and listened to me. Ayan would often send me texts or call me during the week on days I

did not visit. Sometimes, she would send me encouraging texts and prayers, starting the out with "*Salaam my adopted daughter"* and ending them with a phrase familiar to me from my own mother: "*I love you, be good."* My other Somali *hooyos* would greet me enthusiastically, occasionally invite me to go shopping with them, and to eat with them in their homes.

Hooyo Ayan

Illustration 3. Hooyo Ayan overlooking the Barakah Institute. Photo by author, 2016.

Although I became close to several Somali *hooyos*, Ayan's English and professional skills in a medical profession, made her a wealth of information for my research. In the beginning it was Ayan who "vouched" for and introduced me to other

Somali women. She began, along with *hooyo* Dahabo, to teach me Somali. She would encourage me to practice with guests who would often laugh in response. I thought this spoke to my skill, or rather lack of skill, but the women explained that it was funny to see a non-Somali speaking their language.

In addition, Ayan would "double check" the research I was conducting. I showed her outlines of my chapters and larger themes. She would verify that the general analysis I was producing was "correct". I believe she enjoyed hearing about the research I was conducting and how I was making connections. She made several suggestions to me throughout my research collection, including adding to my main topic of diabetes by incorporating body ideals such as female circumcision and embodiment of mental health issues. Speaking with Ayan made me realize the effects of living in diaspora went well beyond a high prevalence of diabetes and I wanted my research to reflect this.

As my key informant and adoptive mother, Ayan's stories about life in Somalia and Somali ideals intertwined with personal feelings and stories that extended beyond the scope of my project. In addition to gathering information from Ayan and listening to her stories, she began asking questions about my personal life. I decided as a non-Muslim to keep my private life out of the mosque, but after spending time with Ayan in her home, I opened up. I was surprised by her acceptance of my lifestyle, her encouragement, and advice in my personal relationships despite these being quite different from her own experiences. Her advice on dating went something like this: *don't accept dates with boys at night who want to drink alcohol with you because they may have bad intentions, but if they ask you for coffee during the day in public then it's ok.* Her advice spoke to the value

she placed on maintaining purity of intentions and forming lasting relationships in contrast to American dating or "hook-up" culture. Needless to say, Ayan became a presence of motherliness that my own mother immensely appreciated from hundreds of miles away.

Despite having never met, Ayan and my mother would exchange messages and gifts through me. When I went back to Kentucky, Ayan would send me home with small gifts for my mother. In return, my mother would send me back to Boston with small gifts for Ayan. And in October Ayan met my father. She took us to lunch at a Somali restaurant and showed him *Juma'a* (Friday) prayer at the mosque. Ayan and my mother plan to meet in the coming months when my parents visit Boston. Without Ayan, I would not have a family in Boston nor would I have been able to conduct this research.

Research and Chapter Summary

Before I address my larger research questions, I outline a brief history of the long and violent civil war of Somalia, in the Background chapter. Without a clear understanding of where Somalis in Boston came from, we cannot examine experiences and perceptions of illness and the body in diaspora. I discuss near and far diaspora resulting from the civil war in Somalia. As the most prominent worldview many Somalis share, this thesis would not be complete without a brief history of Islam in the region and its role in the United States. Next, I outline the theoretical frameworks I apply to my research findings based on the information I have gathered. Finally, I provide an overview of the methodology I chose for this project in the Methods chapter.

My use of modified grounded theory methodology[3] allowed me to incorporate Ayan's advice to add larger bodily practices and illnesses to my research. Initially, I hoped to examine Somalis' perceptions of diabetes in Boston. However, Ayan taught me to ask different, more relevant questions such as: how do Somalis' understandings of the body and embodiment shape perceptions of diabetes and mental health? In addition, how are the effects of migration and diaspora embodied among Somalis in Boston? I argue that for these women, diaspora is embodied in the following ways: 1) through bodily practices based on fluid and complex body ideals and values 2) through food ritual and practices of consumption, and 3) through chronic physical and mental health issues resulting in culturally relevant somatic explanatory models.

In Chapter Four I examine Somali body ideals in diaspora. I draw on Scheper-Hughes and Lock's (1987) concepts of the individual physical body, social body, and body politic. Because Somalis face new body ideals in the United States, they may reject or accept all or certain aspects of Western bodily values. The physical body is an individual's most visible external object of perception by others, but it also becomes a subject of expression in diaspora.

I devote Chapter Five to food practices of the body. Food became a large part of my social interactions with Somali women and contributed to Somali understandings of diabetes onset. For many of my participants, food also conveyed larger social and religious beliefs, therefore they were eager to keep a "Somali" diet in diaspora. These practices of the body are often interwoven with body ideals. For instance, Somali valuing

[3] For more on modified grounded theory, see forthcoming Methods chapter.

of foods that produce weight gain are linked to larger body ideals. This practice of the body is also closely tied to health.

Chapter Six combines the notions of body ideals and food to examine embodiment of stress and illness among Somalis. Differing body ideals and food values often produce conflict in clinical settings between Somali patients and their non-Somali providers. Divergent understandings of how illness and disease affect the body contribute to barriers in management in treatment. More specifically, I examine the ambiguous line between mental and physical illness, showing that Somalis chronically embody illness in a way that is culturally relevant and understood as "safe" expressions of illness.

Finally, within the Conclusion, I demonstrate how body ideals, food practices, and health are intertwined, inscribed, and expressed through embodiment. As noted, food values correlate to body ideals; certain foods and consumption practices valued by society are intimately attached to body ideals the society also values. In addition, diet and nutrition are intently associated with health, particularly diabetes. However, each concept explores how the body expresses, resists, and accepts external "entry points" of exchange and embodiment in diaspora. As a result of my close relationship with *hooyo* Ayan and other Somalis in Boston, I have added suggestions from Somalis involved in my research to improve health services and care. Throughout, I have included photographs to accompany the test. These photographs demonstrate, visually, some experiences I shared and witnessed with the Somali women I came to know and adore. My photographs record events, clothing, and Islamic symbols that I have been lucky to experience with my Somali family.

BACKGROUND

"1991 marked the moment at which the nature of the political violence used as a technology of power changed and became communal violence, perpetrated and suffered by people who shared geographical and social space as neighbors, acquaintances, friends, maternal relatives, and in-laws. At this moment, 'political entrepreneurs,' in the pursuit of their political goals, encouraged, ordered, enabled, and allowed ordinary Somali people to humiliate, rob, rape, maim, kill, and expel other Somali people now constructed as the clan enemy who had to be eliminated and expelled." [Kapteijns 2013:3]

A Brief History of Somalia

French philosopher, Michel Foucault, believed in order to understand an object or specific view, one must understand the system that defines it (Armstrong 1983:3). Somalis' experiences and perceptions of illness in the United States remain incomprehensible without knowledge of Somali history that led Somalis to seek asylum in the United States. Michael Walls writes, "Somalia is frequently cited as the paradigm of a failed state" (2009:371). Recognizing Somalia as a country of various political, economic, and social interruptions is essential to understanding individuals who still, after years away, call Somalia home. However, it is also important to acknowledge colonial histories that have influenced the current state of Somalia, rather than conceptualizing it as a place of failed political and economic institutions.

The northwest area of Somalia was a British protectorate from 1887–1960 until it united with the newly independent ex-Italian territory to the south and east. The civil war began in 1982 as a result of resistance to president Siad Barre. After the collapse of the Barre regime in 1991, the northwest area of Somalia declared independence as the Republic of Somaliland (Walls 2009). Since this period, Somaliland "resolved incrementally a number of internal tensions and conflicts, and has established a thus-far

stable state" (Walls 2009:372). The incremental road to peace within Somalia has been largely unsuccessful, despite sixteen major, externally-funded peace conferences.

Lidwien Kapteijns and Fowsia Abdulkadir conceptualize the civil war and "war of others" in Somalia as one that takes many forms and has continued through various phases (2014:134). The concept of a "war of others" particularly highlights foreign involvement in violence on Somali soil, most notably the Ethiopian government's involvement in dismantling the Islamic Court established in Somalia. Lidwien Kapteijns distinguishes three kinds of violence: large scale political and clan based violence against civilians perpetuated by the Barre regime, clan–based communal violence in situations of state and clan cleansing campaigns, and large-scale violence against civilians as normalized practice during the civil war outbreaks in 1991 and 1992 (2014:134).

Extensive violence in Somalia has drawn attention from international communities, particularly since the collapse of the state and President Siad Barre's regime in 1991. Books and documentaries cast Somalia in a dangerous and unstable light. Take for instance James Fergusson's book, *The World's Most Dangerous Place: Inside the Outlaw State of Somalia* (2013)[4] and the documentary, "Somalia: The African Hell of Life" (Andrés, Castro, and Garcia 2014)[5]. These violent portraits of Somalis must be understood in the context of a political civil war, rather than as an inherent aspect of Somali culture. Nonetheless these shared cultural experiences of trauma and violence

[4] James Fergusson
2013 The World's Most Dangerous Place: Inside the Outlaw State of Somalia. Boston: Da Capo Press.
[5] Andrés, Oriol, Carlos Castro, and Gemma Garcia
2014 Somalia: The African Hell of Life.

have long-term consequences for Somalis around the world.

Political and ethnic violence, as a result of the civil war in Somalia, has led to significant displacement. Somalis are the most consistently displaced population in the Horn of Africa (Hammond 2014). An estimated 1.5 million Somalis, of approximately 10 million nationals, live outside Somalia in both "near" and "far" diasporas, while 1.1 million remain internally displaced within Somalia (Hammond 2014:9–12).

"Othering" Somalia

Outside of Somalia, Somalis are depicted as unfortunate and helpless victims of severe instability as a result of internal, historical clan based violence. Catherine Besteman argues that "the clan-based explanation of warfare derived from anthropological accounts of northern Somali social organization grossly oversimplified the complex and dynamic hierarchies of status, class, race, and language that were central to the patterning of violence in post-1991 southern Somalia" (1996:120). Besteman asserts that the image of Somalis in media outlets in the United States continues to over-simplify these individual accounts and re-produce them in mass scale.

Jeff Gettlemen, writer for the *New York Times*, vividly depicts the violence in Somalia and surrounding seas as a "violent free-for-all" and the "greatest piracy epidemic of modern times" (2009:62). Gettlemen notes that in 2009, the government's zone of control in Somalia was "down to a couple of city blocks" in a country the size of Texas (2009:62). Compounding the extreme violence in Somalia, famine, displacement, drought, sky-rocketing food prices, and an exodus of aid workers contributed to the death of hundreds of thousands of Somalis in the early 1990s (Gettlemen 2009:62).

Gettlemen addresses the history of Somalia by further elaborating on Somalis' helplessness as victims of First World control and domination. He continues, "at the end of the 19th century, the Italians and the British divvied up most of Somalia, but their efforts to impose Western laws never really worked. Disputes tended to be resolved by clan-elders" (2009:63). He acknowledges that Somalia won independence in 1960, but writes that "it quickly became a Cold War pawn, prized for its strategic location in the Horn of Africa, where Africa and Asia nearly touch" (2009:63). Gettlemen goes on to describe Somalia as "not so much a state" but rather a "lawless, ungoverned space on the map" (2009:64). Yet, Gettlemen points out "Somali society often divides and sub-divides, but it quickly bands together when confronted by an external enemy" (2009:64); demonstrated by failures of Ethiopian and U.S. troops to establish a government in Somalia, depicted through the film *Black Hawk Down*. The effects of the civil war and resulting violence, Gettlemen suggests, is a country that collectively suffers from post traumatic stress disorder (2009:69). Gettlemen asserts that there is now an entire generation in Somalia that "has absolutely no idea what a government is or how it functions" (Gettlemen 2009:69).

While the civil war has produced a collective trauma in Somalia and in Somali diaspora, Besteman cautions against the image portrayed through such media outlets. She writes, "the emerging image of Somalis became one of savages who got ahead of themselves technologically; of tribesmen still out there wandering around the primordial landscape, bound by ancient ties and animosities, dutifully following the factional footsteps of their forefathers" (Bestemen 1996:122). In addition, several media outlets

continue to depict colonialism as an improvement for Africa through the creation of European style nation-states (Besteman 1996:122). However, by historicizing clan violence and focusing on external occupations, military campaigns, and domination, we risk "othering" Somalia and Somalis as agentless victims caught in a web of Western judgment, social, and political control.

In order to understand the violence of Somalia's civil war, we must incorporate underlying tensions within Somali society "based not only in kinship divisions but also in divisions of race and class" (Besteman 1996:130). Besteman argues against "othering Somalia by boiling down the intense complexity of race, class, and identity to the simple system of antagonistic clans" because it "allows us to ignore the legitimacy of these categories and our growing inability to manage their 'dangerous' mix within our own societies, borders, and world" (1996:130). As Besteman notes, ancestry has implications for status; southern Somalia took in large numbers of slaves imported from East Africa during the 19th century. The descendants of these slaves are believed to manifest visible physical features that convey their ancestry, often called 'Bantu' (1996:124). Besteman concludes, "conceptions of race, heritage, and status invest Somali identities with much greater complexity than a simple assumption of one exclusive clan identification suggests" (1996:125).

Steve Kibble adds to the background of the Somali civil war in which internationally financial institutions failed to stem Africa's economy that led to major reassessments in the 1990s (2001:5). In addition, the colonial impositions of ambiguous boundaries, Western judicial systems, and centralized governments, colonial influences

"disrupted traditional grazing patterns as well as the authority structures and thereby the equilibrium of clans and management of resources" (2001:11). Since the collapse of Barre regime, the south of Somalia has been divided up between different armed factions under rival warlords (Kibble 2001:12). Somalia continues to exist within periods of relative stability and violence. However, we must concede that colonial rule, dictatorship, and socio-economic failures brought on by internationally funded institutions are contributing factors to the state of Somalia, rather than placing blame and historicizing violence within "Somali culture".

Life in Exile

"You have to understand, that no one puts their children in a boat unless the water is safer than the land." – Warsan Shire [6]

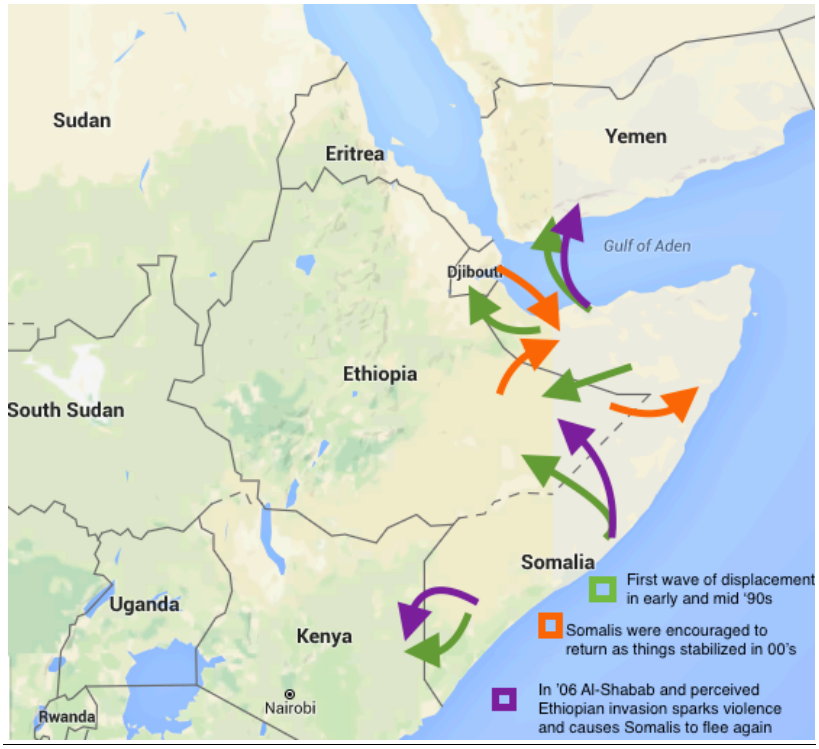

Figure 1. Displacement Chart. Houston, 2015

[6] Warsan Shire, quoted in the *New York Times* "Lost Voices of the World's Refugees" June 13, 2015.

As a result of the civil war and subsequent violence, many Somalis fled out of Somalia. London-based Somali poet, Warsan Shire, captures the aspect of forced migration by writing that parents do not put their children in danger unless it is the safest option; Shire therefore alludes to the extreme violence during the civil war. In the first "phase" of displacement, many Somalis fled to neighboring countries, Kenya and Ethiopia. After President Siad Barre was overthrown in 1991, Somalis continued into Kenya and Ethiopia and began to flee to the north into Djibouti and Yemen. Between 1996 to 2006, violence decreased within Somalia. Refugee camps' intake of Somalis slowed in neighboring countries and people began to relocate on their own to urban centers or return to Somalia (Hammond 2014:4–6). However, toward the end of 2006 Ethiopia ousted the newly developed Union of Islamic Courts, an Islamic government system in Somalia; Somalis viewed this political move as an invasion. As a result, violence began to escalate again with the formation of the Al Shabaab movement, driving Somalis back to Kenya, Ethiopia, and Yemen (Hammond 2014:7)

Fleeing Somalia presented many challenges for refugees. Host countries were heavily burdened by new arrivals of Somalis. Many camps were already hosting refugees from Ethiopia. Refugees often arrived by foot just across the borders of Somalia after travelling for weeks without adequate food and water supplies. These camps were ridden with malnutrition and death. Thousands of Somalis crossing to Yemen faced drowning or fell victim to human smugglers (Hammond 2014:4–5).

Presently, refugees from Somalia continue to move toward urban areas in host countries to compete for resources and job opportunities. Others remain in refugee

camps. The largest camps in Kenya, including Dadaab, are located away from the urban areas. The camps' isolated geography creates barriers for mobility, trade, and commerce. Many camps are overcrowded and still do not have adequate resources to provide for Somali refugees (United Nations High Commissioner for Refugees 2015).[7]

As "Global Refugees", so termed by the United Nations High Commissioner for Refugees (UNHCR), many Somalis have immigrated or have been granted asylum and resettlement in a third country. Approximately 500,000 Somalis live in "far" diaspora, away from Somalia, with large concentrations in the United States (Hammond 2014:13). The Department of State's Summary of Refugee Admissions estimates 6,226 Somalis will arrive to the United States in 2015 alone, constituting the largest African refugee group entering the United States. Moreover, in terms of ongoing connections from "near" and "far" diaspora, Somalis in far diaspora, who have immigrated or been resettled, often provide remittances for Somalis living closer to home. These wider diasporic connections demonstrate "engagement with multiple places at the same time, the constant use of social and economic networks across great distances and international borders are important individual and collective survival strategies" (Hammond 2014:14). Since 2012, relatively financially stable Somalis may also travel back to Somalia to check on family members and property, as security permits.

"Diaspora" is a contested term, often used without clear definition. William Safran's (1991) theory of diaspora is defined by identification of a group with a homeland. Critics of Safran's theory argue that this definition excludes dispersed

[7] UNHCR 2015 Country Operations Profile: Somalia
http://www.unhcr.org/pages/49e483ad6.html

individuals who do not consider the concept of homeland essential to their identification. An example may include modern Black communities brought together by a shared experience of racial oppression rather than a sense of belonging to a specific, identifiable African country (Curtis IV 2014). Instead of relying on a single homeland, these theories of diaspora argue for collective hopes within multiple places and through various networks in race, ethnicity, or religion. Edward Curtis IV offers a specific African diaspora definition, the "physical scattering of human beings across time and space that has political, economic, social, cultural, psychological, religious, and emotional meanings" (2014:9). This experiential definition of diaspora, conveys physical displacement that manifests in a variety of ways extending beyond physical movement by highlighting the bodily experience. This foreshadows how we embody our social experiences.

Addressing Concepts of the Body

You brought the war with you
unknowingly, perhaps, on your skin
in hurried suitcases
in photographs
plumes of it in your hair
under your nails
maybe it was
in your blood.
You came sometimes with whole families,
sometimes with nothing, not even your shadow
landed on new soil as a thick accented apparition
stiff denim and desperate smile,
ready to fit in, work hard
forget the war
forget the blood.
The war sits in the corners of your living room
laughs with you at your tv shows
fills the gaps in all your conversations

sighs in the pauses of telephone calls
gives you excuses to leave situations,
meetings, people, countries, love;
the war lies between you and your partner in the bed
stands behind you at the bathroom sink
even the dentist jumped back from the wormhole
of your mouth. You suspect
it was probably the war he saw,
so much blood.

You know peace like someone who has survived
a long war,
take it one day at a time because everything
has the scent of a possible war;
you know how easily a war can start
one moment quiet, next blood.
War colors your voice, warms it even.
No inclination as to whether you were
the killer or the mourner.
No one asks. Perhaps you were both.
You haven't kissed anyone for a while now.
To you, everything tastes like blood. [8]

Somalis revere oral traditions such as spoken poetry and literature. The lasting effects of the war and a long history of oral tradition are reflected in low literacy rates, made worse by years of civil war (Kibble 2001:14). Modern practices, such as conference telephone calls that connect Somalis in diaspora, showcase an emphasis on oral communication. Some of these conference lines focus exclusively on Somali literature and poetry.[9] Warsan Shire, references the long-term effects of exile on both the body and mind in her poem "Souvenir". She suggests these effects of the civil war "sit in the corners of your living room"; the war follows Somalis everywhere they go. Shire also writes, "no one ever asks" about a person's role as a perpetrator or victim of violence in

[8] Warsan Shire
2014 "Souvenir" *In* Our Men Do Not Belong to Us. New York: Slapering Hol Press.
[9] Information gathered through my participants

the war, alluding to the lack of communication involving atrocities of war. Somalis flee Somalia, yet the embodied experience of the civil war does not allow Somalis to escape the chronic and lasting effects of physical and emotional trauma.

Shire (2014) refers to 'hidden' aspects of the refugee experience yet, refugees and immigrants from Somalia are often visually distinct from the dominant, mainstream "American" society. Refugee bodies become subjected to medical checks and treatment. Moreover, for dark-skinned African Somalis, identifying visibly as Muslim through dress has compounding and potentially stigmatizing social consequences in the United States. The Somali body, therefore, becomes both the subject and object of diaspora and perception.

The concept of cultural citizenship illuminates the experience of Somali bodily regulation, intervention, and medical checks in diaspora. Laurence Pawley (2008) addresses three modes of cultural citizenship discourse. My aim is not to divulge into this discussion but rather to highlight the similarities in each camp of cultural citizenship discourse. Pawley writes that these similarities "share a concern with the 'working out' of difference, an emphasis on communication, and the underlying assumption that to secure citizenship is to secure 'full', equitable membership in a community" (2008:596). As Toby Miller (2011) points out, this includes the right to communication and to the representation of cultural difference. Medical checks and refugee assistance programs aim to contain the refugee body but also focus on other aspects of life that refugees may bring with them such as food, dress, and odors of the body and diet.

Aihwa Ong (1995) draws on Foucaldian beliefs of the body politic to expand the

concept of refugee cultural citizenship. She notes that Western state policies and services including: welfare, public health, housing, and education participate in the creation of bio political subjects. She continues, "the modern democratic state dominates through the mundane administration and surveillance of individual bodies and the social body, adjusting them to normalizing standards, and thus rendered governable as citizens" (Ong 1995:1243). When Somali refugees and immigrants come to the U.S., they become part of the medical and political system of bodily regulation through Western state policies.

Conceptions of the body are central to work in medical anthropology, and carry multiple philosophical and psychological underpinnings. Western assumptions regarding the concept of "the body", the individual-self, and society "affect both theoretical view-points and research paradigms" (Scheper-Hughes & Lock 1987:6). Therefore, it is essential to establish clear and concise definitions of the body, which calls for physical, psychological, and symbolic components of understanding.

Body/Mind Dualism

A mentalistic perspective of the body dominated anthropology until the mid-1980s when some anthropologists began to question how people express themselves through the body (Halliburton 2002:1123).[10] Before this time, Rene Descartes' Cartesian Dualism commanded Western thought. Descartes proposed the mind as a spiritual substance and the body, a material substance (Armstrong 1999)[11]. Marcel Mauss (1973)

[10] Marcel Mauss's *Techniques of the Body* (1950) and Mary Douglas's *Natural Symbols* (1970) are earlier anthropological works on the body.
[11] Armstrong (1999) provides an extensive history of the mind-body debate. His book examines various models of thought on the mind-body connection, particularly emphasizing materialist perspectives.

recognized techniques of the body, such as walking, sitting, eating, dancing, and sport, are shaped by culture (Johnson 2000). The divide between physical and social or spiritual therefore, becomes obscured.

Halliburton (2002) points out that most anthropological research of the body focuses on the mind-body connection particularly when examining women and oppressed ethnic groups or immigrants. This creates the impression that only individuals with limited access to power within a given society locate experience within the body or transcend mind-body dualism (2002:1125). Halliburton warns against assuming Western individuals are incapable of transcending mind-body dualism and suggests examining local and multiple phenomenologies before framing research around the body. Scheper-Hughes and Lock (1987), among others, illustrate the need to transcend mind-body dualism within medical anthropology in order to examine individual experience as a whole.

Defining "The Body"

Thomas Csordas (1990) argues that the human body is more than a physical object; it is also a model of embodiment which incorporates the study of culture and the self. Csordas emphasizes a phenomenological approach in examining embodiment, which regards the body as a *subject* of culture. Hallowell (1955) sees perceptions and practices[12] of the body as major forces for understanding the self and the body. Without perception of the body, there is no object of study (Csordas 1990:9).

Theoretical viewpoints of the body may be understood in three aspects: a

[12] Merleau-Ponty emphasizes perceptions of the body while Bourdieu emphasizes practices of the body; for more discussion See Csordas 1990.

phenomenal experience of individual body-self, a social body, and as a body politic (Scheper-Hughes and Lock 1987). The individual body-self constitutes how one experiences health and sickness, phenomenologically. The social body refers "to the representation uses of the body as a natural symbol" (Scheper-Hughes and Lock 1987:7) drawing on anthropologist, Mary Douglas. The third viewpoint is the body politic which refers to "regulation, surveillance, and control of bodies" (Scheper-Hughes and Lock 1987:7) incorporating Foucault's concept of surveillance. Thus the body politic is defined by its ability to regulate populations, the social body, and discipline the individual body.

The Symbolic Body

Body imagery or body image refers to "the collective and idiosyncratic representations an individual entertains about the body in its relationship to the environment, including internal and external perceptions, memories, affects, cognitions, and actions" (Scheper-Hughes and Lock 1987:16). Mary Douglas (1996[1970]), a symbolic anthropologist, observed the body as a natural symbol supplying some of our richest sources of metaphor. The body as both a physical and cultural artifact obscures the line between nature and cultural symbolism.

The larger social body may be read as an expression of social and physiological experiences. Douglas points out that the body is not merely a physical object but a medium of expression often "limited by controls exerted from the social system" (1996 [1970]:91). In addition, bodily control can be linked to social control. For example, in societies of strong social control, strong bodily control is also present (Douglas

1996[1970]). Among Somalis, the individual body may be influenced by both Somali and U.S. social bodies.

The Political Body, Power and Surveillance

In addition to symbolic functions, the body conveys political functions. As a political tool the body "illustrates the constraints on medical citizenship" (Sargent and Larchanché 2011: 348).[13] Mark Nichter writes that medical citizenship refers to "policies of entitlement" that "articulate what we deem to be the basic rights of citizens . . . and who gets excluded or sacrificed when health resources are rationed or restricted" (2008:183). As Kathryn Goldade (2009) notes, medical citizenship incorporates the notion that bodily illness is more often becoming a powerful way of shaping relationships to the state and establishing claims for rights and resources. Furthermore, medicalization of the body is intimately associated with colonization and political control (Lock 2004:117). Thus medicine is an integral part of regulating health and moral behavior of the entire population, or social body (Lock 2004).

Foucault argues new ways of bodily surveillance are not accidental but rather derived from the understanding of the body as an object and target of power. Similarly, Ong emphasizes the role of biomedicine in shaping the political body, asserting "the biomedical gaze is not such a diffused hegemonic power but is itself generated by the complex contestation of refugee subjects pursuing their own goals" (1995:1243). The body is framed as something that could be improved, subjected, used and transformed (Armstrong 1983:3). Knowledge and power are political tools and techniques to control

[13] Sargent and Larchanché (2011) refer to policies of entitlement in health care that separate citizens from non-citizens.

the body, the biological existence is reflected in political existence (Foucault 1978:142). This regulation on the Somali body is often seen in the clinic, where Somali notions of "healthy" are reframed by Western biomedical categories of body size.

The Body in Diaspora

In diaspora, the body becomes both a medium and subject of expression as well as an object of control. The physical body relays messages that may be perceived by others, which can link or distance one from social inclusion. Diaspora creates new opportunities for the body to be viewed and controlled, especially in medical settings. Differing bodily practices, ideals, and inscriptions can be a source of conflict in diaspora and new medical and governmental systems seek to objectify the body into categories of "bad", "good", "ill" and "healthy".

Therefore, the body cannot be examined without regard to both physical and symbolic place, in this case, diaspora. Diaspora is fundamentally about the body—therefore the body should be examined under the conditions of diaspora (Ruiz 1999). Lester Ruiz outlines several features of diaspora including: dispersal from original "center", retention of collective memory about homeland, belief that refugees can never be fully accepted by host society, belief that their descendants would and should return to homeland under appropriate conditions, collective commitment to maintenance of homeland, and collective consciousness with relationship with homeland (1999:634).

Not surprisingly, the theme *life in exile* is often present in existing ethnographic literature and research on Somalis (Svenberg et al. 2009). The diasporic experience is illustrated by a "longing for homeland, pain–a companion in exile, prejudice and

discrimination, family–comfort and trouble, religion and beliefs in Jinns" (Svenberg et al. 2009:282). Life in exile plays a role in altering many aspects of life for Somalis. For instance, religion becomes particularly salient, food habits may change to accept or reject host country's preferences or accessibility of traditional foods, and new or unfamiliar illnesses become associated with host countries. The body—physically, symbolically, and politically—becomes a monumental subject of transition in exile.

Religious "Inscriptions" on the Body

Many Somalis rely on Islam as a central framework and value system informing daily practices (Ajrouch and Kusow 2007:80). Somalis typically become "more Muslim" in immigration. In diaspora, particularly when confronted by Western Islamophobia, Islam unites Somalis across clan distinctions despite clan tensions highlighted during the civil war (Langellier 2010). A tendency to practice strict interpretations of Islam upon arrival to a new place is common among many Muslim immigrants (Ajrouch and Kusow 2007; Langellier 2010; Zine 2001). This often occurs as a way "to create a familiar cultural space in response to an otherwise strange and alien value system" (Ajrouch and Kusow 2007:89). Celia McMichael (2002) writes that for Somalis in diaspora, Islam provides a 'home' not in the sense of a physical place but rather as an anchor that provides stability.

Religious dress and speech become methods of identifying oneself to a larger Muslim community. These signifiers of religious inscriptions upon the body become a way for Muslims to insert themselves into a non-Muslim society without surrendering an identification that connects them to home (Langellier 2010). The *hijab,* or head-covering

scarf, is believed to reduce stress, assuage anxieties about gender mixing, and legitimize presence in public spaces (Langellier 2010). Covering with the *hijab* in the face of discriminatory reactions to Muslims and non-'blending' immigrants then, can be read as a conscious political and social act. Emma Tarlo highlights the diversity of *hijab* style on the streets, where women often mix and match colors and patterns, a contrast to the image of "dull uniformity" of black dress depicted in Western media (2010:1). Furthermore, Tarlo points out the Western obsession in media and in literature surrounding the veil is "informed by a long legacy of Orientalist images and texts, integrated within the cannons of Western art history, literature and colonial writings" (2010:3).

For many Somali and other Muslim women, the *hijab* embodies their on-going commitment to Islam. This visual marker of public piety is exclusively inscribed upon women's bodies. In her ethnography on Shi'a women in Lebanon, Lara Deeb explains, "visibility is crucial to public piety on both the personal and communal levels" (2006:34). The visual and symbolic feature of the *hijab* is valued within the community, conveys religious ideology, and enhances social status, which in turn motivates women to dress in a pious fashion.

Body Ideals, Practices, And Conflict

The body conveys symbolic cultural values, which may be read through body ideals. In addition to religious dress, cultural practices distinguish Somali women from their Western counterparts and may highlight potential conflicts within and surrounding the body in diaspora. One such bodily cultural practice is infibulation, or female

circumcision. Infibulation is common in Somalia. However, it is essential to understand infibulation as a cultural practice (Langellier 2010) rather than a religious one, despite frequent association with Islam in emic conversation and existing literature. Some Somali women may hesitate to discuss this topic in the West, as conversations are generally marked by Western reactions shaped by years of colonialism which "frame traditional practices as barbaric" (Langellier 2010:81). Langellier notes that Somali women understand that infibulation has become a fixation in the West as an 'exotic' topic.

Lila Abu-Lughod (2010) examines how the concept of "Muslim women's rights, particularly incorporating infibulation, should be studied ethnographically to convey the active social life of gender studies. She cautions against arguing if Muslim women have rights at all by instead focusing on how women's rights are mediated and how infrastructures support them. Abu-Lughod notes that the United Nations (UN) has set out to address violence toward women, specifically focusing on infibulation. She writes that the organizational efforts to frame female circumcision as violence toward women is expressed in her participants' comments about their understandings of violence, noting that violence means female circumcision (2010:28). In a separate article, Abu-Lughod reflects on the work of Edward Siad's (1978) *Orientalism*. She emphasizes that Middle East gender studies has been negatively impacted by argument of Orientalism in three ways: 1) social analysis is devalued in favor of representation 2) through binary thinking about East and West, which has trained us to focus on the West and not the heterogeneity of Middle Eastern societies and 3) it has deflected attention away from cultural processes

that produce and reproduce gender hierarchies and subordination (2001:112). In comparing current gender studies among Muslim women, Abu-Lughod points out Western ideological suppression and misrepresentation of "Eastern" practices, including circumcision. Abu-Lughod contends that while women's lack of rights may be deplored, we must be cautious in applying negative Western stereotypes and ideals upon Muslim women because these ignore larger problems, namely, that knowledge is produced for the West which supposes Western dominance over "the other" (Abu-Lughod 2001:105).

While some view infibulation as a gender ritual of gaining social mobility and cleanliness (Abusharaf 2009), others use a feminist model to critique the practice as violence toward women (Manderson 2004). Those in the latter camp refer to this practice as female genital mutilation (FGM). I do not intend to enter into this critique or evaluate the morality of the practice however, it is important to acknowledge the topic as both highly politicized and controversial. I aim instead, to highlight literature on the bodily ideals and values that have been woven into the body through diaspora, and through discussion of infibulation as one such bodily ideal and gendered ritual.

Body size ideals are similarly culturally engrained and subject to emic interpretations. As Brewis (2010:84) notes, "body size is imbued with cultural meaning in all human societies." In Belize and Jamaica, for instance, people view bodies as variable and natural without interpreting anything particular about the individual (Brewis 2011:100). These bodies are viewed as a symbol of the community rather than a symbol of the individual. In contrast, Western society ascribes moral and individual attributes to body size (Brewis 2011:107).

Body size, particularly the ideal size and shape for women, is another topic of obsession in the United States. Body size is viewed as a reflection of the individual-self and is often medicalized. However, medicalization and stigmatization of overweight and obese bodies, prevalent in Western biomedicine, does not apply cross-culturally. In some cultures, obesity may instead be a sign of social inclusion, good health, and beauty (Brewis 2011). Perceptions toward body weight vary within communities and across generations (Gele and Mbalilaki 2013). With new generations consuming Western media, one may assume generational differences of body size ideals are influenced by globalized media images. Rebecca Lester's (2007) work examines the effects of globalization and media on cross cultural body ideals. However, her work among Mexican girls with anorexia only complicates new incorporations of Western 'thin' ideals.

Abdi Gele and Aneth Mbalilaki's research on Somali perceptions of obesity in Oslo found that "Somalis do not consider overweight and obesity as a disease, but rather as a sign of success, wealth, good health and happiness" (2013:3). Similarly, in their study of dietary patterns among different immigrant groups, Trigwell et al. (2014) found that Somali parents in the UK not only have a tendency to perceive a larger body size to be healthy but also were less likely to consider being overweight in childhood as a problem. Somali women, in particular, are increasingly considered overweight by U.S. standards. Obesity profiles for Somali women show only 5% of adults classified as obese in Somalia, whereas numbers for women in resettlement countries are nearly seven times higher (Murray et al. 2015:83).

Western biomedical tendencies to categorize weight differences and obesity as an

illness of individual responsibility overlooks economic and structural barriers that lead to weight gain and/or contribute to chronic illnesses. Personal responsibility for being overweight is implicit in our scientific and cultural understanding of weight. It is not surprising that larger-bodied people perceive discrimination in the United States, and "there is evidence of systematic bias against them" (Brewis 2011:11). However, these ideas of personal responsibility for weight gain divert attention away from the larger systemic factors that put individuals at risk (Brewis 2011).

Food and Eating Practices of the Body

Diet is one factor associated with weight gain, yet food is essential to human existence and carries multiple social and symbolic meanings. The field of anthropology has a long history with the study of food and eating habits, from Mallery and Boas to Levi-Straus and Goody[14], and has matured to serve as a platform to examine both theory and methodology (Mintz and Du Bois 2002). Food illustrates societal processes including "political-economic value-creation, symbolic value-creation, and the social construction of memory" (Mintz and Du Bois 2002:99).

Food rituals carry implicit and explicit meaning. Explicitly, food rituals create a sense of harmony and sustaining community; implicitly, food rituals expose tensions (Thomson and Hassenkamp 2008). David Marshall (2005) notes the difficulty in defining consumption rituals because they are extensive, varied, and complex. Instead, he emphasizes food rituals' expressive and symbolic function that manifest as repeated

[14] See Garrick Mallery's "Manners and Meals" (1888); Franz Boas Kwakiutl salmon recipes (1921); Claude Levi-Strauss (1965); Jack Goody's *Cooking, Cuisine, and Class: A Study in Comparative Sociology* (1982).

behaviors acted out and performed by individuals to establish shared understandings of appropriate behavior (2005:72). Similarly, Victor Turner's dualistic observation of ritual relates to their purpose in maintaining an expressive function of communicating lay values and serving creative functions for both shaping and re-shaping categories through which individuals perceive reality (Thomson and Hassenkamp 2008:1777).

Mary Douglas, another anthropologist who analyzes food behaviors, views food practices as a code; patterns of social relationships are messages conveyed by this code. This message denotes hierarchy, inclusion, exclusion, and boundaries. Douglas believes sharing meals are structured social events (Douglas 1999:240) because the social event of sharing food incorporates performance of race, gender, and citizenship determined by power structures, which offers opportunities for "symbolic critique" (Rouse and Hoskins 2004:228). David Sutton points out that Douglas "draws our attention to the properties of food through a number of basic sensory contrasts that she sees related less to structures of the mind than to structuring meals and, through them, social identities" (2010:210).

Eating, as a creative activity, entitles subjects to choose "what will come to constitute their very being, both corporeally and symbolically" (Rouse and Hoskins 2004:246). How and what we eat is shaped by both emotional and socio-political processes. Eating, a practice of the body, gives cultural form to principles governing power relations and orders through acceptable, repeated food rituals (Rouse and Hoskins 2004). The production and eating of food becomes a performance of agency "owned not so much by individuals, but by a community on authoring new social configurations" (Rouse and Hoskins 2004:228).

Changing Food Practices in Diaspora

Food changes accompany immigration and migration. Life in refugee camps often limits Somalis' consumption of meat, in particular. Despite financial constraints in the United States, Dharod, Croom, and Sady (2013) found that Somali refugees in the U.S. prefer to buy more familiar cultural staples like meat and eggs. Additionally, many Somalis prefer to keep a "Somali" diet although they will use substitutes for bread or meats not available in the host country. Some Somalis use the cultural ties to food to create economic opportunity by preparing and selling Somali food, as Mulki Al-Sharmani (2006) found among Somali women living in Cairo. Richard Shepherd (2002) notes, food choices are complex and influenced by both biological and socio-cultural factors. Similar to other migrant groups, resistance to adopting a "Western" diet becomes a way to maintain and embody Somali culture in diaspora.

Although Somalis comprise one of the largest asylum-seeking populations in the UK, little is known to date about how migration affects their attitudes toward food and eating habits (McEwan et al. 2009). Similarly, studies within the United States reveal little about Somali eating habits despite Somalis being one of the most prevalent refugee groups to come to the country. McEwan et al. (2009) found that Somalis in London primarily eat rice, pasta, and red meat, and reported low consumption of fruit and vegetables due to uncertainty about what constitutes as a healthy diet.

Physical Effects: Chronic Illness and Mental Health

With the Western emphasis on body weight and size as near-exclusive indicators of health, obesity and diet are strongly linked to a number of chronic conditions,

including diabetes (Brewis 2011). This emphasis on body weight as an indicator for disease is critiqued as an incomplete picture that perpetuates fat discrimination. In Western diaspora, there are "multiple pathways through which health and well-bring are produced and eroded" (Patil et al. 2010:155). Somalis' understandings of healthy weight and healthy eating may be at odds with Western messages conveyed to the public. Noted hindrances to care and management of illness, from a Western perspective, include: language barriers, health literacy issues, low socio-economic status, discrimination, environment, lack of appropriate resources, and conflicting views of health and diet (Deshaw 2006; Edge and Newbold 2013; Fosse-Edorth et al. 2014; Geltman et al. 2013; Patil et al. 2010; Schoenberg et al. 2005). Before elaborating on accepted Western barriers to care and management, dominant explanations of disease disparities must be explored.

Paul Farmer encourages a critical and self-critical approach to understanding illness by evaluating existing frameworks, which may "limit our ability to discern trends that can be linked to the emergence of diseases" (1996:261). The "thrifty gene" hypothesis, a superficial model of diabetes disparities, is one such framework explored by Ferreira and Lang (2005) among Indigenous Peoples. The thrifty gene hypothesis assumes certain individuals, particularly Indigenous Peoples, are more genetically prone to develop diabetes (Ferreira and Lang 2005). This genetic theory is often proposed as the main component to increasing diabetes and other obesity-related illnesses among groups recently introduced to Western diets. The "thrifty gene" hypothesis provides a model to ignore economic, social, and historical determinants in favor of blaming

individuals for their genetics, which are construed as incompatible with a 'Western' diet (Ferreira and Lang 2005).

Ferreira and Lang provide an alternative and comprehensive overview of diabetes disparities; they raise the question: "how can a genetic cause be applied across the borders to 300 million people divided into thousands of ethnic groups, living across the planet under strikingly different circumstances" (2005:12)? A multifaceted approach considers diabetes within a "broader semantic domain that extends well beyond the narrowly defined biologic and genetic condition into the realms of social relations, history and the politics" which allows one to consider diabetes as a reaction to adverse life conditions rather than a genetic certainty (Ferreira and Lang 2005:16).

To further expand on this point and highlight potentially racist and limiting thinking, Gravlee writes, "a growing body of evidence establishes the primacy of social inequalities in the origin and persistence of racial health disparities" (2009:47). Gravlee attempts to 1) reiterate why biological race as a concept is inconsistent with human genetic diversity 2) refocus attention to the complex environmental and sociopolitical factors on human biology and 3) revise the claim about race being culturally constructed in order to expand research on sociocultural realities of race and racism. Therefore, as refugees and immigrants embodying a new "Western" diet, Somalis' diabetes diagnosis may be regarded as a genetic pre-disposition in clinical settings rather than a result of social inequality.

An increase in the prevalence of diabetes among Somalis can be associated with socioeconomic development (or lack thereof) and residence patterns. As Sharon

Okonkwo points out, differences in economic conditions and opportunities often parallel health and nutrition disparities (2002:1). Economic conditions generally determine residence patterns, which also undermine health status (Schoenberg et al. 2005:95). As the world urbanizes, so do refugees and immigrants, which has consequences on policies and services, including health care (Amara et al. 2014). Resident patterns and urbanization may lead to physical inactivity and changes in diet (Fosse-Edorh et al. 2014:143). By migrating to the U.S., Somalis find themselves in new social environments—in Boston these urban environments host many changes and challenges.

Concepts of Trauma

Arthur Kleinman's concept of social suffering is applicable in understanding the complexity of trauma among Somalis in the U.S. Kleinman proposes to situate health, social, subjective and spiritual problems within the term "social suffering" to avoid these problems being split into separate objects of inquiry (Kuah-Pearce, Kleinman, and Harrison 2014). Kuah-Pearce, Kleinman, and Harrison define social suffering as a range of "painful and debilitating human problems" that extend beyond the individual into the collective, social body and has roots in the social world pointing to "the policies, programmes, institutions and practices developed to respond to suffering, often also contribute to suffering via the unintended consequences of purposive action or in a more intentional manner" (2014:4–5).

In addition to chronic illness, Somali immigrants and refugees experience mental health disparities and barriers to care in diaspora. As a result of several years of ongoing violence from the civil war and displacement, Bentley et al. note that Somali refugees

"may be exposed to more traumatic life events than those from other regions of the world" (2011:479). There are links in multiple directions between such physical health factors as malnutrition, diabetes, in particular, obesity, PTSD, and depression (Kinzie et al. 2008; Anderson et al. 2001; Bogner et al. 2012). This suggests that Somalis in diaspora may face inter-related health challenges embodying mental stress and connections to food.

The body, for many Somalis, becomes precisely a physical space for trauma to manifest. Culture may have an impact on the somatization of symptoms as cultural norms may predispose an individual to experience "somatic as opposed to psychological symptoms" (Waitzkin and Magana 1997:818). Other cultural norms may prevent seeking mental health treatment. Piwowarczyk et al. found that Congolese and Somali refugees rarely seek help of mental health services (2014:211). Instead, Somali refugees often rely on religion and other community members when dealing with mental health issues (Piwowarczyk et al. 2014).

Embodying Illness

Nancy Krieger expands on the concept of embodiment in regards to social inequality and illness. She writes, "taking literally the notion of 'embodiment', this theory asks how we literally incorporate biologically-from conception to death-our social experiences and express this embodiment in population patterns of health, disease, and well-being" (Krieger 1999:296). Krieger points out that the body is more than a singular physical object—it creates, consumes, excretes, reproduces, and evolves often through social functions of bodily practice and experience. Thus, the theory of embodiment

draws attention to "why and how societal conditions daily produce population distributions of health" (Krieger 1999:296).

The effects of social inequality, including discrimination, are socially structured and sanctioned, "justified by ideology and expressed in interactions, among and between individuals and institutions, intended to maintain privileges for members of dominant groups at the cost of deprivation to others" (Krieger 1999:301). Somali embodiment of discrimination can be traced historically through colonialism, nationally through a collectively shared experience of social suffering as a result of the civil war, and in diaspora based on racial, religious, and perceived legal status. These experiences of discrimination and social inequality are more "visible" than others. Krieger continues, "some experiences of discrimination may be interpersonal and obvious, they are also likely to be institutional and invisible" (Krieger 1999:305).

Compounding Social Factors

The concepts of multiple violences—including everyday, structural, and symbolic—incorporate less obvious forms of institutional discrimination. As Philippe Bourgois writes, "ethnography's challenge is to elucidate the casual chains and gendered linkages in the continuum of violence that buttresses inequality" (2001:5). Bourgois defines political violence as "violence directly and purposefully administered in the name of a political ideology, movement, or state such as the physical repression of dissent by the army or the police as well as its converse, popular armed struggle against a repressive regime" (2001:6). Additionally, structural violence, defined by Bourgois, refers to "the the political-economic organization of society that imposes conditions of physical and

emotional distress, from high morbidity and morality rates to poverty and abusive working conditions" (2001:7). Bourgois defines symbolic violence, a concept developed by Bourdieu, as "how domination operates on an intimate level via the misrecognition of power structures on the part of the dominated who collude in their own oppression to the extern that every time they perceive and judge the social order through categories that make it appear natural and self-evident" (Bourgois 2001:8).

Applying each of Bourgois's concepts to the experience of Somali diaspora calls attention to political violence experienced in Somalia at the hands of the Somali government and later through the brutal civil war. Structural violence among Somalis in diaspora is evident in discriminatory social environments and limited opportunities for economic mobility as a result of language and cultural barriers in a host country. Finally, symbolic violence may be illuminated by the "self-evident" external-other perceptions of Somalis as "outsiders" in the West; perhaps justified by skin color, religion, and language. In day-to-day life this may be demonstrated by the belief that somehow Somalis are "less American" than dominant, white American citizens through rhetoric that recent immigrants are "unwelcome".

The evidence of such violence may be physically embodied through higher rates of disease and illness. As Paul Farmer reminds us, "an anthropology of structural violence necessarily draws on history and biology, just as it necessarily draws on political economy" (2015:308). By analyzing political economic relations and social constructions of youth in South Africa and Brazil, Scheper-Hughes (1996) draws on invisible, political violence. Scheper-Hughes notes that despite contrasting scenarios in both countries, both

share an oppressive political history. This suggests that invisible and political violence may be applied to various countries with a similar history and discriminatory treatment along class and racial lines including Somalia and the United States.

In order to grasp the complexity of illness among Somalis in the United States, the Somali physical and social body must be examined as bearers of collective traumas and suffering from the civil war. As Shire (2013) reminds us *you brought the war with you unknowingly, perhaps.* And yet, in diaspora other social factors of discrimination, economic immobility, language barriers, and structural issues compound Somali experiences with illness often manifesting in embodied, somatic ways. Practices of the body, food and consumption values, and chronic health conditions, including diabetes, PTSD, and depression, are ways to "see" how Somalis bring their diaspora experience and the civil war with them to the United States.

METHODS

From Diabetes to the Body

In September 2014, just a few weeks after moving from Kentucky to Boston, I became involved at a Barakah Institute,[15] a local mosque and community center. The mosque became a central location for my fieldwork that spanned three blocks to Somali women's houses, a nearby Somali restaurant, and a health clinic in the Roxbury neighborhood. My interest in refugee and immigrant care led me to design a qualitative anthropological study among Somalis in Boston. Using grounded theory methodology, I proposed to identify barriers and facilitators to treatment and management of type II diabetes mellitus (referred to as diabetes from here on). However, my aims shifted once I established a rapport with Somali women in Boston. Modified grounded theory allowed for multiple paths and flexibility in examining Somali perspectives of health and the body in diaspora.

Research Question and Aims

To answer my original research question, how Somali Muslims in Boston perceive and manage or treat diabetes, I developed a semi-structured interview guide to cover the following question: what factors do Somali refugees and immigrants associate with care and management of diabetes? In addition, I asked physicians and Somali community leaders to answer: what factors do others perceive are associated with diabetes among Somali immigrants and refugees in the United States? These research questions were meant to identify barriers and facilitators to care and management in order

[15] Pseudonym, developed by my key informant, Ayan.

to redirect services and aid in treatment and prevention efforts of diabetes among Somalis in the Unites States.

Initial Research Proposal to the Institutional Review Board

This study was designed as an anthropological, mixed methods research project involving participant observation, interviews, pre-existing de-identified quantitative health data, and community based participatory research through a photography component, Photovoice. I recruited participants from the Barakah Institute and through Greater Boston Muslim Health Initiative (GBMHI) events. Because it would be difficult to find refugees and immigrants willing to discuss their diabetes diagnosis and/or other health conditions, I proposed convenience and respondent-driven sampling. Due to possible language barriers and refugee history, a total of ten to fifteen participants was considered ideal for data saturation.

I planned to interview Somalis with diabetes, Somali community leaders, and physicians who treat Somalis with diabetes. I proposed this diverse group of participants for comparative purposes. The interviews were to be between thirty and sixty minutes in length, depending upon the participants' wishes. I used a semi-structured approach that was broad, yet direct when asking questions. I chose six topics to address: (1) when diagnosis occurred (2) initial reactions to diagnosis (3) management advice received (4) how individuals manage or treat diabetes (5) reflections or perceptions about diagnosis (6) what material or information is perceived as most helpful in understanding diabetes.

Ethical Considerations

Because refugees have likely experienced trauma and adjustments while moving

to the United States, particularly with governmental agencies, it is conceivable that some potential participants would be concerned about their confidentiality or documentation status, which could put them at risk for harm. To address this concern, I de-identified all data collected and used pseudonyms in their notes. In addition, I use composite profiles of participants rather than detailed case studies to avoid identification of participants. The composite profiles I created obscure certain aspects of identifying characteristics such as tribe, specific employment agency, and specific location of residence.

If at any time during an interview a participant seemed to be on the verge of discomfort in sharing their views and experiences, the interview would have been stopped, though this issue did not arise. To avoid any appearance or perception of coercion, given that I recruited refugees whose first language was not English, pains were taken to clarify that participation was entirely optional, would result in no immediate benefit to them, and that they should only participate if they are entirely comfortable doing so. I verbally clarified that a decision to participate or not would in no way affect personal relationships. Furthermore, I ensured to recruited participants that I had existing relationships with, or mutual trusted connection, in order to form an added layer of trust.

Results

As a qualitative anthropological study, I incorporated participant observation. Therefore, finding an internship and field site required that I be able to directly work and interact with Somali refugees and/or immigrants. Originally I hoped to enter a field site through a refugee resettlement agency or community health program. In Kentucky, I had experience working in a refugee resettlement agency and felt I was qualified for a similar

position in Boston. After reaching out to potential internship and field sites, I realized that these organizations could not guarantee interactions with Somali refugees and/or immigrants in particular.

Setting

Reluctantly, I entered an internship at the Barakah Institute toward the end of September 2014. The Barakah Institute is a grand, ornate mosque and community center in the Roxbury neighborhood. It takes up a large corner of the block, hosts an Islamic school, and its minaret can be seen from several blocks away. The community center and mosque hosts Muslims from many different countries, which is demonstrated by food options (including Somali sambousa, Moroccan bread, and Malaysian tea), languages spoken within the mosque, and dress. For instance, some women wear long all-black *abayas*, other prefer bright colors and patterns, and some women wear a fashionable scarf with jeans and T-shirts; each are "indicators" of ethnicity or nationality. After several weeks of noticing these differences, I was able to "guess", to some degree, where women at the mosque were from. Originally, I believed the religious setting of this recruitment site would prevent me from forming relationships with Somalis that would be willing to talk with me about health. However, I was accepted on a health team at the mosque and community center.

My position on the health team included creating a resource guide but provided little interaction with Muslims and Somalis. Later I was advised to enroll in a weekly Islamic Arabic class held at the Barakah Institute. My health team supervisor suggested I take the class to interact with Somali women while improving my Arabic communication

skills. Once I exhausted my usefulness on the health team, I began to take on responsibilities with GBMHI. Soon thereafter I became outreach chair for the organization. The tasks I was assigned through GBMHI included: conducting interviews, transcribing and coding interviews, helping with survey mapping, networking with potential participants for a study on social network mapping of Muslim health resources.

Although my entry into an internship site felt like a challenge, I believe these two different and distinct roles working with Somalis and Muslims were well suited for my research project. My position as a peer and Arabic student at the Barakah Institute cultivated as aspect of respect, piqued curiosity about myself and my project, and ultimately allowed me form close personal connections with Somali women. My interest in Islam and Arabic made my Somali peers exclaim *Mashallah*, a phrase of appreciation, and taught me more about Islam. My role in the GBMHI allowed me to connect to various health professionals and community activists including: physicians, psychiatrists, community leaders, and advocates. These individuals offered advice, interest in health practices and cultural understandings, and connections for my research. If I had met Somalis through a resettlement agency or community health program, I believe power and social dynamics would be more obvious and divisive. Although I have attempted to avoid shaping my internship site drastically, I believe my presence allows Somali women to 'teach' me about Islam, Somalia, and social rules as friends.

When not at the mosque, I often went to a Somali owned restaurant nearby. Its guests are primarily Somali and Arab men, although occasionally non-Somali and non-Muslim patrons comes to enjoy spaghetti and rice dishes. My first time visiting the

restaurant, I was taken aback by the tomato aroma that filled the block leading to its entrance. I had not expected spaghetti and pasta to be a main dish served at the restaurant. Inside, the walls are covered with wood paneling and paintings in an "African" style of food. Pasta, spaghetti, bowls of milk, and rice are not only decorative but showcase the menu. At the restaurant, I was able to observe eating habits and become more familiar with Somali food in this setting. I particularly enjoyed my weekly Somali tea. If the restaurant was crowded or my key informant, Ayan, was home, I walked over to her house. Our weekly meetings outside the mosque were spent cooking together and drinking tea. Within a few months of learning Arabic and coming over for food and tea, Ayan took on a role as my adoptive mother or *hooyo*[16]. My *hooyo* and key informant, Ayan, encouraged me in my research, read through my notes as my research progressed, often clarified points I came across in literature, and offered insights and suggestions for my work. In addition, she helped me incorporate questions about the body that extended beyond diabetes. Therefore, as a result of her encouragement, I began to ask about other bodily practices, dietary choices, and mental health issues.

As Elizabeth Fernea (1989) describes life in an Iraqi village in her ethnography *Guests of the Sheik*. Fernea (1989) discusses her positionality as a female among Muslim women; because of her role as a woman, she had access to spaces her partner, Bob, did not. Therefore, she would take fieldnotes in these regular meetings and intimate female interactions. Similarly, my positionality as a female allowed me to gain access to Somali women that a male researcher may not have been able to witness. The gendered

[16] Hooyo is a Somali term for mother.

difference of data collection was highlighted when my father came to Boston to visit. He was escorted, with the men, to Friday prayer. I took my usual place next to Ayan and Dahabo upstairs. When my father and I reunited for lunch, he described his interactions with Somali men and being introduced to the director of the mosque. This was a privilege I was not afforded because of my role as a woman and my interactions with women, who share different experiences and opportunities in gendered social spaces.

Documenting Settings and Events through Photography

In order to capture the intimacy, beauty, and inspiration that I felt doing my research, I often photographed aspects of daily life with my Somali participants. This included: food, food preparation, dress, and Islamic rituals including prayer and Qur'anic recitation. Photography not only acted as a visual component of cultivating personal memory but also as a constructive reminder of how to complete various tasks, particularly in food preparation, in the "correct" Somali way. Susan Sontag writes, "photography has become one of the principal devices for experiencing something, for giving an appearance of participation" (1977:10). The power of photography in conveying social and political messages can be seen in magazines and newspapers. Online platforms, too, take advantage of messages conveyed in photographic form. While photographs may furnish evidence (Sontag 1977:5), they may also be used to control, misrepresent, or enlarge realities that seem hidden.

Initially, I began photographing environmental settings around the neighborhood I was working in, including murals and restaurant fronts. Next, I began asking participants if I could photograph events or experiences. Toward the end of data collection,

participants would ask me to take photos of specific activities or tasks and photos with them for personal memory. Through photography, I was able to discern what kinds of events and practices are most important and therefore, worth documenting.

Recruitment

In order to recruit individuals for my study, I developed flyers and distributed them to GBMHI contacts and at my Arabic class at the Barakah Institute. Ayan advised that word of mouth was the best way to reach Somalis in Boston. She mentioned that many Somalis may not be literate in English although they may be able to speak English. In addition to flyers, I developed an email and phone scripts and began to contact potential informants using phone or email. After meeting Somalis interested in my topic, I asked if they would let me know if others would be willing to participate. Most of my interviews developed from respondent driven sampling through contacts of Somalis that I built relationships with in my two field sites at the Barakah Institute and GBMHI events.

Interviews and Participants

My research project was approved by the IRB in March 2015 and I began interviewing in May 2015, after establishing relationships with the women in Arabic class. Between May 2015 and September 2015, I formally interviewed six participants including three Muslim physicians, one who was Somali. All the physicians I interviewed work with Somali patients at a local clinic in the Roxbury neighborhood near Barakah Institute. The other three participants were Somalis living in Boston. The youngest participant was twenty-five and the oldest was in her sixties. Five participants were female and one participant was male; Jama agreed to talk about his own diabetes

diagnosis. My position as a female likely influenced the fact that most of my participants were mostly. However, Jama's perspective as a Somali man and as a Somali with diabetes was useful in triangulating the data I was receiving from Somali women or women working with Somali women. On average the interviews lasted around thirty minutes with the shortest lasting thirteen minutes and the longest lasting approximately sixty minutes. In addition to formal interviews, I informally interviewed four Somali women who either work with Somalis or who have diabetes.

I developed my interview guide for Somali's with diabetes; the questions were broad in order to allow participants the opportunity to share their experiences and perceptions in accordance to modified grounded theory methodology. I re-framed questions about personal diagnosis for physicians and Somalis without diabetes to address how Somalis they knew with diabetes typically reacted to diagnosis and management. All participants worked closely with Somalis with diabetes and/or had a close relative with diabetes.

Quantitative Health Data and Photovoice

The quantitative health data I obtained from a prior study conducted by Harvard Family Van did not reveal the type of data I had originally believed it would. Instead of providing de-identified health information, it illuminated challenges and barriers to diabetes management for the entire Roxbury neighborhood. However, Somali women at the mosque began to open up about the experience working with Harvard Family Van and expressed disappointment with the lack of communication after the project was completed. Overall, this aspect of my research yielded qualitative field note data.

Similarly, the Photovoice aspect of my research project did not yield results. After several attempts to reach out to Somali community members, the Photovoice component reached a halt. After understanding the importance of food, particularly Somali food, I thought photographing Somali food would be a great way for Somalis to open up about eating habits. Due to time limitations to complete this project, I ended up not utilizing this method of data collection. However, Photovoice could be a powerful and useful perspective to explore in future projects.

Chasing Modified Grounded Theory

After several months of involvement in this qualitative research study, I began to notice a shift in topic with participants. I was told on several occasions that diabetes was not a "serious" disease. Instead, participants opened up to share information on how the concept of the body and diet becomes part of life, and sometimes a source of conflict in diaspora. Ayan and others taught me to ask different questions that were more important to them, such as: how does embodiment of the diaspora experience shapes Somali perceptions of diabetes and mental illness? Thus, I remained responsive to data although at times this felt like I was chasing a moving target. My thesis argument shifted many times as I collected more information.

Grounded theory presupposes a researcher will follow data in the field without imposing expectations on data. Russell Bernard writes, "grounded theory approach is a set of techniques for (1) identifying categories and concepts that emerge from text; (2) linking the concepts into a substantive and formal theories" (2006:492). Although I originally began my project as a study on diabetes, my research expanded to incorporate

other bodily changes and practices after participants began to speak more about the body, and embodiment, than diabetes. The body, then, is a way to frame life in diaspora including experiences with diabetes although it yielded information about mental illness, chronic disease experiences, body ideals, and diet more directly.

Data Processing and Analysis

All interviews were conducted with a hand-held recorder and transcribed on my computer using ITunes and Microsoft Word. I focused mainly on content when transcribing interviews. As Philippe Bourgois and Jeff Schonberg note, "transcribing accents and pronunciation is especially problematic because a phonetic representation of language can distance readers from 'cultural others'" (2009:12). Because Somalis in the US are seen as 'cultural others' in more ways than language use, it was essential that I keep their messages authentic in their meaning. In an effort to convey the personalities of my participants as well as social factors linked to language use—particularly the fact that English was not their first language—I kept certain aspects of speech present. However, occasionally I deleted redundancies and clarified syntax in order to ensure my participants voices could be "heard".

I employed modified grounded theory methodology to analyze and process data. As Kathy Charmaz writes, "grounded theory methods consist of systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories from the data themselves. Thus researchers construct a theory 'grounded' in their data" (2014:1). Grounded theory methodology involves simultaneous collection and analysis of data (Charmaz 2014:7). In addition, it includes open, inductive coding and creating memos to

elaborate on categories and their relationships for analysis. I was able to develop theory from these larger concepts identified through memo-ing. I found that hand coding produced more extensive reflection and computer assisted data analysis Nvivo software facilitated in narrowing down larger themes within the data. Therefore, I uploaded field notes and informal interview notes to Nvivo to identify major themes and concepts to add to my comparative analysis. I ultimately used a modified approach to grounded theory (See Charmaz 2014 8) as a result of collecting literature before and during the process of data collection.

Because I wanted my research project to have an applied focus, I relied on a critical medical anthropology (CMA) framework to interpret data. The nature of health care disparities involves personal, social, and political perspectives as CMA emphasizes. Understanding the limitations of focusing on larger social structures, I incorporate phenomenological experiences of illness and treatment. This multi-dimensional viewpoint allows for Somali experiences and perspectives to shine through while simultaneously acknowledging disease disparities, often expressed phenomenologically.

In accordance to modified grounded theory methodology, my first round of analysis included line-by-line hand coding, structured narrative analysis, and memo making. This allowed me to identify categories and concepts as they emerged from the text, as Bernard describes (2006:492). As more interviews were collected I could compare codes and distinguish categories. The comparisons proved useful in developing relationships and gaps between larger themes that emerged from the data. Second, I used focused coding to advance the direction of my work; these were more conceptual than

line-by-line codes (Charmaz 2014:138). Finally, I uploaded interviews and field notes in Nvivo software to apply theoretical coding. This helped me compare themes and categories (i.e. codes) easily among all interviews in order to develop theory. Throughout the process of analyzing data, I frequently visited my key informant. During these weekly meetings, I asked for advice on how to approach topics, what terms were preferred, and if themes I had identified were "correct".

CHAPTER IV

EMBEDDED IDEALS: SOMALI BODY IDEALS IN DIASPORA

In diaspora, the body becomes an individual's central and most visible form of expression, subjected to both external and internal perceptions. The expressive physical, personal body acts as a system that responds to a social system or social body (Douglas 1996 [1970]:91). The social collective body represents shared ideals, values, and goals influenced by the power and political structures of the body politic (Scheper-Hughes and Lock 1987). Knowledge and power, as political tools and techniques, control the social and thus the individual body.

Marcel Mauss recognizes the body as a person's first and most natural instrument and an object of practical means (Loong 2013). The individual body acts as a physical object that individuals use to express and experience the world. By emphasizing the lived experience, scholars actively draw on phenomenology to understand these experiences of individual bodies (Shilling and Mellow 2007). Bodies have clear physical boundaries, which separate them from the outside world. Yet they also have points of entry and exchange that connect the body to exterior spaces (Masi de Casanova and Jafar 2013:ix). In diaspora, multiple entry points for exchange compete to re-shape bodily practices and ideals.

Diaspora offers opportunities for Somalis to create and re-create ethnic individual-identifications from deeply rooted social values, especially regarding gender and religion. Forced migration, as Cathrine Brun and Anita Fábos (2015) remind us, add to a layer of identification that cannot be unhinged from the complex notion of "home".

Similarly, the concept of place is dynamic and encompasses physical, social, economic, and cultural realities (Brun and Fábos 2015:6). By tying in the concepts of place and home, Somali refugees are able to proclaim their singularity from and shared values with other Muslim and Black Americans in the U.S. As Fábos (2008) points out, Muslim Sudanese in Cairo use ethnic identification as an ambiguous and flexible tool to voice their unique concerns and values while simultaneously acknowledging a shared identification with the Egyptian community. Fábos (2011) found that Sudanese in the UK and in Egypt express their ethnic identification as a form of resistance to racial labelling. Similarly, my Somali participants in the U.S. reject racial labels of "African American" in favor of "Somali", regardless of country of birth, to convey larger social and religious values held with Somali identification.

As Muslims, Somali women in the U.S. also face external perception from visible Islamic practices and may also resist or accept labelling. Gentles-Peart (2013:25) acknowledges that women's bodies are most vividly policed by cultural and ideological norms and regulations. This is especially true for Muslim women who veil. Visually, Muslim women are more prone to external and internal self-surveillance of their bodies on a day-to-day basis in the U.S. due to Muslims' minority status. Therefore, within this chapter I specifically focus on Somali women's perceptions of bodily ideals and practices. I argue that the body is both an *object* targeted by power and political structures as well as a *subject* of expression in diaspora. First, I outline Somali ideals of the body. Next I illuminate viewpoints of Islam and its role in shaping Somali bodily practice. Finally, I discuss Somali cultural and beautification practices of the body, including

henna and infibulation. I take into account generational differences and various structural components that shape and influence expressions of and upon the body.

The social body and body politic shape perceptions of the ideal body (Scheper-Hughes and Lock 1987). Cultural values inform the ideal body and motivate individual self-surveillance of the body. In turn, self-surveillance influences bodily practices to cultivate an "ideal" image of the self. Women in many societies are particularly associated with self-surveillance of the body (Gentles-Peart 2013). In diaspora, however, shared values and ideals may shift. Cultural ideals of the body and bodily practices are formed by and interact with new ideals and bodily practices within the diaspora community.

The Ideal Somali Body

Somali ideals of the body, particularly body size, convey deeply rooted cultural values. As Gele and Mbalilaki (2013) suggest body size can symbolize success, wealth, good health and happiness for Somalis in Oslo. Ayan explains the Somali preferences for a bigger body:

> The African style, the Somali style, is the heavier you are, the prettier you are. [**Ok, so Somalis here still believe that?**[17]] Yeah, the older fashioned people. If I'm walking on the street or somebody saw me they would say 'oh my goodness, what happened to you? You better eat some more' [*laughter*]. That is their perception of health. [18]

Ayan's comment not only demonstrates a physical appreciation for body size related to beauty, it also illuminates cultural ties between a larger body size and a healthier body. She relates this body ideal to preferences across Africa and Somalia.

[17] Bold text indicates author's questions; "here" references the United States
[18] Interview with Ayan, September 3, 2015

Dr. Saaye, a Somali physician at a clinic in Roxbury, similarly reflects on Somalis' body size preferences and underlying cultural values that influence them:

> So maybe culture wise, we come from [a] poor country so only people who has enough food may gain weight…So maybe people are avoiding to be stigmatized, like 'you skinny, you poor'. [19]

Dr. Saaye's explanation of body size preferences link visual appearance to wealth or economic prosperity, conveying larger social messages. The cultural value placed on larger body sizes represents socio-economic strains in Somalia that hinder weight gain; however, larger body sizes indicate a person is beautiful, healthy, and economically able to feed themselves.

Ladan, a twenty-five-year-old Somali woman and the youngest participant in my study, left the Somali community to attend a university outside of Boston. She spent her college years learning about Islam and health. She later came back to the Somali community in Boston to promote healthy living through diet and exercise. Like Dr. Saaye, Ladan contextualizes body preferences by highlighting economic constraints in Somalia:

> Well, right now, there's huge malnutrition going on back in Somalia. Three million people suffer from malnutrition. So I'm just gonna say people are skinnier there compared to what they want, a lot of hunger and homeless back then. But they most[ly] like really bigger, healthy body weight. [20]

The social forces that restrict Somalis' ability to gain an ideal, big body reflect larger social ills and the effects of structural violence plaguing Somalia from the civil war. As Paul Farmer (2005) reminds us, structural violence refers to the systematic way social

[19] Interview with Dr. Saaye, May 19, 2015.
[20] Interview with Ladan, July 11, 2015

structures harm individuals and manifest in individual bodies. The systematic harm in this case operates on a social, economic, and political scale, with downstream effects on cultural ideals and beauty norms, among Somalis in diaspora.

Cultural practices perpetuate and explain body ideals and preferences. Storytelling and humor are some ways these ideals are shared by Somalis. Dr. Saaye describes a comedy put on by Somalis in the United States. This comedy both makes fun of and contrasts body ideals and the connotations these ideals carry within the United States and Somalia:

> There was two people looking for a, they came to someone they don't know. But he was a guy who had a store in the neighborhood. But these people, he didn't know them very well. But he saw them several times. He had seen them. But he didn't know them, where they came from. So the two people come up and say can you borrow [lend] us some money? And we will give you tomorrow like $20 or something. One was so skinny. And the other one was kind of chubby. And he said if I wanted to lend my money to one of you, I want to give it to the chubby one. [*laughter*] Because I know he can give me my money because I see that he feeds [eats] very well and he has money. And it was the opposite. The other one's family was richer than the other one. But this one was skinny [*laughter*] It was in a comedy . . . that they made the joke in the United States. They are showing how people in our country were thinking how the skinny person . . . and he said no, no, no I don't know you. If I want to give my money to one of you I want to give it to the fat one, not the skinny one.

When telling me about this comedy, Dr. Saaye, an already upbeat and lively woman, laughed hysterically; at some points, her laughter overtook her ability to speak. Her story about the Somali comedy uses humor to convey assumptions made based on the physical, perceivable body. In this case, the skinny body symbolizes low economic status and untrustworthiness for Somalis. Later, Dr. Saaye explains that she is aware of differing body ideals in the United States that emphasize and associate the "small," meaning slim, body with attractiveness and good health. Because the comedy was

performed in the United States, the joke about the skinny man having money to pay back the loan may reflect the hilarity and unfamiliarity with the preference for slim body ideals.

Traditional Somali body ideals emphasize a "big," or plump, body. Dr. Saaye emphasizes, "some people in my country, culture wise, people they don't like skinny people." However, as Ayan mentions earlier, this is not only perceived as the Somali style, but also the African (and possibly Arab) style. These preferences reflect the embodiment of social structures that carry the association of wealth to larger body sizes. A larger body size preference, as a symbol of social or monetary wealth, also contributes to the formation of beauty ideals. Therefore, the body's size reflects social structures and also becomes part of generating social values of "beauty" and "good health".

Altering Body Ideals

Somalis in diaspora may be able—socially and economically—to gain desired weight and a larger body size, even as divergent bodily beauty and health ideals present themselves within a new host country. Dr. Saaye, like other Somali women, is aware of contrasting body ideals in the U.S. Competing ideals are often enacted along generational lines. Ayan explains how younger Somalis carry new ideals of a smaller body in contrast to their parents:

> Younger Somalis who grew up here, raised here mostly, they watch what they eat. [**They do?**] Yeah, getting heavy is not something that is expectable. They avoid it and they would like to lose more … And the thing is, I feel that ok the mom has to understand her daughter even though she says 'you better eat, you're so skinny'. But from maybe the T.V., the media, this and that, they know that the skinnier, the better.

Ayan links the generational differences of Somali body ideals to Western media, namely the T.V. Younger Somalis who are heavily influences by American peers and American movies, shows, and magazines more readily adopt "Western" body size ideals. Ayan hints at familial conflicts between parents and their children who view body size in very different ways; the mother who believes "skinny" is "unhealthy" and the daughter who believes bigger is unacceptable.

Ladan, a young Somali raised in the United States, suggests factors that contribute to why older Somali women may not be *as* concerned about their weight or adopt body ideals held in the United States, regardless of education or Americanization:

> They're old and they already lived life and they already have a bunch of kids so they're not really concerned with yeah, body image. Yeah, they're not trying to impress anyone. And the dress code is mostly universal so, they wouldn't have to worry about you know cleavage or you know what I'm saying; stuff that kind of triggers you to want to change your body image.

Ladan's comments reflect her acceptance of a more, and self-confessed, "American" understanding of body ideals. Although she may not pursue a "white" ideal of thinness (Gentles-Peart 2013:37), Ladan aims to look and feel healthy. Her suggestion that married or unavailable women, including mothers, do not "align themselves with the dominant standards of beauty . . . reinforces the ideal that women's bodies are primarily for the consumption of others" (Gentles-Peart 2013:41). By situating older Somali women's ideals of beauty as more or less irrelevant to self and external perception, Ladan frames the physical female body as an object of value solely for marriage and reproduction. Her comments, aligned with Ayan's, demonstrate the tensions Ayan alluded to between mother and daughter; both addressing ideal body size from two

unique perspectives.

While some forms of cultural bodily practice are made visible, others are carried through speech. As I became more involved in Somali gatherings and events, I noticed the use of the word "moms" and "mami". To my surprise, "mami" was not a term of endearment per se but rather a term of respect to refer to women as mothers. Ayan frequently referred to the women in my Arabic class as "Somali moms" rather than Somali women. The ideal role for a woman is made clear through these aspects of speech. A woman is a mother above all other responsibilities. The value placed on reproduction and motherhood is demonstrated through these references.

However, Somalis' acceptance and adoption of body ideals prevalent in the United States are not entirely exclusive to younger generations and as a result of reproductive value. Dr. Saaye identifies length of residence in the United States as another factor:

> The people, even if they are like twenty or fifty years older but they recently arrive, they still have the mentality you know [preference for a larger body]. So I know one girl, she was very skinny and she was pregnant when she came in and her husband brought her here. She was 19 years-old and she was very beautiful girl; tall, like she was 5'7 or 5'8 I think. She was like, for Somalian views, she was very skinny but her BMI was perfect.

Dr. Saaye's comment about her BMI being "perfect" yet being "skinny" for Somali views hints at differing body expectations between the American medical system and media and Somali preferences. She continues:

> And when she delivered she gained a lot of weight. And I didn't recognize her after six months and I said 'oh my god I did not recognize you' and she said 'oh, I was waiting [for] this for years'. She was happy to gain weight. But she looked really fat. [*laughter*] And I said listen, you are very young. You are twenty years [old] now . . . And I said you don't have to gain a lot of weight. And she said 'Uh

> oh, you don't know how I was struggling to be skinny and people are you know like no, are you hungry?' and this and this and this, because she came from a refugee camp … And now she cannot wait to go to America and feed herself and gain weight.

Dr. Saaye's story of the young Somali girl shows that some Somalis link life in the United States with ability to gain weight, which they are eager to do. The United States, then, represents a place where Somalis will be more economically stable and therefore able to gain weight. Dr. Saaye's story, again, links economic prosperity to body size. Yet, a new conflict emerges between the Western biomedical system, emphasizing weight loss or management, and Somali peers who pressure Somali women to gain weight. This conflict is often represented by the biomedical body mass index (BMI) scale, which does not always depict an accurate account for health. For example, Alexandria Brewis points out that in contrast to overall BMI measurements, lower abdominal fat even within larger body sizes improves a person's health profile (2011:25).

Dr. Saaye continues by reflecting upon Americanization and education as factors in shifting body ideals:

> Now you know, our Americanized group and educated people now they understand more and they don't want to gain a lot of weight. [. . .] All my, you know, my family members also the new generation are all skinny.

Saaye describes the "Americanized" group as educated, who "understand" health in terms of weight and body size. New, Americanized understandings of a healthy weight reflect the adoption of Western biomedical and cultural models of the small, healthy and attractive body in contrast to the traditional Somali large, healthy and attractive body. These new ideals of the body are policed by BMI models that are learned by and taught to Somalis, which operate as a biopolitical tool to regulate the individual body. BMI

measurements conflict with Somali indications of health—as new, weight centric understandings of the body—but is none the less relied upon in the medical setting that many Somalis are now accustomed to in the U.S. As Dr. Saaye mentions, this Somali woman's BMI was "perfect" when she was "skinny" for Somali views and now the woman is encouraged to loose weight at the expense of becoming pressured to gain weight by other Somali peers.

As a political tool of bodily regulation, the BMI model operates on the basis that a high BMI conveys poor health (and unattractiveness). However, several scholars have contested its direct correlation to health. The "obesity paradox" is conveyed by Horwich et al. (2011) who note that "contrary to expectations, an increased BMI has been associated with improved, rather than impaired, outcomes in a broad range of heart failure"; thus the obesity paradox. Susan Greenhalgh (2015) criticizes the emphasis on using the BMI model. Instead, she suggests that like height, weight is relatively biological and genetic-based part of our bodily-identification. Therefore, our body weight be accepted and respected rather than condemned and used as a tool to create a "good" biocitizen. Greenhalgh contends, "instead of wasting time and money" to achieve artificial standards of thinness, we should address being "healthy" at every size (2015:11).

Medicalizing "Foreign" Body Ideals

Western biomedicine not only aesthetically emphasizes a slim body; it also associates the slim body with good health. Although Somali women in the United States may face culturally dissonant expectations of body ideals and even accept these as the

ideal of their new environment, they may still resist medicalizing or pathologizing a larger body as unhealthy. Ayan mentions some common interactions between healthcare providers and Somalis:

> When the doctor says you need to lose weight it's like 'oh here he goes again, he keeps talking about weight. I'm losing so much' and if you see them they're two hundred pounds.

Some Somali patients feel misunderstood and criticized by doctors who focus on weight rather than acknowledging different cultural ideals of health and beauty. These interactions cause Somali patients to question their doctor's competence and sometimes dismiss their doctor's suggestions.

Dr. Saaye, as a Somali physician working in the United States, emphasizes the importance of education about weight through discussion of BMI with her Somali patients:

> Sometimes I explain to them about the BMI, the height and the weight of the people and how you know […] Yeah, the first time BMI I heard - I studied my medical college in Somalia - but the first time I heard BMI was in Boston.

Saaye demonstrates that the concept and use of BMI is not universal, therefore BMI may be constructed to hold symbolic meanings of Western biomedical control of the body. She links BMI and its meaning to education: she had to be educated about healthy weight and therefore knows Somalis who come to the United States must also be educated.

Once the concept and understanding of BMI is explained to Somali patients, other educational needs surrounding attainment of a healthy body are necessary. Dr. Saaye recognizes challenges some Somali patients have with the concept of having to lose weight:

> Some people you know when you say you have to lose weight or else you'll get some chronic disease like high blood pressure or diabetes. And they said I know, the doctor told me but I don't know how to lose this. You have to walk, you have to.

Dr. Saaye addresses how attainment of a new integrated body ideal, linked particularly to health becomes a challenge. As a Somali woman and physician, her advice to Somalis may be taken seriously in contrast to Ayan's earlier observation that many Somali patients believe "American" doctors do not understand Somali culture. Brewis reminds us, as Ayan alludes, that the Western biomedical system is a culture in itself that carries its own cultural values and ideal; particularly surrounding the "thin" body as a model of self-control, health, and attractiveness (2011:7).

Dr. Saaye has learned Western cultural values and ideals of the body and now operates between two viewpoints: Western biomedical emphasis of weight management and Somali emphasis on attaining a larger body. As a broker of sorts, Dr. Saaye acts as an educator in the sense of her role in the clinic and socially, as a Somali woman. Despite Dr. Saaye's role and adoption of the BMI model as an indicator of health, Western scholars have begun to contest BMI as an accurate portrait of health. As noted earlier, Brewis (2011) points out abdominal fat is a more comprehensive indicator of health rather than overall size.

Islam and the Body

As I walk toward the gymnasium across the street from the mosque with hooyo Ayan to pray for Eid Al-Adha, she calls out "No!" when I go to cross Malcolm X Boulevard. The sidewalks and streets are packed with Muslims from different backgrounds and different countries, dressed in a variety of styles and colors. A multitude of languages, expressions, and laughter pour into the street; there is excitement in the air. Cars try to weave through the rush of people going to pray. A couple of police

officers, white, are attempting to keep things organized. They are stopping traffic and waving on groups to cross the street. "Now we can go," Ayan says, at the policeman's nod. As we walk across the street, she leans over to me and tells me that we have to be careful. She continues, "I don't want them to think we're all bad so we need to follow all the rules." [21]

While Islam informs daily practices for many Somalis, being visibly Muslim may invite discriminatory and prejudicial stereotypes from others. Somalis are aware of the varied non-Muslim, external perceptions of Islam in the United States. As Ayan points out, her actions as a visibly faithful Muslim woman may either facilitate discriminatory thoughts and actions or divert them. Her intentionality even in simple acts, such as crossing the street, becomes a reflection of self-surveillance. One can understand self-surveillance as the attention an individual pays to her/his own behavior, particularly when facing observation by others whose opinion is deemed relevant and who tend to be of the same or superior social position (Vaz and Bruno 2003:273).

The recent "Black lives matter" campaign exposed simmering racial tensions in the United States and went from, as Alex Altman (2015) describes, a protest cry to a "genuine political force". As previously noted, although Somalis do not identify as "African American", they may be lumped into this category from their visual appearance of black skin. As Agyemang et al. (2005) acknowledge, "African American" is the preferred term in the U.S. to describe those of black skin; it's generally used to describe Americans who originated from sub-Saharan African as slaves in the 17th and 19th century however, the distinction between those who came to the U.S. from African more recently are ignored. Visual bodily practices and skin color contribute to the formation

[21] Field Notes from Eid Al-Adhar, September 24, 2015

of foreignness in the United States. Although many Americans associate Muslims with Arabs (Shaheen 2014), Africans and African-Americans [22] have a significant history with the practice of Islam. African American conversion to Islam gained momentum in the 1970s as a result of the conversion of key figures in civil rights movements like Malcolm X. In contrast to African-American peers, Somalis consider themselves ethnically and racially Somali. The religious implication of identifying as Somali attaches one to a long history of Islam and Arab influence in their home region. Instead of identifying with other Africans, Somalis often claim to look share more culturally with Arabs (Agyemang et al. 2005).

In addition to the "foreign", Black body of Somalis, the symbolic Muslim body is also politically inscribed as inherently in conflict with the West. Cesari (2010) notes that Islamic terrorism discourse is influenced by cultural stereotypes that is predicted on the binary oppositions of the West versus Islam. Muslims are associated with negative or discriminatory ideals in the United States, which may be observed and perpetuated through various media and Hollywood outlets (Shaheen 2014). Furthermore, the United States since the 1990s has remained skeptical of Islam in the political sphere. For example, after the Oklahoma bombings in 1995, public officials speculated Muslims were responsible (Ewing 2008). Although the study of how Muslims are depicted in media of multiple prints is not new, Aydin and Hammer, note that the topic is becoming

[22] I use the term African American to indicate Americans with African descent brought to American by the slave trade, who have less ties to a particular African nation but are united historically by social oppression.

more complex "requiring new scholarly insights as well as more interdisciplinary approaches" (2010:2).

Informing Daily Practices of the Body

Many religious traditions, including Islam, enact proscriptions and sanctions upon and within the body to ensure health is managed (Tober and Budiani 2007:5). These sanctions and proscriptions upon and within the body relate to forms of religious symbolism of purity. What is sanctioned (*halal*) and what is prohibited (*haram*) in Islam is found in the Qu'ran, as well as Islamic texts such as the Hadith[23] and Sunnah[24] and proscribe practices relating to the body both through expression and consumption.

Islamic reasoning influences a variety of practices and perceptions (Tober and Budiani 2007). Understanding practices of the body dictated by Islamic thought are essential in understanding Somali experiences and practices of the body. By using techniques of community based participatory research, this section is a product of my key informant Ayan's wishes. The importance of Islam is apparent in each conversation with Ayan, from health to personal issues and situations. For instance, while discussing the horrific events of the Somali civil war, Ayan highlights Islam's role among Somalis:

> *Today Ayan mentioned many of those women have seen awful things. She said their faith in Islam is maybe the only reason they are not in a mental hospital or paralyzed by trauma.*[25]

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[23] The Hadith are a collection of reported sayings and behaviors of the Prophet Mohammed compiled by his peers. Some Hadith are considered more legitimate than others (Tober and Budiani 2007:5).

[24] The Sunnah is a set or code of practices of the Prophet Mohammed established during his lifetime. Muslims follow The Sunnah to become closer to Allah. These include performing ablutions before prayer, praying five times a day, and completing the Hajj among others (Tober and Budiani 2007:5).

25 Field Notes with Ayan. June 5, 2015

Fatima, a Muslim convert and physician, similarly shares a similar all-encompassing view of Islam:

> *I mean it* [Islam] *has tools for every kind of situation that you could encounter. . . And I think, too, that the community, like Islam brings everyone together at least on a weekly basis. Usually, not everybody but many, many people come* [to the mosque] *Friday. So it's a chance to interact with each other, enter faith with each other, just share knowledge, share problems.* [26]

Speech is one way for Somalis to embody Islam in daily practices. Islamic phrases *Masha'Allah, Insha'Allah, Hamdulillah*[27] are a few examples of religious embodiment through speech. These "reminders" of piety convey messages to others within the Muslim community and to the larger American population. To other Muslims, these religious phrases exclaim inclusion into a larger Muslim community or *ummah*; to Americans these phrases convey foreignness. Because Somalis hold moral ideals that may diverge from dominant American themes of individuality, sexual freedom, and freedom of self-expression, this foreignness may act as a purposeful barrier or perhaps a marker of symbolic recognition of "kin".

Visual Inscriptions and Perceptions on the Body

Tarlo and Moors (2013) write that veiling practices among Muslim women in the United States and Europe operate on the basis of: concerns about religion, ethnicity, class, generation, and fashion. In addition, they explain various styles worn by women in different regional settings and among women in the same location. For some women,

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26 Recorded Interview with Fatima. July 25, 2015

[27] Masha'Allah: means praise God, often used to show reverence to what was just mentioned in conversation (and to avert the 'ayn evil eye). Insha'Allah: means God willing, often used when making plans and indicates that God is ultimately in control of life. Al-Hamdulillah: means praise to God, used when being thankful of a particular circumstance and accepted as a response to "How are you?".

veiling is a practice of identifying with Islam. For others it goes beyond religious concern to become a feminist practice of confronting sexualization of the female body. Some Muslim women perceive their "secluding Islamic dress" as a means to achieve recognition as full subjects rather than objects of male gaze and desire (Tarlo and Moors 2013).

Many Somali women are culturally attached to veiling practices. However generational differences in dress are apparent among many Somalis in the United States. All my participants wore *hijab,* but occasionally Ayan and I encountered a younger Somali girl without it. Once, Ayan described a family member who wears makeup and does not cover. This was framed as unfortunate, although Ayan admits before she married she also wore make up and did not cover. The choice to veil, as Ayan described, was a personal choice; yet, a choice that should be made. The value in veiling was further demonstrated by Dahabo and Ayan, who gave me scarves to use to cover. They began to notice I wore the same black scarf and wanted to me have options. This appreciated gift and subtle exchange of information conveyed larger concerns about veiling as something that should be done. Ayan said when I wear *hijab*, boys will leave me alone and know I am "serious", which I interpreted as a symbol of purity. I never visited the mosque, the restaurant, or Somali women without my *hijab.* I believe if I had, our interactions would have been marked by hesitation. I did however, take off my scarf in the privacy of their homes occasionally to readjust my *hijab*. This often led to discussion of my hair and was part of the intimate relationship we had established. It also led to some Somali women showing me their hair, too, often noting the white coming in and reflecting on the style

they wore (beneath the *hijab*) in their younger years.

While younger Somali women do not necessarily avoid the *hijab*, or veil, it is more common to see a Somali girl without the veil than an older "mom". Older Somali women tend to express concern over younger Somali women's choice not to veil. However, some Somali moms have mentioned not having put on the *hijab* until they were older. The conflicting expressions of how and when one should veil demonstrates multiple influences on bodily practice from the community in diaspora, Western ideals, and Somali ideals from home.

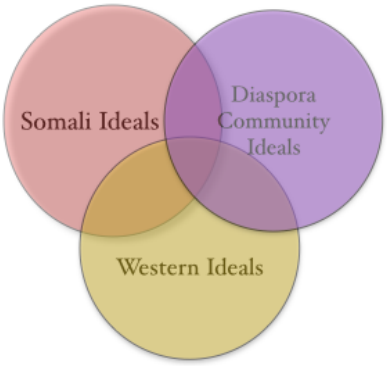

Figure 2: Competing Ideals. Diagram by author.

Religious visual markers become an object for outsider perception as well. Ayan demonstrates how dominant American culture associates the *hijab* as foreign:

> *We continued talking about life in America and I asked her about her hijab or experiences wearing a hijab in the pharmacy. She mentioned that for the most part she is respected but has had a few incidents with customers. She relayed one story in particular about a man who (rudely) asked, "Do you even speak English?" She said that she responded to him, "Why don't you try me?"* [28]

Religious Islamic dress, particularly for women, is a reflection and expression of an inner pious state of being. This performance of piousness through acts of bodily practice

[28] Fieldnotes June 5, 2015

including dress and speech symbolizes piety, purity, and agency. Tarlo and Moors (2013:6) argue that this performance is a technique of the self, which not only serves as a public marker but also as a way to train oneself to be pious, involved in the production of subjectivity.

Cultural Bodily Practices

Culture mediates the way individuals understand the world through bodily knowledge and the ways the body is utilized (Loong 2013:1). Cultural citizenship is obtained through practices of the body and body politic (Gentles-Peart 2013:25). Dr. Saaye clarifies the definition of culture: "it's food really, and language, for example clothing, that's the culture. And religion and blood." The aspects of Somali culture are all related to or are practices of the body. Language and food unite Somalis in cultural interactions with one another. Clothing is a visible part of Somali culture, particularly in the United States. Religion and blood reference the history of Somalia, filled with war and religious influence. The concept of blood may relate directly to the Somali civil war in which individuals were pinned against one another by tribal family connections, hence by blood.

Women promote consistent social and self-regulation of body practices, thus serving as subjects of bodily surveillance. In migration and diaspora, women enter new environments with body politics refined in their homeland. There is a distinct connection between the body and cultural identification (Gentles-Peart 2013). While religious bodily practices may become associated with cultural practices due to the perception that religion is a cultural tradition and practice of the body, cultural practices go beyond

religious influence.

Jamaa, Ayan's husband and revered Somali community leader who has earned the title *Imam*[29] from friends at the mosque, illustrates the ambiguity between religious and cultural embodiment:

> Well you know sometimes there are separate issues that people get the knowledge from the religion when it comes to their health. For instance, back home they have circumcision those things. Here it's illegal. Back home they do those that they think are Islamic. [30]

Jamaa's comment reflects the inter-connectedness between religious and cultural practices yet Jamaa emphasizes that although they "they think" these practices are Islamic, they are not. Because the majority of Somalis are Muslim, Islam may be seen as part of the cultural tradition, thus obscuring practices of the body that may be labelled "Islamic" versus "Somali culture".

Cultural Dress and Body Decoration

Cultural practices such as dress and other bodily decorations convey membership and non-memberships within a community. Through bodily decorations, identification as "Somali" or "American" can be embodied "making these abstract concepts available for critique and refinement" (Akou 2011:2). Akou continues, "a nation cannot be seen or felt, but it can be expressed through the body" (2011:2). Therefore, dress and other body decoration is a form of non-verbal communication and symbolic exchange in diaspora.

Before the civil war in Somalia, Somali men and women wore Western styles of clothing, according to Ayan. The civil war and the collapse of the Bair regime, however,

[29] Imam is a term for a religious leader
[30] Interview with Jamaa, September 3, 2015

sparked a movement toward Islamic governance, or government rule based on Islamic tradition. Political support for Islamic control became embodied through dress. Islamic style of dress become a way to align individuals and groups to political Islamic governance (Akou 2011).

Ladan discusses the link between religion and culture in choosing appropriate Somali attire. Many women wear loose, long dresses with long veils in bright and colorful patterns. Women, in particular, choose Islamic dress for religious and cultural reasons:

> Yeah, religious reasons and also cultural reasons. You know what might not be religious but they're cultured to dress like that. So, it's a bit of both mixed together.[31]

Like Jamaa, Ladan addresses clothing choice as a cultural and religious practice. In this way, clothing is not only representative of political influence and alignment but also inscribed upon the body, which blurs religious and cultural tradition.

In addition to symbolic political dress, Somalia's historical and geographical location on the Horn of Africa influenced shipping trade, which brought Asian and Middle Eastern styles of dress and bodily decoration to the country (Akou 2011). Arab Islamic influences trace back hundreds of years. Thus, Somalis have a long tradition of adopting and tailoring body decorations. One body modification influenced by Arab and Indian trade is the use of henna.

[31] Interview with Ladan, July 11, 2015

Illustration 4. Hooyo Dahabo showing her henna for Eid Al-Adhan. Dahabo's henna design incorporates both red and black henna, which was applied by a friend, to get this coloring. The use of henna designs versus the use of henna as a "finger nail polish" is also visible in this photo.

Henna is a natural plant substance, occasionally mixed with chemical compounds, used to create designs on the skin similar to temporary tattoos. Ayan explains that in the Arab world, the bride is decorated in henna designs on her wedding night. However, Somalis use henna regularly from day-to-day as well as for special religious events, which may be seen at the mosque. In day to day practice, women display henna in lieu of finger nail polish. Hooyo Dahabo explains that henna is easy to maintain and can last for months. While walking with Ayan and her friend one afternoon, we met with two Somali women. The women applied henna to their hands and nails in a public square in Roxbury, indicating the social aspects of henna application.

During Eid, Somali women and children may wear henna with their Eid *Abayas*, a long and more formal dress that is often colorful or designed with beaded details. For these religious events, henna may be more expensive to purchase at the store, Ayan explains. Somali women who are skilled in the art of applying henna offer services through word of mouth. They will invite other women over to their house and apply henna designs on the hands and feet. Ayan says that henna designs are meant to be beautiful but do not necessarily carry specific meaning.

Other beautification practices include makeup and perfume. Ayan explains a story about visiting her aunt in Somalia when she was young to demonstrate daily bodily practices:

> *Ayan starts to tell a story, saying that her aunt had nine children. Each day, her aunt would wake up early, as most Somalis do in Somalia, go buy groceries. Then she would come back and make breakfast, eat and nap. When she would wake up again she would put "cusbur" on her face. Ayan explains cusbur is a yellow plant substance, similar to henna. It lasts seven or eight hours. Ayan laughs about the yellow face her aunt would showcase. Yet her description: brightening the skin, reminds me of foundation. Ayan agrees and says cusbur is like a natural make-up for women in Somalia. I asked Ayan if she used cusbur or if women here still apply it to their faces. She says no and adds that it is probably not available here in the United States.*[32]

Ayan's description of her aunt's daily routine, similar to other Somali women in Somalia at the time, illustrates several perceptions of the body. First, Ayan begins discussing her aunt's role as a mother to nine children, something necessary for me to understand her situation and perhaps to indicate her fulfillment of motherhood. Next, Ayan discusses food preparation (perhaps again to indicate the role of women in making and obtaining food for the family), the importance of which made obvious by its priority in daily

[32] Fieldnotes, October 30th

routine. Finally, Ayan discusses beautifying the body with natural substances. In this way, Ayan describes the physical body as something to be *seen*. The role of cusbur is to brighten the face, making it appear youthful and healthy.

Next Ayan describes another daily bodily practice of perfume. She says many Somali women have *uunsi* burners in their home. *Uunsi* is a similar to incense and has a pungent, woody perfume-like smell. According to an online Somali-English dictionary, *uunsi* is the Somali word for frankincense. [33] Ayan says many women put *uunsi* burners on the ground and stand over them to have the perfume cover their bodies and clothes. Ayan admits that she is not a "good" example of a Somali woman because she believes the *uunsi* is too strong for her body. Instead, she chooses to occasionally burn *uunsi* in her home on the kitchen counter. Each of these cultural bodily practices are perceivable to others both within Somalia and the United States. However, some cultural bodily practices are less visible to outside perception, such as the practice of infibulation.

"Something Becomes Normal": Contested Cultural Bodily Practices

Somalia has the highest global prevalence of female circumcision; 98% of women in Somalia are circumcised (Gele et al. 2013). Infibulation, or female circumcision, existed as a cultural practice in Somali before Islam came to the country in the 7th century (Gruenbaum 1998). Gruenbaum indicates that the practice of infibulation happens to occur in some Muslim communities although the Qur'an does not mandate the practice. In fact, Islamic scholars do not uniformly agree with or sanction the practice. Similarly, Jamaa and Ayan denote how infibulation is often confused with Islam although they

[33] https://en.glosbe.com/so/en/uunsi, Accessed February 13, 2016

emphasis its role as a cultural practice. Ayan says:

> That issue [circumcision] they think it's a religious duty. That's why doctors do not work no matter how much they lecture to them [Somalis]. The only people that might help is the scholars, religious scholars.

Jama adds to Ayan's comments by describing an article he wrote on circumcision and Islam, "Islam does not recognize this in the religion. It's part of the culture, it has nothing to do with religion." [34]

Academic and Somali communities hold multiple viewpoints of infibulation. Some scholars write about infibulation as a gendered ritual that provides social mobility for women (Abusharaf 2009). Other scholars acknowledge the coming of age ritual as empowering for some women (Ahmadu 2010; Shweder 2000). These practices are referred to as female genital cutting (FGC). A more critical approach uses a feminist model to critique the practice as violence toward and sexual suppression of women (Ahmadu 2010; Manderson 2004). Those in the latter camp refer to this practice as female genital mutilation (FGM), which carries a harsher connotation than FGC. To avoid simplifying the complexities of this gendered ritual and bodily choice, I do not wish to enter into this debate. Instead, I will provide a brief overview of current literature and Ayan's views regarding infibulation in diaspora.

Ironically, Ayan had not always rejected this "outdated" [35] cultural practice. Our first conversation about infibulation came in the early stages of conducting fieldwork. I tried to avoid these references out of shyness and respect but as Ayan continued to bring the subject to my attention, I sought her advice on how to address this in my research.

[34] Interview with Ayan and Jama, September 3, 2015
[35] Ayan's word

After Ayan discussed the importance of addressing such a controversial topic, she insisted on calling the practice abuse and mutilation, or FGM. My first encounter with the topic of infibulation indicates my hesitations about addressing it:

> *Ayan mentioned a doctor she goes to today. This doctor has worked with women who have undergone infibulation and her instruments are "comfortable" and smaller. I didn't ask more about this because 1) I feel like it's a focus and obsession for many Americans 2) she was whispering this, which made me think she didn't want to go into much detail and 3) I don't even think I registered what she was talking about for a second. I was surprised that she mentioned at the end of our two hour talk over lunch. It felt like a token of trust or more proof of how forthcoming she is about sharing Somali culture and practice.*[36]

Langellier notes that Somali women may hesitate to discuss infibulation in the West because conversations are generally marked by years of colonialism which "frame traditional practices as barbaric" (2010:81). However Ayan discusses other reasons for avoiding conversations about circumcision: *They [Somalis] don't talk about it much other than in stories about sex because it's a topic that "isn't new" to them.*[37]

Ayan points out how and *why* Somalis discuss infibulation with each other when the topic is brought up:

> *People want to talk about it and how to cope with it, sexually or medically, but not talk about how to prevent the practice in the first place. Ayan says many young brides make comments to older moms about 'how can you do this?'[have sex with infibulation] and talk about how painful intercourse is, especially in the first few months of marriage, but no one talks about stopping the practice.* [38]

Yet, as mentioned earlier, Ayan has not always been outspokenly against the practice. In fact, at the age of five when she was circumcised, Ayan wanted the practice to be performed so that she would be like her mother and other Somali women.

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[36] Fieldnotes, June 5, 2015
[37] Fieldnotes, October 4, 2015

> *Ayan says when Somali girls first become infibulated, they want everyone to know 'I just had it done'. It's something you're proud of. You're a woman or a man then. […] She said her family lived in a row of houses and everyone, one by one, was having it [infibulation] done. She says, 'I remember wanting it to be my turn. So my mother had it done before we left Somalia because she knew I couldn't have it done anywhere else. There are laws.'*

Ayan perfectly describes the culturally embedded desire for infibulation when she says, "something becomes normal, and *Alhamdilillah*, I am complete." [39] Ayan illuminates culturally relevant and "normal" body ideals that may be applied to body size, body decoration, and infibulation. These ideals, as Ayan mentions, make Somali women feel complete, while also demonstrating the deeply rooted nature of culturally shaped ideals of body expression in diaspora.

Because this cultural practice has a long history within Somalia, it is not often discussed as a practice that should be stopped among Somalis outside of advocacy groups, as Ayan points out. However, diaspora provides opportunities for women to become empowered, educated, and forgo the practice of infibulation. *Ayan says that in America Somali women now have choices about infibulation. ' If you don't want to do it, then you won't do it to your daughter,' she explains.* [40] Similarly, Gele et al.'s (2012) study on Somali views toward infibulation in Oslo further demonstrate the role of female "empowerment" that arises in diaspora. Gele et al. (2012) report that 70% of Somalis support the discontinuation of the practice, and only 3% feel this way instead of Somalia. These statistics suggest that diaspora offers an opportunity for women to forgo the practice.

[39] Fieldnotes, November 6, 2015
[40] Fieldnotes, September 2015

Life in the U.S. is not the only deterrent to carrying out infibulation. A new understanding and reliance on Islam addresses why Somalis value the practice:

> *Ayan says older moms and men probably like the practice of infibulation. They believe it stops young girls from desire and prevents them from "going after" men. But Ayan says religion is more important; you can rely on religion to prevent desire and going after men instead of infibulation.*

The social benefits gained from infibulation, Ayan explains, can be attained through piety instead in diaspora. This comment illustrates Ayan's particular framing of the practice as "old-fashioned" and "barbaric". While this does not necessarily reflect the ideas of all Somali women, it indicates a shift in opinion within the United States where women may feel that they have more choices regarding gendered rituals and practices of the body. Diaspora becomes a specific space for adaptation of practices and therefore, embodiment of diaspora incorporates new forms of expression. Ayan also makes apparent that Islam acts as a tool of empowerment for women. This presents a contrast to discussion of Muslim practices of female oppression, especially surrounding sexuality, emphasized in the U.S. (Ali 2016)

As Kecia Ali (2016) notes, that Muslims acknowledge positive aspects of female sexuality along with a contradictory tradition of viewing female sexuality as dangerous with potentially disruptive effects on society. However, Ali points out that Islam is practiced within other cultural, social, and economic systems. Islamic Somali discourse emphasizes social pressures of purity and virginal. A deviation from purity has serious consequences for marriage among Somalis. In addition, an entire male's family and village may be involved in the process of rejection or acceptance of a woman's infibulation, a symbol of both her womanhood and purity.

Ayan mentions after the marriage ceremony, the village goes back with the bride and groom to the house. They go inside and the family and guests wait outside. The husband "examines" the bride to ensure she is a virgin and that her infibulation is done "right" – that is done "all the way". Then he comes back out. She says the moms and him will have a signal or there will be a signal to give the families and village. If the husband gives the signal and everything is good, people celebrate and leave. But if the new husband is not pleased, then he can leave the woman and the marriage will not be formalized and thus rendered void. I tell her that sounds like a lot of pressure. She agrees, and says it is SO MUCH pressure on the women.

In addition to possible social pressures on females to go through infibulation and "go all the way" to full circumcision, often referred to as type III[41], medical complications may arise in the U.S. Because the practice of infibulation is illegal in the U.S., few gynecologists are familiar with the practice. Thierfelder et al. (2005) found that African women in Switzerland faced similar barriers to care in the clinic regarding infibulation. However, they note this is not done out of ill will, but rather a result of lack of experience and guidance on how to care for women who have undergone infibulation (2005:89). Though, African migrant women who'd undergone infibulation specifically reported they felt they'd received substandard reproductive health care because of their European OBGYNs perceptions of infibulation (Ostrach 2013). The lack of training and guidance in providing care for infibulated women may be another deterrent to seeking preventative care among Somalis in the U.S. Additionally, complications surrounding infibulation may have medical consequences especially during birth. Physicians and Somali women may have different opinions on how to manage infibulation during birth.

[41] There are three "types" of infibulation, with some becoming "outlawed" and others remaining legal. Type I involves partial (or total) removal of the clitoris. Type II involves partial (or total) removal of the clitoris and labia minora. Type III involves partial or total removal of the external genitalia and a sealing of the vaginal opening, leaving only a small hole for fluids to pass (Gele et al. 2013a)

> *Ayan mentions that some women want a natural childbirth. Actually, she makes it sound like many do. But she says that she, herself, would just want what was best and if the doctors had to "cut her" (C Section) then she would let them. But other women, she mentions, say 'we've been doing this (women have been circumcised for generations), it will work just let me do it natural'.*

Ayan's comments illustrate barriers that may arise between doctors, namely those who have little to no prior encounters with infibulation, and Somali patients. Somalis view the practice as a long historical, cultural tradition. Labor with infibulation is thus constructed as an act of the body that unites women throughout Somali history in a collective female experience. Ameresekere et al. (2011) indicate that Somali women's beliefs about labor and delivery dictate why they may be hesitant about cesarean delivery. However, provider-patient communication may improve birth experiences for Somali women in the U.S. (Ameresekere et al. 2011).

As Gele et al. (2013a) note, colonial powers and church missionaries sought to stop the spread of female circumcision in Africa during the 20th century with church rules and government laws. Presently, literature on the health risks and effects of circumcision are spread to further "demoralize" and pathologize the practice in the West. For example, Chen et al. (2004) write that immediate complications of infibulation include infection, hemorrhage, urinary retention, and damage to nearby structures. Long term consequences include abscesses, cysts, frequent urinary tract infections, and contribute to infertility. Gele et al. (2013a) suggest psychological consequences including: posttraumatic shock, depression and lack of bodily wellbeing as well. Gele et al. go on to suggest that "when people lack awareness of how their behavior affects their health, they have little reason to put themselves through the misery of changing the risk behaviors they have engaged in

for many years" (2013a:3).

In Somalia and other African countries with high rates of female circumcision, advocacy groups attempt to stop the practice. Nevertheless, many Somalis are suspicious of total abandonment and social change and hear Somali religious leaders sympathetic to circumcision (Gele et al. 2013a). Gele et al.'s study on Somali perceptions of female circumcision suggests that most Somalis residing in Somalia prefer to continue the practice. The news outlet *Aljazeera* recently published an article on how Sudanese midwives are education and empowering women in an attempt to stop female circumcision. A rigorous schedule prepares these Sudanese women to become midwives and role models for women in the community; if they are caught preforming circumcision they will have their license revoked (Naib 2016).

Despite large amounts of literature surrounding the harmful effects of circumcision, some studies indicate that these accounts are exaggerated. Obermeyer (2005) asserts that there are no statistically significant associations for a number of health conditions frequently associated with infibulation. Furthermore, Ahmadu contends that writers' aversions to the practice of infibulation "has more to do with deeply imbedded Western cultural assumptions regarding women's bodies and their sexuality than with disputable health effects" (2000:284). These attitudes toward infibulation from non-Somali providers may further contribute to the construction of risk. By dividing into opposing sides on the subject infibulation, scholars and media outlets miss the embodied reality of Somali women in diaspora and further demonstrate the role of Western biomedical control of the "healthy" body, similar to body size.

Conclusion

As I have shown through body ideals and practices, diaspora becomes embodied through fluid and complex body values. While some bodily ideals and practices may be shaped by competing ideals in the United States, others are reframed as instrumental to constructing and maintaining Somali culture. The physical body becomes an *object* of perception from other Somali peers and non-Somali Americans, which in turn shape Somalis' concept of self surveillance of or modification of bodily practice. In other ways, the Somali body becomes a *subject* of expression through cultural practices of beautification, dress, and infibulation. For example, Somalis express purity and piety through dress, particularly symbolized by the *hijab*, and historically through infibulation.

Veiling is a practice more obviously visible to non-Somali peers in the United States. The practice of veiling with *hijab* subscribes a distinction from dominant non-Muslim culture in the United States, and conveys deeply religious values and messages; these messages proscribe a level of expectation on how one will act, particularly how pious an individual is. However, each practice in diaspora may be altered, re-enforced, or dismissed as a result of new social and educational experiences in diaspora. New viewpoints shared by Somali women in diaspora become a shared cultural logic for them to make new assumptions about body ideals and practices. Somali women in the West may re-enforced the *hijab*, perhaps altering a particular style, but many may dismiss the practice of infibulation for another symbol and aid in purity, such as increased religiosity.

Yet, each practice of the body shapes a Somali diaspora ideal, incorporating "Somali" values with "American" values. Weight gain may be the most obvious and

visible bodily enactment of both ideals. In some ways, Somalis continue to view the larger body as healthy yet may accept the Western bio-medical models of BMI and weight management. As my participants have shown, education, length of residence, and age are contributing factors in motivating the acceptance of new bodily practices in the United States. Similarly, infibulation has become a topic of controversy in the West that may influence Somali women's choices of body modification and gendered rituals.

Although Somali bodily practices and ideals may be altered in the U.S., they reflect and express concepts of "purity" and "piety". As a result of *hijab*, infibulation, and henna adaptations, other Islamic practices may begin to replace "traditional" symbols of purity. As Ayan suggests, openly relying on Islam instead of infibulation empowers women to stop this practice. Similarly, *hijab* styles are often modified among younger generations of Somalis who prefer shorter veils or wish to remain unveiled until they are married.

CHAPTER V

SOMALI FOOD PRACTICES IN DIASPORA: INTERNAL CHANGE AND RESISTANCE

"Because food behavior is a part of a larger cultural complex, it serves other social and cultural functions than the obviously nutritional."
Mary Douglas 1984:135

In this chapter, I explore food behaviors as a bodily practice of Somalis in Boston. Food represents one way diaspora is embodied, which I examine by drawing on symbolic and ritual components of dietary practice and consumption. First, I consider historical and cultural influences on food choice among Somalis. Next, I examine religious Islamic sanctions placed upon food. Finally, I tie in political-structural components of food choice, access, and practice within Somali diaspora in the United States. Food choice and practice become forms of embodiment, directly tied to the body, through associations of health and body size. This is particularly true in the United States where body size, attributed to individual-level diet and food choices rather than structural factors like poverty, is often medicalized as "healthy" or "unhealthy" (Brewis 2010).

Food and dietary practices, much like beautification and cultural practices, are enacted upon the body. Food and dietary behaviors showcase cultural, religious, and political-structural influences. For instance, Somali food consumption often centers around cultural food staples rooted in colonial influence and religious rules of eating *halal.* [42] In addition to cultural and religious influence, low socio-economic realities

[42] Halal is an Arabic term meaning permissible. In relation to food, this means food is sanctioned by Islamic Law. The Qur'an states: *"He hath forbidden you only carrion, and blood, and swim flesh, and that on which hath been invoked any other name besides Allah's"* (Chapter II, Verse 173).

within Somalia, displacement, and resettlement affect food behavior and access. Johan Fischer, in his discussion of middle-class Malay *halal* eating practices in London, argues that "food consumption and its religious, social, and cultural context may be the closest one can come to a core symbol in the everyday lives" of individuals (2011:160).

British and Italian colonial rule in Somalia left lasting effects upon food choices and practices. Pasta and rice comprise Somali household food staples, both in Somalia and in diaspora. Italy ruled much of the south Somalia, where pasta continues to be prepared as a common dish. In the north, British influence inspires rice dishes. However, several years of failed international economic aid measures across Africa subsequently left Somalia economically depressed (Kibble 2001). Drought, famine, and war in Somalia have further exacerbated economic constraints and affected availability of food since the 1990s. The most recent drought continues to compound famine within the country.

Life in Somalia included walking daily to the market to buy fresh produce—however, in the United States, finding fresh food is more difficult (Geltman et al. 2013b). As a result, Somalis in diaspora may not immediately think of American supermarkets as a source of fresh food, yet they often stock up on dry foods to make Somali meals. Traditional Somali dishes in the U.S. are sometimes made with "American" ingredients such as tortillas, quick-cooking rice, and pancake mix rather than "traditional" Somali ingredients. Through these adaptive practices, Somalis maintain a sense of Somali tradition in food practice and consumption because their outcomes remain similar despite "American" ingredients. In contrast, some Somali moms prepare

Americanized meals for their children such as Somali-style chicken with ketchup or mayonnaise in a tortilla.[43] Although the dish includes chicken from a Somali restaurant, it is no longer truly "Somali" because the outcome is unrecognizable as a Somali meal and therefore rendered "American" by the mothers who feed it to their children.

Changes in dietary behaviors often reflect larger structural factors of political economy and/or access. However, assimilation pressures from children attending school in the U.S. and being exposed to "American" meals, may also affect Somali moms' cooking choices for their children. Mary Douglas (1984) reflects on Margaret Mead's work among immigrants during World War II to examine the effects of displacement and migration on food. Douglas notes that when access to habitual food is disrupted, some individuals reject food that is offered. However, food choices among immigrants and refugees, or population often *in extremis*, are harder to examine based on individual food item preferences. Rather we must explore them by examining regular food menus in their entirety (Douglas 1984:29).

In order to properly study food behavior one must examine physical, symbolic, and social factors tied to food rituals and consumption. As O'Kane and Pamphilon (2016) note, qualitative research is equally essential as quantitative research in understanding how social and environmental factors affect food and eating patterns. According to the recently deceased "father of food anthropology" Sidney Mintz (2002), anthropology has a long history, beginning in the nineteenth century, of studying food and eating. Mintz viewed food as a necessary topic to study because it is not only

[43] Fieldnotes, September 30, 2015

essential to human existence but has proven valuable for debating and advancing anthropological theory and research methodology; some theories advanced by the study of food include political economic value creation, symbolic value creation, and social construction of memory—all relevant lenses through which to examine the Somali body in diaspora.

Symbolic and Ritual Dietary Practices

Mary Douglas also writes that many nutritional anthropologists emphasize social and cultural frameworks, but that these often lack general theory (1984). Pierre Bourdieu (1984) conceptualized food as a reflection of social dominance and subordination, often enacted by food-sharing rituals. Marshall Sahlins (1976) adds to Bourdieu's concepts of food by incorporating food metaphors and inner/ou ter social dimensions that are projected upon food. Douglas agrees with Bourdieu and Sahlins that food has the capacity to become a symbol of social groups.

Food, as a tangible object, is also symbolic. Douglas writes, "gifts of food are flows of life-giving substance . . .long before life-saving is an issue the flows have created the conditions for social life" (1984:12). In addition to exploring social symbolic features of food, Douglas emphasizes the meal as a physical event. This event often reflects and reinforces social, religious, and cultural beliefs. The food shared within a meal is aligned with moral, social, and aesthetic meaning that goes well beyond physical nourishment. Marshall (2005) specifically highlights embodiment of food, noting that food, literally, becomes part of the body in ways similar to tattoos, piercings, jewelry, and medicine. In the field, I witnessed how very true this was for Somalis, especially as

enacted and embodied by Somali moms who embraced me and brought me into the 'body' of their community through food consumption and ritual.

Cultural Food Values and Practices

Illustration 5. Hooyo Ayan cutting Halwa during an Eid celebration. The main ingredients of Halwa are oil and sugar. It is a particularly special "treat," often served on special occasions and at weddings. The end result is sweet and chewy. Photo by author, 2015.

At the urging of key health informants and supposed 'experts' on Somali immigrant health concerns who worked with the community, I initially set out to conduct a study about Somali experiences with diabetes in the United States. Yet, I quickly found Somalis often preferred to addressed cultural aspects of food and diet when I asked about diabetes. While diet was acknowledged as a major factor for diabetes onset, it was also an important facet of social life. Participants seemed impatient with a narrow research

focus on diabetes, to the exclusion of other topics, or with the idea that food needed to be tightly controlled for the sake of health. As Ayan once told me, "if you meet with someone and they don't offer you food, how boring is that?"[44]

Dr. Saaye identifies food as a primary aspect of Somali culture, highlighting its importance within daily life: "If you explain what is culture, I think culture is food". She continues,

> We have a lot of fried things like Sambosa, like you know we, sometimes when we prepare, we like goat meat. And goat meat also has a lot of fats and you know, we fry it. Even the rice, we fry it… And we put a lot of oil in it… And we use a lot of goat meat and we use also vegetables too. But we have more carbs than not. And we have more bread than vegetables and minerals I think. So Somalian, you know, you have to have meat. Number one is meat, rice, and meat is number one. [45]

Dr. Saaye demonstrates cultural staples of Somali diet including an emphasis on fat, fried foods, and simple carbohydrates including rice and breads. In Dr. Saaye's description of food, she hints at "unhealthy" or "bad" aspects of Somali food; it is high in fat, often fried, and includes generous amounts of oil. Dr. Saaye's occupation as a physician in Boston may account for her detail in describing fats and carbohydrates while noting a lack of vegetables and minerals. But nonetheless Dr. Saaye emphasizes the value of food in cultivating and maintaining Somali culture, indicating that food is culture itself. Her emphasis on Somali food choices represents the tension of acknowledging a symbolic value in reinforcing cultural practice, while also being enculturated through her training in the biomedical emphasis of health. Thus, Dr. Saaye is implicitly noting the difference between nutrition for health and nutrition for culture.

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[44] Field notes, June 5, 2015
[45] Interview with Saaye, May 19, 2015.

Similarly, Ayan details the importance of a Somali cultural diet in the United States:

> I mean, because Somalis are very old fashioned. Even if they've been here forever they always want their own diet. Their own food so they will look for places that either they will cook in a Somali style and eat in a Somali way the same portion and everything or get it from restaurants the way they want it. [46]

Ayan and Dr. Saaye showcase the importance of maintaining traditional Somali culture with food choices in diaspora. They emphasizes both food choice and portion size of meals. Ayan's comment about being "old fashioned" indicates a refusal of dietary change in the United States. This resistance becomes a way of maintaining Somali identification rather than becoming "Americanized". Ayan takes Dr. Saaye's comments about food, itself, being an aspect of culture further by acknowledging portion size and locations where Somalis seek out food as part of Somali culture.

Ladan adds a generational component to maintaining Somali culture through food behavior.[47] She suggests that older generations, in particular, refuse food other than Somali food because they've been "doing it for so long". If they decide to eat outside the home, it would be at a Somali restaurant to ensure that the food is both *halal* and Somali. Many Somalis believe a healthy diet is a Somali diet. Yet Ladan admits younger Somalis, who become "Americanized", will try "new" non-Somali meals at restaurants in the U.S.

"Without Tea Something is Missing"

Tea acts as another major social component of Somali life in addition to traditional Somali food. Somali tea consists of ginger, cardamom, cloves, loose-leaf black

[46] Interview with Ayan, September 3, 2015.
[47] Fieldnotes, July 11, 2015

tea, sugar, and cinnamon. To make Somali tea, you allow all the spices to come to a boil in water. Once the water and spices are boiling, you add black tea. When this mixture is done, you pour the tea over a strainer into a cup and add evaporated milk, although some Somalis prefer to drink tea without evaporated milk. Ayan and Jama admit that Somali tea consists primarily of sugar.

The importance of Somali tea is embedded culturally and holds meanings which are inscribed within place names. Jama explains:

> We don't, we don't have that much sugar food like cakes. We don't eat that much of those things. But the only thing we consume sugar in is tea. We drink a lot of tea. At least three, four, five times a day. That's why we come up with that name, Mogadishu, means like a place of tea.[48]

The city of Mogadishu, named for the cultural ritual of consuming tea, represents this social act of consumption. Jama depicts a typical sight in the city of Mogadishu, reflecting the city's own name:

> All the city you can see people sitting, after they come back from work at 3 o'clock until 7 or 8 o'clock night time people sitting out all over the streets in from of the restaurants just drinking tea.

Ayan powerfully adds, "It's the best social gathering. Without tea, something is missing." Thus, the practice of consuming tea is a social event. Men and women gather and drink tea as part of a social Somali ritual. It not only becomes embodied culture but also reflect social and political status of the environment. She indicates that the absence of Somalis gathering and consuming tea in the city at night, would reflect larger issues of social and political instability of the current war-torn situation in Somalia.

Despite the importance of food among Somalis, surprisingly little research has

[48] Interview with Ayan and Jama, September 3, 2015

been conducted on Somali food behaviors. Among the limited literature on the topic, Geltman et al. (2013a, 2013b) found the concept of "fresh" food particularly important to Somalis in the United States. Ladan explains the concept of fresh food availability, echoing Geltman and co-author's studies:

> Everything was fresh in Somalia, nothing is refrigerated. Get up in the morning, early morning. Get fresh meat, freshly slaughtered, grass fed. Fresh produce. Cook and you have your breakfast, your lunch, and your dinner and you go out the next day and you go shopping again for all the meals for the day. So everything's fresh, fresh fruit, fresh vegetables. But it's still, people walk more. People ate fresh produce not processed. [49]

Ladan's emphasis on "fresh" food highlights technological and economic or structural accessibility differences between Somalia and the United States. For one, in Somalia access to fresh food was easier to come by than in the United States where consumers pick through large supermarket chains with imported fruits and vegetables, if these are even present in their neighborhoods. In addition, Somalis did not own refrigerators in Somalia, making daily food market trips and fresh foods necessary and typical, while immigrants in the United States tend to go grocery shopping less often and buy more canned, dry, or frozen goods. Ladan's comments demonstrate the attitude that food is something to prepare, in more ways than just cooking. For Somalis, it involves a daily ritual of physical activity and demonstrates a need for accessibility in ways that are lost or inaccessible for those in diaspora within the United States.

McEwan (2009) notes that although Somalis comprise one of the largest asylum seeking populations in the United Kingdom, very little is actually known about how migration affects traditional Somali attitudes toward food and eating habits there.

[49] Interview with Ladan, July 11, 2015

Through mixed-methodology, including focus groups and surveys, McEwan's study on Somali dietary behaviors in London concluded that the main diet consists of rice, pasta, and red meat. Somali participants in this study reported low consumption of fruit and vegetables was generally due to uncertainty about what constitutes a "healthy" diet. The extent to which a similar uncertainty surrounding the understandings of "healthy" among Somalis in the U.S. also remains unclear.

Religious Food Practices

As noted in Chapter Four, religious and cultural beliefs and practices among Somalis are often intertwined. Many Somalis not only claim lineage to the Prophet and to Arabs, but also describe Islam as inherently part of Somali culture. Douglas's (1984) study on the Oglala Sioux American Indians indicates that some food choice distinctions are made on religious grounds. This is also true for Somalis in the United States. Ayan and Jama note that many Somalis shop for meat at *halal* stores.

Ladan explains the importance of eating *halal*, even if "*halal"* is simply used as a marketing tactic:

> So, if I'm Muslim and I'm selling you meat then I'm automatically going to buy it because you're going to assume that you know, that this is healthy, fresh, permissible, halal food. Whereas in the person who's just trying to make money to survive, so it's, they, they trust in them based on religion. So there's a couple of meat markets here. [**Mhmm**] Just because I would say this, like it's because the person's Muslim and they say it's halal doesn't necessarily make it *halal*. And the only meat that's not halal is pork. Right? [**Mhmm**] So what does halal meat mean? So I feel like it's like a slogan people use to make sells. [**Ok**] Uh, there's however really, the correct term is zabiha. Is it, was the animal fed healthy, permissible foods. In the process of slaughtering them was it in the name of God. That's the term *zabiha* but they say *halal* so I think people would buy it because it has the word halal on it.

Ladan's comments demonstrates how the concept of trust facilitates a relationship

between buyer and seller. As she says, some Somalis will buy meat from another Muslim assuming it is *halal* because of their shared religious tradition. Other times, shopkeepers may use the word "*halal*" to indicate what Ladan describes as "*zabiha*," yet the word halal is so well known and important for Somalis that this term suffices to ensure they are eating in accordance to Islamic Law. Like many cities and towns with Muslim diasporas, Boston has several *halal* stores.

Religious sanctions upon food do not just cover *halal* and *haram*. Religious sanctions or "rules" surrounding food behavior and practice have other symbolic meaning and scientific function. Ladan gives an example in breaking fast, typically during Ramadan:

> So when you break fast, um, the first thing that you're supposed to break your fast with is dates and water. [**Mhmm**] And I've always been like why dates? I never ate it because I was like why, everyone does this so I'm gonna do it? And then I found out, when I asked them, no one could answer the question so I did a little bit of studying myself and they used to do it because of the prophet. The Prophet used to do but The Prophet did it because it had health reasons. They [dates] hydrate you . . . Back then Muslims were very, they were you know how everyone comes here to America to get an education? [**Yeah**] That's, that's how they were back then. They were a lot of scientists, a lot of [**They were booming**] Yeah, they were booming. They were very educated on everything. So I found out it hydrates you faster and it's much more, it has a lot of nutrients and minerals for you. That's why you need it because you haven't been drinking and eating all day. It gives your body what it needs right there and then so I was like oh. So now I eat it regularly [**Yeah**] So actually religion is pro-health.

Ladan's comments explore two concepts of religious sanctions and eating behaviors. One, following the teachings and practices of the Prophet, including dietary practices, are encouraged among Somali Muslims. Two, although these practices are first and foremost revered for religious symbolic purposes, they also hold scientific function for Ladan. As she explains, dates quickly hydrate the body. Therefore, scientifically, culturally, and

religiously they are an essential component of food practice after fasting—health is embodied through this ritual.

Somali Wedding Feast

In November 2015, well into my fieldwork and after the bulk of my data collection was complete, I continued maintaining communication with my key informants because of the strong friendships we had established, largely through preparing and consuming food together. I was invited to a Somali celebration dinner. A twenty-year old Somali woman had just been married. Somali women close to her family and from her family's tribe, hosted the bride, the bride's mother, and grandmother for dinner. After the bride arrived, the women prepared a seating area around the floor. The new bride, her mother, and grandmother remained sitting while other women brought food to place in front of them. Each woman invited to the house for dinner helped prepare the meal or brought a small dish to serve for the bride and her family. The meal was *halal*, according to religious sanction. *Moos* (banana) and *baaris* (rice) were combined together in traditional Somali practice along with fish, meat, vegetables, and fruits.

The event fostered a sense of celebration focused on gender and womanhood, since all the guests were women. Shortly after filling everyone's plate, the women began talking in Somali. The host turned to me and said "we are talking about serving food in America". Several Somali women took turns to explain that in Somalia, men are served food first. But in America, women have begun to serve themselves first. One woman laughed as she described the confusion this causes her husband. She said "I told him, this

is America, I can do what I want here!"—embodying her understanding of a new form of independence in diaspora that disorders traditional Somali food customs. After dinner, the women served Somali tea with a sweet, fruity strawberry cake dish. Finally, the women brought a big bowl of custard for the bride to taste.

What I observed at the wedding dinner further illustrates food as a symbolic component of Somali culture in diaspora as well as it being a physical event which both reinforces and reflects social, religious, and cultural beliefs. The women adhered to traditional cultural food practices: rice, banana, meat, and Somali tea served to the bride by specific family members. Religious observances of *halal* dictated meat choices. New practices such as the incorporation of box-mixed cake, which the Somali host learned about in Virginia, reflected food adaptation in diaspora. Ayan described this cake dessert as a convenient, easy to make dish. Although it was not "traditionally" Somali it was also not a "traditional" way to serve cake in the U.S. Ayan baked the cake, then cut it up in small pieces. Next she mashed the pieces in a bowl with two cans of fruit cocktail. The final product lacked the visual components of cake typically eaten in the U.S., but its ingredients were nonetheless described as "American" by Ayan.

In addition to discussing food presented at this wedding feast, the women began to discuss the implicit rules of Somali serving practices and how these can be challenged and broken in a new cultural context and setting. Marshall writes, "much of our engagement with food is unspectacular and inconspicuous, undertaken in private, and regulated by a series of unspoken rules regarding eating" (2005:69). However, life in the United States offers opportunities for Somali women to showcase new dishes bring

unspoken rules to light and break them—in particular by serving themselves first. These new practices can be seen, like practices of the body, and demonstrate the aspect of empowerment Somali women may discuss only available within the context of diaspora. The ability to be outspoken about social rules changing in diaspora, may be encouraged among women who share a relaxed social environment with one another. That is not to say that their words and actions would be different in front of their husbands, but I must acknowledge my role and privilege to be amongst Somali women in such an intimate setting. This setting, comparable to Erving Goffman's (1973) concept of "back stage", allows for openness in contrast to specific audiences outside of these "female" spaces.

Somali Diet in Diaspora

Illustration 6. Hooyo Ayan showing me how to make Somali sambosa with beef and vegetables. Ayan uses "American" substitutes for example, tortillas as the flour outside

of sambosa. First we fold the tortilla piece into a "kite" like shape. Next, using water and flour, we seal the tortilla after putting in our filling. Finally, we drop the sambosa into a fryer to cook until golden brown. Photo by author, 2015.

As my experience with Somali women suggests, diaspora offers opportunities for dietary and food behavior modifications, with associated shifts in cultural and symbolic meanings. Life in the U.S., for many Somalis, is accompanied by economic constraints that affect food and diet choices. Economic limitations among refugees and immigrants in diaspora are noted in existing literature; food insecurity, as a result, has been linked with poor diet choices and long-term health consequences (Dharod et al. 2013; Chrzan et al. 2007; Hadley and Sellen 2006).

Dharod et al. (2013) examined the association of food insecurity, dietary intake, and BMI among Somali women living in the United States. The conclude that Somali women in the U.S. often experience food insecurity linked to inadequate diets and associated with numerous chronic health concerns, including diabetes. Several risk factors for food insecurity include: poor economic conditions, low educational attainment, work-limiting disabilities, and being the head of single parent families (Dharod et al. 2013). Although participants in my study did not use the term "food insecurity," many discussed economic issues surrounding dietary choices. For instance, Dr. Saaye discusses:

> I think because they are all living on you know, the social economic, you know, life is really very low if you compare it to the Americans. So the people who come to this clinic and they all live in a public housing. They live on welfare and food stamps. So I don't think they can buy like healthy food. […] Myself, you know, I like to eat a lot of things everyday but sometimes I can't [*laughter*]. It's too expensive for me.

Even as a Somali physician in the United States, Dr. Saaye experiences economic

constraints that dictate her food choice and indicate a level of food insecurity. Dr. Saaye also acknowledges the clustering of low socio-economic clients in the clinic she works at, noting that they all live in public housing, are on welfare, and use food stamps. Dr. Saaye's comments about the clients of the clinic where she works, being unlike "Americans," demonstrates the rift Somalis feel in the U.S. that extends beyond, but is perhaps most recognizable through, socio-economic comparison.

Similarly, Ladan explains how economic factors influence diet and health when discussing how to eat "healthy:"

> Or it's really expensive […] Yeah, expensive. Money is like a, it's an issue for a lot of individuals in the area. So, a lot of them depend on, rely, depend on government assistance.

As Ladan goes on to discuss the low socio-economic status of many Somalis, she notes another factor in diet:

> Yeah, even if they wanted to live a healthy lifestyle, they wouldn't be able to afford it. What matters is putting food on the table so kids won't be hungry.

Ladan emphasizes the idea that putting *food* on the table to alleviate hunger is a priority over putting "healthy" food on the table. Somali parents, therefore, often have to choose between a healthy diet that does not provide for the entire family or feeding the entire family so they are not hungry. This leads to embodying 'unhealthy' practices, even while embodying Somali cultural rituals, when the two go together.

Chrzan et al. (2007) indicate that refugees from developing countries often experience dramatic differences in shopping for food after arrival in a new setting. Often, a case worker assigned to a refugee upon arrival plays a key role in the refugee's social network. The caseworker explains how to navigate the supermarket, an unfamiliar food

environment for many refugees, and in some cases is key to facilitating dietary preferences. For example, a refugee may ask a caseworker if it is acceptable to eat chips; the caseworker may respond "yes" (Chrzan et al. 2007). These situations bring up issues of power given that the caseworker plays a role in determining what is best for the refugee in terms of nutrition. Chrzan et al. (2007) also discovered children's preferences, along with those of caseworkers, friends and family, seem to play a large role in dietary choices among refugees. Parents often want their children to feel satisfied.

Many of my participants discussed where and how they shopped when asked about diet. *Halal* stores, as described earlier by Jama and Ladan, are one option where Somalis in the United States purchase food. Other stores, however, also carry specific associations for Somalis. Ladan says:

> They shop at Stop N' Shop, Whole Foods, actually Stop N' Shop mostly. Save A Lot, um, Tropical's[50] here. Basket, um, Market Basket. [**Why do they shop at these places do you think?]** It's a common area to shop, one. And some of them might go to Whole Foods or Market Basket because it's cheaper. Some of them go to BJ's a lot. (0.2) Price wise, location. [**So, Whole Foods is cheaper than some of the** =] Whole Foods is expensive. [**Ok**] It's a lot of money.

Similarly, Dr. Saaye discusses where Somalis shop for food:

> Yeah sometimes I see if I compare to Stop N'Shop, I see sometimes the difference is sometimes not that much. But some people they don't even go to Stop N'Shop. They go to the Save A Lot, they go to like American Food Basket. So they go to the cheaper places. You know? They go to Tropical you know Stores, you know, cheaper.

While Somalis may not describe themselves, others, or use the term food insecurity, discussions about where to shop for food are often framed around affordability and

[50] Tropical Foods

location or access. As I walking through the area one day, I came across a food market discussed by Ladan and Dr. Saaye. Outside was a mural of "neighborhood" folk. In the picture, immigrants, refugees, and people of color were depicted. To me, this indicated the neighborhood demographic as well as the shoppers who use this super market, a stark contrast to affluent "white" grocery stores.

Another resource within the community is a local fresh food truck run by Fair Foods, Inc. Dr. Saaye explains that this truck offers two-dollar "bags" of fresh fruit and vegetables. The truck sets up outside of the mosque each Saturday in Roxbury but also makes stops in other neighborhoods such as Jamaica Plain and Dorchester, where there are also large numbers of Somalis. The local two-dollar bag truck[51] targets low-income neighborhoods with a higher proportion of immigrants. While I witnessed these trucks and the two-dollar bag, I am unsure how many Somalis regularly use their services. However, both Dr. Saaye and Ayan mentioned the program separately, leading me to believe the truck and its discounted produce program is widely known around the community.

As Dr. Saaye and Ladan acknowledge, Somalis face affordability barriers to attaining fresh and healthy food. Yet this is compounded by that fact that many Somalis live in Boston's food desert. Etingoff and Zeuli (2015) write that the term food desert is often applied to urban neighborhoods that lack access to healthy food and grocery stores,

[51] The Two Dollar Bag is operated by "Paul", an Italian man according to Ayan. Paul brings the two dollar bags to local Somali restaurants. Ayan mentions, when discussing the truck and two dollar bag, that Paul knows "a little" about Islam and is nice. Information on Fair Foods Inc. (who provide two dollar bags) may be found here: http://www.fairfoods.org/index.php?page=dollar_bag.htm

incorporating both affordability and access. Etingoff and Zeuli (2015) address affordability, and echo Dr. Saaye's concerns, that the median income for the Roxbury neighborhood, where many of my participants live, is $28,000; the median income for Boston as a whole is $52,000. In terms of availability, Roxbury is also one or two food deserts located in Boston. Etingoff and Zeuli (2015) provide a detailed infographic below (Figure 3):

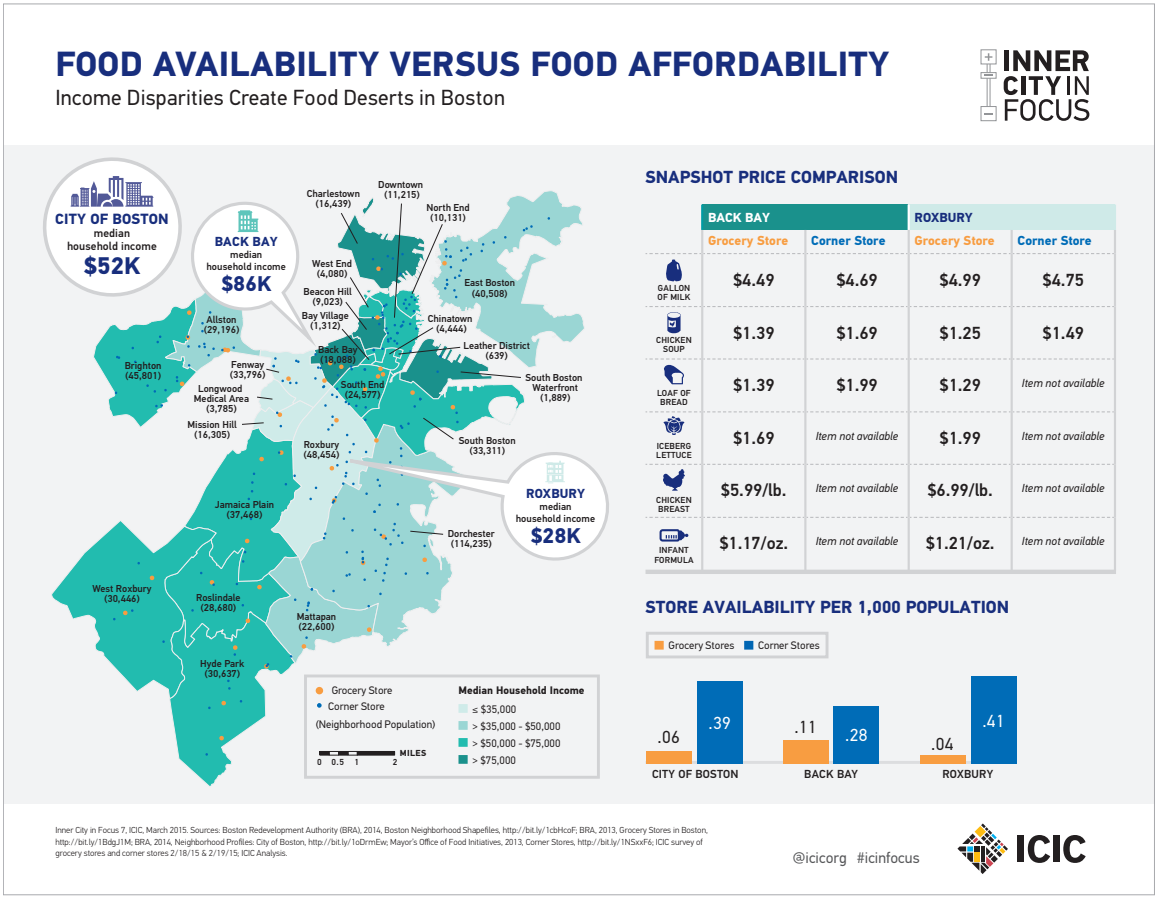

Figure 3. Food Availability vs. Food Affordability

Sense of Community and Food Sharing

As Douglas (1984) notes, sharing meals and eating provides an insight into community construction. Who and how one eats with others demonstrates boundaries of

inclusion and exclusion. Despite coming from experiences of extreme violence perpetuated by the Somali government and civilians along tribal lines, Somalis emphasize a sense of Somali community once they arrive in Boston. This sense of community is essential in creating social networks that are often framed around food sharing. Ayan and Jama mention that construction of a tight-knit group is a Somali cultural trait rather than specific to Islam. Ayan explains:

> Somalis like to be this [*fingers entwined*] even though we have tribal issues, big time tribal issues. I might not like this tribe, I might not like that tribe. But when it comes to gathering information or gathering, being together, I can never leave you outside even if you are in a different, you are lost or. You would never go hungry if you are Somali because we take care of each other. That's what it is. Even back home, especially outside, you would never be alone or hungry for long if you are Somali because there is always somebody else. And at that time what tribe you belong to doesn't matter. What clan you belong to doesn't matter.

Based on my participant-observation and interviews, I suggest this dynamic is emphasized because of years of violence, war, and famine in Somalia that have led many to seek asylum in an unfamiliar place where they may forgo tribal distinctions in favor of cultivating a broader *known* community among Western individuals. I asked, "Do you think that happened after the civil war or before, too?" Ayan responded: "No, I think before, right? The connection between Somalis has always been so strong. Correct?" To which Jama confirmed "yeah."

While some Somalis deny the existence of tribal distinctions in the United States, situations often present themselves that demonstrate how tribal differences have been reframed in diaspora. In my field notes, I wrote about one experience where I felt I could "see" tribal distinctions:

> *Today Ayan took me to the Somali mall in Roxbury to look for my Eid Abaya [dress]. When you walk into the "mall", there are small rooms with spices and kitchens near the front door. The small hallway of rooms opens up to a giant warehouse space where Somali women and men have set up little "shops" along the corners and walls. Dresses and scarves are hanging, making the giant room seem small and colorful. Ayan hurried past a shop and bee-lined to the back. On the way back to Ayan's house, I asked her why she ran toward the back of the mall and if she was avoiding someone. She said it was tribe related. She mentioned we bought a dress from someone outside of her tribe and it was a little embarrassing to go there and not buy from her own tribe. I told her I understood, it's kind of like buying from a stranger instead of your family. She said "exactly."*

Ayan demonstrates how tribal distinctions are dealt with on a day-to-day basis versus when someone was "in need":

> I might be going to [redacted] clinic and it might be ok. This person might say 'hello' to me and maybe somebody else will ignore me. But if I need them, they'll be there. Yeah, if I need them they will be there. We had a young lady who by mistake, she, her family sent her – she's I think she's 25 or 26 something like that – her family sent her from Arizona to, she wanted to leave to Canada. Smuggling, kind of. And uh, she end[ed] up in New York on the wrong bus. [**ohh**!] And a cab driver found her. Luckily he is a friend of my husband so he says oh, I know a Somali guy, I know a Somali guy that can help so he called. He said I have a lost, somebody that's lost, and she doesn't have a return ticket to go where she came from. And she's here. So he said bring her over. She stayed with us how long? Two weeks, two, three weeks?
> *Jama*: Mhmm.

Regardless of "uncomfortable" situations that may make Somalis act or react in a particular way according to tribal loyalty, Somalis do indeed foster a sense of shared Somali identification in the United States. Many of the women Ayan hosts for dinner, lunch, or tea regularly come from a variety of geographic areas within Somalia and represent multiple tribal relations. This expanded shared sense of community among diaspora Somalis and the idea that "they will never go hungry" or without can help to offset food insecurity that often accompanies resettlement and migration.

Gallaher et al. (2013) note that the urban poor may be "worse" off in comparison

to rural populations due to the urban population's inability to grow and produce food. Urban poor rely on the cash economy and social capital. Social connections, or social capital, can positively influence health in the context of meal and food sharing (Mohnen et al. 2011; Moore et al. 2014). The relationship between food sharing, social connections, and health can be seen among Somalis in urban settings. Although Somalis do rely on a cash economy to pay for housing, food or other items may be obtained through social connections. Food sharing is the main way social connections are shown and reinforced. For example, after a series of unfortunate family events, one woman from the mosque was struggling financially. Ayan and other women gathered generous amounts of food, diapers, and small household items to share with her. These acts of kindness and donation are framed as expressions of Somali culture, as Ayan and Jama note above. Social connections create a relationship between community members and often rely on the social connections fostered and maintained by giving and receiving food.

Thomson and Hassenkamp (2008) examine meanings of food rituals among physiotherapists in the UK. Through interviews, Thomson and Hassenkamp reveal implicit and explicit meanings of food rituals. Explicitly, food rituals serve in creating a sense of harmony and sustaining community; implicitly, food rituals expose tensions. Turner (1969), a symbolic anthropologist, describes ritual as a social phenomenon. Thomson and Hassenkamp's (2008) piece draws on Turner's dualistic observation of ritual: as an expressive function of communicating values, and in addition, serving as a creative function for creating and re-creating categories through which

people begin to perceive reality. Similarly, Douglas (1984) asserts that food is a code which expresses messages of hierarchy, inclusion and exclusion, as well as boundaries.

Dietary Changes in the United States: Trust and Cultural (Mis)Understanding

In addition to sharing physical resources with one another, Somalis often share educational and nutritional advice. Dr. Amira, a non-Somali Muslim doctor at a local clinic believes that information on management of illness is often passed along from Somali to Somali rather than from a doctor. Dr. Amira says, "A lot of it is just you know, passed on from family members." Jama also notes the importance of informal networks about maintaining a healthy diet. When I asked if he helps people who come into his restaurant he says "Yes, to eat those things, yeah." He continues:

> And a few ask me what kind of meals that have less sugar [**mhmm**]. Like spaghetti, which is you know =
> Ayan: = wheat
> Jama: Yeah, no sugar. Sugar also with bread. I pick sometimes wheat bread so they can have those options . . .

As a medical professional and wife of a man with diabetes, Ayan notes that she often acts as a community advisor:

> Yeah because, I mean, I'm not with them in the clinical aspect where they are [**Mhmm**], maybe they go to the doctor's office, but from time to time if I encounter anybody that has diabetes and maybe having a tough time managing it or not even caring about it I would just throw ideas that we have. Maybe from my husband's experience or [**Right**] from my background. Ok is your medication working? How often are you taking it? Are you missing your pills [**Yeah**]? Things like that, it just comes up from medication talk. I mean if you don't take your medication, if you don't watch your diet, if you don't maybe grains or add whole wheat and this and that, then forget about it.

Ayan's medical background facilitates her role as an informal medical educator within Somali informal networks. However, Ladan notes that many Somalis "come off as

doctors" [52] even when they do not have medical training. This indicates that Somalis rely on other Somalis as a source of trusted information networks, in which they operate, despite any medical training, within informal community networks of health exchange.

Ladan clarifies that this means Somalis listen to nutritional recommendations from their doctors but also rely on community members' advice, particularly with chronic diseases like diabetes:

> Along with what the doctor tells them. [**Yeah**] Yeah cause they're like my uncle had diabetes, my mom has diabetes, too this is the type of food she eats. So they'll recommend foods to eat.

Ladan's comment reflects the high proportion of Somalis with diabetes. Because many Somalis have close family members or friends with health conditions that require dietary changes for management, community members also act as trusted resources for nutritional tips. These informal community advisors are seen as essential because many Somalis believe "American" doctors do not understand Somali cultural food practices and therefore cannot properly advise them on health matters.

Biomedicine dominates American culture and is often treated as the most trusted source of information. However, Dr. Amira notes the limitations of nutritional advice given to Somali patients from American nutritionists:

> You know, we also don't understand their culture as well. Maybe if we had a nutritionist that was more familiar with their way of eating, then we could understand their diet and their food and then you can make recommendations, right?

Dr. Amira admits part of the issue with Somali patient adherence to nutritional changes is a lack of cultural understanding necessary make informed and helpful dietary

[52] Fieldnotes, July 11, 2015

recommendations. This lack of cultural understanding perpetuates denial and mistrust of American doctors.

Ayan highlights cultural misunderstandings in the clinic setting that lead to many Somali patients' mistrust or denial of doctors' and nutritionists' recommendations:

> It's so funny that, it's the pregnancy there's a, a female when they're pregnant Dr. [redacted] has most Somali patients. She specializes in Somali patients. [**Yeah**] So she sends everybody to a nutritionist [**ok**]. Because gestational diabetes is on the rise [**yes**]. And what she does is, because that the nutritionist, I went there the first time *alhamdulillah* I was pregnant. She gives you this much of rice [**wow**] {closes fist to indicate a fist-size portion of rice}. She's like all you can eat is this much rice. And I, my sister-in-law was like can you believe that nutritionist, she said 'I can eat this much' [*laughter*] 'what does she think'? What is this? I'm not gonna eat this much. [*loud laughter*] I need this! This is how I can eat rice! [**yeah**] {makes a bigger circle with both hands}. That's what it is. We don't have greens that go with it [**right**]. That's why we consume the whole thing [**ok**]. It's like goat on the side maybe but not green-y leaves. No way.

Ayan's story indicates doctors who "specialize" in Somali patients utilize American nutritionists who make recommendations without Somali cultural food practices in mind. Many Somalis, including Ayan, laugh almost uncontrollably at the 'outrageous' recommendations. These cultural misunderstandings contribute to the general feeling that American doctors do not "get" the Somali way when it comes to diet. As Merry White (2004) notes, the concept of dietary regiments for weight loss are generally understood but may not apply cross culturally.

Jama reflects on cultural misunderstandings of American doctors toward Somali culture and makes a suggestion for improvement:

> The other thing also, the benefit would be bigger if they find, they see a Somali doctor who knows the culture [**yeah**] and they give them attention when they see a Somali doctor. For a Somali to tell them: 'you're eating this, this, this and those are not good for you.' But when they see any doctor, they say 'oh this guy is just talking about the American style.' They don't get the conversation.

Ayan continues:

> What is he talking about? Now we're in America. I've never been told back home, now they're telling me. [**ok**] Now they're telling me. So the best way to do it is don't go to the doctor. [**Oh, so they avoid going to the doctor?]** Yeah. [**Oh, wow. That's dangerous.]** Why even bother? Why do you bother going? […] Because their assumption is this doctor, he's American. He doesn't know. [**yeah, ok**] He doesn't know what we're going through or how. He's just treating us in an American style. [**ok**] It's a big denial thing.

As Jama mentions, Somali doctors are taken seriously. The trust and acceptance that comes with being Somali is demonstrated by Somalis preference of informal community member advice over their American doctor's advice. The danger in feeling like an American doctor does not understand Somali culture, is to avoid dietary and other health recommendations or as Ayan says, stop going to doctors completely because they only provide "American style" healing and advice not suitable for Somali patients.

The reliance on other Somalis, whether medically trained or not, not only demonstrates an aspect of informal health networks but also incorporates Brigitte Jordan's (1993) concept of authoritative knowledge. Doctors in the U.S. tend to have a large degree of authoritative knowledge because they are in authoritative positions, giving advice and treatment to patients. However, among Somalis, the trust advice of other Somalis speaks to a new kind of authoritative knowledge, stemming instead from a shared social and cultural group.

Resisting and Accepting Dietary Change

Shepherd (2002) notes that dietary changes can be difficult to effect in both individuals and populations, and even when changes do occur, they are often slower and less pronounced than hoped for and expected by biomedical providers. Shepherd

considers three possible reasons: complexity of food choice and competing influences, attitudinal ambivalence, and optimistic bias. My participants discuss rejecting or accepting nutritional recommendations based on the following criteria: holding on to traditional meals, roles in meal preparation, generational differences, and education.

While not all Somalis are resistant to dietary recommendations, many believe that they know best what they should eat and what is best for their bodies, which complicates the notion of "nutrition". Somalis may understand that from a Western biomedical perspective, a Somali diet is not "healthy", socially and culturally, their diet fulfills and sustains them. This brings in the dichotomy between "soul food" and "health food". Yet, In the United States they are told what is "best" for them in terms of diet by non-Somali providers. Jama explains how frustrating these clinical interactions may be:

> And some believe they don't even go to doctor that can give them you know, the talk about the meal that they can eat [**ok**]. They know automatically what they eat just rice, spaghetti, goat. That's just the tradition, that's what they eat. [**Right**] They don't want to go to the nutrition[alist] and tell them to each broccoli.

These recommendations are seen as attempts to 'Americanize' Somalis in the United States, which may therefore be rejected in favor of remaining Somali through dietary practice. Ayan explains:

> Becoming Americanized. It's not something that fulfills their need. [**Ok**] It's like, as Jama said it's not enough. I'm hungry, it's not enough, what do you mean itsy-bitsy of rice and green-y broccoli. [**Right**] I told him [Jama] yesterday broccoli and he was like "oh no!"

In another effort to resist "Americanization" and the understanding that Somali food does more than just provide nutrition, it provides a sense of belong to the Somali community, Jama explains Somali parents' response to their children:

> The only way the parents believe that their children have enough food is to eat more rice [**eat more rice**]**.** Eat more spaghetti. [**yeah**] Like if they eat one slice of pizza or two slices of pizza, they don't think they had enough.

The "American" food, according to Somali parents is not "enough" food and is not satisfying to their children. The only way to correctly feed their children involves also incorporating Somali meals.

Another factor of resistance to dietary change is the gendered nature of food preparation, an expectation of labor which usually falls on the woman, or domestic head of the household. Amira explains:

> They're very, they're family oriented [**Mhmm**]. Their idea of meals tend to be something that the entire family would share. [**Mhmm**] So it's difficult for them to then you know, to make a meal for the family and then also make a meal for a diabetic diet. So the idea would be if you're going to limit, they tend to eat a lot of rice and oily foods. [**Mhmm**] And it's hard for them to cook for the entire family, their big family, six or seven kids and then for me to recommend you know, a diabetic diet for them that consists mostly of vegetables to them.

The domestic head of the household, in terms of food preparation, makes one meal and if that meal requires dietary changes for one person due to health reasons, these may be overlooked in favor of supplying the larger family with a traditional Somali meal. Because economic access, as Dr. Saaye acknowledges, may restrict ability to eat the way Somali want to in the U.S., it is also possible that economically making a separate meal for a diabetic (and non-Somali) meal is unattainable.

Ladan agrees that the responsibility for food preparation often falls upon one member of the family:

> I have a coworker who is always looking for healthy recipes. Her mother is sick so she can incorporate that in her household. So, she's that's her daughter. She has a bunch of kids, her mother lives with her [**Mhmm**] and she's like the head

> chef [**ok**] and she's very conscious and aware of what foods are and the health benefits.

As Ladan indicates, the head chef at home, a woman, may have final say in meals and be health conscious for those she feeds. However, sometimes the "head chef" of the household faces resistance to changes in diet. This resistance often results in an inability to provide healthy dietary changes. Ayan discusses her sister-in-law who cooks for her husband with diabetes:

> And I said why? Da-da-da and said can you change his diet? Can you just add this? Add greeny things? Add maybe beans? [**Mhmm**] Add whole wheat, anything? And she says 'no, I can't. He's not allowing me to do that'. He wants the old fashioned way, just the rice and just I can't do anything about it.

Ayan's brother-in-law with diabetes rejects the Americanized meal because it goes against Somali cultural tradition. Thus, the "head chef," his wife, is unable to enact dietary change for the entire family in order to keep her family happy with the "old-fashioned" Somali diet.

In a qualitative study among Somalis in Minnesota, Hearst et al. (2014) examined the feasibility, acceptability, and impact of parent-centered interventions to increase fruit and vegetable consumption. Their results indicate that parent-centered interventions on dietary changes do work. However, Ladan notes that many dietary interventions are addressed on an individual basis usually among younger generations of Somalis in American schools, which neglects older generations of Somalis. She says parents are often left out of nutritional education.[53]

Wilson and Renzaho (2014) conducted a similar qualitative study among Somalis

[53] Fieldnotes, July 11, 2015

to explore food beliefs and perceived health risks, echoing Ladan's observation. This qualitative, cross-sectional study identified differences between parents and adolescents in relation to: lifestyle, diet, and physical activity. Dietary and health inventions may also be perceived differently between generational categories.

Ladan explains the difference and conflict between generational health practices:

> The older generations, they, they know. Like it's like you're supposed to exercise, eat healthy. They know, they just don't practice it. Whereas the younger generation they incorporate a little bit more action compared to the older generation. […] if you go down to the younger generations, they're a bit more concerned with what they eat and they work out, go to the gym, and they you know get healthy foods.

Ladan continues by reflecting on why these differences are so apparent between generations:

> I think growing up here or being born here has a lot to do with it. Secondly, some are just tired of eating rice and spaghetti all the time [**Yeah**]. The Westernized culture is just, there are different areas where you adapt. [**Yeah**] Where the elders are not still adapting. They still have their old culture ways [**Mhmm**]. And the younger generation has been more educated now.

Younger generations of Somalis who grew up in the United States are receiving multiple health messages that may not be getting through to older Somalis who still prefer word of mouth and trust informal networks of health information. In addition, older Somalis are not accustomed to relying on written health material or pamphlets that nutritional charts and recommendations that are often distributed on. Schooling, or education, in particular is one way younger Somalis are learning about health. However, Ladan continues by addressing other factors:

> Yeah, they're going to school and they're learning about these things. And it's kind of opening up the way they think compared [**Ok**] to the older generations so [**Right**]. Education, the cultural differences of growing up here, being born here.

> Um, media. Some people are doing it not necessarily because they want to be healthy but they want to be fit and look good [**Ok**] because it's what's being portrayed out there.

As Ladan explains, the media in America and attaining an Americanized "ideal" body is another factor in dietary change. For some younger Somalis, the desire to be fit overcomes their desire to eat traditional Somali meals packed with carbohydrates and fats that may lead to a "Somali" bigger body ideal. Ladan makes the association between eating "other" food beside Somali food and Americanization, something older generations particularly avoid. The avoidance and acceptance of new dietary choices marks both resistance and incorporation of embodied diasporic experiences.

Conclusion

Mary Douglas wrote that anthropologists have "a privileged position for cross cultural comparison" and thus also "have a responsibility to exercise it" (1984:7). Qualitative studies on food and nutritional practices benefit public health efforts to alleviate and prevent several chronic diseases often associated with diet but are ultimately not reaching the Somali community. As Satia-Abouta et al. (2002) note, immigrant populations are growing within the U.S. thus the health status of racial and ethnic minorities is increasingly important to overall public health. As Dr. Amira mentions, little is known about Somali dietary practices in the U.S., yet rates of diabetes in this population are high. Because diabetes is associated with lifestyle "choices" such as diet, examining Somali practices of consumption is crucial to addressing increasing rates of chronic disease in diaspora.

Typically, immigration to the U.S. is accompanied by environmental and lifestyle

changes that increase the risk for chronic diseases. Dietary patterns in the United States tend to be high in fat and low in vegetables and fruits (Satia-Abouta et al. 2002). Both consumption and shopping practices mark the Somali body as operating within a value system brought from Somalia or contrasting incorporations of norms found in diaspora. Because dietary patterns are complex and dynamic, successful nutritional interventions must focus on understanding the process of and identify factors that predispose groups to, and enable dietary recommendations to occur.

Margaret Mead (1943:137) notes that food habits change along three principles: morally dictated changes, socially desirable changes, and scientifically sanctioned changes. Morally dictated changes among Somalis rely on whether food habits are deemed "healthy" or "good." For example, if the Somali way is considered "healthy" then Somalis will continue to agree that they know best what to eat. If, however, "healthy" diets are re-framed in the United States through biomedical messages, as younger generations of Somalis increasingly accept, food habits will change. Socially desirable changes to dietary practice usually reflect advances in socioeconomic status and incorporation or embodiment of dominant messages from the new culture into which immigrants are assimilating. For instance, in the United States, many Somalis are no longer restricted by famine, and are surrounded by new messages about ideal body size and health. However, many also live in a lower socio-economic bracket than their dominant white "American" peers and therefore may be compelled to choose high-calorie, high-fat, low-nutrient foods. Scientifically sanctioned changes rely on individuals taking advantage of nutritional science.

Younger Somalis receiving nutritional advice may enact and embody this change due to the availability and efficacy of repeated educational interventions in their early years in the United States, despite conflicts with cultural ideals that are perpetuated in the Somali diaspora. However, older Somalis may be more inclined to reject such changes because of their mistrust of biomedicine in general, and non-Somali clinicians in particular, within the United States and as a form of resistance to "Americanization" by remaining "Somali" through consuming a Somali diet. In addition, older Somalis may identify other Somali community members with authoritative knowledge on how to be "healthy" over the knowledge of physicians in the U.S.

In addition to conscious choices of resistance and acceptance, lack of access and affordability influence Somali dietary practices. The political-economic implications of separate meal prep for Somalis with diabetes highlight the lack of affordability. Women's roles as the head chef also dictate the diet of an entire family; as my participants suggest older "moms" tend to prefer a traditional Somali diet. Thus, many Somalis are encouraged to continue consuming a diet high in fat and carbs. Due to education in the school systems and younger Somalis' more accepting attitude toward "American" food, including healthy options, may lead to a visible change in Somali dietary patterns in the coming years.

CHAPTER VI

Chronic Embodiment of Stress: Somatic Symptoms & Health Among Somalis in the United States

The notion of embodiment reflects "how we literally incorporate biologically—from conception to death—our social experiences and express this embodiment in population patterns of health, disease, and well-being" (Krieger 1999:296). Nancy Krieger emphasizes the importance of the physical body which creates, consumes, excretes, reproduces, and evolves. Similarly, Thomas Csordas (1990), echoing Marcel Mauss, argues that the human body models culture through embodiment, becoming more than an isolated physical object of study. The concept of embodiment therefore allows us to directly conceptualize how and why societal conditions produce distributions of health within and upon the body, especially in relation to physical and social location that extends beyond biology (Csordas 1994).

In this chapter, I employ the concept of embodiment as a framework for understanding the prevalence of diabetes and mental illness among Somalis in Boston. By acknowledging the impact of migration, including structural violence and discrimination, I outline barriers to care and management of illness as described by participants. Issues of embodiment among Somalis involve three key components: 1) divergent understandings of health between Somali patients and non-Somali clinicians 2) chronic embodiment of emotional trauma and stress through somatic symptoms, impacting the social world and disease management 3) the impact on clinical interactions and resulting responses to diagnosis and adherence.

Discrimination is particularly embodied through health. As Krieger reminds us,

discrimination is socially structured and sanctioned, "justified by ideology and expressed in interactions, among and between individuals and institutions, intended to maintain privileges for members of dominant groups at the cost of deprivation to others" (Krieger 1999:301). Discrimination is not always visible, it may be less obviously constructed and perpetuated by institutions, including health care systems (Krieger 1999; Scheper-Hughes 1996). Sara Edge and Bruce Newbold describe discrimination as taking on "many forms at a variety of scales, from conscious and sub-conscious interpersonal interactions between individuals, to more institutionally engrained, systematic practices" (2013:141). Furthermore, they argue that discrimination "can be based on race, language, religion, country of origin and/or other characteristics" (Edge and Newbold 2013:141). As Black, Muslim, immigrants and/or refugees, Somalis in the United States represent a population faced with multiple intersectional forms of potentially discriminatory external-other perception.[54] As various studies note, discrimination is linked to poor individual health, supporting the notion that discrimination becomes embodied (Cohen 1999; Derose et al. 2009; Beneduce and Matelli 2005; Singer 2004).

Discrimination, as structurally and individually produced and reproduced, closely relates to the concept of structural violence. Paul Farmer, a medical anthropologist and physician, incorporates and defines the concept of structural violence, first coined by Johan Galtung.[55] Farmer et al. define structural violence as "one way of describing social

[54] I employ the term external-other perception to explain outside perceptions of the Somali body by non-Somali American citizens.
[55] Johan Galtung developed the term "structural violence" in the 1960s to describe social structures including: economic, political, legal, religious, and cultural that prevent individuals, groups, and societies from reaching their potential (Farmer et al. 2006:1686).

arrangements that put individuals and populations in harm's way" (2006:1686). Structural violence combines embedded political, social, and economic organizations of the social world within the concept of violence, because they cause injury to people (Farmer et al. 2006:1686). Structural violence, among other social factors, is often identifiable when examining the root of health disparities in the United States along racial or ethnic and socio-economic lines. As immigrants and racial minorities in the United States that face discrimination, it is no surprise that many of the Somali participants in my study knew various family members and friends with diabetes, increasingly recognized as a disease of poverty. Yet, structural violence extends beyond clinical access and interactions; it encompasses access to food and is an expression of global political-economic drivers of contested colonial presences and wars within Somalia.

Structural Factors that Contribute to Disease Prevalence

In order to discuss social forces that affect Somali experiences of embodiment and illness beyond patient control, I employ the framework of structural violence. One obvious structural factor affecting Somalis in Boston is low socio-economic status, which carries repercussions for access and availability of resources. These structural factors are depicted by Somalis, in addition to access to food, through perceptions of their neighborhood environment. Dr. Saaye explains:

> So and in the night time, like they are, some of them if it becomes dark, they all live in this neighborhood, they are kind of scared of it. [. . .] Mostly they live in this area, in Dorchester or some people live in Cambridge. There's a lot of people you know in other places, they have houses. But this group doesn't come to here. So the people who come to this here, and the majority of Somalians, is they live in Dorchester and Roxbury and Jamaica Plain and some people in Mattapan. [. . .] But mostly in these so they have, like, they have also like I live here, is a crime area kind of. [**Ok. So they're afraid?]** Yeah. Sometimes. Even the kids, they

> don't like the kids going outside in the night time. There is a lot of gangs here. And police come inside and I don't want to have, we don't want to have trouble to be called. They kind of you know some of them get section eight,[56] they move in like Malden in that area. And they move in from here and they're like because of the kids, they are scared. For the kids. [sic]

Dr. Saaye details the neighborhoods where many Somalis live. However, she is not entirely focused on neighborhood descriptions for geographical purposes. Instead, Dr. Saaye is trying to convey the social dynamics within the neighborhood. She indicates that it is a "crime area", with gangs and police who "come inside", which instills a level of fear among Somalis who have fled neighborhoods of violence in Somalia including violence carried out by government and police forces. In addition, she notes socio-economic realities of many Somalis who rely on government assisted housing but are scared for their children. Dr. Saaye's comments convey a sense that socio-economic factors are related to crime, housing, environment, fear, and stress among Somalis in Boston.

In these neighborhoods, many social forces are visible in a lack of education within school systems, infrastructure, and security. However, some forms of structural violence become embedded in social and political systems, as invisible forms of violence. These concepts are so ingrained that they are difficult to "see" in daily life. Yet, they create a level of stress among individuals in day-to-day processes. Goodman et. al. note that repeated stress may lead to a "variety of functional disorders, including

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[56] This is a Housing Choice Voucher program established by the federal government and enacted by local public housing agencies to assist low-income families, elderly, and disabled individuals to afford housing in the private housing market. Eligibility is determined by income, which may not exceed 50% of the median income for the county or metro area. U.S. Department of Housing and Urban Development: http://portal.hud.gov/hudportal/HUD?src=/topics/housing_choice_voucher_program_section_8

cardiovascular disease, ulcers, hypertension, and immune suppression" (1988:173) thus contributing to prevalence and difficult management of disease.

In examining the high prevalence of diabetes among Somalis, we must acknowledge these structural and social factors, leading to stress. Leatherman and Thomas (2009) emphasize three central points to structural violence and its relation to health: structural violence leads to violence, changes in food security, social cohesiveness, and political power that are relevant and important measures of public health outcomes, and the effects of conflicts are uneven. Using Leatherman and Thomas's (2009) argument, we understand that health goes beyond the absence of disease.

Perceived Discrimination

Many Somalis are aware of heightened tensions between Muslims and non-Muslims in the United States. News reports, civilians, and government organizations frequently target Muslims as "dangerous" immigrants. Being made to feel "un-American" or out of place in the United States because of religious belief affects how one identifies and affiliates with the nation (Kunst et. al. 2012). A Norwegian study examined the results of perceived discrimination on the basis on Muslim identification and found several harmful side-effects of psychological well-being among those Muslims who perceived discrimination (Schmitt et. al. 2014).

Discrimination can be subtle or overt. Subtle discrimination may be experienced in a clinical setting where Muslim women feel subjected to embarrassing or inappropriate contact with male staff (Padela and Curlin 2013). Some Muslims may feel a general

disregard of personal privacy and time for prayer in a hospital setting. These instances are examples of self-perceived discrimination. Krieger acknowledges that self-reported experiences of discrimination are "associated with poorer mental health"; however, associations with somatic health and discrimination are "far more complex" (1999:311).

The effects of perceived discrimination hold enormous physical and mental health consequences. However, throughout my study, none of my participants mentioned discrimination by name[57]. Instead, they became hyper-aware of their presence walking down the street. One week, a man walking near the mosque and Somali restaurant began shouting in support for a particular Republican Presidential candidate who aligns himself as anti-immigrant and has been outspoken about banning Muslims from entering the country. The man shouting on the street was inevitably directing comments to non-Muslim neighbors but also to Muslims walking down the street.

The effects of public outbursts, such as the one described above, were never conveyed to me by Ayan as a threat or an instance of discrimination. Instead, she blamed his ignorance and called the incident a general "nuisance". However, upon hearing this story from Ayan, I was unable to detach the underlying discrimination, or signs of a toxic social environment resulting from Islamophobia, from the man's obnoxious screaming. I probed Ayan for more details about how anti-Muslim rhetoric in public and on the news affects her daily life. After a moment she responded that she refuses to use public transportation to go into the city center alone. This did not seem like a new caution but may be heightened in response to recent terror attacks and Islamophobia in the media. In

[57] See Ellis et al. (2010) for more on lack of perceived discrimination among Somalis in Boston.

addition, she and other Muslim moms have been attending group meetings with a psychologist about how to discuss discrimination in the media with their children. When Ayan told me about these meetings, she emphasized the need for mothers to "be strong" in front of their children even if they are scared about the discrimination. Despite Ayan and other participant's lack of overt discussion about discrimination, it clearly adds layers of stress to Muslim Somalis' daily lives in Boston and is subtly referenced when describing day to day events. In fact, Ayan and Dahabo, specifically mention they avoid areas outside their neighborhoods when alone. Their *hijab* protects them from a sexualized male gaze, however, Ayan explains that it does not protect them from non-Muslim, Islamophobia gazes.

Less Obvious Barriers to Care

While diet, health literacy, and language barriers are more obvious barriers to management and care of diabetes, other barriers to care stem from a lack of trust of non-Somali doctors to understand the Somali perspective. In addition to body ideals and diet misunderstandings between Somali patients and non-Somali doctors in the United States, general denial of diagnosis and resistance to medication also arise. Dr. Amira generalizes her experience of Somali patients' immediate reactions to diabetes diagnoses:

> A lot of it is denial that they really have diabetes. Sometimes they try to um, give it another term: "I need my sugar regulated." But they don't want to accept the fact that you know, you have diabetes that might require something like medication and insulin.

Ayan also notes the role of denial in diabetes diagnoses among Somali patients:

> They would still be shocked because maybe there's a denial part [**Ok**]. Even though you know it's not mostly something that we talk about it a lot. Most people it's like, "oh no no, not me." [**So they don't talk about it?]** No. [. . .] And

> uh, the reaction is like 'oh', not thinking that this is really diabetes because diabetes for back home is not understood as like how serious it is here [**Ok**]. In terms of here, when you hear diabetes you work hard changing your lifestyle, trying to motivate your diet because you're hearing so much. How dangerous it is [**Right**] this and that. So the reaction back home is not as serious as it is here. Here is like you take it seriously. Like oh really, I didn't know I had this and that. Or no wonder why I've been urinating all along. [**Right, right**]. It seems like "oh, ok now it explains, the doctor told me I'm more thirsty. Am I more thirsty? [**Right**] Am I this and that?" [**Right**].

Ayan's comments illustrate several points. First, many Somalis' immediate reaction is one of denial. Secondly, diabetes is not something that is talked about often because generally, there are more important issues at hand for many Somalis. Thirdly, Ayan mentions that Somalis may be in denial but later try to understand their diagnosis in terms of somatic manifestations of the disease, such as frequent urination. This hints at the reliance on outward, physical, embodied manifestations of disease and illness in order to accept a diagnosis rather than internally "hidden" aspects of illness. Finally, diabetes and somatic symptoms associated with diabetes "back home" in Somalia is not as understood, or as diagnosed, in comparison to the United States, drawing attention to how illness becomes embodied and understood through physical symptoms in diaspora.

Here, in the United States, there is a large amount of education around the severity of diabetes and its long-term complications and risks, in contrast to Somalia. This may indicate a higher prevalence of diabetes diagnosis in the United States as well as a more comprehensive health care infrastructure in comparison to Somalia, where education, management, and diagnoses may be hindered by structural and economic issues due to the civil war. Because diagnoses and understandings of illness must be "seen" or embodied in a physical sense, categories of illness diagnosed in the United

States receive different "levels" of importance, acceptance, and seriousness. Somali understandings of bodily symptoms and severity influences these "levels" of importance and acceptance. When discussing diabetes, Somalis often bring up kidney failure as a justification of the seriousness of diabetes. Yet, in contrast to cancer, which may affect the body in more visual ways as a result of treatment (loss of weight and/or hair), diabetes is seen as relatively unimportant for Somalis. Despite diabetes relative insignificance in comparison to other diseases, in the first few months of my fieldwork at the Barakah Institute, a Somali woman told me my project would be successful because "everyone here has diabetes". This comment reflects the high prevalence as well as the general lack of secrecy surrounding this "unimportant" health issue.

In addition to denial of diagnoses, Somali patients may also reject medication as a treatment plan for management of diabetes. Dr. Amira notes:

> They generally don't want medication. [**Do, do they manage this in another way other than medication that you know of**?] That they have, you know I haven't seen any consistent thing that I'm noticing in the population. But there are different misconceptions [**Mhmm**]. Like one patient has said, 'if I go home and just drink a glass of milk before bed, I'm gonna cure it'. [**Wow**] A diabetic who needs insulin and refuses to take insulin has said something like that to me. Um, If I take the medication for a month it's gonna cure it. There's this concept that it's gonna get cured with the meds. I'm gonna cure it so I don't continue the medication. I see that a lot actually among other populations as well. [**Really**?] Yeah.

In general, Dr. Amira highlights avoidance of medication among Somali patients. Instead, it appears that Dr. Amira's Somali patients accept home remedies to treat diabetes including milk. In addition, Dr. Amira understands her patients have a concept of being 'cured' that does not correlate with biomedical understandings of diabetes. Somalis believe medicine is not something that will be necessary for a long period of

time but will only alleviate current symptoms or treat the disease temporarily until the disease is cured.

The avoidance of medication, and preferring alternatives to biomedical treatment and management of diabetes, is often passed through informal, lay networks. I ask Dr. Amira how Somali understandings of cures and non-medication based remedies become known among them:

> I don't know. A lot of is just you know, passed on from family members. This is what you do if you have diabetes.

Informal networks of community health support indicate a need for Somali community involvement in health, as trusted, authoritative sources of information in contrast to non-Somali clinicians. The reliance on other Somalis for health information, despite its differing messages about management of diabetes in comparison to Western biomedicine, also reflects the high prevalence of diabetes within the community and what is perceived as accurate information and authoritative knowledge. Many Somalis know others with diabetes and therefore, know what to do if they have diabetes, as Dr. Amira explains.

Islam and Diabetes Management

In addition to relying on informal networks of Somali community members, some providers highlight the role of Islam in treating and managing diabetes. Dr. Amira explains the reliance on Allah and Islam of her Somali patients:

> Another huge thing that I forgot to mention and I'm sure you've done, if you've talked to other people about this, they're, they truly believe that God will cure everything. [**Yeah**] That if I just pray to God then God will cure everything. [**Yeah**] And that things will get better if they just say insha'Allah, Alhamdulillah and these things.

Islamic language and understandings are a way to consistently incorporate Islam into

daily life and highlight Allah as the ultimate source of authority and healing. Dr. Amira explains that the concept of illness is often seen by Somali patients as a gift or a test from Allah allowing them to spiritually grow. Islam is the framework through which many Somalis view and operate within the world.

Ramadan, a time when Muslims fast from sun-up to sun-down during the holy month, may involve health risks among Somalis with diabetes. Ladan indicates that Islamic Ramadan practices can sometimes affect her grandfather's management of his diabetes:

> Today he is fasting so he doesn't take no medicine. When you're fasting there's no water, no medicine. There's absolutely nothing. [**Ok, so only if you're really sick would you take medicine?]**Yeah, if you're really sick and you need it. Like if his blood sugar, if he instantly needs something to eat or medicine, he would break it. [sic]

Ladan highlights the importance of Islamic practices, such as Ramadan, among Somalis. The adherence to fasting during Ramadan remains strict until there is a medical emergency or immediate reason to go against the practice of fasting. Therefore, Ladan explains that while Islam has a strong influence over behavior, health is of most importance despite traditional practices that may disrupt diabetes management. Islam, then, is not viewed by Somalis in contrast to medical adherence or maintaining good health.

Dr. Amira notes that some Somalis depend on their doctor's advice to change medication, avoid fasting for health reasons, or motivate them to accept their diagnosis during Ramadan:

> The issues we tend to see during Ramadan is problems with low sugar. [**Low sugar?**] Yeah, low sugar because they would continue to take their insulin

> [**Mhmm**] and then they fast so their sugar would drop. So we try to do more education around what to do with your insulin during Ramadan. [. . .] We adjust it to try to accommodate the fact that they're fasting. Some patients also come to their doctors so we can let them know that's it's ok from our perspective that it's ok not to fast. They sometimes feel like they don't want to do it on their own because they feel guilty, they feel like they should fast. But when you hear it from your doctor as a recommendation, you know I would say Mr. So and So, your sugars are fluctuating too much, I don't think it's safe for you to fast. They're more receptive to that from me [**From the doctor?**] than if they were just to do it on their own. They feel like it's more accepted by their family. And community and family is huge [**Yeah**] so whether it's, that's why they don't want an interpreter because they don't want anyone from their community hearing about it and then for them it's also important for their family to know that it's my doctor who doesn't want me to fast or something [**Yeah**]. [sic]

Dr. Amira points out key contradictions, from her biomedical perspective, among her Somali patients. They rely on other Somalis, who they know and trust on a personal level, as informal community health networks. But, they avoid interpreters who they may not know personally, to keep their medical information private. They also value non-Somali doctor's medical advice to excuse them, rightfully so, from fasting during Ramadan due to serious health concerns with low blood sugar. While Somalis may go to their non-Somali doctors for advice during Ramadan, other issues are often presented by Somali patients during regular check ups.

Somali Perceptions of Diabetes

The United States is often the place where Somalis first receive their diabetes diagnosis. Dr. Amira, a non-Somali physician at a local clinic in Roxbury, discusses her Somali patients with diabetes:

> I would say the majority of patients get their diagnosis here, and given the way they're presenting and their lab findings indicates that they probably have had diabetes for many years prior to their diagnosis being made.

Dr. Amira's comments provide an insight into structural issues in Somalia and/or refugee

camps near Somalia, where health infrastructure may be limited, yielding inadequate care and screening for chronic diseases like diabetes. Although the United States may be the place of many Somalis' diabetes diagnosis, it does not necessarily indicate that their diabetes began here. Despite this, many Somalis link the United States to diabetes onset. Thus, from sufferers' perspectives, diabetes becomes one vehicle through which diaspora is embodied—from both the clinical view of constructing a stereotypical Somali refugee body, and the Somali experience of somatization of stress and struggles within diaspora.

Jama highlights an example of misdiagnosis in Somalia and diagnosis beliefs about diabetes, or *sukar*,[58] in the United States:

> My father, when he was back home in Somalia, was told that he had sugar. [**Mhmm**]. Then we brought him to the U.S. in 1990, 1989 [**Ok**]. When he came to the U.S. we took him to the special hospital. They checked and they say 'you've never had sugar.'

As Dr. Amira noted earlier, some cases of diabetes go un-diagnosed in Somalia and others are misdiagnosed like Jama's father. Both point to limited medical care in Somalia and surrounding camps. Jama explains that he, his mother, and his brother were all diagnosed with diabetes in the United States. Jama's close personal ties to diabetes through family members represents other participants' familiarity with the disease as each have or have had close family members with diabetes, many of whom were diagnosed in the United States.

Ladan however highlights the far reach of diaspora and its effects on attaining a diagnosis.

[58] Sukar is the Somali word for "sugar", a common way to describe diabetes in Somalia, hinting at the fact that high sugar in the blood relates to diabetes diagnosis.

> Author: Ok, alright so you said people are usually, some are diagnosed here in the United States and some are diagnosed in Somalia or in a [refugee] camp?
>
> Ladan: Yeah, in the camp or, [**Ok**] they travel from all over. [**Ok**] So some are in Europe. So from what I heard, they travel from Somalia, too. Once they get their paperwork and it's approved for them to start the process of coming. [**Right**] Some of them will be placed in camps in other countries [**Mhmm**]. And then they'll handle it from there so they might get diagnosed in other camps in other countries.

Ladan's comments about diagnosis being far-reaching shows the expanse of Somalis across the world as a result of displacement and war. It is worth mentioning that being displaced to camps may have health consequences including malnutrition and disease exposure. Ladan's comments about the diagnosis of diabetes show the importance of traveling and leaving Somalia, along with the lengthy process including paperwork and approval. Ladan's emphasis on movement when discussing diabetes diagnoses indicates conflicting priorities: finding a safe place to go to and reside outside of Somalia and chronic health conditions that do not prove to be an immediate, severe threat in comparison to war. Yet, displacement and movement to other countries provides an opportunity to address chronic health conditions.

Cause and Care of Diabetes Among Somalis in Boston

Both Somali patients and their Somali and non-Somali doctors report that diet is the main factor and cause of diabetes among Somalis in the United States. As I discuss in Chapter Five, the Somali diet represents Somali ideals and cultural beliefs and primarily consists of carbohydrates and sugars. While non-Somali physicians in the United States are less familiar, if at all, with Somali dietary practices, they also know that nutrition and diet are a main cause of diabetes among Somalis. As noted in Chapter Five, diet often

becomes a proxy for discussions of health. Dr. Amira explains:

> Nutrition is more likely to do it. It's sometimes food choices, they tend to eat a lot of lamb, cooked and fried in oil. A lot of rice cooked in oil. Not so much of a focus on fruits and vegetables so much as there is on meats and carbs.

Dr. Amira focuses on the nutritional choices of Somali patients and its contribution to diabetes. She neglects other social influences on diabetes in her first impression of disease onset among Somali patients. As Farmer et al. (2006) note, physicians are not often trained to facilitate structural interventions because these interventions are seen as 'not their job'. While diet is an agreed-upon factor among Somalis and their non-Somali doctors for diabetes onset, the focus on this one factor alone of many indicates the health care system's willingness to place individual blame on health outcomes.

In addition to diet, health literacy and language barriers are often cited as factors in diabetes onset and mismanagement of diabetes. Dr. Amira explains some barriers to management among her Somali patients:

> Because of lack of, because of difficulty communicating with patients for me mostly due to language barriers and difficulty to get patients to accept an interpreter on the phone. [. . .] Dealing with patients is very difficult with my Somali patients mostly because of the fact that they refuse interpreters. And they have a significant fear that because it's a small community and everybody knows each other that even if there's an interpreter on the phone that they would recognize them. And that they would know their business or their medical problems. [. . .]And their English is often sometimes broken and they don't understand you but they nod their heads and they say they do. And I've realized that they don't sometimes understand me.

Dr. Amira experiences issues with getting her Somali patients to accept a phone interpreter because some Somali patients fear speaking with other Somalis. They may feel that they are within the small community, who will know "their business" and

medical problems if they accept an interpreter. This alludes to the amount of privacy Somali patients value in clinical interactions. In addition to refusing interpreters, Dr. Amira indicates that many Somali patients nod and speak broken English yet she hints that many do not actually comprehend all English instructions on management and care. By insisting they understand, even when they do not, Somali patients present themselves as knowledgeable patients, which may result in a lack of actual comprehension.

Dr. Fatima also recognizes language barriers in clinical interactions, but says her patients often accept phone interpreters:

> Yeah, probably the majority of Somali patients, I use the phone translator. Some providers might be different. Sometimes a patient, well I ask them. I usually ask them as soon as I sit down if they prefer Somali or English. And then if they prefer Somali we use the interpreting line. [**Mhmm**] Um yeah. I've been with some people who prefer not to but I would say the majority prefer the interpreter line even if they speak a little bit of English. It's better just to make sure everybody's ideas get across as much as possible. [. . .] As soon as I sit down I say, you know, I say "do you prefer Somali or English?" And then I point to the phone line. Like we can use the translator line just to show them you know immediately that we can do that.

Dr. Fatima emphasizes the availability of phone interpretation, an acknowledgement of awareness of language barriers in the clinic. I ask her why her patients accept phone interpreters when, as she admits, some doctors do not utilize this service often. She explains:

> I think it's probably in part the doctor's style like how you approach it. You know even how you ask you know I don't know how other people ask but if you ask because it does take a little extra time to call the person. You have to call the interpreter and everything has to be said twice basically. You have to say it in English and then they have to translate it so it does take a little extra time.

Dr. Fatima points out an important part of the clinical interaction: the value and emphasis on time or lack of time clinicians convey they are able and willing to spend with Somali

patients. She continues,

> Some might just try to do English and just try to see if the person gets along fine [**yeah**]. I think it just depends, some might you know just start with the question is English, can we use English? And you know that's a little bit biased but [**Right right]**, yeah, I think that um, not giving people the choice in a really open, unbiased way can really. I mean there's already cultural barriers but if you have the language barrier, I think it's gonna be like wow, really, really. [**yeah**] I don't think everything is gonna get across because honestly using the interpreter line at times I've had patients where I thought everything was clear and then another sister[59] from the community will be like yeah that person had no idea what you're talking about with his medicine.

Dr. Fatima stresses the need for an unbiased approach when asking if a patient would like an interpreter. This awareness of how physicians come across to their patients highlights aspects of power dynamics in the clinic where some Somali patients may feel "bad" asking for a Somali interpreter. In addition, it points to subtle, and perhaps implicit, forms of discrimination. Dr. Fatima also notes the importance of time, alluding to the fact that some physicians do not want to "waste" or spend time by calling a translator and prolonging a conversation about diabetes management. Again, this highlights power dynamics through unconscious construction of the physician's time as more important than patient comprehension. In addition to noting the language barrier in diabetes management among Somali patients and non-Somali providers, Dr. Fatima understands that language is one part of a larger cultural barrier between Somali patients and non-Somali providers in the clinic.

Spoken language is not the only communication or language issue within the clinic. Dr. Amira notes problems and advances in written translation:

[59] Muslim women (and men) call each other "sisters" (or "brothers") as an indication of Muslim identification. Fatima is a Muslim convert, sometimes called "revert" to Islam.

> I see a lot of Spanish speaking patients. It's, we're kinda doing better about putting Spanish speaking instructions on the labels. But a lot of my Somali speaking patients are not literate [**Yeah**]. So it doesn't, they can't read in any language [**Right**] so um, it becomes, that makes it harder. But also I think that for them, they also want to feel like they can trust a provider. [**Yeah**] So I walk in there and I say something like "salaam alaykum" and I throw in a few Arabic words [**Yeah**] every now and them to just give them that sense of comfort [**Right**] that I'm on the same page as they are. And that I understand where they're coming from and I tend to get a lot more.

Somali was first written in 1972 (Lewis 1988:5); the civil war followed shortly after, disrupting education systems and thus the advancement of literacy throughout Somalia. Therefore, as Dr. Amira indicates, familiarity with written language is limited among many Somali immigrants and refugees in the clinic. While Spanish speaking patients benefit from Spanish translation on medications and medical pamphlets, Somali patients rarely benefit from these attempts in communication. Instead, Dr. Amira uses her knowledge of Arabic and Somali words as a way to facilitate trust with her patients. Dr. Amira understands the importance of "effort" to reach Somali patients and their comfort speaking Somali in order to circumvent trust issues and maintain the ability to effectively communicate medical needs. However, the lack of available and useful communication efforts in the clinic highlight subtle micro-aggressions. These implicit forms of discrimination in the clinic—constructing the physician, and non-Somali's time as more important and not providing effective communication tools—are another factor that contribute to embodiment of discrimination among Somalis in diaspora.

(In)Visible Illnesses: Somali Perceptions of Mental Health

In addition to differing perspectives of diabetes between Somali patients and their non-Somali doctors in the U.S., mental health is another topic with potentially differing

beliefs between both groups. Dr. Amira, speaking of her Somali patients, references these conflicting opinions on mental health: "They also don't, don't believe in mental illness as much as what's become more widely accepted." Dr. Amira indicates that within the United States discussion about mental health is becoming more accepted but perhaps not as readily among Somalis.

For many Somalis, mental illness is not a concept widely discussed in Somalia. Like diabetes, many Somalis' first encounter of the concept of mental illness as a biomedical construction occurs in the United States. Nadia, a Somali woman who works at a refugee and immigration center in Boston, explains how there are not direct translatable terms for mental illness in Somali. She notes that "there is no word for which there is no action" to explain the lack of Somali terminology or conceptualization for depression or PTSD, and other mental health diagnoses, used in the United States.[60] Similarly, Ayan explains that mental illness may stem from displacement and factors associated with displacement but religion keeps Somalis going.[61] Both Ayan and Nadia indicate that the civil war in Somalia and subsequent migration are the root cause of mental health issues among Somalis.

Ayan continues to suggest mental illness is not a "problem" for Somalis, saying schizophrenia and depression do not exist among them. But she also admits that she believes it is a sin to openly sob or express emotion. Ayan's comments give insight into a Somali perspective of mental illness and emotional displays. My first visual display of Somali suppression of emotion occurred after Ayan's explanation at the mosque:

[60] Field notes from meeting with Nadia, January 22, 2016

> *A young Somali girl, perhaps four years old, began screaming uncontrollably today after prayer. She had been playing with a doll that was another girl's and her mother decided she needed to give it back to its owner. Her mother, in a hushed yell, reprimanded her but the girl did not stop shrieking. Several non-Somali women looked away or gave half-hearted smiles in the Somali moms direction but did not seem to acknowledge the situation. Finally, four older Somali women came to the mother's aid. They grabbed the little girl, telling her to stop and saying 'we don't do this'. Normally, I would look at this incident as a sort of communal style of child rearing, where multiple women are involved in discipline or 'teaching' and caretaking. However, after Ayan's comments about how Somalis view expressing emotion and reflecting on the comment 'we don't do this', I believe it speaks to how cultural values, i.e. emotional control, are taught in diaspora.* [62]

Perhaps because mental illness is not widely discussed, Somalis, as a collective unit, consider themselves to "not have that problem." However, Ayan suggests that the "problem" is not about absence or presence of mental illness (or emotion), but rather Somali ideals that emphasize emotional strength and control which make talking about mental illness (or emotional instability) difficult. In another talk with Ayan, she mentions hearing stories and gives a few examples of Somalis with mental illness who are "locked away" by their families to prevent them from harming themselves or others.

In one of my weekly visits to Ayan, we walked to another Somali woman's apartment complex to visit. The next week when I went to see Ayan, she asked me if I remembered the woman's building. She then explained that the day after our visit to the building, an older Somali man jumped from his balcony after drinking bleach, committing suicide. After Ayan told me about the incident, I asked her if suicide has occurred before among Somalis in the area. Ayan said this Somali man's suicide is the second one that she knows of among Somalis in Boston this year. Eva Melstrom (2014)

[62] Fieldnotes, February 12, 2016

discusses suicide within the Ethiopian community in Boston, as more than a product of depression. Instead, she relates this to numerous harmful social factors that become embodied as dis-ease. Using Melstrom's understanding of suicide, we understand that what is often framed as mental health issues, including events of suicide, are bodily responses to deleterious social experiences.

Ayan's discussion of suicide was very matter-of-fact. She did not get openly emotional, although she discussed the strain this man's wife was under with several children she will now raise alone, with compassion and care. Ayan's comments about being strong and resilient, resisting the urge to cry out even during extremely painful events such as childbirth, were immediately recognizable during this conversation. Ayan's ability to discuss this man's suicide with compassion and emotional control made me reflect on the long history of death and violence many Somalis are, unfortunately, accustomed to knowing.

Clinically, a history of extreme violence and resulting displacement is often associated with post-traumatic stress disorder (PTSD) and depression (Deshaw 2006; Lincoln et. al. 2015). Ayan and Nadia's understanding of depression and PTSD, while questioning the relevance of biomedical mental health diagnoses to their community, correlates to this viewpoint—they see it as a result of the extreme violence many Somalis witnessed in Somalia before coming to the United States. Several studies indicate high rates of depression and PTSD among Somalis (Deshaw 2006; Lincoln et. al. 2015). Many participants, including non-Somali doctors, also emphasize the large effects of trauma among Somalis in Boston that manifest as "stress," "depression," or "PTSD".

Despite the atrocities of Somalia's civil war and subsequent experiences in overcrowded, disease-ridden camps, Dr. Amira mentions lifestyle changes that also contribute to mental health issues among Somalis. She alludes to generational experiences with mental illness for those with little or no memory of the civil war in Somalia, and factors that exacerbate the stability of those who have witnessed extreme violence due to these lifestyle changes. She says,

> Besides PTSD, there's also a sense of community that they've had back home where when you had six kids, there's this shared responsibility. [**Yeah**] Almost with your community and your family. Whereas when they come here and it's the struggle of taking care of six kids. [**Right**] You know and so it becomes very difficult. It's back breaking work almost and then they don't have that support that they would generally have and maybe becoming depressed because of it. [**Yeah**] So it's not just from experience back home, it's that the lifestyle here is different than what they experienced back home. Where they have the supportive family members and here they don't. Maybe they're on their own [**Right**]. So, they like big families.

Life in the United States, with a sense of community disrupted by displacement contributes to the sense of longing for home, loneliness, and overwhelming, new circumstances. Raising a large family without community support, and perhaps without a husband, puts strain on Somali mothers who have to learn to navigate an entirely different way of life. From Dr. Amira's comments we may deduce that among Somalis in the United States, PTSD is considered a common issue by non-Somali doctors, but depression may also be present (Ellis et al. 2010).

Nadia not only highlights the traumatic effects of the civil war on mental health, saying nightmares are common among many who have witnessed extreme violence, but also points out lifestyle changes in the U.S. that affect mental health. She frames her discussion around the concept of "stress," only occasionally using the word "depression".

Like Dr. Amira, she relates mental health issues that are diagnosed and/or self-recognized to trauma that extends beyond Somalis who lived and have memory of the civil war. She explains a concept of inherited trauma that has lasting effects on Somalis who have never lived in Somalia or been directly affected by the civil war. Nadia explains that mothers pass on depression and stress to their children because the constant, chronic stress and trauma affects their daily life and behavior. By indicating that mental health issues extend beyond the initial period of resettlement and migration or trauma encounter, Nadia conveys the idea that the stress and trauma from the civil war affect an individual's entire life course and then may be passed along to the next generation. The notion of trauma becomes an explanatory model for subsequent symptoms either placed upon Somalis or conveyed by Somalis. Although she hesitates to use the diagnosis of PTSD, she acknowledges that Somalis, both in Somalia and in the U.S., have developed a term '*buufis*'[63] to identify and discuss the all-encompassing side-effects of the civil war. While my other participants never discussed the term "*buufis*" with me directly, Nadia frames this as a new development and response to Western bio-medical diagnoses made in diaspora and conveyed to Somalis back home in Somalia.

Somatic Symptoms and Mental Distress

Waitzkin and Magana (1997) examine how culture mediates how severe stress produces symptoms that cannot be explained by the presence of physical illness.

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[63] See Cindy Horst (2006) for more on the term's use among Somalis in the Dadaab refugee camp.

Horst, Cindy
2006 *Buufis* Amongst Somalis in Dadaab: the Transnational and Historical Logics Behind Resettlement Dreams. Journal of Refugee Studies 19(2):143–157

Similarly, Shweder (1985) reminds us that there is a social regulation on what is "ok" to display and how emotions and/or illnesses are expressed. Shweder echoes Kleinman et al.'s (1978) work on defining and contrasting the concept of illness versus disease. They assert that illness is an undesirable change in body feeling that continues with labelling from trusted individuals. Finally, Alex Cohen (2004) suggests that the range of acceptability in behavior is dictated by a multitude of factors including social, psychological, and biological. Despite biomedical tendencies to seek out biological explanations of illness, including mental illness, Cohen (2004) obscures the distinction between "physical" and "mental" health by acknowledging shared symptoms of both malaria (physical disease) and depression (mental illness).

Because mental health is not often discussed openly among Somalis, and physical illness is more accepted as visible and thus "real," somatic symptoms are often reported by Somali patients and understood by providers as code for mental distress. As Ayan points out, mental health is a "less obvious" illness than a physical condition and Somalis pride themselves on being "culturally strong and resilient people." Therefore, in the U.S. mental illness may often be described somatically in order for it to be embodied– "seen" within and upon the body, in ways that are culturally acceptable and "safe" to express and seek treatment for. Shweder (1985) points out that somatization of depression, or embodied depression, is most likely to occur among non-white, non-male, non-protestant individuals especially when direct expression is thought to be socially dangerous.

Dr. Amira highlights her Somali patients' chronic embodiment of stress,

illustrating this understanding of somatized depression as an expression of social suffering (Scheper-Hughes and Lock 1987):

> They tend to, a lot of their depression takes on the form of somatic dysfunction. They come in and complain: "my back hurts, my neck hurts, my shoulder hurts, my knee hurts" and as a result we don't get to talk about their diabetes because we're trying to sort out all the other issues. Like everything else that hurts when basically, it stems from depression and mental illness, lots of PTSD that's not treated. . . But probably greater than that is the amount of mental illness, depression, PTSD, anxiety that turns into, that they can't define in any other way other than somatically. So they say things like, " I feel like there is a snake running through my body"…When really it stems from mental illness.

Dr. Amira notes both the prevalence of somatic dysfunction related to mental stress and the barriers to diabetes treatment. From Dr. Amira's experience, it appears that many Somalis are eager to seek treatment for mental health with their primary care providers but attribute their symptoms as physical dysfunctions unrelated to mental health. This emphasis on embodied explanations of mental illness may complicate conversations about chronic health conditions. In addition, it illuminates the stigma many Somalis perceive and perpetuate related to mental health issues (Ellis et al. 2010).

Despite stigma surrounding mental health issues among Somalis, Nadia indicates that there is a hierarchy of stigma present among Somalis in diaspora. She explains that for young Somalis who may become involved in drug use in the U.S., perhaps as a method of self-medication, mental health may be a way for their Somali family to "cover up" the *haram* use of illegal substances. In this example, Nadia explains that the stigma of mental health is less than the stigma of drug use. Her statement about using mental health as a "cover" also points to the fact that mental health categories and diagnoses in diaspora are well known, in contrast to Somalia.

While stigma influences how Somalis conceptualize and accept mental health diagnoses, other factors may also shape how mental health is accepted or rejected. Ladan discusses the prevalence of mental health issues among Somalis and the "American" perspective of assuming every Somali suffers from PTSD:

> You can't even, you can't just have a bad day you know? It's a problem. A lot of them [Somalis], they're fine. They went through that and they're fine you know, they went through so many horrible things and it doesn't really necessarily affect them. Some of them, it really affects them but they don't, they don't realize that that's the problem. That that's where the problems are stemming from.

Ladan emphasizes the strength and resilience of Somalis, which she explains may be a religious or cultural trait. Her emphasis on resiliency also indicates frustration with the biomedical system in the U.S. that categorizes many Somalis as having PTSD that may be *only* expressed through somatic dysfunction. Similarly, Ong (1995) found studies that framed Southeast Asians as both unwilling and unable to differentiate between psychological, physiological and supernatural causes of illness. Ong believes these statements suggest that doctors believe they "are 'difficult' patients whose noncompliance stems from cultural passivity, the traumas they had experienced in war-torn Cambodia, and their imputed intellectual limitations" (Ong 1995:1247).

Ladan indicates that while the majority of Somalis are "fine," some Somalis don't realize the real problem of mental illness in the United States, alluding to the potential resistance to accept a mental health diagnosis. She continues:

> And then some of them are actually receiving medication for it and they getting assessed for it because it's really affecting them, really badly. But most Somali people have the same uh, the same mindset about everything that happened, you know post traumatic stress. You know, something that happened, that they experienced and they're fine, they're alive right now. And they made it through it

> and they don't have to take medicine or have to see a therapist necessarily because they're [Somalis in general] fine.

Ladan does not dismiss mental health diagnoses in general, but she highlights what she perceives as over-diagnosis and over-medication prevalent in the United States.

Ladan continues to note differences between American and Somali understandings of mental health and mental health treatment. She explains:

> In America, you see someone die, they created this whole culture where 'oh my god, it's horrific.' You know, you need therapy and you can't sleep, maybe we'll prescribe you medication and now the person is just like on all these chemicals. It's like it's ok, I witnessed someone die, I just need some time to get over it and I'll be fine. [**Yeah**] Some people just end up in medicine because they create this, it's crazy. My people say "ok you saw someone die, ok I'm scared, I'm nervous. I might not sleep a couple nights but I'm fine, I'll get over it."

Ladan rejects the "American" urge to medicate every Somali who has witnessed the horrors of extreme violence for post-traumatic stress, noting that Somalis are capable of healing by themselves. Her rejection of medication is on the basis that in the United States, people have created a culture that is consumed with the horror of death. The United States, for Ladan, is a land of overreaction. As a Somali woman, Ladan emphasizes her cultural pride and belief in the strength and resilience of Somalis and is critical of the American mindset that Somalis need help, a diagnosis, and medication. She thus rejects the American tendency to see the embodiment of Somali suffering as necessarily a biomedical phenomenon. The obsession with diagnosing PTSD is noted in literature. Leatherman and Thomas (2009) point out that most studies on refugee trauma focus on PTSD, yet most individuals in these situations show varying degrees of resistance and resiliency. Similarly, Cohen (2004) critiques the tendency to apply Western mental health categories, including PTSD, to non-Western individuals who have

a different range of normality when it comes to social experiences, perceptions, and reactions.

However, diaspora offers opportunities for change; Somalis beliefs about illness are dynamic and contextual. For example, Nadia believes the stigma surrounding mental health among Somalis is lessening. Emotional "control" may be revered but the effects of war have come to be acknowledged. In diaspora (particularly in the West), PTSD and/or depression are categories used by the biomedical community and Somalis' doctors to convey mental distress and its symptoms as a result of the war. However, the idea that the traumatic experience of the war has had long-term, embodied health effects is beginning to be acknowledged *within* Somalia. Nadia believes the acceptance of therapy and the concept of mental health issues in Somalia is a result of Somalis living in diaspora, who "report" back to Somalis living in Somalia. This "exchange" has even led to a new term to be developed which Nadia explains is "*buufis"*. *Buufis* is an all-encompassing term to describe the effects of the war including nightmares and other symptoms associated with PTSD in the West, according to Nadia.

Islam and Understandings of Illness

When discussing mental health, Ayan continually mentions Islam as a way to enhance an individual's resiliency. Islam inspires many Somalis' perceptions of the world, including their experience with illness and mental health. Dr. Amira explains her understanding of the Somali viewpoint of mental illness related to Islam:

> So the more difficult patients to treat are the ones that have mental illness. They see mental illness as God being upset with you and I haven't done anything wrong so God is not upset with me so hence, I'm not depressed. But they're depressed and they won't take their medication.

Dr. Amira indicates a frustration about patients not taking medication for depression because they believe they could not be depressed. If they have not done anything wrong, God cannot be upset with them to cause mental illness. This is a form of denial that goes beyond diabetes diagnosis denials, as it relates more to deeply rooted religious viewpoints.

Similarly, Nadia explains that some of the stigma surrounding mental health issues among Somalis comes from a belief that illness is a test from Allah. She says some Somalis may believe that if they are not strong enough to deal with stress alone and instead require medication, they have failed a test from Allah. As noted previously, strength especially in regards to emotional strength in a quality many Somali women hold and value. As a cultural value, strength incorporates personally dealing with issues and emotions without having to rely on assistance from others or in the case of health, on medication. However, Nadia explains that Islam is not anti-mental health or anti-medication. She emphasizes the similarities between religious points of view and Western bio-medical points of view. She explains that these two viewpoints are entirely the same until treatment is considered. Then, the religious viewpoint emphasizes recitation of the Qur'an and prayer before the use of medication. Taking medication should not be the first resort but instead should be considered through Allah's direction and will, which is discovered through prayer and recitation.

Islam may be conceptualized by some doctors as a tool for denial, but as Nadia point out, Islam also holds significance as a coping resource for mental health issues. Similarly, Ladan explains the relationship Islam has with mental health issues, especially

PTSD:

> It [Islam] gives them a sense of peace. Yeah, that there's going to be good, there's going to be bad. You know, just pray to God and be hopeful and be positive and help others. It just gives them a sense of peace. You know bad things happen, it rains on your crops.

Ladan does not highlight reading or reciting Qur'an but notes the peacefulness faith brings when experiencing a range of traumatic events and experiences. She believes prayer relates to positivity and hopefulness, as well as peace, which combats the violent and traumatic life experiences Somalis faced prior to moving to the United States.

In addition to religion and faith, Somalis associated traveling back to Somalia to be a valid and valuable treatment option. In fact, visiting Somalia along with reading and reciting Qur'an may be a way to find a "cure." Ayan describes her cousin, Sadia, born and raised in the United States, who has suffered from depression for years. Sadia goes to therapy and has taken medication for depression but her family is worried that these treatments are not working. Ayan says going to Somalia would be a more helpful treatment course for Sadia now. Ayan associates the social advantages of being among other Somalis, the Somali way of life, potentially finding a husband, and warmer weather, with a cure for depression, in addition to relying on religion. This explanatory model illustrates the role of Islam as a healing tool and place anchor (McMichael 2002), framing how Somalis view the authority of faith as encompassing every aspect of life, health, illness, and embodiment.

Thus Islam helps in the management of illness but it also facilitates trust in non-Somali providers. Earlier, Dr. Amira mentioned how Islam can sometimes lead her patients to believe their management and diagnosis is a product of Allah's will. She

suggests a general lack of medical adherence due to the belief that Somali individuals play a small role in their own health. Yet, she notes that she uses Islam and her knowledge of Islam as a tool in motivating her patients:

> I always bring up the point that, oh and in Islam, God created medicine and you're supposed to really follow the recommendations and they buy into that. You know, I use that as a tool sometimes.

By grasping a clear understanding of how Somalis perceive mental illness, physicians can continue to bridge barriers to successful care and management of mental health. Dr. Amira's multiple strategies to help Somali patients relies on her approach with Islam and with understandings of mental health perceptions:

> They don't like it when you start off you know, saying ok your pain is not really pain. You're depressed. Understandably. Who really would feel that way if they went to the doctor complaining about back pain and were told they were depressed. [**Exactly**] So I think it's about our approach, too, as physicians.

Dr. Amira highlights a couple important points, that a doctor's approach is essential to facilitating care and understanding a patient's perception of embodied stress should be taken seriously. Instead of denying somatic embodied symptoms of mental health, physicians should act as listeners and accept their patients' understandings of mental health.

Living with a Chronic Illness in a Negative Social Environment

While many Somalis live with chronic mental health issues such as depression and PTSD and chronic health conditions like diabetes, many do not frame these illnesses as inherently related. However, experiences with both mental health and chronic physical health conditions uncover the concept of embodiment in diaspora. For instance, new diagnoses are made in the U.S., and treatment courses do not always align with Somali

perspectives of care and management. In addition, chronic mental health issues including what some Somalis call “stress”, depression, and PTSD as a result of the civil war in Somalia, often compounded by discrimination and structural violence within the United States, add to the connection between a chronic physical condition and mental illness. By embodying mental health issues through somatization of symptoms, Somalis demonstrate the connectedness of chronic health conditions and their social and mental worlds; this is framed in existing literature as the bidirectional relationship between diabetes and depression.

Bogner et. al. (2012) acknowledge the bidirectional association between depression and diabetes; depression is a risk factor for diabetes and diabetes increases risk for the onset of depression. Bogner et. al. (2012) also note that depression also contributes to poor adherence to diabetes management. Dr. Amira discusses the practical difficulties of helping her patients manage diabetes when they instead discuss somatic dysfunction, recognized by her to be symptoms of depression and/or PTSD. Failing to adequately treat and manage diabetes may lead to anxiety about health consequences and disappointment, perpetuating a vicious cycle of syndemic interactions between mutually exacerbating diabetes and depression, in settings of poverty and cultural displacement. This could be especially difficult for biomedical providers, who are trained to treat individual diseases as isolated events, to effectively address among individuals who incorporate social components of mental illness into their diabetes presentation, which are then not heard or acknowledged as appropriate factors of biological disease by their doctors.

When non-Somali doctors exclude physical symptoms from the body and place them in the realm of mental illness, Somalis may disagree, undermining trust in the physician/patient relationship. Similar to body weight and body ideal differences between non-Somali doctors and Somali patients, disagreements about the root cause of symptoms may lead to assumptions that the doctor is discussing an "American" style of treatment that does not apply to them. In turn, this lack of understanding may make Somalis resistant to medication as a form of treatment for both mental illness and chronic illness.

Ladan explains her perception of the medical system in the United States and its reliance on medication:

> But I know that the medical system here, I'm not saying this is all doctors but mostly what happens is we go there. You know people go there when it's too late. So they get there, doctors prescribe them medicine. Of course they give you advice about a healthy lifestyle you know the whole shebang. But you'll get prescribed medicine for whatever you have. Now, that person is just gonna go home and take the medicine. That's it. They're, it's more so here stop the pain or suppress it rather than let's figure out what the root of the problem is [**Mhmm**] and how can we get you to be better and reverse what you have.

Ladan emphasizes two points. One, in the United States doctors are more concerned with prescribing medicine for "whatever" Somali patients have in addition to giving general advice about living a "healthy" lifestyle. Two, when doctors in the United States prescribe medicine without understanding the "root" of the illness or issue at hand, they are simply suppressing symptoms, not treating an illness. Ladan's comments reflect general distrust in medication and a lack of care in addressing larger, social factors related to disease.

Similarly, Ayan explains concerns about her husband's diabetes treatment:

> So that is the concern, the biggest concern, just to make sure he stays on medication and not even think about insulin [**right, right**]. That is the main concern.

Ayan discusses her husband's diagnosis and insists he just stay on a medication rather than insulin. While this may seem contradictory, in that Ayan accepts medication in this case, it highlights the give and take of acceptance. Ayan and her husband believe a pill is more acceptable than a shot of insulin; and the pill reflects her husband's proper management of his diabetes diagnosis. Ayan's acceptance also demonstrates how medication may be acceptable when treating and managing "physical" illnesses but perhaps not mental illness.

Resistance to medication extends into Ayan's perspective of mental health treatment. When discussing mental illness, she indicates that medication is "bad" and that Islam and travelling back to Somalia would be more effective and safer treatment options. By acknowledging Islam and travelling back to Somalia would be better treatment options, Ayan points to one "root" of illness: living within a non-Muslim country and living in diaspora, outside of Somalia. In addition, Ayan insists that medication has harmful side effects and is therefore not a reliable treatment plan. Ayan's emphasis on medication when discussing mental health illuminates her understanding of mental health in the United States. She assumes, and perhaps rightfully so, doctors in the United States prescribe medication for mental illness with ease before exploring other treatment options.

While Ladan is more outspoken about her concern with over-medication in the United States, there is a general belief that medication should be avoided among my

participants. Many express a concern that medication often treats symptoms without addressing the root cause of the illness. For many, only Islam has the power to address the "root" of the issue. Although both Somalis and non-Somali doctors, like Dr. Amira, wish to uncover the "root" cause of illness, denial of a mental health diagnosis may prevent the consideration of treatment options in addition to Islamic healing tools. As Dr. Amira points out, telling a patient they do not actually have a snake running through their body, but instead have PTSD, is a difficult process:

> And they get, they don't like it when you start off you know, saying ok your pain is not really pain. You're depressed. Understandably. Who really would feel that way if they went to the doctor complaining about back pain and were told they were depressed.

Patients, Somali and non-Somali alike, do not appreciate denial from their doctors or having their symptoms dismissed despite their eagerness to be diagnosed and be alleviated from pain.

Bidirectional Relationship between Diabetes and Depression

Mental health issues (namely PTSD and depression) and diabetes affect Somalis in Boston. While these may seem like two different sets of conditions, researchers have conducted several studies on links and interactions between depression and diabetes over the last few years, including in the field of medical anthropology (Anderson et. al. 2001; Bogner et. al. 2012; Mendenhall 2012; Lerman 2015).[64] The majority of studies note that depression is associated with an increased risk of type 2 diabetes. Yet Pan et al. (2010) examined the relationship between diabetes and depression, and their cohort study

[64] See Emily Mendenhall's (2012) book *Syndemic Suffering* on diabetes and depression among Mexican immigrants in Chicago.

provides evidence that the association between diabetes and depression is bidirectional.

In another study, Kinzie et. al. (2008) found that "traumatized individuals" have higher rates of medical disease that extend beyond the average norm of disease in the United States. Kinzie et. al.'s (2008) study particularly focused on the prevalence of hypertension and diabetes among refugees. Among several refugee groups in their study of psychiatric patients, Somalis had the highest rates of diabetes in the study and also some of the most extreme trauma experiences (Kinzie et. al. 2008). While displacement and trauma associated with violence in Somalia may be a leading factor in developing depression and/or PTSD, structural factors, discrimination, and chronic illness diagnosis may exacerbate these conditions.

The concept of syndemics is particularly useful in examining the full picture of how diseases interact and compound one another; the concept has been applied to diabetes/depression interactions, including among immigrants. Merrill Singer developed the concept of syndemics to examine health disparities in a more complete, fresh light. He writes that syndemics involve "mutually enhancing health problems" that work together within "a context of noxious social and physical conditions" (Singer 2009:xiv). The definition of syndemics inherently incorporates social inequality and the unjust exercise of power in explorations of interactions between two or more diseases or conditions, and the worsened health consequences that result. Using a syndemic approach to examine disease, a more complete picture of illness can be uncovered to show how multiple factors interact and worsen a set of conditions. Although my study originally focused on perceptions of diabetes and the body, it progressed to incorporate

the topic of mental health, demonstrating the interconnectedness of mental, physical, and social factors embodied in diaspora.

Singer expands upon the factors that contribute to health disparities, noting "social inequality, class, gender, racial, and other discrimination, poverty, structural violence, social trauma, relative deprivation, being forced to live or work in a toxic physical environment" (2004:26), among others. Syndemics is a particularly important framework for studying health inequality because it offers a unique, more 'holistic' perspective. The syndemic perspective reframes co-occurring health problems, that are generally conceived biologically, by incorporating and acknowledging social components which exacerbate deleterious biological interactions (Mendenhall 2012:22). Through the syndemic approach, Singer, Mendenhall, and other medical anthropologists are able to highlight determinants of health that reach beyond biological factors in diabetes interactions with mental health conditions.

Diabetes and Depression Interactions

Mendenhall's Violence Immigration Diabetes Depression and Abuse (VIDDA) syndemic framework is especially useful for examining the relationship between diabetes and depression among Somalis in the United States. VIDDA syndemics incorporate Violence, Immigration, Depression, Diabetes, and Abuse to communicate "an interactive framework that analyzes social contexts as intrinsic to the clustering of depression and diabetes" (Mendenhall 2012:23). Each of these concepts may be applied to Somalis' experiences immigrating or resettling in the United States. Although it was beyond the scope of the study I designed for this project, and was not a focus of my research

questions, replicating Mendenhall's study conducted with Mexican women in Chicago among Somali women in Boston might reveal similar syndemic patterns.

Ayan, a Somali community leader and pharmacist, notes that many Somalis do not readily accept or understand illnesses that are not "visible" or outwardly experienced in/on the body. If a doctor tries to medicate Somalis for mental health issues or internal chronic diseases (sometimes including diabetes) that have limited or no physical symptoms, Somalis may lose trust in the doctor, dismiss or deny diagnoses, and avoid seeking primary health care. Yet, primary health care providers often "see" somatic manifestations of mental illness when treating diabetes. Similar to Mendenhall's findings among Mexican women with diabetes in Chicago (2012:110), many Somali patients embody their social world, including experiences in diaspora.

Mendenhall's VIDDA syndemic framework demonstrates how epidemic health problems reflect epidemic social problems revealed through narratives and clinical interactions. In my own research I did not directly examine the bidirectional relationship between diabetes and depression, in which depression is seen as a precipitator for diabetes and diabetes contributes to depression. This was a result of originally being asked to study diabetes in this population. I quickly found that participants wanted to talk with me about many things other than diabetes. Despite these limitations (and the resulting alternate opportunities that arose, to ask different questions about embodiment and diaspora), I believe the concept of VIDDA syndemics is particularly relevant to Somalis in Boston and should be explored further in the future. Exploring how diabetes and mental health conditions, whether acknowledged or not, interact and worsen

suffering in the context of migration, diaspora, stigma, and other structural factors including discrimination, could illuminate a great deal about disease disparities experienced by Somalis in this setting.

Conclusion

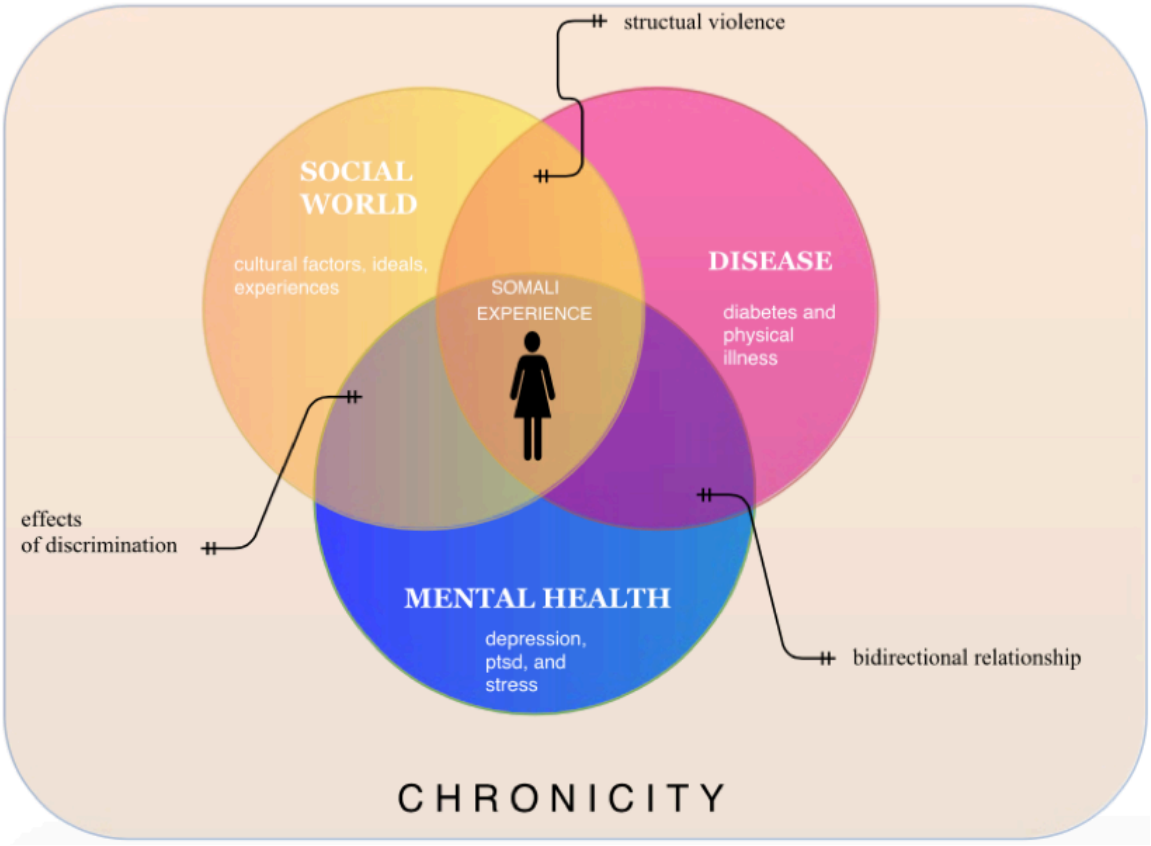

Figure 4. Chronicity Diagram, by author 2016

For Somalis in Boston, divergent understandings of illness and of the body in diaspora are illuminated in clinical interactions. The high prevalence of diabetes, and PTSD and depression, among Somalis speaks to larger social and structural factors that interact with biological disease, especially chronic conditions. Somalis understand illness in terms of embodied physical symptoms, culture loss, and spiritual weakness, and therefore construct illness as part of the individual embodied experience. Weaver and

Mendenhall (2014) reflect on the relationship between epidemiological patterns of high prevalence in certain populations and individual-level experiences with illness. Using the concept of syndemics, Weaver and Mendenhall (2014) uncover the multiple layers of suffering that contribute to health outcomes. My Somali participants showcase a multitude of factors in perceptions of illness, from body ideals, food, structural factors, and cultural and religious perceptions of chronic and mental health. In the diagram above, I illustrate three components that interact, and are not inherently unrelated to one another, to demonstrate the ways Somalis discuss embodiment. In addition, literature I found throughout my fieldwork emphasized specific connections between social experiences and discrimination, bidirectional relationships of depression and diabetes, and finally, social violence and disease. These distinct categories shown above are not separate entities, each interact with each other to create a bodily experience. The divide is merely to demonstrate how they are discussed by my participants and within the literature.

While obvious barriers to culturally sensitive and more effective diabetes care for Somalis, including health education and language difficulties, are present and affect medical adherence; improving care and lowering rates of illness also require attention to complex social layers. Integrated care management, involving collaboration with Somali community members and physicians, has been shown to facilitate education and treatment recommendations (Bogner et. al. 2012). A model of care that involves individualized programs to improve adherence based on social and cultural contexts would aid in addressing both depression and diabetes and circumvent misunderstandings within the clinic.

As Farmer et al. (2006) illustrate, physicians are not trained to facilitate structural interventions, and these interventions are viewed by physicians as 'not their job'. However, Farmer et al. (2006) note that structural interventions may have a greater impact on disease control and prevention than clinical interactions. In addition to working with Somali community members, physicians would benefit from incorporating social and structural components in discussion with patients to establish how patients conceptualize their illness.

Through chronic physical and mental health, Somalis physically embody the effects diaspora, resulting in culturally relevant somatic explanatory models of illness. For many Somalis, this means conceptualizing illness as somatic dysfunction or embodied physical symptoms, which is not unique to Boston. Waitzkin and Magana (1997) found unexplained somatoform symptoms in primary care settings. They found that patient narratives[65] were particularly useful in addressing these issues of embodied illness. In addition, Kathleen Lynch (unpublished) mentions the benefits of social and therapy management groups in health and social well-being that could also address issues of embodied illness. As Farmer et. al. (2006) note, many physicians do not consider talking about social factors as their job, yet helping individuals in the clinic construct narratives could facilitate trust between non-Somali doctors and Somali patients. When Somalis feel their concerns are being heard, they may overcome denial; and providers may overcome a narrow gaze of illness.

[65] Waitzkin and Magana define narratives "as attempts at storytelling that portray the interrelationships among physical symptoms and the psychological, social, or cultural context of these symptoms" (1997:811).

Furthermore, Waitzkin and Magana emphasize the creation of social situations where patients feel empowered to express "more coherent narratives of their prior traumatic experiences" (1997:811). Waitzkin and Magana (1997) found that illnesses associated with psychiatry manifest in the body, and unique tools for healing may improve quality of care. Poetry, is one such tool for healing among immigrant patients with somatic symptoms, along with anti-depressants that Waitzkin and Magana (1997) identify. This is particularly useful to consider among Somalis, who revere oral traditions and often shy away from medication.

By looking toward cultural explanations of how stress manifests on the body and eliciting Somalis' own explanatory models for somaticized symptoms, physical expressions may be explained and healing tools may be easier to identify. Keeping in mind the power of a syndemic approach to understanding chronic disease among Somalis, a variety of factors associated with care and management are illuminated to reveal social components of illness that cannot be ignored, nor treated simply with a pill or an injection. Research "tackling part of the mind-body problem that has puzzled clinicians and researchers for generations" (Waitzkin and Magana 1997:813) does not resolve the confusion but rather, opens up new possibilities for understandings and more respectful, relevant treatment.

CONCLUSION

In the previous chapters, I argued that Somalis embody diaspora in three ways: through body ideals and practices, through food consumption, and finally, through chronic and mental illness. I have demonstrated how body ideals, food practices, and health are interconnected and expressed by the individual and social body. Food values correlate to body ideals through the effects of what and when an individual eats. In addition, diet and nutrition are intimately linked with health, particularly diabetes. Each chapter examines how the body expresses, resists, and accepts external and internal pressures in diaspora. New opportunities for change regarding ideals, values, and beliefs arise in diaspora; demonstrating that the embodied experience of Somalis is fluid and contextual.

Chronicity

Time is an important factor in understanding the Somali body and the concept of health. In fact, the chronicity of diaspora and its effects on the body goes beyond one lifetime; it extends into the realm of inherited trauma, according to my participants. My goal in highlighting the chronicity of the effects of diaspora is not to argue that the negative health impacts on the Somali body are inevitable. Rather, I aim to highlight the importance of addressing multiple factors of entry and exchange upon the body and the depths at which these factors are embodied.

The body in diaspora becomes a focal point for expression of traditional, religious, and cultural ideals and practices. Some of these practices are modified or rejected when new ideals are encountered. The effects of social, cultural, and religious

value placed upon the body and its expression are enormous and contribute to the fact that new bodily practices are often accepted along generational lines, with younger individuals adopting more "Western" body ideals and practices such as dress, makeup, and valuing thinner body types. However, the body is not only a tool of expression, it is also an object to be perceived by others in diaspora. In the U.S., the Somali body may be perceived by multiple accounts, through dress, religious inscriptions particularly among women wearing the veil, and skin color. All of which carry a potential for discrimination and embodied health factors including chronic stress.

Other practices of the body include food behaviors, which may become modified in diaspora due to accessibility and new preferences for "American" foods. Like body ideals, these acceptances and exchanges are more readily accepted along generational lines; younger Somalis tend to embrace "new" foods and ideals more readily than older Somalis. Traditional Somali food practices are known by my participants to contribute to chronic health conditions because of its admittedly high carbohydrate and fat content. However, the United States becomes a place where food may be more available in quantity. Even when Somalis eat a semi-traditional Somali diet (perhaps substituting some ingredients with "ready made" mixes), larger quantities of food per meal are more common, perhaps for the first time. Diet and living a more sedentary lifestyle in diaspora exacerbates health risks. Because a bigger body ideal is culturally valued, weight gain is not seen as a contribution to health risk but instead as an indication of beauty and good health.

The effects of diaspora, where weight gain may be a reasonable possibility, diet

may include high quantities of carbohydrates, fats, and sugar, and the body becomes a subject of expression (embodiment of chronic stress) and an object of external perception (discrimination) that contribute to the risk for poor health. Because Somalis value having control over emotions and rely on Allah and Islam to cope with mental anguish, expressions of mental health issues are embodied through somatic manifestation and dysfunction. Experiences of discrimination and trauma extend beyond one lifetime. Mothers believe they can pass down the effects of the violent civil war, framed as stress, to their children. Discrimination within the United States on the basis of skin color and religious identification only exacerbate Somalis mental health risks despite age.

Applied Medical Anthropology

Throughout my research I found a common theme: Somalis know their body, and therefore their illnesses, best. This understanding often leads to difficult clinical encounters, as I have shown. While discussing clinical issues with my Somali participants, I began to ask how these difficulties could be addressed and improved. My attachment to the Somali women I worked with and my desire to conduct research for positive change leads me to incorporate aspects of applied medical anthropology. Andrea Dyrness writes, "the underlying assumption that research is separate from action for change prevents us from seeing other possibilities in activist research: how community members also produce knowledge that is useful in struggles for change, and how the research process itself could be an important possible arena for making change" (2008:25). In line with Dyrness' observations that research is often viewed as unrelated to action, particularly from community members, I will incorporate suggestions from my

Somali participants.

Many suggestions are tied to "common-sense" understandings of trust and relationships. For one, representation in clinical settings or in the health field eases Somali patients' fears and anxiety. Jama explains:

> The benefit would be bigger if they find, they see a Somali doctor who knows the culture . . . For a Somali to tell them: 'you're eating this, this, this and those are not good for you.' But when they see any doctor, they say 'oh this guy is just talking about the American style.' They don't get the conversation.

Ayan suggests "even a Somali nurse" would help facilitate trust. Ayan and Jama go on to explain a story about a local Somali doctor in residency. They joke that several of her patients are Somali because despite knowing of her skill or concentration; they already trust her and want to see her for all their health needs. This suggestion speaks to larger issues of Somali representation and social factors of education and career choice. For one, there are several Somali women that I have met with university degrees and professional jobs. Yet, there seems to be a lack of medical doctors and/or nurses in the Boston area. This would greatly benefit the Somali community and is especially essential in Boston because over a thousand Somalis are resettled in Massachusetts and the Greater Boston area each year. [66]

Jama, Ayan, and I brainstormed more ideas. Jama says that in the clinic, doctors and staff hand out English brochures which are useless to Somali patients. He says, "they're like what is this?" Ayan agrees, "Exactly. Even if it's written in Somali." Jama explains, "even if they live here and know English, Somalis are not accustomed to

[66] Proposed Refugee Admissions for Fiscal Year 2015: Report to Congress. http://www.state.gov/documents/organization/232029.pdf

reading." I suggested a C.D. or tape that Somali patients could listen to instead. Ayan shook her hand and suggested: "Visual! Like a video. Something they can look at." And within these videos, Jama and Ayan explain that Somalis love to see Somali doctors and nurses or Somali community advisors explaining health because they are trusted resources. Ayan and Jama explain that Somali health advocates and doctors not only understand Somali cultures and thus factors that contribute to certain health conditions, but also are able to deliver a diagnosis and recommendations in their "mother tongue".

Besides language and representation in the clinic, Ayan brings up transportation issues. For many Somalis, finding transportation to the clinic can be a challenge and interfere with scheduling and making regular appointments. Ayan says management of illness would be improved:

> if somebody could provide transportation, I think they might be willing to go. And if they also provided interpreters, which I'm sure they will, they will come. And the thing is to even remind them, a phone call from an interpreter to say, 'can you please come, this is important.' Just to remind them of the building or something, build communication, yeah.

Ayan's suggestion of having transportation may be difficult to implement but building a system of trusted Somali community advocates for illness management could make Somalis more willing and able to come. [67] For instance, volunteer services could be set up to facilitate transportation to appointments. Translators from the community could also help hold patients accountable and remind them of upcoming appointments to build a level of trust and collaboration.

Ayan and Jama's comments reflect potential solutions to current barriers to

[67] Gatrad (2000) suggested similar options to reduce non-attendance rates.

management, yet the main component of improving care illuminates through each of their suggestions: maintain a network of Somali community advocates that can act as cultural brokers between non-Somali doctors and their Somali patients. This method would provide a level of trust, circumvent language barriers, and Somali volunteers may even be able to assist in issues of transportation. Seeing and working with Somali doctors could inspire Somali first or second generation youth to pursue medical degrees if they see the benefit and need. In conclusion, benefits to Somali health, management, and prevention of illness is only possible with the help of the Somali community in Boston.

However, our community must also address social factors that compound mental health issues and illness. As my participants noted, going out in public spaces beyond their neighborhood may produce stress, anxiety, or fear of discrimination; Dr. Saaye mentions this stress may be felt at night within their own neighborhood. I interpreted the lack of representation in the clinic, and location of residence for many Somalis, to be a result of lack of educational opportunity for Somali youth to enter into a professional field. Through encouraging and representing Somali doctors and medical professionals in our community and allowing Somali youth, as immigrant, black, and Muslim Americans, to reach these educational and professional achievements, implicit discrimination and hopelessness may be diverted. In addition, providing a welcoming environment for Somali Muslims within the city through countering and resisting discriminatory, static, and over-simplified images of Islam within the media would also deter fear of discrimination. These forms of external, non-Somali surveillance will take time to counteract. However, as a country that stresses "freedom (and safety) for all", it is our

duty to close barriers, welcome, and learn from our neighbors.

As Warsan Shire (2014) beautifully writes, the effects of Somalia's civil war follows Somalis everywhere. These experiences shape Somali conceptions and perceptions of the physical body, often through embodied "signs" of social experiences including discrimination, war, violence, and resilience. While a history of violence may be a chronic condition of life in diaspora, embodied through illness, diaspora also offers opportunities of exchange. Traditional bodily practices, ideals, food, and understanding of illness have the opportunity to co-exist with new, Western ideals that are constantly open for exchange. As Francis Nyamnjoh writes, "bodies and forms are never complete; they are open-ended malleable vessels to be appropriated by consciousness in its multiplicity" (2015:5).

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CURRICULUM VITAE

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RESEARCH INTERESTS

- Qualitative research design and data collection
- Qualitative data analysis
- Modified grounded theory methodology
- Individual perceptions of health experiences
- Chronic disease
- Comorbidities and syndemics
- Obesity and fat studies
- Gender and minority health
- Health care disparities
- Applied Medical Anthropology

EDUCATION

2014–2016 BOSTON UNIVERSITY SCHOOL OF MEDICINE — Boston, MA
Master's of Science
Medical Anthropology and Cross Cultural Practice, Graduate Medical Sciences

2010–2013 UNIVERSITY OF LOUISVILLE — Louisville, KY
Bachelor of Arts in Anthropology, *Cum Laude*
Minor: Middle East and Islamic Studies

2009–2010 WESTERN KENTUCKY UNIVERSITY — Bowling Green, KY

RESEARCH

4/2015–4/2016 Principal Investigator, **"(In)Visible Stress: Embodied Experiences of Somali Women in Boston"**
In this original master's thesis based on over a year of fieldwork, I use qualitative research (extensive, repeated interviews and participant-observation) to examine the embodied experience of illness in Diaspora, focusing on Somalis with diabetes and mental health issues in the greater Boston area, to reveal their understandings of health care and management. For this project I drafted an Institutional Review Board protocol that was approved within one month.

Ongoing Co-Investigator, **"Immigration Detention Amplifies Tuberculosis Risk: A Transnational Syndemic"**
Participated in a team research project at the Boston University School of Medicine (Graduate Medical Sciences), engaging in extensive literature review and analysis of conceptual syndemic modeling to identify and propose ways that current immigration detention policies promote disease clustering and interaction between malnutrition, tuberculosis on both side of the U.S.- Mexico border. *In preparation for publication* (Lead author Dr. Bayla Ostrach).

01/2015–Present Research Assistant, **"Improving Care and Community Collaboration for Muslim Women Experiencing Domestic Violence"** With Dr. Lance Laird.
Assisted in a qualitative study on health and domestic violence among Muslim women in Boston; analyzed and coded qualitative data; met and worked with larger research team to brainstorm project goals and evaluate ongoing research design.

10/2014–6/2015 Co-Investigator, **"Syndemics & Legislative Outreach: An Experiment in Educating Congress About the Health Effects of War"** With Dr. Bayla Ostrach, PhD
Collaborated on a research project to disseminate public health findings based on an extensive literature review and analysis proposing a war-related malnutrition/infectious disease syndemic to members of Congress, and tracking responses. Co-developed the research design, conducted outreach, data collection, data analysis, and manuscript preparation.

9/2012–5/2013 Principal Investigator, **"Self-Identification Among Muslim Students at the University of Louisville: How Perception and Politics Influence Identification"**
An examination of how Muslim students perceive religious identification and external perception by non-Muslim peers and these effects on the self-identification process.

1–5/2013 Principal Investigator, **"Social Implications of Language Variation: Consequences of Language Inequality"**
Using historicity and anthropology as tools in this research I addressed linguistic inequality and its effects within American school systems.

8–12/2012 Principal Investigator, **"Self-Identification Among Muslim American University Students"**
Through this qualitative research project I explored how Muslim students perceive they are identified by non-Muslim peers, and how Muslim students self-identify in the face of Islamophobia.

COMMUNITY INVOLVEMENT AND EXPERIENCE

10/2014–Present	**Greater Boston Muslim Health Initiative**	Intern, Outreach Chair
	Assisted with a qualitative research study on contemporary Islamic healing in Boston; interviewed, transcribed, and analyzed research findings; worked with a team to create social network map of community resources; served as outreach chair to recruit new participants in an online survey; created brochures to promote the organization; facilitated in planning two yearly conferences for Islamic scholars and researchers.	
9–12/2015	**Brookline Public Health Department**	Team Member
	Worked on a four-person team through Boston University's School of Public Health to update and revise Brookline, Massachusetts resource guide for newly arrived immigrants. Reviewed over 60 pages of the old resource guide; edited and updated these to create visually appealing and easy to understand online and hard copy pamphlet.	
10/2014–5/2015	**Islamic Society of Boston Cultural Center**	Intern, Volunteer
	Re-organized and added to a resource guide for Muslims and community members; participated in an Arabic class taught in English and Somali.	
10/2011–5/2013	**Kentucky Refugee Ministries**	Volunteer
	Taught small group activities in English outside ESL classrooms; tutored elementary-aged children in their homes after school; participated in English conversation tables with advanced ESL students.	
1–5/2012	**Kentucky Refugee Ministries**	Youth Services Intern
	Coordinated a field trip to increase community awareness and promote literacy within the refugee youth community; organized and assisted refugee children in creating visual representations of their life as refugees; submitted case notes for refugee appointments in international databases; taught ESL as a substitute teacher in the Family Center's World of Work Program, which provides employment services to women with children; developed educational worksheets for pre-school aged children involved in the Youth Program; accompanied clients to medical appointments.	
6–7/2012	**East West Initiatives**	Participant
	Participated in cultural events and talks in Amman, Jordan with American, Russian, Canadian, English, and Jordanian college-aged adults; attended lectures on the Palestinian/Israeli conflict outside of Al-Aliyya University; volunteered in low-income area around Amman painting school rooms.	

PUBLICATIONS

Ostrach, B., **Houston, A.,** Singer, M., "Syndemics & Legislative Outreach: An Experiment in Educating Congress about the Health Effects of War." Anthropology News 56(6): e1–e12.

Ostrach, B., **Houston, A.,** Singer, M., "Anthropology on the Grond: Insularity & Impenetrability – What Happens to Health Funding and Policy When Voters Can't Reach Lawmakers." Newsletter of the Society of Medical Anthropology 4(1).

Houston, A. "Photos from the Field: Bodies and Embodiment at a Boston Mosque. Newsletter of the Society of Medical Anthropology 4(1).

PRESENTATIONS

3/2016 **Houston, A.** "Embodied Values in African Diaspora: Body Ideals Among Somali Women in Boston", 24th Annual Boston University Graduate Student Conference in African Studies. Boston, MA.

OTHER RESEARCH ACTIVITIES & CERTIFICATIONS

2014–2016	Active Participant, Research in Progress Group, Department of Family Medicine, Boston University School of Medicine
12/2014	Peer Reviewer, Co-reviewed articles with Dr. Lance Laird for publication in the *Journal of Religion and Health*.
2012,2015	Human Subjects Research Certification Training (CITI Course)
2013,2015	Wrote protocol and completed Institutional Review Board of original study designs; University of Louisville (2013) and Boston University School of Medicine (2015)

HONORS

Provost's Merit Scholarship, Boston University School of Medicine *2014–16 (*awarded annually)
Dean's List, University of Louisville *2010–2013*
Lambda Alpha National Scholarship Candidate to represent the University of Louisville *2013*

Anthropology International Travel Award, Study Abroad in Jordan *2012*
Modern Languages Travel Scholarship, Study Abroad in Jordan *2012*
Lambda Alpha National Anthropology Honor Society *2010–2013*
National Society of Collegiate Honors *2009–2013*
Henry Ford Merit-based Scholarship *2011*

REFERENCES

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