



Understanding Chronic Kidney Disease in the Somali Population: Letter to Editor

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Abbreviations

CKD: Chronic Kidney Disease; RAAS: Renin-Angiotensin-Aldosterone System.

Dear Editor,

Chronic kidney disease (CKD) poses a significant health burden among the Somali population, with a prevalence of 5.7% reported in a 2020 study by the Danish Ministry of Immigration and Integration [1]. This Letter explores the multifaceted factors contributing to the elevated prevalence of CKD among Somalis, including genetic predispositions, socioeconomic disparities, dietary habits, and limited healthcare access. Addressing these challenges requires culturally sensitive interventions aimed at promoting early detection, optimal management, and kidney-healthy behaviors. Collaborative efforts involving healthcare providers, policymakers, community leaders, and individuals are essential for mitigating the impact of CKD and improving kidney health outcomes in the Somali population.

Chronic kidney disease (CKD) remains a significant public health concern globally, affecting millions of individuals worldwide. Among certain ethnic groups, such as the Somali population, the burden of CKD appears to be particularly pronounced. In a report released by the Danish Ministry of

Immigration and Integration in 2020, it was highlighted that 5.7% of the Somali population suffers from chronic diseases, including kidney disease. This review aims to delve deeper into the factors contributing to the prevalence of CKD among Somalis and explore potential interventions to mitigate this burden. The prevalence of CKD among Somalis is alarmingly high, surpassing the global average. Several factors contribute to this elevated prevalence, including genetic predispositions, socioeconomic factors, dietary habits, and access to healthcare. Studies have indicated a higher incidence of risk factors for CKD, such as diabetes mellitus, hypertension, and obesity, within the Somali community, further exacerbating the burden of kidney disease.

Genetic factors play a significant role in the development of CKD among Somalis. Certain genetic variants prevalent within the Somali population have been associated with an increased risk of kidney disease. Polymorphisms in genes encoding for components of the renin-angiotensin-aldosterone system (RAAS), as well as genes related to inflammation and oxidative stress pathways, have been implicated in CKD susceptibility among Somalis. Socioeconomic determinants, including poverty, limited access to healthcare services, and educational disparities, contribute to the disproportionate burden of CKD within the Somali population. Socioeconomic challenges often hinder individuals from seeking timely medical care, leading to delayed diagnosis and management of CKD. Furthermore, inadequate access to renal replacement therapy, such as dialysis and kidney transplantation, exacerbates the morbidity and mortality associated with advanced CKD. Dietary practices within the Somali community may also

contribute to the development and progression of CKD. Traditional Somali cuisine often includes high-sodium foods, processed meats, and sugar-rich beverages, which can exacerbate hypertension, diabetes, and obesity – all significant risk factors for CKD. Moreover, cultural beliefs and dietary preferences may influence adherence to recommended dietary modifications for CKD management.

Improving access to healthcare services and raising awareness about kidney health are crucial steps in addressing the CKD burden among Somalis. Culturally sensitive healthcare interventions, community outreach programs, and education initiatives aimed at promoting healthy lifestyles, early detection, and optimal management of CKD are essential for reducing morbidity and mortality associated with kidney disease [2,3]. The prevalence of CKD among the Somali population is a pressing public health issue, necessitating comprehensive strategies to address its multifactorial determinants. Genetic predispositions, socioeconomic disparities, dietary habits, and healthcare access barriers contribute to the disproportionate burden of kidney disease within this community. Efforts to enhance early detection, optimize management, and promote kidney-healthy behaviors are imperative for mitigating the impact of CKD among Somalis and improving their overall health outcomes. Collaborative endeavors involving healthcare professionals, policymakers, community leaders, and individuals themselves are essential for combating CKD and fostering kidney health within the Somali population.

Recommendations for addressing chronic kidney disease (CKD) among the Somali population should be multi-faceted, considering the various factors contributing to its prevalence within this community. Here are some key recommendations:

1. Implement community-based screening programs to identify CKD risk in Somalis, emphasizing regular health check-ups, especially for those with predisposing conditions like diabetes and hypertension.
2. Develop culturally sensitive education campaigns for the Somali community, emphasizing kidney health, healthy lifestyle choices, and early CKD management, utilizing community leaders, religious institutions, and culturally appropriate communication channels.
3. Address healthcare access barriers in Somalia, including language, cultural differences, and insurance coverage, to ensure timely and appropriate medical care for CKD prevention, diagnosis, and management.
4. Nutritional counseling in Somali communities should focus on promoting kidney-friendly habits, reducing salt intake, consuming a balanced diet, and limiting processed and sugary beverages.
5. Genetic counseling services assess kidney disease risk in Somalis, support research to understand genetic factors, develop targeted interventions, and support research initiatives.
6. Community empowerment and engagement can promote kidney health by establishing support groups, peer mentoring programs, and community-based initiatives to encourage healthy behaviors and advocate for improved healthcare services.
7. Advocate for policy changes and resource allocation to address systemic issues causing CKD disparities among minority populations, including the Somali community, reducing socioeconomic inequalities and improving healthcare access.
8. Foster collaborations among healthcare providers, community organizations, government agencies, academic institutions, and other stakeholders to develop comprehensive CKD prevention and management programs for the Somali population.
9. Implementing these recommendations in a culturally sensitive manner can reduce the burden of CKD in the Somali population and enhance kidney health outcomes for all individuals.

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