CHAPTER 3
INTRODUCTION TO MELAA CULTURES

Sudan

Ethiopia

Afghanistan

Iraq

Iran

Somalia

Burundi

MIDDLE EASTERN AND AFRICAN CULTURES (MELAA)

This chapter covers Middle Eastern* cultures of Iraq, Iran, and Afghanistan, and African cultures of Somalia, Sudan, Ethiopia, Eritrea and Burundi. Afghanistan is included here (instead of in the Asian Chapter) since it shares significant aspects of culture with the other Muslim based cultures in this chapter.

The MELAA grouping is extremely diverse in its cultures, spiritual and health practices and backgrounds. However, despite this diversity, most of the cultures in this chapter share some beliefs and practices inherited through deeply embedded and ancient cultural traditions, many of which pre-date Christianity or Islam. This introduction provides a little more detail on specific health and religious practices outlined in the individual cultural sections.

A high percentage of the people from these cultures who have resettled in New Zealand arrived as refugees (as well as people from the Burmese, Vietnamese, Cambodian and Laotian cultures in Chapter 2, Asian Cultures). Some information on refugee issues is also provided in this introduction.

Middle Eastern people are the largest of the MELAA groups in Auckland, with Iraqis and Iranians forming the largest group of refugee intake since 1994. 50% of the Middle Eastern group identify as Muslims and 30% as Christians.

Africans are the second largest MELAA group in Auckland with Ethiopians and Somalians the largest identifiable groups in Auckland. 65% of Africans identify as Christians.

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*The term 'Middle Eastern' can be confusing as there is no universally agreed definition on which countries are included in the Middle East. Some countries may be geographically aligned, but not politically or culturally. The term is also sometimes used to refer to the Muslim countries in the region. Note that although 'Iraqi' is not an ethnicity, in this resource it is used to refer to a group of people who share similar cultural practices and issues (Perumal, 2010).

COMMUNICATION

Particular gestures and greetings for each of the cultures are provided in the individual cultural sections, however since Islamic practice has a significant influence on many of the cultures in Chapter 3, the following is a general guide. For those cultures that do not follow Islamic practice, or for Christians living in the Muslim countries, the following would not be offensive and so can safely be followed:

- **avoid prolonged or direct eye contact** (*for some cultures eye contact is avoided out of respect for others, particularly authority/elders, and for others because of the belief in the '**evil eye**'. Most of the resettled people accept direct and prolonged eye contact from the host culture of New Zealand, however, many will decline to return it for the aforementioned reasons*)
- **shaking hands is best between members of the same sex only**
- **the right hand ONLY is used to shake hands**
- if the practitioner is male, or in doubt, use **customary greeting with women**
- assume that **respect for authority will prohibit people asking questions** of the health practitioner, or answering in the negative; offer explanations and invite questions from the client
- **'yes' may be ambiguous** (because saying 'no' is not acceptable in some cultures)
- Western custom of asking direct questions is unfamiliar to some cultures and may evoke reticence to engage. Preface interactions with questions of wellbeing, including about the family
- **respect, especially to elderly** is appreciated
- **over-familiar touch** is not appreciated**,** and in some cases prohibited, especially **amongst Muslims**

HEALTH CARE BELIEFS AND PRACTICES

Interesting note: It is reported by most of the community representatives consulted for this resource, that subscription to many traditional beliefs in general, but particularly about spirits and sorcery, are diminishing amongst those who have received formal education, and by many resettled people. However it is interesting to note that the traditions that embody the beliefs have become so embedded in the cultures that some of the related practices continue, in spite of changed beliefs. For example, Burundian women do not reveal pregnancy until absolutely necessary. This tradition has its origins in precaution against evil spirits, and although many educated and/or resettled Burundians no longer subscribe to beliefs in spirits, they nevertheless continue to conceal pregnancy, even from relatives and close friends.

There are factors believed to influence health that are common to some Arabic and African cultures in this resource. Some of these pre-date Christianity and Islam. More detail is provided in this chapter than in the individual cultural sections.

[1] Much of the information in this section is sourced from Jackson (2006), Chs.2 and 12.

Supernatural/religious factors

A hierarchy, headed by a most powerful deity (God, or a god), followed by spirit entities or angels (good and bad), ancestral spirits, persons, animals plants and other objects, is seen to influence health. Entities can interact causing ill health or restoring health and reduce or enhance the power of a person.

- Ill health can be as a result of punishment by ***God*** for sins committed
- In Islam spirits called ***Jinn*** can be good or bad and are recognized assistants of God. The 'good' help people whist the 'bad' punish sinful actions. Possession by either can cause 'mad' behaviour
- ***Zar*** spirits are believed to influence mental health. They occur in Sudan, Somalia, Ethiopia and Iran. *Zar* possession explains unusual or inexplicable behaviours, including those that might be attributable to sin. Attributed possession also removes responsibility from the individual for actions or events. The spirits may be helpful or harmful. The condition is treated by a *Zar* doctor (or a traditional healer) who negotiates between spirits and humans and offers particular kinds of treatment. Although both genders are affected by *Zar,* it is suggested that women are more likely to be affected by them. *Zar* possession is associated (by western practitioners) with powerlessness and it has been noted that after resettlement possession can increase amongst refugees in general, but also in men, perhaps in response to their experiences of powerless
- ***Evil Eye*** is a common Muslim concept throughout the Eastern Mediterranean Region. It is believed by many that people (in some cultures it is particular people imbued with supernatural powers, or born with an *evil eye*, whilst in others it can be anyone) can put a curse on another by looking at them, or through prolonged eye contact. For this reason any or prolonged eye contact is avoided in these cultures. Babies and young children are believed to be particularly vulnerable and for this reason it is best not to praise a child openly. It is believed that the child may be protected if the person offering the praise immediately follows this by touching the child, or the parent may make a negative statement about them, spit, put dirt on the child or recite religious verses. Some may wear amulets as protection. Others protect their newborns by keeping them away from community and the public during the first couple of months after birth. It is believed that the *evil eye* generally causes physical rather than psychological illness, and in particular, epilepsy. Many educated and resettled people may no longer subscribe to the belief
- ***Sorcery*** occurs (in both Arabic and African cultures) as a result of the combined actions of humans and evil spirits and is performed by a sorcerer at the request of a client. It is believed to cause significant distress, disrupt social relations and can create sexual dysfunction in men. The belief in these spirits is pre-Christian and pre-Islamic although it has been incorporated into the Koran and is widely accepted. The beliefs and attributions are more likely amongst less educated people and those with little power
- ***Ancestors*** can protect, or they can cause harm if they are angered, either by disrespect or by neglect. Some refugees who have fled war situations may not have been able to fulfill specific obligations to ancestors before or during flight and may need to complete these in order to restore a sense of wellbeing as part of their treatment

Balance

Maintaining 'balance' is seen to be essential to good health. Imbalance causes ill health. Balance may refer to the humours within the body and can include concepts of hot/cold, dry/moist which need to be restored with the opposite foods or conditions. These terms do not refer to temperatures but to qualities. They differ from one culture to another. In some cultures balance is also needed to be maintained between subjective and objective worlds (e.g. feelings and social relations) and between the physical and psychological.

Traditional and current treatment practices

Most people of the cultures in this section are familiar with and accept Western biomedical intervention, particularly once they have resettled. Traditional medicines may be used in the countries of origin because of scarcity of medical resources, as well as out of tradition.

Some traditional practices may continue in New Zealand however, and it is reported that in some cultures substitute herbal treatments are being used. Such remedies may be beneficial physiologically, and because the client has faith in them. However, research indicates that some herbal treatments may produce interactive effects when used in conjunction with biomedical interventions. It is necessary to ascertain what other treatments the client may be utilizing since it is not unusual for people to use a number of different treatments concurrently, including religious, herbal and biomedical.

Since traditional, indigenous and religious frameworks do not usually incorporate a mind-body split, both physical and psychological conditions are often treated with similar interventions. Clients may also not make the distinction. For this reason, psychological symptoms are often expressed somatically. Jackson (2006) lists a few other reasons for what might be described as 'somatisation' by western practitioners:

- No familiarity with mental health terminology and conceptions because of lack of mental health facilities in countries of origin
- Because of the absence of the split between mind and body, people readily recognize that ill health may be a combination of both
- In different cultures the 'sick' role is prescribed in certain ways and people may need to conform to these to be acceptable and receive attention
- There are differences in the range of words available in each culture to express emotions
- Metaphors are sometimes used to describe psychological distress, e.g. "I have pain in my heart"
- The stigma of mental illness, and in particular 'weakness' that is sometimes associated with it, would encourage people to express problems in physical terms
- Physical symptoms are sometimes more easily accepted and understood in environments where verbal dissent is punishable and unacceptable

Traditional treatments/practices	
Traditional and Religious/ Supernatural Healing	Religious practitioners or traditional healers may recite holy verses, write prayers which can be worn in amulets on the body, or may perform rituals for cleansing or purification. Some rituals may involve the healer requesting assistance of God, spirits or ancestors, through trance states, and receiving instructions through these states. Traditional healers also use herbal treatments (see below). Some traditional healers are trained by elders and healers within their community, others inherit powers and skills. Their official status differs across countries, with some countries giving recognition and status to the practitioners.
Herbal treatment	The use of herbs to treat ill health is widespread in both Arabic and African countries. Herbs, plant extracts, roots and animal products can be boiled in water, heated or dried and inhaled, ingested or made into potions which are applied externally. The remedies are often administered as enemas (inducing severe complications from frequent use). Herbal treatment is an essential component of Traditional African Healing. There are however, dangers of unknown pharmacopoeia, and particularly of drug interactions when used in conjunction with western biomedical medicine.
Ritual cutting/ scarification	Some conditions are treated by ritual cutting, or blood letting, which may leave marks on the body.
Cupping 	A series of heated 'cups' are placed on the skin, forming a vacuum that draws on the underlying soft-tissue. Different cultures use different objects to create the suction. The process can be repeated a number of times and can leave marks
Moxibustion	A soft combustible material (e.g. a herb) is heated and burned indirectly at specified spots on the skin. This may also leave marks on the body
Patent Medicines	Some patented medicines are reputed to be available from Asian and Middle Eastern stores in Auckland

OTHER CULTURAL PRACTICES RELATING TO HEALTH

Female Genital Cutting (FGC) *(Most of the information in this section is sourced from Kemp and Rasbridge (2004), and www.who.int)*	
What is it?	FGC is a collective name given to various traditional practices that involve the partial or total removal of the external parts of the female genitalia (also known as Female Genital Mutilation (FGM), or female circumcision), for cultural or non-therapeutic reasons. The WHO regards the practice as a human rights violation and there are international agencies providing information and education on the issue. It is reported that many subjects of the practice and particularly the men in the respective cultures are not aware of the consequences other than those immediately following the procedure. However, it must be noted that for many women the tradition is considered a rite of passage for womanhood, is an ancestral practice and provides status and preparation for marriage. Some cultures believe that the uncircumcised woman is unclean (*haraam*) by Islamic law, and some erroneously believe it is required by Islamic law and Christianity. It is also practised by non-believers and animists. Families who are unable to have the procedure performed in the country of resettlement will often try to send the female children home for the purpose.
What age?	The procedure commonly takes place between the ages of 4 to 12, however the range can vary as much as from birth through to a first pregnancy across different cultures. It is usually performed by traditional practitioners or lay persons (elders or birth attendants) in the community, and often in unsanitary conditions using non-sterilized instruments such as broken glass, blades, kitchen knives etc. The more affluent are increasingly obtaining the procedure by trained health practitioners in medical clinics.
What countries?	FGC is practised in 28 African countries, and in parts of Asia and the Middle East. Although there are widespread attempts across the various countries to have the practice outlawed, it is reported to be increasingly performed where immigrants from these countries of origin have resettled.
Reasons for the practice	There are varied and complex reasons for the practice. Refer to http://www.who.int/mediacentre/factsheets/fs241/en/ for more details.
Types of FGC	4 types are defined: • **Type I** – the removal of the prepuce, and/or all of the clitoris ('Sunna circumcision', is considered a non-WHO classification) • **Type II** – the removal of the clitoris with partial or total removal of the labia minora

	• **Type III** (infibulation) – the removal of part or all of the external genitalia followed by the stretching of the scraped sides of the vulva across the vagina. The sides are then sewn to narrow the vaginal opening. A small opening is left for urinating and the passing of menstrual fluids. An infibulated women usually needs to be cut before intercourse can take place, or at least before childbirth • **Type IV** – includes a number of practices which involve pricking, piercing or excision of clitoris or labia, stretching of both, cauterization of the area, scraping of the tissue surround the vaginal orifice (*angurya* cuts)and cutting the vagina (*gishri* cuts), and introducing caustic substances for the purpose of narrowing the vagina. Type II is the most common, accounting for up to 80% of most cases.
Sequelae	Long-term and immediate consequences of FGC depends on type and conditions under which the operation is performed • Shock • Chronic and severe pain • Haemorrhaging and infection (sometimes leading to death) • Ulceration of genital region • Cysts and abcesses • Long-term difficulties with intercourse and childbirth • Difficulties with menstruation • Sterility • Increased risk of vaginal infection • Increased risk of HIV infection • Urinary retention • Incontinence • Increased risk of urinary infections • Psychological problems between couples because of painful intercourse

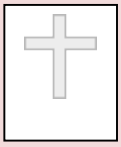
RELIGION/SPIRITUAL PRACTICES

For most Arabic and some African cultures, religion plays a more central role in life than is common in many Western cultures. It provides a framework for understanding all aspects of living, including illness and health. For those who practice Islam, it is a belief system, a culture, a structure for government and a way of life. It is important to acknowledge the role of religion with clients and to have some understanding of the implications of the belief systems.

For some cultures the beliefs and practices are a composite of a number of traditions. Such diversity in spiritual beliefs requires that assessment precede implementation of any type of spiritual care during illness. The most common of the faiths amongst those cultures in this chapter are:

FAITH	DESCRIPTION	COUNTRY (where significant numbers practice)
Islam 	A unifying belief of all **Muslims** is the belief in One God (Allah). The Koran (*Qur'an*) provides the scriptures, revealed from God through the prophet Mohammed. The cornerstone of Islamic faith, the 'Five Pillars' are the obligations which are required of every Muslim. They are: *shahadah* (statement of faith), *salat* (prayers x 5 per day), *zakat* (giving alms), *sawm* (fasting from sunrise to sundown), and *hajj* (pilgrimage to Mecca). Sunni Muslims constitute 85-90% of followers and Shiites about 10-15%. Sunnis believe that Mohammed died without appointing a successor, whilst Shiites believe that Ali was appointed. Sunni Muslims are contained in their expression of grief whilst Shiites grieve more openly. Sufi Muslims can be Shiite or Sunni oriented and focus on the ascetic and mystical elements of Islam. In all the cultures in this section, Sunni Muslims are the majority except in Iran where they are mostly Shiites. **Implications:** • that ill health may be God's will. Some Muslims may passively accept this whilst others will seek treatment • during **Ramadan** practitioners need to ascertain whether clients intend to observe regular or modified fasting and advise re medication, particularly for clients with chronic systemic illnesses (sometimes doses are doubled, tripled or missed by clients to accommodate fasting). Practitioners can also remind clients of the exemptions stipulated by the *Qu'ran* • practising Muslims with ill health, or those hospitalized may be challenged to meet the obligations of the 5 daily prayers and fasting and may need assistance to meet these • dietary restrictions include pork and meet that is not *halaal* (blessed by a Muslim clergyman) • ritual washing is required before prayers (5 x a day) and can present difficulties for devotees in non-Muslim environments including schools and places of work	*Afghanistan* *Iraq* *Iran* *Somalia* *Sudan* *Ethiopia* *Eritrea*

Holy days	These include: • ***Ramadan*** *i*s celebrated by Muslims in the 9th month of the lunar Islamic calendar and is regarded by many as the holiest time of the Muslim year. During this month Muslims fast from dawn until sundown (including no water or other liquids). Those with ill health are exempt from the fast although many nevertheless like to partake. Young children, menstruating, pregnant and nursing women are also exempt from fasting • ***Moulid*** (Milad) marks the anniversary of the birth of Prophet Mohammed and occurs during the month after Ramadan. Some Muslims celebrate whilst others do not since this day also marks the anniversary of his death • ***Eid (Eid Al-Fitr)*** (celebrating after fasting) • '*Eid*' is the Islamic word for 'feast' and is celebrated at the end of Ramadan and the month long fast. The *Eid* prayer is performed as a ritual and food and non-alcoholic drinks are offered in mosques and homes, with the celebration lasting for 3 days • ***Eid Al –Adha*** (important holiday for making pilgrimages to Mecca) • This is celebrated 70 days after *Eid al-Fitr*. The holiday is in honour of the sacrifice of Abraham to God, and it is also the day when Muslims from all over the world try, at least once in a lifetime, to go to Mecca. The occasion is commemorated with an early morning prayer and ritual, and celebrations follow for 3 days. In New Zealand, many families will buy a goat or sheep from a butcher in their name in place of performing a sacrifice themselves.	
Special Concepts	The ***Hijab*** is generally known as the head scarf worn by many Muslim women. In its broadest sense, however, it means modesty which includes behaviour as well as dress. *Hijab* includes a head covering (actually called a *khimaar)*, and also a garment covering all but hands, feet and eyes. Full covering is referred to as *purdah*. Modesty and covering, is part of a code of morality and many women wear *hijab* with pride and to make a statement that they are followers of their faith. Westerners often associate *hijab* and some of the related principles with the oppression of women in Islam. This is not necessarily the case and practitioners need to assess client's attitude and positions on an individual basis. Different cultures, clans and sects vary in their adherence to modesty protocol.	

Animism and ***Indigenous Religions*** 	Whilst animism and indigenous religions are not necessarily synonymous, what they commonly share is that all aspects of the environment are seen to have life. Both share the belief in positive and negative entities/spirits which affect humans. Shamans or traditional healers can traverse at will, between the worlds of the spirits and the consensus-reality world, and influence the entities and the effects they have on humans. It is believed that the traditional healer can not only avert bad luck, but also be instrumental in resolving tensions and conflicts between the living and the dead. The influence of ancestors is central to this practice. The correct burial rituals following the death of a relative are thought to ensure wellbeing for the individual and family. **Implications:** • That external forces are responsible for ill health and that appeasing the forces either through their own actions, or with the help of a traditional healer, will resolve the problem • Many refugees who have experienced displacement and flight may not have been able to perform the necessary obligations to ancestors for some time and may need to do this as part of therapeutic intervention to restore a sense of wellbeing	*Somalia* *Sudan* *Ethiopia* *Eritrea* *Burundi*
Christianity 	Christianity is a monotheistic religion and includes the doctrines based on the teachings of Jesus Christ. Divisions within the faith are based on whether the Bible is seen as the literal or inspired word of God. The earliest division was between the Church of Rome (Catholics) and the Eastern Orthodox Church (includes **Assyrian Church of the East** and the Ethiopian and Eritrean Coptic Churches). The forms of Christianity practiced by people in the Eastern Mediterranean region have their roots in the oldest forms of Christianity, some aspects of which are pre-Christian and are evident in current practice even though they may not be formally accepted by church leaders. These include the belief in spirits (‘z*ar*’ and ‘*adbar*’) and the need for protection or purification. The Christian elements of the **Ethiopian Coptic Church** (and Eritrean Orthodox Church) include God, angels and saints, where the angels and saints are messengers of God. Fasting and ritual is involved in practice and only those devotees following required practice can partake of communion. An ark (tabot) dedicated to a church’s patron saint is consecrated (not the church) and this is carried in procession on holy	*Sudan* *Burundi* *Iraq* *Ethiopia* *Eritrea* *Iran*

	days. Lay followers are required to fast for 165 of the year including Wednesdays and Fridays and the two months of the year that include Lent and Easter. Memebers of the Assyrian Church also practice fasting. **Implications:** • Medication during fasting may require monitoring and adjustments • For those who believe that illness is a result of God's will, a fatalistic attitude may prevail • For those who encoporate spirits into their beliefs, purification may be a necessary aspect of treatment	
Zoro-astrianism 	This is a very old faith pre-dating Christianity and Islam. It developed in Persia and is a monotheistic religion based on the teachings of the prophet Zoroastra (Zarathustra). *Ahura Mazda* is the supreme God, and the *Avesta* the holy text. The faith is based on the belief that good and evil are the two forces in the world and that humans have to decide which one to follow. It is believed that ultimately good will prevail and the forces of evil will be overcome. **Implications:** • Purification is an important aspect of the practice and clients who are ill may require religious rituals to assist in the healing process	*Iran*

REFUGEE HEALTH

Refugees require **special consideration in health care** due to their traumatic pre-settlement experiences and related resettlement challenges. Unlike migrants who usually migrate out of choice, refugees' re-location is forced and associated with trauma, and often war and torture. They necessarily flee persecution, often in fear of their own and their family's lives, and without opportunity to plan their re-location.

New Zealand can be for many, a 2nd or 3rd place of refuge after internal displacements within the home country, long journeys to find protection, and finally extended periods of hardship in refugee camps (for some, as much as a generation). Conditions within refugee camps are often not much better than the place from which refugees fled. Scarcity of food, lack of physical security, separation from family members and loss of life purpose are a few of the challenges that accompany many refugees during their wait to be resettled, or return home to enjoy their human rights.

Many refugees have had inadequate health care before coming to New Zealand, and arrive with high needs including significant mental health needs. Of the 35% (per average intake) of refugees arriving at Mangere Refugee Reception Centre (MRRC) who elect to use mental health services, only 3% of these suffer from a diagnosable

condition. However, people present with a significant number of **symptoms** of mental health disorders, many of which evolve into full-blown syndromes and disorders if they remain untreated. PTSD (Post Traumatic Stress Disorder) often only emerges after a person has settled.

United Nation's definition of a refugee:
"*. . . owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it*".

- **Quota refugees** are refugees who have been recommended by the United Nations High Commissioner for Refugees (UNHCR) and have been accepted for resettlement by New Zealand Immigration Service. Most of these people will be re-located from refugee camps. Quota refugees arrive in New Zealand with permanent residency status and are entitled to the benefits available to all New Zealanders
- **Convention refugees/Asylum Seekers** are people who arrive in New Zealand of their own accord and petition for permission to remain here because of the threat of persecution in their home country. They are assessed in accordance with the criteria for refugee status set out in the 1951 Geneva Convention. Those who are granted permanent residence fall under the category '**Convention Refugees**'. Their application follows a legal process and can take from weeks to years before a decision is made, leaving the person living in uncertainty for long periods of time. Those who arrive with valid entry documentation (e.g. visitor or student visas) are usually permitted to remain while their application is being processed. Those who arrive without valid documentation may be detained in Mount Eden prison or at the Mangere Refugee Reception Centre until identity and security issues have been resolved. There are considerable disparities between services provided for quota refugees and asylum seekers.

Factors that impact on a refugee's physical and emotional health

Pre-settlement trauma	Re-settlement challenges
• War • Rape and assault • Physical injuries • Lack of safety • Imprisonment and torture • Family separation and disappearances • Refugee camp life with daily struggle for survival and safety • Disempowerment • Lack of justice • Witnessing of violence and atrocities • Extreme poverty and deprivation	• Cultural shock, as well as loss of own culture • New language, people, religions • Lack of personal belongings • Separation from, and loss of loved ones • No extended family for support • Authority issues due to previous experiences (torture and persecution) and disempowerment • Loss of control over own and family's life • Sense of shame • Confusion • Loss of confidence, dignity • Loss of previous lifestyle and career • PTSD symptoms start • Fear of being sent back (the threat is often used by authority figures, sometimes those in the family, to maintain control)

Notable statistics for New Zealand (provided by RASNZ, 2011)

- 19% of refugees entering New Zealand have survived torture and trauma
- 79% of these have survived severe trauma
- 68% of these are women and children

Common health presentations of refugees

Physical symptoms	Mental health symptoms
• Pains in different parts of body • Headaches/dizziness • Heart palpitations • Heightened state of arousal • Hypertension • Nausea • Ulcers • Breathing difficulties • Sleep problems • Tremors, numbness, weakness, fainting, sweating • Stomach disorders • Dairrhoea and constipation • Specific sequelae from torture	• Social withdrawal • Irritability, aggressiveness, anger • Impulsiveness • Suicide attempts • Sexual dysfunction (severe) • Fear, anxiety, panic • Confusion, disorientation • Memory disturbances • Loss of concentration • Rumination • Lack of motivation • Attention blocking • CTSD[2]

Chronic and long term physical sequelae of torture

Organs	Complaints	Possible causes. What to check for.
Eyes	Blurred vision, double vision, problems with accommodation	Chronic conjunctivitis, possibly caused by wearing a dirty hood for long periods. If no abnormality, **check for** whiplash syndrome, paying special attention to status of cervical spine
Ear, Nose, Throat	Impaired hearing, vertigo, tinnitus, earache, poor air flow through nose	Blows to face and ears. Beating both ears at the same time (*telefono*) can result in damage to middle and inner ear, and chronic otitis media. If tinnitus and vertigo cannot be explained, whiplash syndrome should be considered

[2] CTSD (Chronic Traumatic Stress Disorder) is a term used by STARTTS (Service for the Treatment and Rehabilitation of Torture and Trauma Survivors) in Australia indicating that PTSD in a refugee population usually involves more than one major stressful event. It usually involves a multiple of sequential events, any or all of which could cause PTSD symptoms in the average population.

Teeth	Teeth missing/ broken/aching, bleeding gums, poor chewing, headaches, pain in face, possibly dyspepsia	Possible causes: • blows to face. • teeth may have been extracted without anaesthesia • poor food and poor dental hygiene **Check for** gingivitis
Lungs	Sometimes persistent irritable cough	Possible cause: • By aspiration of dirty water during mock drowning (*submarino*) • Other infection a result of poor and insufficient food and stress during imprisonment **Check for** TB and other infectious illness
Heart	Brief stabbing precordial pain, palpitations, difficulty breathing	Often no physiological cause found but precordial pain may be an after effect of suspension. Pain from vertebral column and whiplash syndrome may imitate precordial pain
Alimentary canal	Complaints of symptoms very common. May complain of symptoms typical of gastric ulcer - epigastric pain, hunger pains with relief on eating, acid regurgitation, loss of weight, nausea and, less commonly, vomiting Complaints of constipation/diarrhea	Despite complaints, gastroscopy reveals that only small numbers have ulcers May have pain and bleeding from anus and rectum, fissures etc. Probably from sexual torture when objects forced into rectum May show signs of previous infections with Hepatitis A, although B and C also seen Depending on country of origin, may present with chronic parasitic conditions, e.g., bilharzia, malaria, and intestinal worms. (In NZ refugees who have spent their first few weeks at MRRC are checked for parasites and infections, but others who arrive as asylum seekers or under the family reunification scheme may not have had these checks)
Urogenital system	Complaints of dysuria and frequency Women may complain of chronic stress, disturbances of menstruation (oligomenorrhea), lower	Physiological basis for these complaints are rare May be sequelae of sexual torture. Check for chronic inflammation of internal sex organs. Check also for referred pain from the spine

	back pain, problems with urination and defecation, dysfunction of pelvic muscles and joints Men may complain of anal problems, premature ejaculation, reduced potency	 May be sequelae of sexual torture **Check** men and women for AIDS and Hepatitis B
Central and peripheral nervous system	Headache (many types, including migraine) reduced ability to concentrate, reduced memory, cognitive difficulties, vertigo, tiredness Parasthesias. Complaints of strong shooting pain in localised area, neuralgia. If this pain occurs in bouts, it may be described as muscle cramps. Complaints of superficial burning, smarting sensations in area, caused or aggravated by light touch, but decreasing with firm touch	Probable causes: • many direct blows to head, especially if client has been rendered unconscious • electric torture causing convulsions • mock drowning (*submarino*) resulting in anoxia to brain **Check for** whiplash syndrome, dysfunction of teeth as possible causes of headache Symptoms similar to dementia, especially poor memory may be psychogenic and respond to psychotherapy Probable causes: • constriction of extremities by cuffs or rope • hanging from arms when arms tied behind the back (*Palestinian suspension*) • repeated and violent trauma to areas of body where peripheral nerves close to surface, including soles of feet (*falanga*) Depending on area about which complaint is made, **check for** damage to trigeminal nerve, brachial plexus, nerves of soles of feet. Check also for sensory disturbance to pinprick and temperature Pain may be chronic or intermittent. Failure to find physiological basis for pain can be harmful to psychological well-being of client
Musculo-skeletal system	Complaints about muscles, tendons, nerves and joints extremely common	Probable causes: • continuous beating of body and extremities, electric torture

		• high levels of stress causing extreme muscle tension and sometimes faulty posture
	Pain in arms, radiating to corresponding extremity, parasthesiae and tiredness. Pain in/around the heart	Suspension by arms. Besides **check**ing **for** damage to brachial plexus, **check for** strained and malfunctioning muscular connections of arms/shoulders and thorax. This may trigger precordial pain
	Lower back pain without radiation to lower extremities	Possible cause: • Being forced to crouch in restricted cage for long periods. May cause over-stretching of stabilizing ligaments and joint capsules of spine. This results in segmentary instability and malfunction. May also cause irritation of afferent sympathetic nerves with segmentary radiation to viscera and skin. Depending on the segment of the spine that is affected, symptoms may mimic cardiac, gastrointestinal, urogenital conditions etc.
	Intermittent, often burning pain of lower legs and feet, Made worse by walking	Damage to tissue of feet as a result of beatings to feet (*falanga*). Destruction of fatty pads of foot during beatings
	Varied complaints of pain in the neck possibly with radiation to one or both upper extremities. Blurred vision, dizziness, tinnitus, migrainous head, paraesthesie of face, toothache, chest pain	Possible cause: • whiplash from being beaten or pushed from behind while blindfolded and unable to predict the blow • damage to cervical spine, discs and ligaments, also to vessels and nerves supplying head and neck
Skin	Not usually associated with complaints of pain	**Check for** scars from whipping, cigarette burns, electric torture, cutting and stabbing, application of acid

Sourced from Jackson (2006), Appendix 2.

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Useful Resources

1. RAS NZ (Refugees As Survivors New Zealand) can provide assistance to mental health practitioners on clinical issues related to refugee and cultural needs, and contacts for community leaders/facilitators. They can be contacted at +64 9 270 0870.

2. ARCC can provide information on resettlement issues and contacts for community leaders. Contact +64 9 629 3505.

3. Refugee Services can be contacted on +64 9 621 0013 for assistance with refugee issues.

4. www.aucklandras.org.nz for links to related sites.