



# COMMUNICATION

## Greetings

Hello greeting                      *Salaam aleikum* 'Peace be upon you' (Muslims)  
Goodbye greeting                    *Ma'a alsalama* 'God be with you' (Muslims)

## Main languages

The official language is **Somali**. It has 3 distinct dialects and is written in Latin script. English, Italian (especially in the south) and Arabic are spoken by educated Somali. A small number are of Swahili and Bantu origin and speak these languages.

## Gestures and interaction

- It is appropriate **shake hands** with the same gender (using the right hand) but cross gender handshaking is **not** appropriate
- **First names** are expected
- Hand gestures are used expressively in conversation:
  - A quick **twist of the open hands** can indicate 'nothing' or 'no'
  - **Pointing a finger** is considered rude
  - The western '**thumbs up**' is an obscene gesture
- The **right hand** (the 'clean' hand) should be used for passing objects and shaking hands
- Elders are treated with **utmost respect** and a courteous address can include 'aunt' and uncle' even if the elder is a stranger
- **Eye contact** is likely to be less than in New Zealand out of respect
- Showing an **interest** in the culture and practices will likely enhance relationship with the practitioner and compliance
- Health practitioners are generally highly regarded and deference usually accorded to their opinions. It would be helpful for practitioners to **invite client's** to share their opinions and questions

# FAMILY VALUES

- Allegiance to the clan is of utmost importance, as is loyalty and devotion to the family
- Extended families are traditionally the norm
- Genders are generally separated in most spheres of life as per Islamic culture
- Males are heads of families and women usually responsible for the care of the members
- Boys and girls receive the same education, and literacy amongst women is higher than in some other Islamic cultures
- Marriages can be arranged or be of the individual's choice although family will need to approve of the match
- It is customary for marriage to take place at 14 or 15 and for men to have more than one wife. Laws in countries of resettlement alter these norms

# HEALTH CARE BELIEFS AND PRACTICES

(See Chapter 3 Introduction to MELAA Cultures, 'Traditional treatments/practices' pg 5, for additional information on some practices).

## Factors seen to influence health

**1. Western biomedical** concept of disease causation and disease communicability is accepted as explanation for some illnesses rather than for all. Other attributions of ill health may be preferred or may co-exist along with western concepts.

## 2. Spiritual/supernatural

Beliefs in spiritual and supernatural causation are reported in the literature to be common. Generally Somalis believe that spirits reside within the individual and can cause harm or illness if they are angered. Local resettled residents in New Zealand report that these beliefs are not common amongst the younger generations and those who have education.

- '**Zar**' spirit possession is common. However it is reported that some Somalis believe that these spirits do not accompany them when they resettle in New Zealand
- Belief in the '**evil eye**' is common and it is believed that an individual can put a curse on others by looking at them. This mostly affects children and is associated with physical illness, in particular epilepsy (See Jackson Ch.2, 2006 for more information). Local resettled community members report that this belief is not common amongst those with education, or with the younger generation
- Many Somalis believe in **jinn** spirit possession. Symptoms are more likely to be of a spiritual/psychological nature than a medical one, and can range from minor to serious conditions
- **Sorcery** and witchcraft is believed to occur as a result of the actions of people and evil spirits working together (similar reports by local Somalis suggest that some of these beliefs are also outdated amongst the educated and the younger generation)
- Ancestors can cause ill health if offended or neglected

## Traditional and current treatment practices

### 1. Western medicine

This is commonly practiced in urban areas. Most Somalis will have had some exposure to Western medicine, however the medical conditions customarily taken to doctors and clinics can be circumscribed. Herbal and biomedical remedies may be used together

### 2. Traditional/complimentary practices

Traditional medicine is practised by 'traditional doctors' who are usually elders of the community and have learned their skill from other elders in the family. Midwives, bone-setters and religious practitioners provide service for various conditions. Many herbal and 'traditional' remedies are used, some of which are ingested or applied externally, others involve rituals or procedures. The most common practices are:

- Use of the herb *Khat* (**Note:** it is possible that there is cross-tolerance for amphetamines by *Khat/qat/chat/kat* users. See Jackson 2006, p.134 for more

- detail). This herb is reported to be available in New Zealand and is often used as a drug, not just for medicinal purposes
- *Fire-burning* (has some similarity to **moxibustion**). This may leave scars which should not be assumed to result from abuse

See Kemp and Rasbridge 2004, p. 321 for examples of specific conditions and treatments). Some practices are less common in New Zealand due to lack of availability or prohibition. However, substitutions may be found and this needs careful exploring by the practitioner in view of possible drug interactions.

### **3. Magico-religious articles and religious/spiritual rituals** may be used.

#### **Important factors for Health Practitioners to know when treating Somali clients:**

As many Somali who enter New Zealand have arrived as refugees, extra sensitivity and care in treatment is necessary given the possibility of extremely difficult pre-settlement experiences (see 5. below)

1. Men are heads of households and will often attend consultations with family members and expect to speak on their behalf. Make sure there is agreement from clients.
2. Women do not take the husband's name after marriage and records need to accommodate this preference.
3. Same-sex practitioners are appreciated by Somali women in general, but are imperative for gynaecological examinations.
4. Literature reports that female genital cutting (FGC) is common throughout Somalia, with infibulation (Type III) the most common. Less severe forms are also practiced. Respectful handling of the issue is crucial with assistance and/or education as needed. This is part of the culture and is expected and accepted as such by many women. Of some concern to resettled women is how their infibulations will be dealt with at childbirth. Practitioners need to familiarize themselves with the needs and sequelae. (See Chapter 3 Introduction to MELAA Cultures, pg 6 for more information on FGC).
5. Women who follow traditional custom cover their bodies and veil their faces. Some may wish to keep a veil/headscarf on during examinations for modesty reasons, and will want male family members to leave the room.
6. It is reported that Somalis associate doctors and clinics with ill health in their homeland. The concept of preventative medical care is not familiar and families may need education regarding the benefit of preventative health care, depot treatments, prophylactic medications and routine check-ups.
7. In Somalia professionals are consulted for symptom relief which is usually given, setting a precedent for expectations. When no tangible intervention is provided in New Zealand, it would be helpful for practitioners to give the rationale behind treatment decisions and lack of medication particularly when it is expected that the condition will resolve naturally. It is reported by local residents that clients will otherwise 'doctor shop'.

8. A term '*walli*' will sometimes be used in describing ill health. However the meaning can range from 'not feeling oneself, through a number of other symptoms to schizophrenic symptoms so this needs careful investigating (see Jackson 2006, pg. 133 for more detail).
9. Herbal and traditional remedies may continue to be used after resettlement and practitioners may need to assess for drug interactions.
10. Compliance is likely to be enhanced if some traditional practices can be incorporated within the current treatment plan where possible, and if clients are involved in decision making regarding their treatment. *Qu'ran* readings are an important part of traditional healing and can be used in conjunction with western treatment. The services of a religious practitioner can be offered during hospitalization.
11. Compliance with prescriptions can be affected by language difficulties. Interpreters can assist with providing written instructions in the client's own language.
12. Muslim clients will fast during **Ramadan** which may affect medication and/or dietary compliance (medications are likely to be taken at night). Assistance in this regard may be needed. (See Chapter 3 Introduction to MELAA Cultures, pgs 7-11 for more information on religions and spiritual practices).
13. Clients and family are not usually informed of terminal illness, although the severity of the symptoms is explained. Since New Zealand health law contravenes this custom, sensitive handling of the matter is needed and the elder of the family may need to be consulted first. If in doubt, consult a community leader. RASNZ will have access to appropriate contacts. (See references for contact details)
14. Corporal punishment is customary; the family may need assistance or counselling with alternative means of disciplining their children.
15. Informed Consent may be a new process and will need explaining.
16. The extended family and friends may want to stay with a client during hospitalization. Hospital protocol may need explaining; however it would be appreciated by the family to have some of their needs accommodated where possible.
17. When doing HOME VISITS:
  - Give a clear introduction of nature of service, of roles and purpose of visit
  - It is usually appropriate to remove shoes before entering the home
  - It is customary to address the elders of the household first
  - Food or drink will usually be offered. However, it is acceptable to decline politely, although accepting would be appreciated (especially by recently settled people) as offering food is a gift of hospitality
  - Modest dress is appropriate
  - Be aware that no food or drink is consumed from sunrise to sunset during Ramadan

## **Stigmas**

The condition and term 'mental illness' is stigmatized since it is associated with dissociative states and behaviours. In Somalia people in such conditions are often institutionalized or chained for safety reasons if no institution is available.

## **Diet and Nutrition**

Southern Somali's diets generally include more vegetables whereas those with a nomadic lifestyle in the north have diets heavier in meat and milk. People in the cities tend to be familiar with western foods. Rice is a staple. It is noteworthy that malnutrition is common in the south given the long-term situation of scarce resources.

## **Death and dying**

### **Muslims**

- Terminally ill clients will be attended at home, whenever possible, by the family. It is considered both a responsibility and a privilege to look after family members, especially parents
- Islamic rituals are important at death for Somalis. The ill person will be faced towards Mecca, verses from the *Qu'ran* will be recited with a sheikh or elder leading the prayers
- After death the body will be ritually prepared and wrapped by members of the same sex
- Traditionally Muslims need to bury their deceased within 24 hours
- Burial in a cemetery is required, not cremation
- Mourning lasts for several days and is shared by community
- Transfusions, transplants, autopsies and life-support are controversial issues amongst the Somali as in accordance with Islamic law, it is believed that life is given and taken by God

## **HEALTH RISKS**

According to the Perumal (2010) report on MELAA people living in the Auckland Region, key health concerns for African people include:

- Diabetes (significantly higher prevalence than Europeans, including associated hospitalizations)
- Respiratory diseases (asthma for females, and pneumonia)
- High HIV (23% of all the people diagnosed as HIV positive in the Northern region from 1996-2009 were African)
- Asthma, especially women
- TB (highest rate of hospitalization within MELAA group)
- Cellulitis (highest rate of PAH amongst females from all ethnicities)
- Kidney and urinary infections (highest amongst all Other females)
- Low vitamin D deficiency (particularly women and girls which may be due to avoidance of sun and because of dress code to cover up)
- Malnutrition (due to prolonged periods of war)
- Obesity after suffering malnutrition

- Lack of sufficient physical exercise (may be prohibitive for some women with conservative dress and behavioural expectations)

### **Social issues affecting health**

- Isolation (including older people who spend a lot of time alone at home)
- Unemployment and poverty (many have significant financial issues and difficulties finding work)
- Loss of standing in society
- Being marginalized (race, cultural difference, clothes, education and refugee experiences)
- Cultural adjustments impacted further by the lack of support from usual networks of family and community
- Experiencing racial discrimination based on ethnicity (within own cultures)
- Stigma of mental health, HIV and disability often means no societal support, and no disclosure of issues

### **Mental Health issues** (particularly PTSD and depression):

- African communities experience a disproportionately higher rate of mental health illness compared with the rest of New Zealand, largely due to their earlier life experiences and potential exposure to torture, violence, rape and harassment
- There may be strong emotions of grief and loss for family, culture, and country especially following refugee experiences
- Experiencing discrimination is strongly linked to high levels of anxiety and depression which negatively affects Post Traumatic Stress Disorders (PTSD)
- Mental illness is stigmatised which results in limited use of appropriate assessment and treatment services, especially in smaller communities

Unexmundi (August 2014) lists the following major diseases for people living in Somalia:

- Hepatitis A and E
- Typhoid fever
- Malaria
- Dengue Fever
- Yellow Fever
- Japanese Encephalitis
- African Trypanosomiasis
- Cutaneous Leishmaniasis
- Plague
- Crimean-Congo hemorrhagic fever
- Rift Valley fever
- Chikungunya
- Leptospirosis
- Schistosomiasis
- Lassa fever
- Meningococcal meningitis
- Rabies

In addition, Malnutrition resulting from prolonged war and severe famines.

## WOMEN'S HEALTH

According to the Perumal (2010) report on MELAA people living in the Auckland Region, issues for African women include:

- Within the MELAA group, African women had the second highest number of live births followed by Latin American women.
- Low levels of health screening, particularly in cervical and breast cancer screening
- Female Genital Mutilation (FGM/FGC) and its associated complications (See Introduction, Chapter 3 for more details)
- The need for more education around pregnancy and child birth in New Zealand
- Health issues related to refugee backgrounds, and sexual violence in particular
- A preference for women to use interpreters and health care practitioners of the same gender. For issues of trust, appropriateness and awareness, it is important to engage professional interpreters whenever possible

For Somali women who have resettled as refugees a careful history taking will be needed to ascertain whether sexual abuse or rape has occurred. This is a frequent experience amongst refugee women in general, but it has been particularly widespread in Somalia for some time. The history taking will need to be done when women only are present and disclosure will depend on rapport and trust built. In general, refugee women (and men) need to be treated with extra sensitivity and care since they are very likely to have suffered the conditions related to the atrocities and trauma of war, of trauma during flight, and re-location stress. In addition they are often responsible for the emotional wellbeing of the family who too may be weighted by similar psychological and physical loads. Some Somali women re-locate alone as a result of family losses, separations and displacements.

Literature reports that female genital cutting (FGC) occurs extensively in Somalia (98%). There are ongoing educational programs to encourage Somalis to abandon the practice, and although it has been illegal since August 2012, it is not clear how effectively the law is being enforced across the country. Puntland (in the North), which is the most proactive area in this regard, enacted laws against Type III but not against Types I and II, and since 2014 it has banned FGC in correspondence with Islamic laws. (See Chapter 3 Introduction to MELAA Cultures, pg 6 for more information on FGC Types). Local Somali residents in New Zealand report that the practice is outdated amongst educated families.

### **Traditional fertility practices**

- Large families are valued so birth control, planning and abortion is uncommon; pregnancy is seen as God's will

### **Pregnancy**

- Childbearing is encouraged soon after marriage
- Episiotomies are not common, nor caesarian sections as it is believed these may cause harm

### **Labour and Delivery**

- Midwives and female relatives will assist in labour in rural areas, however people in the cities and those who are resettled usually prefer hospital care
- In their homeland women have significant support from their female relative and community members. Due to lack of sufficient community after resettlement, women may need more support from health care providers in New Zealand

### **Postnatal care**

- Warm baths and sesame oil massages are customary
- After the birth the mother and baby stay home for 40 days and are visited by friends and family. It is a time of abstinence and female relatives and neighbours assist the mother. This period is known as *afatanbah*. This is for protection purposes (from the 'evil eye' and conditions of the world). Hospital procedures requiring birth certificates have changed this practice
- The use of diapers is not common. A basin is held beneath the baby at regular intervals and 'potty' training is reputed to happen easily
- Breast feeding is the norm and can last up to two years although early supplementation is not uncommon
- Some mothers erroneously believe that colostrums is not healthy for a newborn

### **Religious Ceremonies Related to Birth**

- *Afatanbah* ('mothering the mother') is followed by a naming ceremony with a large gathering and celebrations
- Prayers are held at the ceremony which customarily includes a ritual killing of a goat

## **YOUTH AND CHILD HEALTH**

According to the Perumal (2010) report on MELAA people living in the Auckland Region, key health concerns for African children include:

- A possible higher standardized mortality ratio (SMR) as compared to Others
- The PAH rates in children from all causes was higher in African children compared with Others
- Asthma was the main cause of PAH, followed by dental conditions
- African children had the highest rate of hospitalisation for asthma, pneumonia and bronchiolitis
- They had higher hospitalisation rates than Others for dental conditions and gastroenteritis
- At the 6 month mark only 23% of African babies were exclusively or fully breastfed, (below the recommended 2007/08 national health target of 27%)
- In children <5 years of age and in Year 8, there were more African children with caries than in Others
- FGM (FGC) for Muslim African girls has associated difficulties (See Introduction, Chapter 3 for more details)
- There is a common misconception amongst Muslim boys that circumcision is a protection against sexual 'disease'
- Chlamydia infections are prevalent in all teenagers in the MELAA group
- Many refugee children have spent much of their lives in refugee camps with associated deprivation, violence, and lack of resources including education. These

children may need assistance with cultural adjustment, and may display behavioural disorders and delayed educational progress

### **Newborn & Child Health**

- Circumcision, a rite of passage, is universally practiced and is viewed as necessary in order for a person to become a full member of the community in their adulthood
- Males are circumcised between birth to 5 years (usually by a traditional doctor or in a hospital by nurse or doctor)
- 98% of girls are circumcised from between birth to 8 or 9 years old (see above on FCG/FCM)

### **Adolescent Health**

- Many Somali children and adolescents, especially those from rural areas, and those born since the unrest from 1991, may have received little or unreliable education. In such cases they may suffer considerably within a new education system and with low literacy levels, and may require additional assistance and support
- Most resettled adolescents will be faced with:
  - role changes at home
  - pressures from peers to integrate more quickly than they or their families may be comfortable with
  - the stigma of 'difference'. Assistance and sensitivity from authority figures will be helpful in the schools
- Many young refugee children and adolescents have been subjected to violence or have been witness to the atrocities leveled at their families and communities during war, and in refugee camps. They may bear their experiences unnoticed. Parents managing the challenges of resettlement as well as their own pre- and post-relocation traumas are often unable to attend to, or to manage the distress of their children adequately. Sometimes children do not tell their parents in order to avoid added stress on the family, out of respect, or because they believe they are in some way to blame. Symptoms of trauma may present as behaviour problems, withdrawal, learning difficulties, poor concentration and motivation as well as with various somatic complaints. These presentations may mask post-traumatic stress, depression, anxiety and other mental health conditions. Practitioners and teachers need to be alert to the possibilities of pre-relocation trauma
- Some Islamic traditions and the difficulty in explaining these because of language barriers, may deter children from attending social or school functions (e.g. no cross-gender touching for adolescents, ablutions required during fasting and before prayers, time schedule for prayers, *halaal* food etc.)
- Menses, genital malformation, urinary infections and chronic pelvic complications can occur as a result of the FGC
- Young girls are equally as exposed to rape and sexual abuse in their home country as the adult women
- No sex education is given to adolescents and the subject is not discussed at home. Of concern are illegal abortions, pregnancy-related dropouts from school, and potential risk of HIV infection

## SPECIAL EVENTS

<b>Ramadan</b>	(fast month)
<b>Id al-Fitr</b>	(celebration after fasting)
<b>Id Arafa</b>	(important holiday for making pilgrimages to Saudi Arabia)
<b>Moulid</b>	(celebrates birth and death of Prophet Mohammed, occurs during month after Ramadan)

## SPIRITUAL PRACTICES

Most Somalis are Sunni **Muslims**. Religion plays an important part of all aspects of life for Muslims, and *Qu'ran* readings are a source of comfort and intervention during illness and distress. **Christianity** is practised by a small percentage of Somalis.

(See Chapter 3 Introduction to MELAA Cultures, pgs 7-11 for more information related to religions and spiritual practices).

### **DISCLAIMER**

*Every effort has been made to ensure that the information in this resource is correct at the time of publication. The WDHB and the author do not accept any responsibility for information which is incorrect and where action has been taken as a result of the information in this resource.*

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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. University of Washington Medical Centre provides information sheets at: <http://depts.washington.edu/pfes/CultureClues.htm>
5. A number of health fact sheets can be found in Somali for download in pdf. format at: <http://www.healthtranslations.vic.gov.au/>
6. The <http://www.ecald.com> website has patient information by language and information about migrant and refugee health and social services.