



Culture, context and mental health of Somali refugees

A primer for staff working in mental health
and psychosocial support programmes



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Acronyms

ARRA	Administration for Refugee/Returnee Affairs (Ethiopia)
CFI	Chain-Free Initiative
CVT	Center for Victims of Torture
FGS	Federal Government of Somalia (since 2012)
GAVO	General Assistance and Volunteer Organization
GBV	Gender based violence
GRT	Gruppo per le Relazioni Transculturali
IDPs	Internally displaced persons
IMC	International Medical Corps
INGO	International non-governmental organization
IPV	Intimate partner violence
IRC	International Rescue Committee
MH	Mental health
MHPSS	Mental health and psychosocial support
MOH	Ministry of Health
PoC	Persons of concern
PTE	Potentially traumatic experiences
PTSD	Posttraumatic stress disorder
SGBV	Sexual and gender based violence
TNG	Transitional National Government (2000-2004)
TFG	Transitional Federal Government (2004-2012)
UIC	United Islamic Courts
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

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INTRODUCTION



1. INTRODUCTION

Rationale

For several decades, the people of Somalia have been confronted with severe levels of armed conflict and forced displacement. As a result, 1.1 million Somalis have become refugees, fleeing primarily to neighbouring countries (Kenya, Ethiopia, Yemen and Djibouti), with yet another 1.1 million Somalis living as internally displaced persons (IDPs) within Somali borders (1). Additionally, sizable populations may be found in countries scattered along the route to Europe, North America and South Africa. Communities of Somali migrants, asylum seekers and refugees have also emerged further afield in North and sub-Saharan Africa, the Middle East, the United States of America, Canada, Australia, New Zealand, Western Europe and Scandinavia.

Health professionals frequently find it challenging to provide assistance to displaced Somalis with mental disorders or psychosocial problems due to distinct cultural and religious conceptualisations of mental health and psychosocial wellbeing. This is compounded by lack of understanding of the specific socio-political organisation of Somali society and the complicated migration history of the population (2,3).

Therefore, this review's aim is to provide information about the sociocultural background and contextual aspects of mental health and psychosocial wellbeing of the Somali population. It is primarily written for humanitarian staff involved in providing mental health and psychosocial support (MHPSS) to Somali people who have been affected by displacement, both within Somalia as well as countries hosting Somalia refugees, particularly within neighbouring African countries. The content of this review should assist MHPSS workers in the design and delivery of interventions to promote mental health and psychosocial wellbeing. It may also be relevant for other humanitarian professionals working with Somalis, and for mental health professionals working with Somalis in resettlement countries.

The specific information in this document complements more generic guidance, such as the *IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings* (4), *UNHCR's Public Health Strategy (2014-2018)* (5), and *UNHCR's Operational Guidance for Mental Health and Psychosocial Support Programming in Refugee Operations* (6).

Structure of the document

Chapter 2 contains essential background information to assist practitioners in gaining a broader understanding of the political, social, religious and legal context impacting Somali refugee and displaced populations. Chapter 3 gives a brief overview of the formal mental health services available to Somalis, primarily within Somalia. Chapter 4 provides information on the role of culture and context in the presentation and expression of mental disorders and psychosocial distress, and how such beliefs are explained and understood within Somali cultural and religious belief systems. Chapter 5 describes informal, religious and traditional healing practices in Somalia and health seeking behaviour among Somalis. Chapter 6 provides final remarks and a concise summary of the main issues that were discussed in this document. The reference list provides practitioners with key resources to further understand the issues contained herein.

Methodology

The report is based on literature review and key informant interviews conducted from August to November 2015. The methodology was adapted from the *'template for desk review of pre-existing information'* from the toolkit for *'MHPSS needs and resource assessments'* (7). A major source of information was the data collected by one of the lead authors, Massimiliano Reggi (a social psychologist and cultural anthropologist), during visits on the ground between 2003 and 2011 that led to his PhD dissertation in 2014 (8).

The search strategy used to create this primer was designed to capture relevant clinical and social science literature examining the sociocultural aspects of mental health within the Somali population. The main medical, psychological and social sciences databases (PubMed, PsycInfo) were searched for relevant information, up to June 2016, with additional searches on specific websites such as those of *'Bildhaan: An International Journal of Somali Studies'*, UNHCR, nongovernmental organisations (NGOs), and MHPSS.net. Moreover, relevant information has been collected through posts on TCPSYCH (the Transcultural Psychiatry mailing list and discussion group from McGill University in Canada).

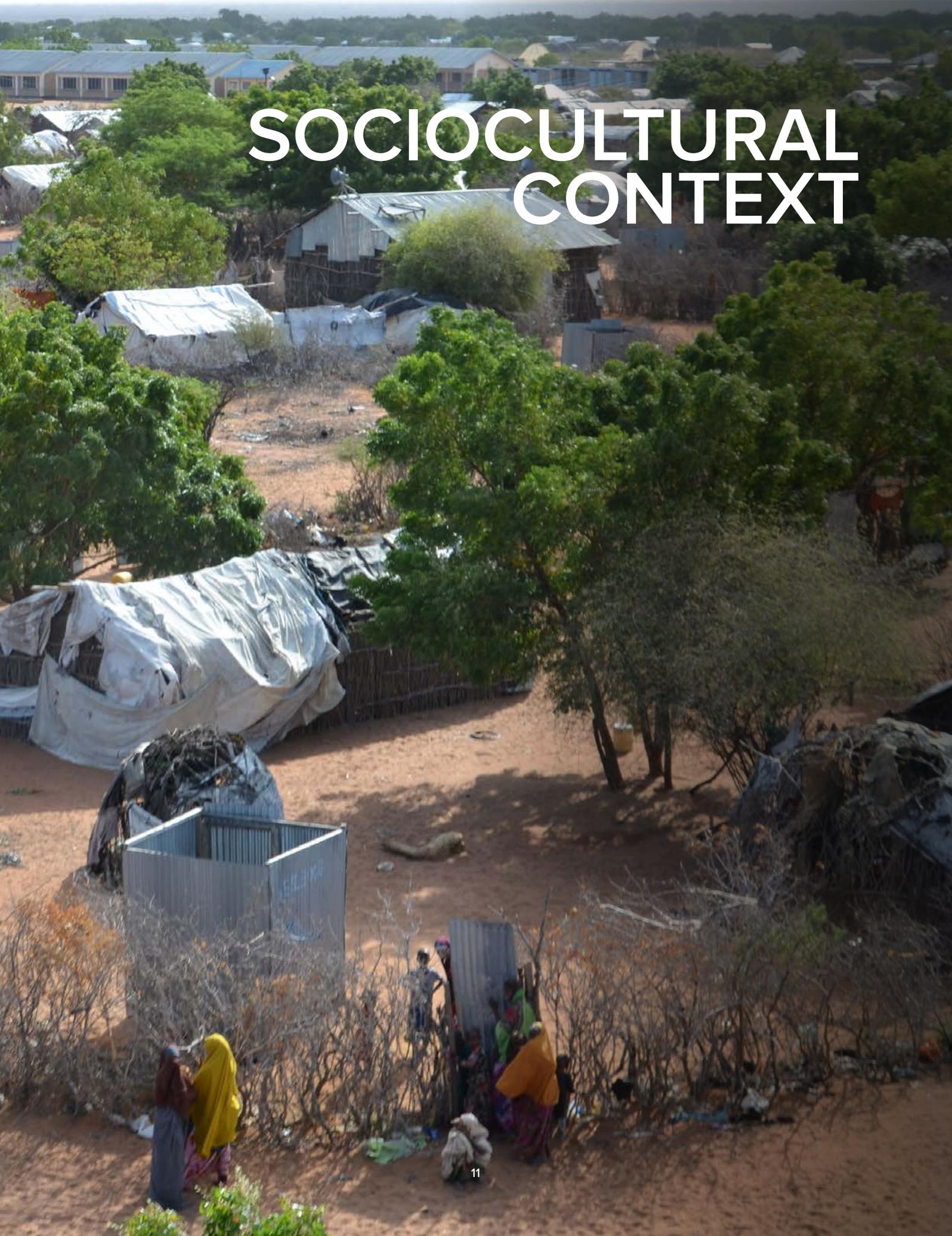
Search terms included combinations of the following terms: Somal*, psychiatr*, mental health, mental illness, mental disorder, psychosocial, immigrant and refugee. English, French and Italian language sources were included. The database search was supplemented with web-based searches in English, French and Italian media, as well as Google Scholar, to retrieve key books and other literature relevant to the Somali situation. Additionally, manual searches of the reference lists of key papers and books or articles relevant to Somali mental health were conducted. Important information was also found in assessment reports and evaluations by NGOs, intergovernmental organisations, and agencies of the United Nations (UN). Many of these were retrieved through direct communication.

The multidisciplinary team working on this paper included Somali mental health practitioners and academics, as well as others who were familiar with working with Somali refugees in the Horn of Africa. While this search strategy provided rich information, this review should not be taken as a fully comprehensive assessment of all issues related to mental health and psychosocial support for Somali people.

Disclaimer: this review has been commissioned by UNHCR and a wide range of experts have been involved in its drafting. The views expressed in this document do not necessarily represent the views, policies or decisions of their employers.



SOCIOCULTURAL CONTEXT



2. SOCIOCULTURAL CONTEXT

Somali people

Somali people inhabit the eastern parts of the Horn of Africa and are divided over several countries: Somalia¹, Djibouti, Ethiopia, and Kenya. They are an ethnically and culturally homogeneous group, distinguished by a shared common ancestry, a strong 'clan' system, a single language ('Somali'), an Islamic (Sunni) heritage and an agro-pastoral tradition (9). Somalis are traditionally nomadic herders or farmers, and are organised in patrilineal clans (through the line of the father) that provide safety, support and resources to clan members (10,11). The Somali language is the bearer of a strong oral tradition. It was converted into written form in 1972 (using Latin script) and has subsequently become the official language of government and instruction. However, many Somalis continue to rely on oral tradition today (12,13). Frequently, Somalis also speak Arabic (due in part to the religious influence of Islam), as well as Swahili, French, Italian and English (13).

The overwhelming majority of the inhabitants of Somalia are ethnic Somali, alongside groups who are not part of the Somali genealogical clans, but have been living in Somalia for centuries. The largest group in this population consists of the 'Somali Bantu' (Reer Baare / Jareer), a term used to denote various distinct groups of Bantu descent, who live primarily in farming villages along the river banks in the south (14,15).² Other minorities include Brawanese and Benadir / Reer Xamar, who are of mixed Arab, Persian and Somali descent, living mainly in coastal towns and involved in commercial activities (16–18), and the Bajuni fishing communities on the southern coast and islands (19). There are also minority groups who used to be seen as 'occupational castes', consisting of leatherworkers, such as shoemakers (called Kaba-tole, Midgan or Gaboye) and metal craftsmen or blacksmiths (Tumal) (19–21).³

Somali refugees and internally displaced persons

Refugees

Hundreds of thousands of Somalis have become refugees since 1991 when the government collapsed and a civil war broke out. The impact of collective violence and destruction of social structures was further compounded by a severe drought in 2011, which led to an increase in refugees to Kenya and Ethiopia (22). By mid 2015, UNHCR had counted 1.1 million Somali refugees. Most are in Kenya (in camps around Dadaab and in Kakuma, while others live in major towns) and in Ethiopia (in camps around Melkadida and Jijiga). In addition, approximately 234,000 Somalis crossed the sea to Yemen (23). Due to the war in Yemen, however, thousands have been forced to make the perilous journey back over the

1 In this report we use the term 'Somalia' to indicate the territory of the internationally recognized Federal Republic of Somalia including the 'Republic of Somaliland' that proclaimed independence from Somalia in 1991 and is, since then, self-governed.

2 The origins of the Bantu minority groups in Somalia are not entirely clear. Some may be descendants of migrant groups or slaves. Although there have been Bantu in Somalia for at least two hundred years, they are often viewed as foreigners and have a marginal position within Somali society. Some Bantu are well integrated into Somali society, while others maintain a distinct cultural and linguistic profile. It is only since the humanitarian crisis in 1991 that the various groups of Bantu descent have become collectively known by the term 'Somali Bantu' and have adopted this as an ethnic identity. Others prefer different, distinct terms, such as *Reer Baare* and *Jareer*. These terms are often value ridden and their use is sometimes indicative of political stances or affiliations.

3 Some of these terms can be perceived as derogatory and, therefore, one should be very careful using them for people who may not define themselves in those terms.

sea to Somalia. The largest Somali refugee communities outside of Africa are in the United States, United Kingdom and Canada (23), however, exact numbers are difficult to estimate as many former refugees became nationalised citizens. Some Somali scholars estimate the Somali community in the US to be well over 150,000 people, with similar figures for the UK, and around 100,000 for Canada (24).

Internally displaced persons in Somalia

Somalia itself hosts at least 1.1 million internally displaced persons (IDPs), most of whom are in the Benadir region in southern Somalia. Environmental aspects contributing to internal forced displacement are roughly the same as those for refugees: (armed) conflict, environmental hardships due to climate change, (prolonged droughts and flash floods), combined with inadequate resource distribution that is often exacerbated by clan based, ideological differences (25).

Political history

The opening of the Suez Canal in 1869 stimulated European expansion in the region. By the end of the 19th century, Somali people were living (primarily) under the rule of three foreign powers: British, Italians and French. In 1960, British Somaliland and the Italian administered 'United Nations Trust Territory of Somalia' became independent and merged into the Republic of Somalia. After the assassination of president Shermarke in 1969, Major General Mohammed Siad Barre seized power. The rule of Barre was characterised by political repression and human rights violations, including dissolution of the parliament, suspending the constitution and abolishing political parties (26). However, also during Barre's government, legislation was passed to improve the position of women. The enrolment of girls in schools increased, as did women's political and economic opportunities (27).

That notwithstanding, Barre's repressive regime faced increasing armed resistance, and from 1988 there was an outright war in the northeast of the country. The government collapsed in January 1991, with Barre fleeing the country in 1992, after which a civil war erupted among clan based, armed groups (28). Killings, lootings, sexual violence and the destruction of property led to large numbers of IDPs within the country, and to refugees fleeing to neighbouring countries. Many Somalis settled in refugee camps along the Kenyan coast in Malindi and Mombasa until 1998, when all the camps were closed and refugees relocated to Dadaab and Kakuma camps.

Over the years, the political violence turned into clan based, communal violence perpetrated on and by ordinary citizens who had previously been neighbours, acquaintances, friends, maternal relatives and in-laws. As a result, adding to the immense pain and suffering from death and the destruction of properties, mutual trust was also destroyed on a large-scale (29). The situation deteriorated into a severe humanitarian crisis involving the death of hundreds of thousands of civilians, which eventually prompted the international community to intervene militarily in 1992 (30). The UN mission '*Operation Restore Hope*', however, prematurely ended its military action after its troops were attacked in Mogadishu in 1995.

In the parts of the country the unrest continued. A peace process led to the formation of the Transitional National Government (TNG) in Djibouti following the Arta Peace conference (2000-2004). However, in the centre and south of the country, several factions perpetuated the armed conflict and rejected the authority of the TNG. The Somali capital, Mogadishu, was divided among various 'warlords', whose struggle for power paralysed the political and economic development of the country. In 2004, new peace talks led to the establishment of a new unity government, the Transitional Federal Government (TFG). Political divisions within this government were strong, and this hampered its effectiveness.

In 2006, the United Islamic Courts (UIC) seized the capital, driving the TFG out. Initially, the Islamic courts movement had considerable support in the country, but their popularity quickly dwindled with the growing influence of more radical groups within their ranks (31). In reaction to the rise of the Islamic Courts, Ethiopia, with support of western governments, started a military intervention to enable the TFG to regain control over Mogadishu, but this did not lead to durable stability and peace. While the Islamic Courts were defeated, their supporters regrouped in various factions. One of those groups, Al-Shabaab, became a jihadist terrorist group that is active not only in Somalia, but also increasingly in neighbouring countries (32). Joint military operations between the Somali military, the African Union and the United States has led to some stability and in 2012 the Federal Government of Somalia (FGS) was established, the first permanent central government in the country since 1991. After 2012, a process to become to a new Federation State has begun (33,34).

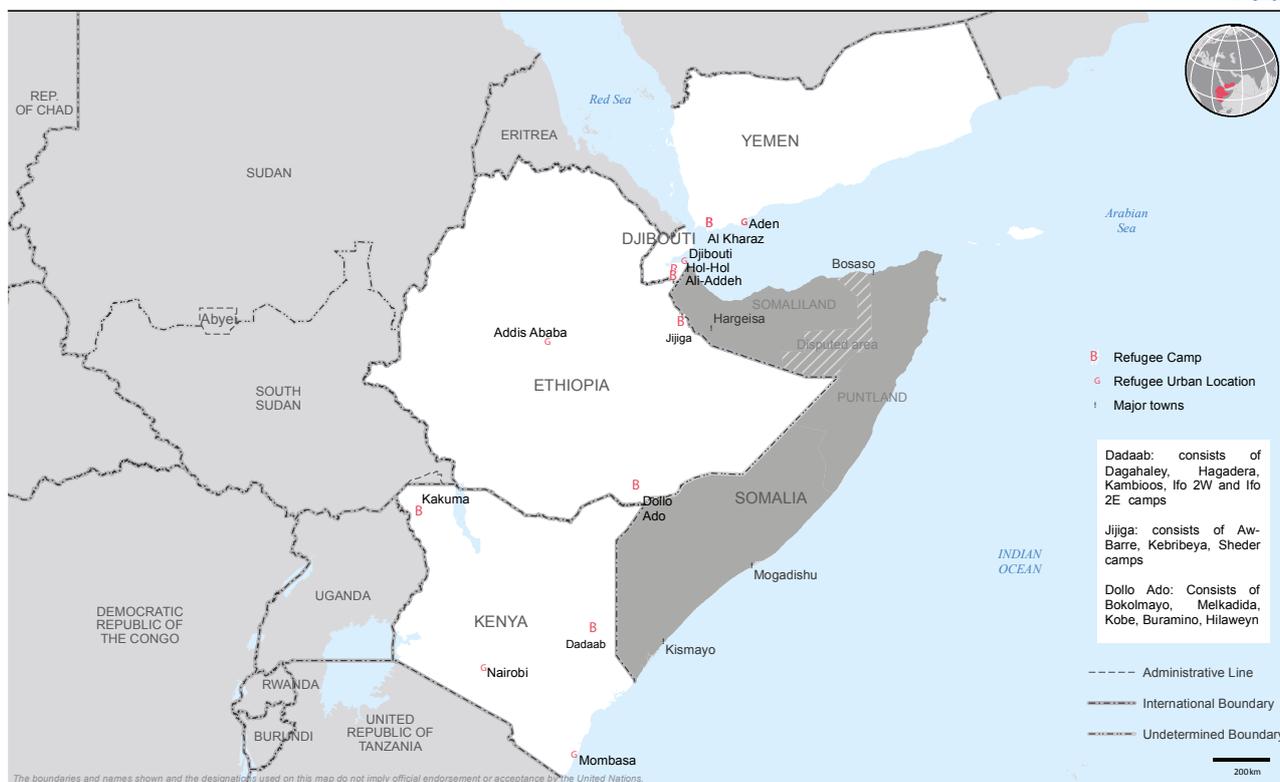
Regions

Somalia has six regions. Two of these form autonomous areas: The ‘Republic of Somaliland’ in the northwest (the area that till 1960 constituted ‘British Somaliland’) proclaimed independence from Somalia in 1991 and is, since then, self-governed. Today, the Somaliland Republic remains formally unrecognised by the international community, and has become a relatively stable area, with regular democratic elections and reasonably functioning state institutions (19). The northeastern region of Puntland declared itself an autonomous State in 1998, but within the framework of a federal State (‘The Puntland State of Somalia’). It also became a relatively stable territory (30). See Map 1 for details.

Map 1: Somali Refugees

Camps and urban settings

as of 09 Dec 2016



The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.
 Printing date: 09 Dec 2016 Sources: UNHCR Author: UNHCR - HQ Geneva Feedback: mapping@unhcr.org Filename: som_refugees_A4L

Religion

Religion has a comprehensive role in the life of Somalis: it is a belief system, a culture, and a way of life. The rhythms of the day, even at work, are organised around the timing of five daily prayers, both in rural areas and in cities (35). The obligatory payment of alms (*zakat*), and other charitable acts (*sadaqa*), benefit those who are less fortunate (36).

Additionally, the role of Islam has been crucial in providing a partial and temporary '*horizontal identity*' (37), which has helped rival clans to overcome their hostility (i.e. in the post 1991 and post 2006 social and political reorganisation). There is no formally organised clergy in Somalia, but men referred to as *wadaad* are traditionally considered to be more knowledgeable about religion. These religious authorities travel throughout the country to offer people their expertise (11), and in large mosque settings they are referred to as Sheiks. Beyond their religious roles, they also act as mediators between clans in cases of conflict. Additionally, they are considered traditional medical experts who offer blessings for a range of misfortunes, including: infertility problems, chronic illnesses, mental illness, and palliative care through amulets when medical treatments have not been effective (8,11).

Approximately 99% of the Somali population are Sunni Muslims.⁴ Traditionally, the practice of Islam in Somalia had been influenced by the Sufi branch of Islam, with moderate religious views. This is particularly true in the countryside and within the central areas of Somalia Sufi Islam is still strong. In the last decades, the Salafi school of Islam, with a more rigid interpretation of the Qur'an and limited tolerance for diversity, has gained influence in Somalia. Armed groups became increasingly ideologically committed to these more extremist forms of Islam, of whom the '*Harakah al-Shabaab*' (Youth Movement) has gained prominence over the last years (32,38).

Social structure

Clans and lineage

This section describes a key element of Somali social structure: social organisation through the lineage of common ancestry, often referred to as '*the clan system*'. This description is meant to give health workers a better understanding of such an integral aspect of Somali social organisation, without going into too many details. The role of clans in Somali life is controversial and sensitive, and several Somali scholars argue that the clan system is often misunderstood by outsiders, as well as simplistically depicted in over-deterministic ways (39). Nevertheless, health workers need to be aware that lineage and clan are often important social realities for their clients as this may shed light on the social support system and potential stress factors in the life of a client.

A key organisation principle in Somali social structure is a division in lineage, in which membership is determined through the father. This leads to a 'segmented' system of descent, in which genealogical lines meet at the top in one single male ancestor (17). Groups with a perceived common descent are

⁴ The five pillars of Islamic faith are: 1) faith or belief in the Oneness of God and the finality of his prophet Muhammad (*shahada*); 2) to offer five daily prayers at prescribed times (*salat*); 3) giving 2.5% of one's income to charity (*zakat*); 4) making a pilgrimage to Mecca, Saudi Arabia, at least once in one's lifetime (*hajj*); and 5) fasting from dawn until dusk every day during the period of Ramadan (*sawm*) (13).

often referred to as 'clans', 'sub-clans' etc., but the terminology in English does not fully correspond with the Somali term '*qabiil*'. The Somali word for patrilineal descent or kinship is '*tol*', so when Somali people who do not know each other meet, the first question is often not '*where are you from*' but '*who are you from*': '*Qolo maa tahay?*' (Literally: '*Who are your paternal kinsmen?*') (40). Knowing one's descent is important because it validates membership of a 'clan', and is a driving factor for both cooperation and opposition between groups. People rely on their clansmen for support and protection and, in return, have an obligation to support their own kinsmen when they need support and protection. All Somali people belong to a *diya*-paying group whose members, between a few hundred to a few thousand men, are obliged to support each other and to pay and receive 'blood compensation' ('*diya*' or '*mag*' in the Somali context – literally 'blood money') (9,17). For outsiders, the working of the clan system is often difficult to grasp because it marks 'invisible differences' between otherwise very similar people (41). The clan system can lead to changing alliances and temporary coalitions that may cause any one person, at any time, to stand in opposition to another (9,17). Further, this division is not primarily geographic, and it is, therefore, common to find a variety of sub-clans within the same area (35). However, while Somalis have had internal conflicts throughout history, they have also adhered to an overarching identity as Somalis in confrontations with outsiders (17). When the country became independent, people developed some sense of national identity as citizens of Somalia, but the civil war deeply affected this sense of identity. Currently, many Somalis feel a stronger sense of belonging to their clan or sub-clan rather than the broader Somali society (42).

The importance of clan and lineage is not easy to publicly acknowledge; however, it does have a significant impact on both community relationships and mental health. Health workers need to avoid getting caught up in clan dynamics or being perceived as 'taking sides' by their Somali clients. In fact, despite its changing role, clan identities continue to play an essential role in the life of many Somali, including those in diaspora. For example, for Somali refugees in Egypt, belonging to a clan is a primary determining factor for access to informal support within the Somali community. Various clan based groups have their own informal leaders and clan members feel responsible for each other. Community support continues to be organised around clans, with new or vulnerable refugees mainly finding protection through clan members and not through the more general Somali population.⁵ While this can have positive psychosocial aspects, the social organisation through clans can also have negative consequences in that those who do not belong to one of the major clans are more vulnerable to marginalisation and violence (43).

Xeer and diya

Somali customary law (*xeer/heer*) is an oral system of pre-Islamic origin and is often practiced for resolving social problems, for example when conflicts arise between families. When a problem has occurred, the elders (*xeer beegti*) come together to find an agreement between the parties involved. Cases are heard at the lowest and most genealogically recent level of the clan that is possible (44). The solution usually includes compensation to restore social order. *Diya* or *mag* (which literally means '*blood money*') is a compensation paid in cases of death, physical harm, theft or defamation (8,44). Payment for a crime or mistake by an individual is made by a person's entire *diya* group that is held collectively responsible for the deeds of its members. The system can be seen as a social contract to hold in check occasional conflicts that may arise between individuals and communities (39). This traditional, customary law still plays a significant role in Somali society, despite being increasingly replaced by western style systems.

5 Personal communication with N. Baron through email (04 April 2016).

Lifecycle

Among pastoralists, younger children stay with the mother and sometimes look after the smaller livestock, while adolescents are expected to assist with daily activities related to care of the larger animals. These tasks are gender specific: boys and young men are responsible for the camels, water supply and protection of the family from enemies and wild animals, whereas girls are responsible for domestic chores as well as sheep and goats (35,42). This traditional account of the Somali pastoralist life cycle does not do justice to the tremendous changes occurring over recent years to the lifestyles of many Somalis. For example, the urban population in Somalia is currently estimated at 39% (45) or higher in certain areas, and many Somalis hosted in refugee camps or who moved to urban locations have given up the pastoralist lifestyle.

During the Barre regime, primary education was compulsory in Somalia, but nomadic life styles limited the number of children who could take advantage of this, and the collapse of formal institutions during the war have created a generation where many do not have a primary education. Only 42% of children of primary school age are in school; of those in education only 36% are girls, while in pastoralist communities this percentage is even lower (11,46). Primary education is available in the refugee camps in Ethiopia and Kenya, but many Somali refugees prefer to enrol their children in qur'anic schools (*duksi*) so their children able to read and write, learn appropriate behaviour and gain religious knowledge before they are sent to formal education (47).

Older people are held in high esteem and retain strong social power. Being considered an 'elder', however, is related more to the role people have within their clan rather than age alone. As a result and regardless of age, a religious leader (sheikh), or a traditional leader (*sultan*, or *boqor*, 'king') are considered to be 'elders' because of the authority invested in their function (8). The term *Hajji* is used as a term of respect for someone who has been on pilgrimage to Mekka.

Family and gender relations

Family

The (extended) family plays a crucial role in support and social care, and family honour and loyalty are deeply valued. This is also largely true for the Somali family in diaspora. In Somalia, approximately one-fifth of the population lives in polygamous household situations, with wives having their own residences (13). It is commonly acknowledged that the first wife of a husband is often distressed when her husband decides to marry another woman. Marriages are often arranged, and are traditionally considered to have strong political and economic value (11). Many Somalis highly value the Islamic prescriptions regarding the family: 1) marriage is a religious duty and social necessity; 2) sex outside marriage is prohibited; 3) the husband is obliged to provide for his wife; 4) the wife's obligation is to obey her husband; and 5) there is an obligation for the family to be kind to one's relatives and have concern for their wellbeing (36). When a woman marries a man of another clan, she is absorbed by that clan, although she retains connection with her own family and keeps legal ties to her original clan. This protects the basic rights of the woman and safeguards her interests (35,36). Throughout history, cross-clan marriages were used to create bonds between clans, but during and after the civil war marriage within the clan and sub-clan became the preferred choice in order to reduce the chance of falling victim to inter-clan conflicts (36).

Traditionally, when a man dies, his wife is offered in marriage to her late husband's brother in order to ensure that the children are supported by his family and clan. This also guarantees the financial security of the family and keeps children connected to their clan and community. A widow can also choose to find another husband, or remain a single parent. Often, the deceased husband's brothers or extended family will assist the widow and her children simply because the children will always remain members of the father's clan (48).

The strong role of the family in Somali life is a major asset and an important source of social support when people become ill. However, it can also lead to strong pressures to conform to traditional roles, which may generate tension between loyalty to the family and pursuing individual aspirations. The protective role of the family may also be affected when families have been separated due to conflict and displacement.

Gender

Women and men are generally expected to fulfil different, but complementary, obligations as partners, family members and members of the community. Men, as heads of the household, are responsible for the financial wellbeing and safety of the family, for security of the herds and for securing water (11,42). Traditionally, the role of women is to do the household chores and take care of the children and elderly. Nomadic women also search for firewood, load and offload the camels, erect and dismantle the traditional shelter (*aqal*), keep count of the livestock, manage the consumption and sale of its by-products, and craft mats and utensils for the household (36). They also take care of goats and sheep, while men are responsible for camels. Within Somali society, women are required to show modesty (*xishood*) and not bring shame to their family by immodest or immoral behaviour (49).

However, it should be understood that the traditional depiction of Somali women as mothers or wives, with roles merely related to domestic and economic tasks in the household is too simplistic, and has been strongly criticised (50,51). Somali women are certainly not powerless, as the depiction would suggest. One Somali saying states that while a man is the head of the household, a Somali woman may consider herself the neck, being instrumental in directing the position of the head.⁶ Older women, particularly in refugee settings, also have significant influence within the community and family. Traditionally, women gather every Friday afternoon and share their experiences with younger female members of the community.⁷

Somali women generally have considerable freedom to learn, work, travel and make decisions (13,49). Moreover, Somali women increasingly play important economic roles in farming, herding and (in the urban centres) in business. The war, drought, and male migration have significantly increased the number of female-headed households. Additionally, the long-term collapse of the economy after the war changed gender roles in family domestic economies where the limited labour market available became more favourable to women (35). However, in some regions women have less freedom due to armed conflict and the rise of radical groups. According to a 2002 socio-economic survey in Somaliland, women are breadwinners in 70% of households (52).

Also, traditionally, women have limited access to leadership roles in the political sphere. Even in modern times, the participation of women within the formal political process is limited, although since 2012 women have been appointed as ministers.⁸

Sexuality

Sexuality is a sensitive topic. Somalis, like many other people, do not easily or openly discuss sexuality (53). Traditionally, chastity in women is highly valued and it is often considered shameful for a woman to show openly, even to her husband, that she enjoys sexual activity (53). A girl's or woman's behaviour reflects on both her family and her clan, therefore, girls' behaviour is much more constricted compared to that of boys and men. A girl or woman who steps out of the culturally proscribed bounds might be

6 Personal email communication with R. Pratt (20 March 2016).

7 Personal email communication with U. A. Maung (04 April 2016).

8 Edna Ismail was appointed minister of foreign affairs in early 2000 in Somaliland, and there have been women ministers in Somaliland, Puntland and Somalia in seats like women and family affairs, health, education, foreign affairs and democracy.

severely punished or shamed, and she and her family might lose face. If a woman is unhappy about her sexual relations with her husband she cannot complain openly, but can seek ways to express her discomfort in indirect ways. For example, a woman may say things like *'my husband does not see his children enough'*, while meaning that her husband does not pay enough attention to her and she is dissatisfied with their sexual relations.

Sexual norms in diaspora are changing considerably. Observations of Somali women in the UK show they are not as constrained by traditional societal norms and many have had more than one relationship, which may have been ended by either side.⁹

Men and boys have more freedom and male sexuality is strongly connected to notions of masculinity and strength and the ability to produce children, in particular sons (20).

Homosexuality is (usually) not accepted in Somali communities. It is often not considered a Somali issue, but rather an outside problem. A man who does not have sex with a woman is called *'khanis'** or *'qanis'**, which indicates any man who does not have sex with a woman for any reason, such as an illness (e.g. erectile dysfunction) or homosexuality.¹⁰ Families may exclude a homosexual person, but, if homosexuality is not openly manifested, a man could leave without being excluded.⁹ Homosexual Somalis often hide their sexuality for fear of discrimination, social exclusion and potential violence, including death. The penal code of 1964 describes homosexual acts as illegal and punishable by imprisonment from three months up to three years. The new provisional constitution, adopted by the Federal Republic of Somalia in 2012, asserts that all laws must be compliant to Islamic Shari'a law. According to Shari'a law, homosexual acts are punishable by the *'death penalty or flogging'* (54). The organization Queer Somalia reported in 2004 that *'whether through suicide following pressure from families or via loosely applied Islamic law that is uncontrolled due to the lack of a central government, their greatest fear is death—a sentence that can be brought upon them just for being homosexual, or for being perceived to be homosexual'* (55).

Gender based violence

Violence against women and girls is widespread across Somalia, notably in politically unstable areas, with increases of such violence during military offensives (56). Conflict and displacement have heightened Somali women's and girls' vulnerability to sexual violence (57,58). During the civil war, sexual violence was used as a weapon to shame, punish or disempower opposing clans (11,49). In refugee camps, sexual violence may occur when women and girls are collecting firewood or have to use the forest as a latrine (11,57). Women who have lost husbands, fathers or brothers are particularly vulnerable to sexual violence (49). In cases of rape, a woman may be blamed by her family for bringing shame to her clan. If a perpetrator is known, traditional clan leaders often negotiate compensation between the perpetrator's and survivor's family, and unmarried girls may be forced to marry the perpetrators of their rape (58,59). Alternatively, the woman may be forced to marry an older man to cover up the disgrace brought to the family.¹¹ Problems with fertility are often blamed on the woman and may lead to divorce. Early marriage is relatively common in Somalia, and in refugee camps poor families have been reported to marry their daughters to wealthy and older men in order to escape their impoverished economic situation.¹²

9 Personal email communication with E. Palazidou (27 April 2016).

10 Personal email communication with J. Abdulcadir (10 April 2016).

* This is term that can be perceived as derogatory.

11 Personal email communication with J. Kivelenge (03 December 2015).

12 Personal email communication with U. A. Maung (04 April 2016).

Female genital mutilation

The term 'female genital mutilation' (FGM) (sometimes referred to as 'female genital cutting') refers to all procedures involving partial or total removal of the external female genitalia for non-medical reasons (60). Most women in Somalia (around 80-95%) have undergone this traditional practice. The form that is most widely practiced is infibulation: removing the external genitalia and stitching or narrowing of the vaginal opening (61,62). The UN considers this the worst form of FGM. The practice is called '*gudniin*' in Somali, which refers to both female and male practices of FGM/ circumcision. It is often done within the privacy of their homes and usually performed by traditional circumcisers (*guddaay*). However, increasingly, it is also performed by professional health providers. Many Somalis are deeply convinced that the procedure is required for hygienic reasons and to maintain chastity of women. *Gudniin* is considered a form of purification (*xalaalayn* or *halalayn*) and women who have not undergone it are perceived as physically and spiritually unclean (63). Additionally, it is considered important to ensure virginity until marriage, to ensure that the woman's children belong to her husband (61). Somali girls usually undergo the practice between the ages of four to ten. Many parents often choose this practice for their daughters out of fear of stigmatising attitudes within the Somali community against women who have not undergone the procedure, and a perceived negative impact on their daughters' chances of marriage (58,64). Also, parents may fear their daughters may become overly sexualised (61).

In Somalia and in Somali refugee camps, FGM is being combatted through large-scale programmes financed by international donors, and attitudes are slowly changing. In the diaspora, due to interactions with other cultures, strong legal barriers, weaker intergenerational households and greater interaction with medical professionals, many Somalis are starting to consider reshaping this particular cultural practice (65).

Changing Somali social structures in refugee camps and in diaspora

Somali social structures are deeply informed by religious beliefs, cultural traditions and socio-political conditions. Decades of political unrest, civil war and drought led to large-scale international refugee and migration flows.

Changes due to life in refugee camps

Life in huge refugee camps in the neighbouring countries, particularly in Kenya and Ethiopia, is to a large part dependent on humanitarian assistance. This has led to changes in social patterns. Being dependent on external assistance without a realistic prospect for change often gives rise to loss of self-esteem and a sense of lethargy, passivity and nostalgia (66,67). The emphasis of providers of humanitarian assistance on gender equality and respect for women's rights leads to changes in gender relations and opportunities for Somali refugee women to get education and employment but can also give rise to social tensions and frictions between men and women.

Changes in diaspora

The emergence of a Somali diaspora in countries across the global north and south has fostered the development of important new forms of Somali social relations and identity. The strongly gendered social norms of Somali social life have largely continued among Somalis living outside Somalia, but they are also being deeply transformed (68–70). In South Africa and Egypt for instance, many female-headed households have emerged. This has raised the status of women within their families (71,72). In the United States, Canada and the UK women are actively pursuing tertiary education.

Restrictions to perform paid work during the long asylum procedure in western countries affects the social status men once enjoyed in Somalia (51). Somali men in diaspora often claim that their role as a man is not recognised within the new setting, with much of their male authority having been lost or transferred to the welfare state (73). In the UK for example, *khat* use has been an additional major factor in changing the gender roles in Somali diaspora, until the recent ban. Some British Somali women describe themselves as ‘*single mothers*’, irrespective of marital status, as they consider the husbands absent from day-to-day family responsibilities, leaving the women to deal with the welfare system, children’s education and other responsibilities normally considered to be within the male domain.¹³

Sending remittances to relatives in Africa is a responsibility that most Somalis cannot avoid. Clan leaders may request their members in diaspora to contribute resources to support the clan and/or clan members (68). The pressure to send money home provides an impetus to remain involved in clan life, but also adds to the stress many refugee and migrants already face.

In addition, differing cultural contexts bring further stress to family life. For instance, aging is viewed quite differently in Somalia as compared to North America and Western Europe, where it is often accompanied by concerns about social isolation and different intergenerational expectations (74). Within Somali communities in diaspora, clan based identities remain important characteristics of self-identification, inter-group functioning and community structures. In South Africa for instance, Somali community groups, businesses and even housing arrangements are strongly informed by clan identities (75). The use of new technology has also shaped Somali social life. Social media is used to remain in touch with families and friends, obtain information on migratory, resettlement and asylum processes and routes, contribute to transnational clan and family processes, and cope with the social pressures resulting from diaspora. However, the possibilities of remaining connected through new technology may also perpetuate clan based divisions. Although mobility can be an opportunity to reconfigure social norms, it also can perpetuate them (72).

13 Personal email communication with E. Palazidou (27 April 2016).



MENTAL HEALTH CARE IN SOMALIA



3. MENTAL HEALTH CARE IN SOMALIA

Mental health services in Somalia

Twenty-five years of civil conflict have destroyed infrastructures, resulting in an underdeveloped and poorly resourced health system (76–78). The public health care system relies strongly on national and international NGOs in urban and other (secure) locations (76).

Formal mental health care

There are very few specialised mental health services in Somalia, with most documented information available from the northern parts (Puntland and Somaliland). People often stay for very long periods in hospital, with some patients staying up to 18 years (76). Somaliland currently has three mental health departments in Hargeisa, Boroma and Burao, and two dedicated mental health hospitals in Berbera and in Gebilay. The public mental health hospital in Berbera used to be a prison, but was then transformed into the first mental health hospital in Somaliland with assistance of NGOs. Families were required to sign a ‘non-abandonment contract’, to ensure that the family continues to pay for and provide resources to the patient throughout the treatment. In Puntland, there is a mental health department within Bosaso General Hospital with both inpatient and outpatient services. The town of Galkayo also has an outpatient service at General Hospital.¹⁴ The Habeeb Mental Health Foundation operates mental health services in Mogadishu (79).

Private mental health facilities

In recent years, private centres have flourished in the main towns. Some are offering a wide ranges of services, others are no more than a repository for mentally ill and do not have any competent staff. There are at least 11 private centres in Somaliland, four in Puntland, and two in Mogadishu. Centres that offer mixed religious and psychiatric-like treatments also exist. The private sector often appeals to health workers because of better working conditions and salary. It is common for doctors or nurses with some background in mental health to work in both public and private clinics.

Many private clinics have been established and are run by psychiatrists coming from the diaspora for some weeks per year while handing over for the remaining months to general health workers without formal qualifications. With the exception of the newly qualified, most doctors work exclusively in the private sector and have not received any continuing professional development (80).

With some significant exceptions, conditions in private mental treatment centres are often bad due to overcrowding, poor hygiene, restrictions on freedom of movement, lack of adequately trained staff, and lack of meaningful activities for patients. Forced seclusion and prolonged isolation are used frequently, including as punishment for aggressive behaviour of residents (78,81). Involuntary admission without proper medical evaluation is widespread and forms a particular problem in private centres as owners are inclined to accept any patient as long as the family pays the bill. The majority of private centres do not keep clinical records of the patients.

14 Personal communication with hospitals, October 2016.

The lack of essential psychotropic drugs is a concern for both the private and public sector. When pharmaceuticals are available, particularly in the private sector, there is a serious risk that they are counterfeit (10,76,82).

Initiatives to strengthen mental health care in Somalia

In the past decade, there have been improvements in the clinical management of main public facilities with ameliorated conditions for patients, mostly chain-free. Community based psychosocial programmes, linking home based rehabilitation to clinical management at public facilities, are sporadically available, based on availability of intermittent funds. The Italian nongovernmental organization GRT is an international organisation that is consistently involved in the development of the mental health sector in Somalia. Since 2008, all doctors from the main universities in Somaliland have received training in mental health face-to-face with international experts, supported online before and after through a partnership with King's College London (83). Since 2008, formal mental health training has been introduced in Amoud and Hargeisa University Medical Schools. There are no specialists in psychiatry, but through these universities general practitioners receive training in mental health. The training includes a psychiatry rotation at the general hospitals, but this is very short and lacks supervision.¹⁵ Additionally, a short mental health course of around ten days has been included in the undergraduate medical and nursing school curricula in Somaliland. International experts regularly organise trainings and provide online support (83). Lastly, there are sporadic mental health courses organised by international organisations (e.g. WHO and GRT). Most of the mental health workforce is represented by nurses who have attended these short courses.

Mental health policy

Lack of regulation is a severe, overarching problem as it allows anyone to open a pharmacy or a health care facility (76). However, change has begun. The first Mental Health Policy was developed in Somaliland by the Mental Health Policy Working Group organised by Ministry of Health and the nongovernmental organization GRT (77). This represented the first policy attempt to address mental health within the Somali context. After the policy was approved in 2012, numerous meetings with different stakeholders have been organised to translate the policy into practice, but progress is slow. In Puntland, a draft and road map for the development of a similar policy has been undertaken, but is not yet completed. For the south and central regions of Somalia no mental health policy has yet been drafted.

In refugee settings in neighbouring countries

In the large refugee camps near Dadaab and Kakuma in Kenya, and Dollo Ado and Jijiga in Ethiopia, a range of health and social services are being provided by NGOs supported by UNHCR. Over the years, mental health care has been integrated into the general health services of these camps. Typically, a health facility within a large camp has a small mental health department with a national psychiatric nurse who is, more or less regularly, supervised by a psychiatrist and assisted with identification and follow up by a team of trained refugee volunteers (84–87). The integration of mental health into refugee primary care is done utilising standardised training materials from the World Health Organization and UNHCR (88,89).

Such interventions in the health sector are complemented by a wide range of psychosocial activities in the community, often with the assistance of refugee volunteers who have followed training in psychosocial counselling. Such activities may include: community centres, child friendly spaces, group counselling, and livelihoods activities (67,90–92).

15 Personal communication Claire Green and Peter Hughes, October 2016.



Dollo Ado, South East Ethiopia / Habibo Wehliye is 38 years of age. Sixteen months ago Al-Shabab forces killed three of my children, she says. (2009). © UNHCR / P. Wiggers

MENTAL HEALTH

4. MENTAL HEALTH

There are no reliable and comprehensive epidemiological data on mental health problems in Somalia due to limited research capacity and poor collection of routine data in health centres.¹⁶ The level of mental distress among people in Somalia is thought to be high (76), and risk factors for developing mental disorders are abundant within the Somali context: loss of people, property and status, disrupted interpersonal relations and social networks, severe and recurring traumatic experiences, displacement, insecurity, uncertainty for the future, and substance abuse (8,93). In some settings, almost all Somali had been confronted with at least one violent event, including witnessing severely injured people, being caught in a combat zone and being in close proximity to shelling or mortal attacks during the previous 2 months (94).

In general, it is challenging to obtain credible prevalence figures on psychological distress and mental disorders across cultural and language boundaries, and even more so in complex humanitarian emergencies. Also, it should be remembered, that while many people may have experienced significant psychological distress, this is not necessarily indicative of mental disorder. The available prevalence data vary widely and give inconclusive results. For example, based on research with brief non validated, self-report questionnaires, Somali refugees in Uganda had an estimated prevalence rate of posttraumatic stress disorder (PTSD) of 48% (95), and in Nairobi this was 62% (96). Among women attending a primary health care clinic in Mogadishu, nearly one third had significant PTSD symptoms as measured with the Somalia-Posttraumatic Diagnostic Scale (94). In contrast, a study among more than eight thousand ex-combatants throughout Somalia, reported symptoms possibly associated with PTSD in 5.6% of the sample, whereas in the north of the country, the figure was 2.1% (97). In Somaliland, a large study among adult males reported an 8.4% prevalence of mental health disorders among the general population and 15.9% among ex-combatants (98). Research among Somali refugees living in Europe estimated the prevalence rate of PTSD to be around 4%, a much lower rate than refugees from other countries in the same research, even though Somali refugees had been exposed to at least as many potentially traumatic experiences as the others (99). In contrast, research among Somali adolescents in the United States found much a higher prevalence (around one in three) for PTSD and other mental disorders (100,101).

The interpretation of these diverging data is difficult due to many factors related to research samples, as well as to the quality and comprehensiveness of the instruments (102,103) and their sensitivity to tap into locally salient manifestations of mental disorders. In particular, prevalence estimations with non-validated, brief, self-report questionnaires have to be distrusted because of the conflation of 'non-disordered distress' with mental disorder. It is, therefore, important to devise appropriate new tools or carefully adapt and validate existing psychological measures (104). Some work to develop and validate mental health instruments has been done with Somali refugees in the United States (105–107).

As in many other conflict affected populations, much research on mental health among Somalis focused on PTSD and its relationship to past experiences, such as facing forced migration, famine, the possibility of death, suffering loss, serious injury and torture (49,108). This is however only one part of the spectrum of mental health problems. It is important not to overlook severe mental disorders, such as psychosis and bipolar disorder, which can be expected to increase in prevalence within humanitarian settings (7). Conditions existing during armed conflict and flight to refugee camps may put those with pre-existing

¹⁶ This section is not meant to be a systematic review on the epidemiology of mental disorders among Somalis. We refer interested readers to consult the cited references for more details

severe mental illness at particular risk of neglect, abandonment or abuse (109). Similarly, epilepsy, a substantial cause of disability in low income countries (110), may be more prevalent amongst refugees because of heightened exposure to head injury, asphyxia during complicated delivery, nutritional deficiencies, and brain infections.

Recently, more attention is being given to the role of daily stressors on the mental health of Somali, particularly in post migration contexts (105,111), to factors promoting resilience (101,112,113) and to the risk factors for psychotic disorders such as *khat* use and traumatic experiences (114,115).¹⁷

Cultural concepts of mental health and idioms of distress

In Somali language and culture, various concepts indicate states of impaired mental health (116). The concepts have both similarities and differences to psychiatric terminology, but it is important to avoid reducing local expressions into western diagnostic categories (117). It is challenging, as well as probably impossible, to give a fully coherent overview of Somali terminology around mental health. Firstly, there are strong regional differences and meanings of words can vary widely. In the northern regions, various Somali expressions are used that can be translated as ‘an illness of the mind/head/brain’. These include *Cudurada dhimirka/ dhimir / dhimiris* or *Xanuunka madaxa/maskaxda* (10,118). These terms are however not used everywhere in Somalia. Secondly, many Somali terms related to mental states often refer to specific behaviour, which makes them hard to translate into other languages. Somali speakers will easily understand the underlying meaning, while outsiders may not easily understand what is meant when expressions are translated literally. Thirdly, Somalis have a huge vocabulary of terms that describe activities or states that may be indicative of mental disorder, but that may also be used to describe behaviours that are transient and not considered as indicative of illness.

Severe mental disorder

The word *waan* is widely used both throughout Somalia and within refugee communities to define a person affected by a severe mental illness. *Wali**, literally translated as ‘craziness’ or ‘madness’ (8), is a word used when someone shows severely abnormal behaviour (119). Forms of mental illness without severe behavioural disturbances are not considered *wali* and do not have the same negative societal implications (8,120). There is a range of expressions used to describe signs or signals that can indicate that *wali* may be manifesting (See Table 1).

¹⁷ Unusually high rates of psychotic disorders have been found among young male Somali refugees resettled in the USA (114) and in Somalia (97).

* *Wali* and *waan* are terms with strongly negative connotations.

Table 1: Somali terms related to mental disorder (modified from Reggi 2014) (8)

Expression	Translation	Interpretation
<i>Siiba waaqaca</i> or <i>Laga dhuunto</i>	'That person is crazy' 'people hide from him because he is violent/dangerous'	The two expressions can be used separately or together. Together they mean that people run away from the person because he/she is crazy.
<i>Waa orday</i>	'He runs away/ he is out of control'	
<i>Dhagaxyeysey/ dhagaxtuur</i>	'He is throwing stones'	
<i>Daah ka kashif</i> <i>Waa kadhigay</i>	'Unfolding/exposing what is behind the drapes' 'He lost it/ put it away'	This expression is used to indicate that the person has lost the capacity of making good judgment and now shows what is secret/ private (the person is unable to differentiate between what is public and what is private behaviour). This indicates that the person crosses the cultural line between 'sane' and 'insane': the person puts away the clothes because they have lost their mind and cannot even dress themselves anymore. Both expressions indicate the onset of mental illness, to the point that the person is unable to dress themselves.
<i>Isla hadlaaya</i>	'Talking alone/to himself'	May refer to a person hearing voices or seeing things that are not there.
<i>Hadal-badan</i>	'Talking too much/ incessantly'	
<i>Aad u fikiraayo</i> or <i>walac badan</i>	'Thinking or worrying too much'	

Additional behaviours that are looked at with suspicion include: yelling, eating from dumpsters, crying, losing control of yourself (*maskaxdaa isdhaafsan* or *wuu waalan yahay* or *madaxaa looga jiraa*: translated literally as 'the brain is mixed up'), loss of hygiene (*raamoolle*: translated as 'having uncut/ uncombed hair'), and being aggressive (10,121).

Within professional psychiatric classification, *waali* would refer to psychotic states (including mania and delirium), in particular the chronic forms (8,121). Labelling someone as being *waali* may lead to social exclusion, isolation and stigmatisation. Persons who are *waali* have an almost total lack of access to marriage and employment, and are usually excluded from taking any form of responsibility within the family or community (8).

The condition of *waali* is thought to be irreversible, as illustrated by the saying *Lafjabtay sideedii manoqoto*, translated as 'a broken bone cannot be fixed' (8). Even when the symptoms are reduced or controlled and the person is medically and spiritually healed, it is very challenging for them to heal the broken social and political relationships. Sometimes, the wider family circle may accept the person when he/she is in a better condition, but socialisation back into the wider community and in the public space remains problematic. One of the problems that many '*walaan*' encounter is a strained relationship within their neighbourhood. These social considerations often prevent real rehabilitation. (8)

Mild to moderate mental distress

The lives of many Somalis have been marked by an abundance of loss of loved ones, of houses, jobs, herds and other means of livelihoods, but also of status, landmarks, protection and trust. These massive losses cross the collective history and individual biographies of many, creating a rich vocabulary to indicate negative emotional states (e.g. states of sadness and demoralisation) (See Table 2). Emotional suffering is primarily expressed in somatic jargon: headache, trouble sleeping with nightmares, forgetfulness, loss of appetite, chest pain, stomach pain and/or pain in the liver (*beer xanuun*) (8,120).

In Somalia, the traditional concepts for mental distress are much more fluid than psychiatric, western categories (118). People who suffer from mental distress, but do not act ‘crazy’, are usually not seen as ‘mentally ill’, and the description of distress may not fall into any specific western psychiatric category. However, these conditions may lead to serious suffering if the person is not able to recover from them. As mentioned in the WHO report, ‘*mental health (caafimadka maskaxda) and treatment (daawayn) are still relatively new concepts among many Somalis*’ (76). For that reason, when talking about mental distress it is always important to remember that emotional states, by themselves, are not the central concern of the Somali population. Zarowsky highlights the fact that ‘*there are abstract terms for what are considered emotional states, but these words are always linked to concrete experiences*’ (122). In Somali culture, mind, body and spirit are seen as a whole, and for many Somalis it may be odd and unusual to define their distress in psychological terms.



Somali refugee at Ali Addeh camp in Djibouti (2011).
 © UNHCR / A. McCauley

Table 2: Local expressions for mild to moderate mental distress (including anxiety and sadness) * (8,10,121,123)

Expression	Translation	Interpretation
<i>Murug</i> (or <i>murugo</i>)	Sorrow/ sadness	The person thinks incessantly about an insolvable problem or loss, leading to a state of sadness. It is associated with headaches, loss of appetite, social withdrawal, poor sleep, tearfulness and sleep difficulties (117), but sometimes also more serious symptoms such as ‘ <i>seeing things others cannot see</i> ’. <i>Note:</i> It indicates a spectrum, ranging from ‘ <i>every day</i> ’ sadness to very serious depression that is associated with physical manifestations (e.g. headache, loss of appetite, crying, trouble sleeping, social isolation, feeling hot (117,123).
<i>Qalbi-jab**</i>	Broken heart (<i>Qalbi</i> means heart)/ disappointment/ unhappiness/ (<i>Qalbijabsan</i> indicates desperation)	The term indicates a state of sadness and hopelessness. It is associated with a wide range of life events including: abusive family relationships, sudden impoverishment, love disappointments/ jealousy (e.g. when a husband takes a second wife), infertility, impotence, excessive rumination (e.g. thinking over and over again about goals in life that cannot be achieved) and death of a close relative. It may lead to insomnia, concentration problems, social withdrawal and losing all pleasure.
<i>Niyad-jab**</i>	Demoralisation Broken morale or will (<i>Niyad</i> refers to the soul, spirit)/ unhappiness, hopelessness	The person is disappointed and demoralised after losing hope. It can be triggered by loss of livelihood and, particularly in women, by the death of a child.
<i>Han-jab**</i> (less common)	Frustration (<i>Han</i> means desire to, but also pride, self-esteem, reputation, respect for oneself, or ambition)	The person is frustrated and disappointed because he/she cannot do the things he/she wants, or cannot achieve his/her ambitions.
<i>Buufis</i> (or <i>boofis</i>)	Balloon filled with air	It is used to indicate people dreaming of or longing for resettlement, mostly overseas, but also to indicate madness can occur when the dream of going overseas is shattered. In the last sense, it used to indicate the state of anxiety, sadness and distress that is related to waiting in vain for migration and resettlement; the person is obsessively thinking about travelling abroad and how to achieve this dream. It conveys the idea of the comparison between one’s life in the camp and others’ lives elsewhere. It may also be related to negative life events in the past (such as traumatic war experiences) and can lead to a loss of confidence in the human condition. Even though not everyone agrees, <i>buufis</i> is, in some geographical areas, considered a mental illness or jargon to label people acting oddly.
<i>Welwel</i>	Worry/ concern	The person’s problems are always on his/her mind. The person is obsessed, worries compulsively (e.g. the word might describe a person who tries to be clean all the time because of a great fear of getting sick), may be anxious, agitated and/or nervous. It is not regarded a mental illness in itself, although it could eventually lead to severe mental disorder (<i>waali</i>).
<i>Qulub</i>	Disappointment/ frustration/ sadness /defeat	The term can be related to a major disappointment and frustration (e.g. a negative decision after a resettlement interview, or loss in a competition), or a deep sadness related to loss. Sometimes INGO staff use the term to also indicate ‘ <i>psychological trauma</i> ’.

*Interpretation of terms may diverge significantly depending on the location where they are used, sometimes even only at a distance of a few hundred kilometres. These expressions are usually used while also describing the contextual events, so that they gain a more specific meaning (8).

** The term *niyad* refers to the spirit, soul and the heart, to the totality of the person (124). *Jab* means ‘to break’, but also ‘defeat’ and ‘loss’. It is used to indicate things like a broken leg, a vase that falls down and breaks, or as an adjective (*jabi-og*) to indicate something fragile and delicate (8).

Specific Mental Health Problems

This section will provide information about specific problems, using the classification of professional psychiatry.

Psychosis (including mania)

As mentioned above, the term *waali* indicates severe mental illness, that could be classified within the Western category of psychosis (including schizophrenia), but more broadly mentally unfit. *Wuu isla hadlayaa*, which means talking to oneself and may be indicative of auditory hallucinations, is seen as the hallmark of *waali*. There are no specific Somali words to indicate manic states. The person suffering from it may be described as being *wuu kacsan yahay*, which means to be ‘up, elevated, agitated, violent’ (literally; ‘he is high!’), and symptoms of being ‘out of control’(8).

Depression

As mentioned in Table 2, *murugo* is the most common word to indicate states resembling depression, ranging from ‘everyday’ sadness, stress, or disappointment to very serious depression that is associated with physical manifestations (117,125). Among Somali, depression is conceptualised in a way that is indistinguishable from everyday life struggles and survival (126). The main causes of *murugo* are thought to be traumatic or distressing external events (clearly identifiable structural and social events and situations) such as war events, life in refugee camps and financial stress while living abroad after resettlement (125,127). Feelings of depression are not associated with a classification of ‘illness’ and not considered a problem until they begin to seriously interfere with daily lives and responsibilities (125,127). Depression is usually accompanied by somatic manifestations and practical complaints, such as headache, loss of appetite, crying, not sleeping, abdominal pain, general body aches, social isolation, feeling hot, hair loss, trouble interacting, concentrating, lack of energy and interest in taking care of family and children and staying at home. These features, including the somatic symptoms, are common presentations of depression in most cultures, and are the symptoms that should alert the health worker to the possibility of depressive disorder. Depressive symptoms involving negative ideation, such as feelings of worthlessness or guilt, are less obvious manifestations of depression among Somalis (128).

According to some, *murugo* may run in families and associated with those in which ‘the lights have been turned off’ (*nalkaa ka dansan*), that are ‘drowning with this darkness’ because they are ‘always down’, ‘thinking too deep’, ‘being full with thoughts’ and ‘fed up with life in general’(126). It is important to note that Islam states that if a person who commits suicide they will go to hell. As a result, Somali people find it difficult to disclose having suicidal thoughts. This may lead to the assumption that suicidal ideation and suicide attempts happen less frequently among Somalis than among other groups (125), but there is no clear evidence of that.

Stress related disorders

Somalis do not have a specific word for PTSD and other disorders related to extreme stress (123). These conditions are primarily considered a state of sorrow and not a mental health problem. When a bad event occurs, the family and community members come together to console the person. *Murugo*, the term often used for depression, is also sometimes used to group symptoms, such as nightmares, memories of the war and deceased family, that indicate anxiety responses to traumatic events (11).

Anxiety disorders

Anxiety is understood as just a ‘fleeting situational discomfort that passes away’ and is not conceptualised as a potentially chronic or persistent state (104). Anxiety disorders seem to be more acceptable and less stigmatizing for Somalis than any other mental illness. Moreover, it predominantly presents with somatic symptoms such as persistent headache, joint pains, myalgia and even unfounded fears. Such a person may also be said to have *nerva* (translated as ‘painful nerves’) or referred to as *shaki* (translated as ‘worrier’) (123). These symptoms are common to many cultures, but the main difference within the Somali experience relates to not considering anxiety as a permanent state, but as a passing sensation.¹⁸

Intellectual disability

A Somali word often used for ‘disability’ is *naafo*. It indicates clearly visible physical impairments, in particular referring to people with amputated or seriously injured limbs. Therefore, it also often excludes people with very low intelligence, or without visible disabilities, such as visual and hearing difficulties (129). In reference to intellectual disability, the derogatory terms *doqon* and *nacas* ‘foolish’ are also used (121).

Autism

Autism, traditionally, was an unknown concept within the Somali community. However, among Somali immigrants residing in high income countries, it is being frequently diagnosed. While the evidence remains inconclusive, there are some indications that the prevalence of autism spectrum disorders among Somali migrant children is higher than in other groups and that such disorders are more often accompanied by intellectual disabilities (130–132). For many Somali families, autism can be a hard concept to understand, with the prevailing belief that the child’s delay may be outgrown. A lack of Somali vocabulary, combined with uncertainty about what autism is, makes it difficult for parents to communicate with their own extended families and communities. As a consequence, the wider group often does not understand or accept the diagnosis of the child (133).

Dementia

In Somalia, many people believe that disorders characterized by memory loss, such as dementia, are a result of religious failing, such as not having attended to prayers well enough over the years, saying that memory will be affected adversely when a person does not pray regularly and according to the rules. People with dementia are sometimes seen as *wali*, often experiencing stones thrown at them in the street or being tied up at home by families to prevent them going out.

Epilepsy

Somalis use the term *suuxdin(o)* for attacks of sudden unconsciousness (121). The word *suuxdin* (‘anesthetised’) refers to the lack of feeling external stimulation (such as pain, hearing or seeing) and is therefore used to describe the typical ‘*grand mal*’ tonic-clonic seizures that have a duration of several minutes and are accompanied by loss of consciousness. Other types of epileptic seizures, such as absences (‘*petit-mal*’ seizures that are characterised by a very brief loss of consciousness) or focal seizures (with consciousness intact or only partially affected) are not considered *suuxdin*. However, attacks that may look like epileptic seizures, but are not caused by abnormal brain electrical discharges, are often also seen as *suuxdin*.¹⁹

18 Personal communication with ME. Tiilikainen through (21 April 2016).

19 Personal email communication with E. Kayd (17 October 2016).

The term *qalalka/qallalka* is often used to indicate the typical tonic phase of a seizure. The clonic phase of a seizure is called *rafasho/rafanayaa*. The period immediately after the seizure, in which the person is comatose for a short period, is often called *suuxdin, isla maqnaasho* referring to the lack of response to all stimuli.²⁰

Seizures and related conditions are often believed to be caused by spirits, but there are also fears that seizures are contagious, especially through physical contact with the urine of a person with seizures. Many Somalis will seek help with a traditional or religious healer first. Health workers in Dadaab refugee camp in Kenya report that a commonly shared belief among their Somali clients is that a computer or a CT scan can remove epilepsy from the affected person and, consequently, many Somali clients insist on being referred for such a cure. Health workers also report that their Somali clients have major issues with accepting epilepsy as a chronic condition that can be managed, but not cured.²¹ Epilepsy places a significant burden on families in Somalia and, therefore, remains largely untreated which may lead to social isolation and stigmatisation.

Khat (Qat, Jaad) abuse

Khat, qat or jaad is a plant that grows on the hills of Yemen, Ethiopia (Harrar), Kenya (Meru) and in some areas of Somalia. It is colloquially known as *herari* or *miraa*. Its' use among adult men is widespread throughout the area of the Gulf of Aden, and more recently has spread to other contexts where Somalis live, especially in Europe.²² Cathinone, the main psycho-active ingredient, resembles the chemical structure of amphetamines and affects the central and peripheral nervous systems in the same way. It produces euphoria ("feeling good"), hyperactivity, increased sense of alertness and diminished need to sleep, increased intellectual vigour, increased perception of ability to pursue big plans and solve problems, increased talkativeness, elevated mood and reduced appetite (134–138). Additionally, it increases blood pressure and may induce hyperthermia (high body temperature) and dilatation of the pupils (134–136,138).

Data on physical dependence are inconclusive, but there is some reason to believe that physical dependence on *khat* is mild, because it takes relatively long (between two and three hours) for the active ingredient to reach maximum plasma concentrations (134,139). *Khat* enables people to socialise and is seen as part of local tradition and culture, which makes it difficult for people to stop using it (134,140,141).

Khat users often have mood swings, with episodes of irritability and low mood after the drug has worn off, which may also be associated with increased levels of domestic violence and aggression (121,139). People also often recall being assaulted by nightmares and paranoid dreams during times of abstinence that have followed periods of heavy consumption.

Many authors believe that excessive use can lead to aggressive behaviour, paranoid ideation, and manic psychosis (136,138,140). There is an ongoing scientific debate about the ability of *khat* to induce psychotic states in healthy individuals. A higher risk of mental disorders was found among Somalis who used *khat* (142), but there is no evidence of strict causality between *khat* use and mental illness (137). Odenwald and colleagues showed that *khat* can exacerbate psychotic symptoms, which may be brief or persistent, and induce relapse in people already suffering from mental illness (98,140). A systematic review concluded

20 Personal email communication with E. Kayd (17 October 2016).

21 Personal email communication with J. Kivelenge (03 December 2015).

22 The legality of *Khat* depends on the country: for example it is a controlled substance in France, Italy, Germany, Denmark, Sweden and the Netherlands. In the United Kingdom, only its purified and isolated ingredients that are controlled under the Misuse of Drugs Act. It is illegal in the United States, Australia and New Zealand, and is strictly forbidden in Saudi Arabia (134)

that moderate use is not linked to adverse health consequences but a small recent study, conducted among Somali resettled in Australia, identified adverse physical and mental health effects, social isolation, family breakdown and neglect of social responsibilities among *khat* users (143).

The use of *khat* is so widespread in northern Somalia that afternoon activities seem to be governed exclusively by it, especially on Thursday and continuing throughout the weekend. It begins with people looking for it, buying it or getting it from a friend and culminates in consumption (138). Many Somalis consider the use of *khat* as part of their culture and, therefore, not problematic (121,143).

In the early 1980s, habitual users in Somalia were estimated to be around 18% of the population in the south and 55% of the population in the north (134,136). In the past two decades, the consumption of *khat* has probably further increased (141). The traditional use of *khat* takes place during culturally sanctioned gatherings with a certain homogeneity of status and age in participants (143). Women are not allowed to chew with men because it is socially unacceptable for women to chew *khat* (143), but they often chew among themselves (138). Sessions can last for hours, and were originally linked to special events such as weddings, ceremonies and discussions/negotiations among elders about political issues in the community (138). The phase during which the substance produces its peak effects is called *marqaan* or *mirqaan* (see Table 3) (138,140). After a few hours, the effect fades, silence reigns, and a state of anxiety and apathy can start to grow.

Reasons for the consumption of *khat* can include: (for youth) lack of care and support from parents, few opportunities for education and employment, a lot of unstructured time without constructive and challenging social alternatives, as well as widespread availability of the substance (141).

Table 3 - Expressions related to khat use in Somaliland

(modified from Odenwald 2009) (97)

Expressions to indicate effects of <i>khat</i>	Description
<i>Marqaan</i> or <i>mirqaan</i>	Translated as 'feeling high'. It includes euphoria, stimulated thoughts and grandiose feelings. It lasts approximately 1–3 hours.
<i>Haddaar</i>	Phase of depressed mood that follows <i>mirqaan</i> and that motivates the user to continue <i>khat</i> intake.
<i>Bac</i>	Indicates a state of suspicion, fearfulness, paranoid ideas and illusions, which emerges during or after severe intoxication. Translated as 'plastic bag', it typically presents at night at the end of a prolonged <i>khat</i> session, when the person walks home and misinterprets the sounds and shapes of the plastic bags and other litter as hyenas or enemies lying in an ambush.
<i>Xaraaro/ Xaraarad</i>	The feeling or desire to chew (before chewing <i>khat</i> or can also mean a cigarette), including nervousness, headache, but also cravings at the time of day when the chewer usually start his consumption. It indicates withdrawal symptoms.
<i>Dubaab</i>	Vivid and unpleasant dreams, often with the sensation of being suffocated, which heavy chewers experience in the night after a day without chewing.

Khat use has a strong impact on the household economy, with many households in Somalia supported almost exclusively by women, because men spend large parts of their income on the consumption of *khat*, which exacerbates poverty and creates social problems (137,138). *Khat* is the second most common product imported into Somalia after sugar (144), about \$50 million are spent on purchasing the substance every year. It is also an important source of income for governments thanks to taxation on it,

which accounted for \$5.5 million collected in 2005, or 10% of the Somaliland annual budget) (136,141). While government authorities sometimes pledge to take measures against the negative health and social effects of *khat*, their attitude towards the *khat* business is often ambiguous. A former minister in Somaliland remarked sarcastically: '[...] as we lack industries and job opportunities, people staying at home chewing prevents them to be in the street demonstrating [...] *Khat* is a factor that contributes to peace in Somaliland' (138).

Other drugs and alcohol

In a recent study, interviews of armed Somali combatants indicated *khat* chewing as the most frequent form of drug use (on average 70% in the previous week), which was followed by smoking cannabis (11%), ingesting psychoactive tablets (9%), drinking alcohol (5%), inhaling solvents (2%) and eating hemp seeds (1%) (145). The use of other drugs in the general population is not officially acknowledged as a problem, and in the past they were rarely used in Somalia. Use of other drugs or alcohol together with *khat* seems to be on the increase, despite the risk of severe punishment (145). Benzodiazepines, which are widely available without supervised prescription, may be related to use of *khat* as *khat* users need to fight *khat*-induced insomnia and agitation. Amitriptyline, a tricyclic antidepressant with sedative side effects, is also known as a substance of abuse (121,145). Amitriptyline, as well as cannabis and alcohol, are reportedly consumed as a way to self-medicate, for example to suppress war related traumatic memories, improve sleep or ameliorate depressive symptoms (145).

Shisha or *hookah* is a waterpipe that is used to smoke tobacco mixtures. A special type of tobacco is indirectly heated using coals or wood embers. *Hookah* is also known as *shisha*, *sheesha*, *narghile*, *argileh*, *goza*, and *hubbly-bubbly*. The tobacco used in a hookah is called *shisha* or *maassel*. *Shisha* is a sticky mixture of tobacco, honey or molasses and other flavourings (such as bubble gum, peanut butter, mango, grape or mint). *Hookah* smoking carries the same, or similar, health effects as smoking cigarettes and exposure to second-hand smoke, i.e. cancer, heart and respiratory disease.²³

Mental health effects of torture and trauma among Somalis

The clinicians of the Center for Victims of Torture (CVT), a nongovernmental organisation working with survivors of torture and war trauma in Kenya, note that their Somali clients often complain of headaches, dizziness, generalised body pain and other medically unexplained somatic complaints, poor memory and concentration. When they work with these clients, they also often see a profound hopelessness, irritability, helplessness and loneliness. Frequently reported reproductive health problems among tortured women include chronic lower abdominal pain, irregular or lack of menses and/or lack of interest in sex. The latter is especially true in survivors of sexual and gender based violence (SGBV). Survivors of torture typically have a high medical consumption and may frequently visit health facilities to seek medication and/or pain killers that may provide temporary relief. Survivors of torture may also sometimes resort to risky behaviour, including drug and substance abuse such as nicotine and *khat*, but also the use of a locally made alcoholic brew (not a part of Somali culture) and taking high levels of unprescribed drugs such as diazepam and paracetamol.

23 Personal email communication with R. Mruttu (26 March 2016).

Explanatory models of mental illness and psychosocial problems

Explanatory models refer to the ways that people explain and make sense of their symptoms or illness, in particular how they view causes, course and potential outcomes of their problem. This includes how their condition affects them and their social environment, and what they believe is appropriate treatment (146). Cultural systems of knowledge, belief and practice provide models for illness that include ideas about causality, course, appropriate treatment and likely outcome. These explanations may be drawn from particular ideas about what makes up the person and the world, and theories of the processes of illness and healing. Explanatory models can have important implications for coping, help seeking behaviour, treatment expectations, worries about long-term consequences of illness and stigmatisation. Practitioners must try to understand and respect diverse explanatory models used by their clients in order to optimally engage with their clients and provide more effective support. However, while explanatory models have important applications, they should not be used in a restrictive or over-generalising way as these models vary between populations and over time. They also often have internally contradicting and non-homogeneous elements that continuously re-elaborate personal experiences in varying ways (147,148).

God's will

Somalis often consider the cause of mental illness in spiritual terms: God's will is about pre-destination, one's pre-determined fate. Other explanations that are widespread within popular discourse in Europe and North America are heard less often among Somalis, such as biochemical imbalances, a response to trauma, individual vulnerability (e.g., personality traits or cognitive biases) or learned behaviour (149). When asked about the origin and cause of a disease the answer may simply be 'only God knows' (8). Anything that comes to people in this life, good or bad, is seen as coming from God (150). Illnesses may be interpreted as punishment from God or a test (10). It might be also seen as a consequence of not having been good enough in following one's faith (151). In that sense, mental illness can also be perceived as a punishment from Allah, which can lead the community to assume that the person has not been a good Muslim. The punishment can also be due to having done something bad.²⁴ The ultimate decision on illness is always in God's hands (11,123). However, this does not mean that Somalis passively accept the presence of illness, and do actively seek treatment.

Supernatural forces (evil spirits and possession)

Mental illness is also thought to come from evil spirits. Somalis conform to the Muslim faith, believing that God created multiple realms of life including physical, spiritual and metaphysical worlds. Creatures can be human beings, angels, spirits - good or bad - or devils. Evil spirits are generally known by the generic term *jinn* (*jinn* is plural and *jinni* is singular, also spelled *gin/gini/geni*). They are mentioned in the Qur'an. *Jinn* are found everywhere, but are more common in impure places (e.g. near garbage) and close to the water, they can also enter dreams (8,10). They inhabit the world of humans and have relationships with each other (e.g. they get married, do business, etcetera) (8). They can see humans, but they do not know that humans cannot see them, which is why they defend themselves from unintended attacks by humans, for example if a person accidentally steps on them. *Jinn* intrude in people's lives when they are disturbed, when a person experiences moral weakness and his faith is shaken, when a person contravenes certain social rules and has negative thoughts guide his/her behaviour, or when doubt and conflict between good and evil finds its way to the person (8). When a *jinni* enters a human being, the person may hear voices, or speak with an unfamiliar voice (118). *Jinn* are thought to cause a wide range of distress, including

24 Personal email communication with R. Pratt (20 March 2016).

emotional states of fear, anxiety, apathy, general malaise, violent behaviours, hearing voices, shouting, crying, unhappiness and suicide attempts, but also somatic symptoms such as sleeplessness, tiredness, nausea and vomiting, fainting, persistent headache, loss of appetite, feeling of pressure in the chest, unspecified body pains, blindness, paralysis and seizures (10,11). *Jinn* are commonly seen as causes for mental health problems among many Muslims, including Somali, and these can be relatively stable attributions due to their acknowledgement by Islamic theology (149).

Sar possession

Elements of pre-Islamic Somali culture persist in the form of *sar* (also written as *saar*, *zar* or *zaar*) spirit possession (10,11). The term *sar* denotes both the condition of the person possessed (the spirit enters a person and wants to be satisfied in particular ways) and the healing cult (10). In different parts of Somalia *sar* spirits are known by various other names such as *mingis*, *boorane*, *sharah*, *ayaamo*, *wadaado/ardooyin*, *luumbi/nuumbi*, *barkiin/ba'alwaan*, as well as *saar-gedo*, *saar-habashi* and *beebe* (10,118). *Mingis*, believed to be autochthonous from northeast Somalia, are considered by some authors as the most significant expression of *sar* possession in Somalia (152).

The psychiatric classification system DSM-IV describes *sar* as '*a general term applied in Ethiopia, Somalia, Egypt, Sudan, Iran and other North African and Middle Eastern societies to the experience of spirits possessing an individual. Persons possessed by a spirit may experience dissociative episodes that include shouting, laughing, singing, or weeping. Individuals may show apathy and withdrawal, refusing to eat or carry out daily tasks, or may develop a long-term relationship with the possessing spirit. Such behaviour is not considered pathological locally*' (153).

Sar spirits most often possess married women. The kind of *sar* spirit may be related to her clan affiliation and region. (118). A woman possessed by a *sar* spirit has to try to 'pacify' the spirit and if she succeeds in restoring peaceful relations with the *sar* spirit, she will regain good health and wellbeing (38). *Sar* spirit possession may be a way to concretise and externalise psychological difficulties in a way that is culturally understandable and acceptable (154). *Sar* possession and the accompanying rituals may galvanise the support of family and friends and provide women an opportunity to express emotions in ways that otherwise would have been socially unacceptable. For example, it may enable a disgruntled wife to express hostility towards her husband without actually quarrelling with him (155), however, men may not always be fully convinced of the veracity of the *sar* possession. Fifty years ago, the British social anthropologist Lewis wrote that '*what the wives call sar possession, their husbands call malingering, and they interpret this affliction as yet another of the deceitful tricks employed by women against men*' (156). *Sar* possession is, however, not just a covert way of expressing lack of wellbeing. It is also a powerful cultural phenomenon that has a binding role. The cultural anthropologist Tiilikainen considers *sar* spirits as '*embodied memories that bring forward and force people to acknowledge the commitments of and to the past*' (157). *Sar* ceremonies have a strong social function and may be very rewarding for the participants (118).

During *sar* rituals there is usually loud music, vigorous dance and songs with special rhythms. While *sar* possessions and related ceremonies continue to be reported both in Somalia as well as in diaspora, the cultural tolerance towards the practice has appeared to decrease, partially due to processes of modernisation and globalisation, but also due to the increasing influence of fundamentalist Islam that views *sar* rituals as un-Islamic and punishable. As the *sar* cult has been widely rejected as being at odds with Islam, *sar* spirits may instead appear in Sufi women's *sitaat* rituals that, according to some, may be more easily accepted within the framework of Islam (38).

Evil eye, curses and witchcraft

The 'evil eye' (*ishan, il-dad, ishan, il-dad, or il cayn, cawri*) represents misfortune or illness, meaning that it indicates the desire to cause misfortune to a person one is jealous of (10,123,129). It is common to hang bottles of sea water in the house for protection against the evil eye (10). *Ilcayn* is one of the most common forms and is thought to be conveyed unintentionally between humans: transmission happens from one person to another through the eye and is often triggered by envy (*xasad*) of someone else's possessions, success or love, but also unrequited love, jealousy or anger (8).

Curses (*habaar/inkaar*) from wrongly treated and/or disregarded people, including parents, the poor, and the elderly, are thought to bring about the most dreadful misfortune in life (10,38,123,129).

The term *sixir/sexir* refers to sorcery/magic, sending someone a curse (*sixirtay*) helped by the devil (*sheydaan*), or magic. It indicates a voluntary, intentional action, for example by a person who wants someone else to fall in love with him/her. Other reasons to use it are jealousy, envy, revenge, to get something from someone or to make someone sick or mad or even to kill the person (118). Such sorcery is performed by a witch called *sixiroole* who reads specific words over water that is later unknowingly drunk by the victim or placed in his/her food or on their clothes. However, it often seems to work as a retrospective explanation of a course of events, rather than a strategy used by people with the intention to cause harm (118).

Natural causes

While spiritual factors play an important role in the explanation of severe mental disorders, it is incorrect to assume that Somalis would always attribute mental disorder to spiritual causes. People also see a link between *waali* and excessive use of *khat* (121), or between *waali* and stressful life events ('natural *waali*' are different from 'evil *waali*' or *jinn*) (8).

Stress and emotion as causes

The loss and suffering due to the devastation of the civil war, atrocities during escape and harsh conditions while living in refugee camps are seen by many Somalis as causes of mental disorders (11,117,123). For Somalis resettled in other countries, a common problem is the post migration stress, which includes lack of social support, difficulties in finding employment and the pressure to provide for family members remaining in Africa (117). Accordingly, mental health problems are often explained through the accumulation of hardships, diverse life problems and experiences of poverty and war (149,158). In addition, good social relationships and balance in one's social network are seen as crucial for good mental health.

Furthermore, some forms of mental distress are thought to be caused by excessive emotions (10). In particular, the emotion of *maseeyr* (mainly associated with polygamy and described as feelings of envy or of jealousy) may lead to insanity, and is identified as the social origins of women's sufferings (10,149). Additionally, a love disappointment can also cause illness, during which the person often cries without a reason (10). On the other hand, biological mechanisms are rarely recognised as sources of mental illness (117,149).



Used tires are utilized to create a playground at Child Friendly Space supported by Unicef and operated by Save the Children USA at Hilaweyn refugee camp in Ethiopia (2012).
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HEALING PRACTICES



5. HEALING PRACTICES

Seeking emotional support and prayer, or reading the Qur'an are often the first resources utilised to overcome distress. Alternatively, the Qur'an may be recited by relatives or friends, or by a spiritual healer (11,117,123). These practices may be used in conjunction with other remedies that could be known as either 'western' or 'traditional Somali'. Whichever method is chosen, support of the community and the family are essential for healing. Even in reference to the severely ill, there is almost always an extended family member to rely on to provide practical (e.g. assisting with household tasks) and emotional (11,123) support. Mentally ill family members will only be excluded from the family in extreme cases of violence or deviant behaviour, or when the family's resources have been stretched to breaking point. Tragically, mentally ill family members may also be chained up, caged or imprisoned in a room (123). In cases where witchcraft is suspected as the cause of the illness, traditional healers are primarily consulted. Western psychiatric treatment is considered often as a last resort, or when 'natural' causes (such as distress related to war, etc.) need to be treated (8,117,123). Poor, inconsistent availability and access to appropriate psychiatric care and medications in many settings may be more significant factors, rather than scepticism about efficacy.²⁵ However, a study conducted with Somali refugee populations in London indicated that they underutilise mental health services, even when these are available (159).

In this report, healing practices that are not strictly religious nor biomedical are referred to as 'traditional'. However, it must also be acknowledged that in practice, there is often some overlap between Islamic and traditional healing. Table 4 lists care practices for specific causes of mental health distress. The most frequent options used are then individually addressed and described in the sub-chapters below.



Education in Jijiga camp
in Ethiopia (2014)
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25 Personal communication with E. Palazidou through email (27 April 2016).

Table 4 - Care practices for specific causes of mental health distress

Cause of mental health distress	Care practice
God's will	Islam teaches that Allah has supreme power. Therefore, the human response to suffering has to be acceptance of the current situation as God's will, while maintaining patience and hope (11). God's will covers a wide spectrum of experiences, from explaining causal relationships to disease, to how others perceive those with illness, and whether and how people seek help. This supersedes all other explanations, so while people may believe in other causes, God's will still determines how they deal with illness and misfortune. Prevention of mental illness and alleviation of punishment happens primarily through the use of prayer, living a life according to the Islamic religion and engaging in good deeds (11,123).
Supernatural forces: <i>jinn</i>	Management may include Qur'anic readings by a man of religion/ spiritual healer (<i>sheikh</i> or <i>waadaad</i>), in conjunction with family and community based support (11,121,123). Additionally, evil spirits can be fought by preparing a protective amulet or use of holy water (<i>tahliil/ashar</i>) (10,118,123). The role of health professionals and western psychiatric medication is very limited. If a problem is thought to be caused by supernatural forces, people may not see a need for medical treatment unless there are severe behavioural problems that cannot be handled at home (11,121).
Supernatural forces: <i>sar</i> spirit (possession)	<i>Sar</i> healers treat spirits with rituals that include special incense, perfumes and clothing, various dances, music and animal sacrifices (10). A ceremony can also include exorcism, feasting and ritualistic dancing (11). Additionally, a <i>sar</i> ceremony offers a rare opportunity for women to spend time together in a more relaxed and informal setting, which contributes significantly to the healing process (11).
<i>Social and other stressors</i> (civil war, etc.)	When the primary cause of suffering is thought to be rooted in social or economic difficulties (i.e. lose of job/business, consequences of war, lost loved one, etc.) people will attempt to assist through emotional support, letting the person rest (at home or in private 'resting facilities'), bring him/her to a quieter, cooler place, or to mental health professionals where available (8).

Coping and resilience

Psychological resilience may be partially defined by the ability to resume a normal life, including participation in social relations, after having experienced adverse events (25). Within the specific Somali context, having a strong social network reliant on extended family and community may be the primary factor contributing to resilience. For people with severe mental disorders, the extended family plays the key role in supporting patients, and it is considered the responsibility of the family to do so. In terms of gender, families may protect female patients more rigorously than males in an effort to avoid shame or insult to the family honour. The negative side of the strong role of family in the treatment process is that the voice of the patient is easily ignored. The family, and not the person with mental illness, makes decisions about treatment, including admission and discharge of the patient according to the family's convenience (25).

In a recent study with Somali refugees, resilience was also positively associated with presence of meaning in life, which in the Somali culture is often reflective of the broader cultural influence of Islam on understanding of life experiences (160). Among older Somali refugees in Finland, high levels of religious adherence played a buffering role in the prevention of developing PTSD symptoms, whereby exposure to severe war trauma was not associated with high levels of PTSD among this refugee population (161).

Additionally, religion can boost the morale and spirit, as well as encourage the society to provide support and assistance to mentally ill members of the community. One key aspect of Islam is the acceptance of suffering as evidence to show one's faith. As a local proverb says '*Cawo badanaa nimay caweer maruun ka kacday*' ('blessed is the one who survives his misfortunes') (8). Engagement in cultural practices,

ceremonies, and traditions is significant for many Somalis refugees resettling in western countries (162), while faith provides hope, solidarity and a sense of unity among Somali refugees (75). However, some coping strategies may also have a negative impact, such as the abuse of *khat* or restrictive social networks whereby older women guide younger women's decisions on maternal health. According to tradition, older women may for example, discourage the use of modern maternal health services and advise pregnant women to reduce their diet to avoid large babies (25).

For resettled Somali refugees, protective factors against psychopathology may include speaking the language of the host country, migrating at an early age, having family members residing in the same host country, having completed formal education, employment, marriage, maintaining religious practices and having adequate social support (11). A recent study found that girls' connection to their Somali culture was protective against discrimination (111). However, while firm connections to the culture of origin may be protective, navigating conflicting and changing cultural and religious positions is not easy, and it may be difficult for Somali refugees to access the appropriate form of support. Moreover, while Somali people value support, they also value concealment and fear disclosures (154). Robinson concludes that *'resilience in the context of Somali culture and forced displacement is an interactive process between individual, relational, and cultural "systems" that result in successful navigation toward, and negotiation for, culturally-defined and contextually bound health-sustaining resources'* (160).

An exploratory study identified six major qualities of resilient Somali families: enjoyable time together; appreciation and affection; positive communication; commitment; spiritual wellbeing; and the ability to manage stress and crisis effectively (36). Additional critical strengths include: strong religious faith; close attachment to culture, rituals, and traditions; strong kinship bonds including filial responsibilities; readiness to meet obligations and provide help to extended family; belief in helping people less fortunate; unity during adversity; aspirations to success and wealth; and commitment to invest in their homeland (36).

Religious healing practices in Somalia

Qur'anic healing

People with mental health problems and their families most commonly resort to religious practices. Qur'anic healers, the *sheikh* (or *wadaad*) are easily found and assess the presence of *jinn* through reciting verses from the Qur'an and praying. The *sheikh* further determines the type of *jinni* by listening to the story as told by the patient and family, and by observing the reactions of the afflicted person to specific verses of the Qur'an. If *jinn* are present, they are asked to say who they are and what they want. *Jinn* may ask for food, beverages or new clothes, among other things, which may put a considerable economic burden on the family (8).

A *sheikh* may perform services at the home of the patient or ask them to come to their Qur'anic places of healing (*cilaaj*), where therapeutic sessions are performed, and herbal preparations (and occasionally vitamins and iron tablets) can be bought (77). In bigger centres, clients can stay overnight.²⁶ Additionally, *sheikh* can be found at 'Qur'anic camps', places for prayer and continuing education, where apprentices are available in addition to the main *sheikh*.

The length of stay at the healing centres can vary from a few days to a few months, based on severity of the condition and practical considerations, such distance from home and the ability of the family

26 Some *qur'anic* healing centers are adapting to modern times and employ physicians who do an intake. [Personal email communication with C. Greene (19 September 2016)]

to pay for the stay at the facility. A stay at such healing facilities ensures that the person fulfils his/her religious duties and prevents use of prohibited or harmful substances such as alcohol or *khat*, as well as ensuring monitoring of the effect of administered medicinal plants. Apart from that, the centre also ensures the patient is spiritually protected and benefits from blessings (8). However, living conditions for the patients are often well below acceptable standards, despite that these healing places are commonly financially supported by communities, or by *zakat* (donations of individual charitable people), as well as by contributions by client's family.²⁷

The practices to expel *jinn* from the person vary, and usually include praying and reciting the Qur'an – sometimes using headphones or speakers to spread the Qur'an throughout the room. Often healers also use *cashar* (northern Somalia) or *tahlil* (central and southern Somalia). This is a holy water blessed by readings of the Qur'an that clients may either drink or wash themselves in it. Herbal medicine may also be used, as well as a regime of rest or exercise (8,118). Sometimes amulets (*xirsi*) are given to protect the person from evil attacks. The *jinn* are often ultimately expelled through the little finger of the left hand (which is considered impure because it is used, for example, for personal hygiene and not for eating), the *sheikh* presses hard on the little finger and the *jinn* manifest their exit by causing pain (8). Alternatively, common practice is to bend the two little fingers or little toes as hard as possible and taunt the *jinn*. The *jinn* will then be expelled through the mouth.²⁸

For the *sixir*, there are dedicated healers, the *sixiroole* who perform rituals that are considered 'magical'. Increasingly, Somali see the practices of *sixiroole* as incompatible with Islam, and they have lost much of their popularity. Moreover, these healers tend to be more expensive. Therefore, Qur'anic healers are becoming more frequently also used for expelling *sixir* (8).

Traditional (culture specific) healing practices

Sar Rituals

Sar rituals, like *mingis* or *borane*, are performed through singing songs based on *sar* and local traditions, such as dancing, trance and speaking in tongues, as well as sometimes also including Qur'an verses. The rituals have pre Islamic origins and are becoming increasingly marginalised. The healing rituals include negotiations with the spirit who is invited to leave the person rather than being forcibly expelled (8). The spirit is not violent, but readings from the Qur'an might incite verbal outbursts from the patient. Treatment is expensive, particularly when performed by an *alaqad/ calaqad/ alacot*, the highest level of healer (a *sar* expert) (42,118). Money, silk scarves, special oils and perfumes brought by patients are used as offerings during the treatment, which also involves slaughtering animals, chanting, eating sweet foods such as dates, and dancing for several days. Food is cooked for the altar offering and feast, and a celebration is held for the spirit. However, it is controversial whether feeding the *sar* spirit is beneficial: some believe it helps the healing, while others believe that food encourages the spirit to remain (42). The aim of the feeding is not to expel the spirit, but rather to satisfy it so that it does not 'cause trouble'.

Herbal medication (*daawo-Somali*)

Daawo-Somali may be translated as 'medicine of the Somali', and refers to the use of plants and preparations with a natural composition. This includes plants used for self-medication in the form of

²⁷ Personal email communication with E. Idris (13 September 2016).

²⁸ Personal email communication with N. Baron (04 April 2016).

infusions, powders and roots, as well as complex herbal preparations whose composition is part of oral traditional knowledge passed down through the generations, and whose preparation is only carried out by those expert in this knowledge. The herbs are thought to have a positive effect on blood circulation, believed to be important for physical wellbeing and in the treatment of 'madness' (10). Preparations may be bought directly in an herbalist shop, often following the advice of the elders (8).

Containment (chaining)

Containment of the mentally ill through the use of chains is a widespread practice throughout Somalia, in both urban and rural areas, and also in refugee camps outside Somalia (8,76,163). Chaining people with a mental disorder is a harmful practice that often amounts to the violations of the human rights of the person. Chaining is practiced for both men and women, and is often an act of despair by family members who feel they have no other way to handle a problem.

Family members often justify chaining by stating it is needed to contain the perceived aggression of people with mental disorders towards others and themselves. The control of aggression and prevention of escape are particularly important due to the Somali social organisation: In the event of aggressive acts, the victim has the right to seek and obtain compensation for damage suffered. Families of people with severe mental disorder patients may decide to chain them to prevent them from committing an assault for which the family would be forced to pay compensation. Additionally, there is a common belief that secluding the person in a quiet place may reduce anger, agitation and aggressiveness. If the person can rest in a cool place, the beneficial effect is thought to be increased.

Chaining may also be done out of a motivation to 'protect the person' or to preserve the dignity of the family. Some people with severe mental disorder are chained because family members do not want to be associated with mental illness and try to hide the patient. Families who chained children with intellectual disabilities said they did this to protect them from scorn and ridicule. Families of women with severe mental disorders justified chaining by saying that they had to do this to prevent them getting pregnant. Some families also mentioned that chaining prevents the person from using illegal drugs (8).

Chaining is usually long term, lasting for months or years. Seventy-four percent of the persons identified in a survey in Somaliland and Puntland were chained for more than six months (8). Chaining is also widely practiced within both public and private mental health facilities in Somalia, commonly used as a form of punishment when patients refuse to follow orders, exhibit aggressive behaviour or try to escape (76). It is also widely practiced in religious healing centres, with the use of restraints often not monitored or recorded, and used for prolonged periods (sometimes indefinitely) (81). The Eastern Mediterranean Regional Office of the WHO and the Italian organisation GRT have been assisting the Somali mental health system to use '*chain free*' methods.

Other

Another widespread traditional, damaging and dangerous practice is the ritual 'fire-burning' of the affected part of the body, often through the use of pieces of burning coal, iron rod, or a stick from a special tree that is heated until it glows and is subsequently applied to the skin (155). The aim of the ritual is to facilitate the drying of congested water or blood inside the person (which is thought to be the cause of the disease) (8). For mental health conditions, burns are performed on the forehead, temples or neck (77). Even more frightening and dangerous is the use of hyenas, used in some parts of the country to fight mental illness because they are believed to be able to see everything, including the evil spirits causing the disease. The person is locked in a hut for a whole night with the animal and gets clawed and bitten (and sometimes even killed) so the hyena may eat the evil spirit (76,164).

Over the counter medication

Regulatory mechanisms for medication prescription are essentially absent in Somalia and medicines for ‘crazy’ or agitated persons are widely available without any medical prescription or supervision. Chlorpromazine, a first generation neuroleptic with powerful sedative effect is commonly taken together with diazepam (163).

Pharmacies

Throughout the country, kiosks sell pharmaceutical products. The most common ones available are amitriptyline, chlorpromazine, haloperidol and diazepam, in addition to anticonvulsive medications like phenobarbital, phenytoin and promethazine (76). The absence of regulation in the pharmaceutical sector and lack of qualifications of staff are serious problems in Somalia. Counterfeited, expired or re-packaged medicines circulate easily in the market (8). It is common for doctors with a private practice to also have a private pharmacy to which they can directly refer patients (8). Additionally, self-medication is a common practice throughout the country for any kind of disease, including mental illness. When a relative is in distress, very often families do not seek help from a doctor, but go directly to a kiosk/pharmacy to ask for medication for ‘crazy’. Many pharmacies have a ‘consulting room’ and dispense drugs to anyone, without any prescription nor supervision (8). It is important to note that inadequate medication, premature discontinuation of treatment through lack of understanding of the importance of ongoing treatment to maintain symptom control, or through lack of access to further supplies of medication leads to relapse of illness. This reinforces the belief that mental illness is not treatable.²⁹

Combination of religious/traditional and medical practices

Referrals between the religious/traditional and medical systems are becoming more common because the presence of a *jinn* is thought to weaken the person and, vice versa, an emotionally torn person is more vulnerable to evil spirits that takes advantage of the fragility of the individual (8). Moreover, new healing clinics, referred to as *cilaaj*³⁰ or ‘psychosocial centres’, have been created after the war. They were originally Qur’anic centres, but now they combine medical, religious and traditional treatments. If medical treatment does not work, the patient is taken to a *sheikh* who also works in the clinic. Moreover, families sometimes explicitly request combining western medicine with religious/traditional treatment (78).

Local healers have recently begun to adopt western methodologies as well, with some taking urine and blood samples or measuring blood pressure. Healers may also send their patients to a laboratory or to get an x-ray, even if they cannot interpret the results. A neuro/muscle stimulator is sometimes used to diagnose if a person has a *jinn* and to expel it through an electric ‘shock’ because *jinn* spirits are thought to be afraid of electricity. Furthermore, mobile phones may now be used to recite Qur’anic verses to expel *jinn* spirits, and laptops and the internet are becoming part of healers’ equipment in towns (78).

29 Personal email communication with E. Palazidou (27 April 2016).

30 *Cilaaj* derives from Arabic language and means healing (78).

Health seeking behaviour

The choice if and where to seek help is bound to a variety of factors, including local social dynamics, availability of services, knowledge of resources and the ability to access them. Common mental health problems such as depression and anxiety are often not seen as medical disorders but considered normal reactions to the stresses and pressures of the environment. Somalis typically attempt to resolve these issues first by seeking support and advice from family and community members (151,165). If loss of belongings is a precipitating factor, the community may come together to replace the loss. For more serious conditions, religious healers are consulted first, while seeking help at a formal health facility is rare and often a last option unless the person manifests somatic complaints (8,165). However, when the situation is complex, people resort to using more than one service. Often people have multiple and at time contradicting explanatory models of the same problem, particularly when outcomes of the initial treatments are unsatisfactory (8,10).

Law and mental health

Somalia has no specific laws regarding people with mental health illness. The only two issues that are touched on are the administration of properties and marriage. If a person, due to mental illness, is incapable of administering his/her property, the paternal relatives take charge of the administration of his/her assets (8). Additionally, customary law indicates that mentally ill persons (men in particular) cannot get married because of presumed inability to take care of his wife, children and belongings, to play a useful role in the community life, or because they may be potentially dangerous to themselves or others (8). A common belief is that if a mentally ill woman gets pregnant, she will pass the disease on to her children. This makes marriage for children of a woman with mental illness very difficult. However, men can sometimes avoid this faith, for example, if the person comes from a rich family who can pay a poor girl enough to convince her and her family to take the man as a husband. In this case, the man is often exempted from his marital duties and is not required to take care of his wife. Usually these responsibilities are passed on to the wife's family.

Stigma, discrimination and human rights

Among Somalis, mental illness is often considered a shame and disgrace, and carries high social stigma. People with severe mental health conditions are often discriminated against and socially isolated. People with severe mental impairment are considered less worthy and command limited respect. Somali proverbs state that '*a mentally ill person might get better, but will never be cured perfectly*' and '*the mind that is lost does not come back again easily*' (*Dhimir tagey dhagsi kuma yimaadi*). Children often make fun of mentally ill people, throw stones at them, and run away from them. Apart from chaining and violence, additional human rights violations against mentally ill people include the prevention of access to their funds, properties, and inheritances (76,123,166). Lastly, even staff working in the mental health field may be stigmatised.³¹ Nongovernmental organisations (such as GAVO) have created public awareness campaigns in the form of dramas, publications, workshops and other media outlets to break the stigma related to mental illness. Reports on some of these initiatives suggest that their implementation has been correlated with increased admissions to mental health services.

31 Personal email communication with P. Hughes (28 March 2016).

Barriers to service utilisation

The stigma attached to having a mental illness is one of the main barriers to engaging with mental health services amongst all groups (11). Additionally, Somalis often seek help for concrete matters or somatic complaints, rather than for emotional complaints that are supposed to be dealt with within the family. Barriers specific to resettlement settings include lack of information on services, long waiting lists to access services, unfamiliarity of health professionals with culture and language of Somalis or Somali idioms of distress, mistrusting government agencies - given their history of suffering, and displacement, many Somalis remain fearful of authorities - and xenophobia or racism. Other factors that constitute barriers to care are a reluctance by some Somali clients to use interpreters, an uneasy attitude towards home visits (because they can be seen as an intrusion by someone families identify as a stranger), and reluctance to disclose intimate personal details to a stranger and concerns about confidentiality - Somalis may be afraid to disclose a mental health problem to a medical practitioner and the interpreter for fear that the latter may gossip within the community. (11,82,104,117,155,155,167). Cultural gender norms also may play a role in help seeking behaviour as it can be difficult, for both women and men, being supported by the opposite sex, for women to discuss rape and sexual assault with care providers, or to seek mental health treatment. Additionally, men more often self-medicate with *khat*.³²

The fear of stigma has damaging consequences, such as inability to engage with the community (with a perceived need to 'escape' from community life if someone in the family is diagnosed with mental illness) and unwillingness to seek clinical help or other forms of support; Somali forced migrants make considerably less use of community groups due to stigma, which hinders the building of social capital for their members (126,168).

For resettled refugees, practical issues such as lack of financial resources, childcare and transport, as well as the distance between homes and local services, may all contribute to prohibitive factors to utilisation of mental health services. Service providers also report further challenges, which include difficulties working within a patriarchal family structure, working with interpreters from competing clans, fear of being labelled 'crazy', poor compliance, and the focus on somatic symptoms rather than viewing illness within an emotional framework (155).

32 Personal email communication with P. Hughes (28 March 2016).



CONCLUSIONS

6. CONCLUSIONS

For more than two decades, the people of Somalia have suffered tremendously from armed conflict and natural disasters, such as drought. More than a million Somalis have been, therefore, forced to leave their country, with a million more being internally displaced. The impact of violence, hardships and displacement has had profound effects on both the individual and collective wellbeing of Somali people. For most Somalis, the primary source of support was and remains the extended family and the paternal clan. While the clan system has been affected by the ongoing violence, it continues to play a great role in the lives of Somalis whose identity is strongly influenced by their genealogy – the lines of paternal descent that position them within the social structure vis-à-vis each other.

Cultural and religious values and understandings play an important role in the perception and explanation of mental and social problems, and the methods of treatment. It is important for all health practitioners involved in mental health and psychosocial support programmes to understand and explore their Somali patients' cultural idioms of distress (common modes of expressing distress within a culture or community) and related explanatory models (the ways that people explain and make sense of their symptoms or illness), which influence their treatment expectations and coping strategies.



Levels of psychological stress are high among Somalis, many of whom have suffered from multiple losses, torture and forced displacement, and continue to face ongoing hardships in refugee camps. In Somali discourse, the mind, body and spirit are perceived as inseparable. Consequently, many Somalis do not express their distress in psychological terms, but primarily in a somatic jargon. However, the Somali language has a rich spectrum of terms to describe negative emotional states such as *murug* ('sorrow/sadness'), *qalbi-jab* ('broken heart'), *niyad-jab* ('broken mind' or 'broken will') or *welwel* ('worry/too much concern'). Somalis would, however, not readily label such states as medical disorders, and would not be inclined to seek help in the formal health sector for them.

People with chronic mental disorders such as chronic psychosis are particularly vulnerable, and are at high risk for maltreatment and human rights abuses. *Waali*, the Somali term for people with severe mental disorders has strong negative connotations and many people with severe mental disorders are unable to access services due to the lack of access to such services or because of stigma and shame.

Understanding Somali illness models and idioms of distress, as well as sources of support and coping, and how these are changing as a result of conflict and displacement will allow better communication between health workers and their patients. Such knowledge can be used to design MHPSS interventions that mobilise individual and collective strengths, and strengthen resilience.

When Somalis with mental problems seek outside help they will often first turn to religious and traditional healers, who offer a wide range of different treatment options. In Somalia itself, in the absence of formal mental health services, many people also turn to self-medication or to private treatment centres. In refugee camps outside Somalia various NGOs provide services, but stigma and misunderstanding prevents many from seeking help. In general, mental health practitioners should avoid psychiatric labelling because this can be alienating and have negative social consequences for the person and their family. For clinical mental health practitioners, building strong therapeutic alliances with their patients will allow an open exploration of diverse explanatory models and sources. Clinical mental health interventions need to be accompanied by interventions to mitigate difficult living conditions and to strengthen community based protection mechanisms, in order to help individuals regain normalcy in their daily lives.

There is broad interagency consensus that mental health and psychosocial support services need to go beyond clinical services to include interventions to foster community and family support, as well as strengthen positive coping mechanisms. MHPSS interventions, therefore, should include activities that foster social cohesion among displaced populations and provide emotional and practical support. It is essential that all MHPSS interventions are based on mutual respect and dialogue, and that the perspectives of Somali refugees are taken seriously. Non-stigmatising information about mental illness which utilises acceptable Somali concepts of illness helps engage patients and families in a mutually respectful working relationship.



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Culture, context and mental health of Somali refugees

A primer for staff working in mental health
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