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Experiences against HIV/AIDS/STDs of Somalis in Exile in Gothenburg, Sweden°

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Riassunto

Esperienze di HIV/AIDS/STDs vissute dai somali in esilio in Gotenburgo, Svezia

Dal 1989, l'Amministrazione dei Servizi per gli Immigranti della Città di Gotemburgo (the city of Gothenburg Immigrant Services Administration) si è impegnata a divulgare l'informazione sull'HIV/AIDS. Lo scopo era quello di assicurare che anche gli immigrati residenti nella città di Gotenburgo (Göteborg) avessero l'accesso all'informazione pertinente su HIV/AIDS. Gli impegni dell'Amministrazione sono stati parte di un sforzo collettivo di Gotemburgo per prevenire la diffusione di HIV. In questo lavoro vengono presentati i risultati di un studio qualitativo sociologico il cui obiettivo è quello di esaminare e di descrivere esperienze di HIV/AIDS/STDs vissute dai Somali in esilio a Gotenburgo (Svezia). Sono state compiute interviste approfondite a 13 persone (6 donne e 7 uomini) utilizzando un questionario semi-strutturato. Di seguito sono stati organizzati gruppi di discussione con 10 partecipanti (2 donne e 8 uomini).

Lo studio rivela che il profilo generale della comprensione dei soggetti sulle questione in esame è più o meno la stessa, sebbene dettagli si diversifichino da un intervistato all'altro. In generale la loro percezione di STDs viene descritta come fonte di disonore. Questo è vero specialmente per HIV/AIDS che è castigo mandato da Allah per punire coloro che praticano fornicazione o illecita relazione carnale [z-sinna]. Naturalmente, la tendenza a nascondere il problema induce ad una disinformazione e quindi alla diminuzione della percezione del rischio che è la determinante principale del rischio di infezione. Per quanto riguarda la protezione come misura preventiva, i tradizionalisti hanno argomentato che l'uso del preservativo non fa altro che incoraggiare e aumentare la possibilità di promiscuità o fornicazione, mentre i giovani ed i più moderati vedono il preservativo come una soluzione funzionale.

Possiamo concludere che i Somali che sono arrivati in occidente e in Svezia già adulti non hanno mai avuto per motivi socio-culturali vari un'educazione sessuale moderna e questo ha importanti implicazioni sulla modalità di informazione rivolta ai loro bambini circa gli organi sessuali, lo sviluppo sessuale umano e le misure preventive da adottare contro HIV/AIDS/STDs. Perciò a questi immigrati deve essere offerta una comunicazione informativa diretta e programmi di educazione sanitaria sensibili alla loro cultura e mirata a promuovere la consapevolezza circa la sessualità degli adolescenti e le misure preventive contro HIV/AIDS/STDs.

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Introduction

Foster and Anderson pointed out that traditional people often describe illness in personalistic and naturalistic terms (11). A personalistic thinking misfortune is believed to be caused by the will of a God, a human being (a witch), and spirit-jinn. According to a *naturalistic* explanation illness occurs when improper personal hygiene is practised, from (eating bad food, contagious diseases and vectors), or that it arises when the body's inner equilibrium is disturbed. This type of understanding of illness has been reported from Somali and other African communities (15, 17, 22). Several authors have agreed that whatever the cause of disease in African thinking, it can ultimately be traced back to God (1, 14, 15, 22, 26).

Helander (15) and Thomas (26) suggested that in most Somali communities when a person falls ill, no matter whether there is a modern health service or not, his/her relatives or neighbours and friends first try to find the cause of the disease and to apply treatment accordingly. If this remedy does not work, then most often the sick person is accompanied to several healers, such as a general practitioner healer (sancoole) (7), religious healers, herbalists, magicians and bone-setters for diagnosis and treatment (14). Often, after failure of treatment by traditional medicine, then he/she will be brought to consult western health workers. Helander (15) and Kleiman (19) argued that people prefer to first consult traditional instead of western medicine may be because bio-medicine is primarily interested in the recognition and treatment of disease -curing- while healers provide the sick person, family, and community with meaningful and culturally accepted explanations of illness and related issues. Several authors have suggested that appropriate channels of communication between health workers and the traditional societies do not exist (12, 16, 19).

The National Health Plan of the Somali Democratic Republic (23) suggested that Sexually Transmitted Diseases (STDs) was one of 10 disease problems, the others being malaria, tuberculosis, diarrhoea disease, childhood communicable diseases, acute respiratory infections, malnutrition especially PEM, anaemia, schistosomiasis and intestinal parasitosis. Studies on Sexually Transmitted Diseases (3, 7) suggested that STDs have been a major health problem in Somalia. It has also been reported that there are few Human Immunodeficiency Virus (HIV) positive cases among risk groups (3). However, this seems to miss references to the wider population at risk, such as those treated elsewhere, the self-treated and untreated. In addition to this, there is virtually no information available on the Somalis' socio-cultural knowledge, attitudes and practices, as well as the behavioural factors that affect patterns of infection and utilisation of medical services for HIV/AIDS/STDs.

Although the Somali AIDS National Control Programme (NACP) of the Ministry of Health, has been there since the mid 1980s, during the previous administration not only very little information and educational programmes has been put at the disposal of the Somali people, but also HIV/AIDS/STDs have not been discussed at the political and community level at large, and maybe have never been conceived as a real threat to the public health. Furthermore, during the last 10 years the Somalis have been subject to a tremendous movement within their country, as well as to and from neighbour States with a high HIV seroprevalent, and elsewhere in Europe, North America, Australia and New Zealand due to the civil war at home. This may have triggered further spread and may have worsened the pre-war situation of HIV/AIDS/STDs of the people in and outside of country.

Recent reports from Hargeisa, Berbera and Borama of Somaliland have suggested high rates of HIV seroposivity among Somali volunteer blood donors and other ordinary people (9). More recent research reports from Hargeisa, the capital city of Somaliland, and Bossaso of Somalia, have pointed out that the seropositivies for HIV were seven (3%) out of 236 women tested for HIV, and three (1%) out of 300 women respectively (4). Simultaneously, there has been a growing number of the Somalis who arrived in Sweden during the civil war who have tested HIV-positive (5).

In December 1998 there were 3 085 Somali immigrants in the city of Gothenburg alone out of about 15 000 Somalis in Sweden (18). The majority of which came here from late 1989 to 1996. More than half of them are believed to be between pre-school age and 20 years old. It is believed that most of these immigrants who have arrived in Sweden are abroad from home for the first time. Moreover, they have set off on this journey with little or no information about HIV/AIDS/STDs (2). This paper attempted to explore experiences against HIV/AIDS/STDs of Somalis in exile in Gothenburg, Sweden.

Theoretical Frame of Reference

One of the theoretical perspectives in social science, especially among so called third generation (8) theorists, when analysing cultural issues, perhaps the most influential one, is symbolic interactionism. These theorists have contributed a lot to the understanding of cultural processes like stigmatisation, deviant behaviour and norm distribution. Anselm Strauss is of particular relevance, in this paper, because he, in collaboration with Barney Glaser, has constructed the methodology of grounded theory (13).

The founders of the symbolic interactionist perspective, Herbert Blumer (6) and his teacher George Herbert Mead (21), have postulated that what people think and reflect on, are basically internalised social dialogues. This means that when we try to solve our problems and plan for the future, we are involved in an inner dialogue in which we evaluate our perceived possibilities.

The symbolic interactionist perspective also postulates things about the relations between the individual and society. It is a theory which in a dialectic way, at the same time, considers the fact that people are both determined by and creators of society (8). Even if the individuals internalise the values and norms of their surrounding social environment, they also take active part in the transformation of the same environment. When explaining this phenomenon, Mead (21) on the individual level divides the self of the individual into two parts - the "I" and the "me". The "I" part of the self emanates what can be said to be more private and intuitive but also out of control. The "me" part, on the other hand, is our social self, directly influenced by the feedback the individual receives from his or her social environment.

Following Stevens (24) but applied to our Somali example, this can be perceived as something like what is described in (Figure

I	⇔	Me
I really want to have a woman tonight.	⇔	You are not supposed to have sex before marriage!
But Allah has not given me strength enough to resist this need of mine.	⇔	You should fast (soomid) from food for a couple of days in order to reduce your desire for sex (shahwaadkaaga).
I would rather go for it and ask Allah for forgiveness.	⇔	Okay, but in that case you must protect the women and yourself, for example.
Well, I am absolutely sure I can handle it without a condom.	⇔	No, no!!

Figure 1 - The inner dialogue between "I" and "me".

1). An inner dialogue is carried on between a young, unmarried Somali man living in Gothenburg and the "moral order" of which he is part. The "moral order" talking to this young is the voice of his culture that he listens to and negotiates with. The culture with its norm systems prescribe different things. It is not an inborn gene. But it is transmitted by living people, i.e. by his mother and father, by his other family members in Somalia as well as by friends, and more indirectly by mass media, religious messages, etc. All these people can be regarded as significant others. When you than internalise all these voices in your self, they appear in the shape of what the symbolic interactionist labels the generalised other. With this, culminated the socialisation process.

Method of choice

A qualitative individual in-depth interviews and focus group discussion with semi-structured and thematized emerging design was used in this study (20). Four major themes of the study were originally written in English and later were translated into Somali. The four themes were 1) Somalis experiences' of sex education and sexual relations in Somalia and in Sweden; 2) Somalis perceptions' of HIV/AIDS/STDs and health action in Somalia and in Sweden; 3) Somalis attitudes' to use condom and other methods against HIV/AIDS/STDs in Somalia and in Sweden; 4) Somalis research participants socio-demographic characteristics. This study is primarily governed by a symbolic interactionist perspective (8) implying that the findings are regarded as results of a joint venture between the participants and the research team. The findings are meant to be used as information for education and communication programmes about preventing HIV/AIDS/STDs by the City of Gothenburg Immigrant Services Administration. As well it might be used as a basis for further studies.

Subjects and information gathering

During information gathering process Jamila Said Musse (JSM) the female research collaborator contacted 13 potential research participants (4 women, 2 young girls, and 6 men and 1 young man). These candidates were chosen because they were ethnic Somalis, living in Gothenburg and willing to share with us their experiences against HIV/AIDS/STDs. Each individual research participant was met and given a standard information by ASA the first author of this paper. These include the modality and the information gathering process, our intention to use a tape-recorder during the interviews and that the interview was to be carried out in a private and calm atmosphere, and that it could last between one to two hours. In addition we informed them that we keep confidential the information gathered as well the individual anonymity. We also explained to each research participant had the right to quit from participation any time that she/he wish to do so and chose where the interviews to take place.

All thirteen individual candidates that we contacted initially were interviewed. Questions were asked in conversational style in all interviews and constant comparison was made between the interviews, according to Grounded Theory (13). Ten of them were re-interviewed two or more times. All first leg interview lasted roughly between one and two hours. But all second and third leg interviews lasted less than an hour. All interviews were tape-recorded, except one which we did not need to record as he gave us a very simple diagram about the themes in discussion. The three first interviews were transcribed in Somali and translated-transcribed into English, all the rest were transcribed in Somali and translated into English or just transcribed and partially translated. The reason for this was to make easier for both authors of this paper to share together the analysis and interpretation of data gathered. The interview took place in different

places such as the participant's own flat, a friends' place, a relatives' place, in own car, in the city street corner, in an office library, and in a restaurant. In addition to this we visited and observed during this study period several Somali families households and spent time with them while they ate, watched TV, or get together for social gathering.

We also performed a follow-up focus group interviews session and discussed with 10 participants (2 women and 8 men). They were chosen of being ethnic Somalis and knowledgeable of the Somali community in Gothenburg due to their work relation with it such as being a community leader or community activities promoter, intellectual, interpreter, school teacher, mother, religious, university or other higher institutions student and so forth. They were provided a summary of anonymous selected issues from the individual interviews and their reactions were recorded. The focus group session took place at Hotel Eggers in Gothenburg city centre and in front of the main railway and bus station (for more information see reference 1).

Figure 2, shows which codes under each heading that generated the categories which identified the sub-headings. Our presentation of results follows this figure and in the text the codes are marked out in italics and the categories in italics and bold. Under each heading we introduce our material briefly and give the quotations from our data collection, preferably in narrative form. After this we

Codes	Headings & Categories
	Sex education and heterosexual relations
• Associations (isku xirnaan)[4] • Unmentionable (mamnuuc) • Hidden (qarsoon)	*Sex* – something *invisible*
	Risk perceptions
• Sins (dembi) • Embarrassing (yax yax) • Punishment (ciqaab) • Shying off (xishood)	The disease of *stigma* and *embarrassment*
• Denial (inkiraad) • Secrets (sir) • Hidden (qarsoon) • Understanding (garasho)	Who is mad, the doctor or the client: An important *choice*
	Suggested health actions against HIV/AIDS/STDs
• Blame somebody (eedeyn-qof kale) • Plead bad luck (nasiib darro cuskasho) • Blame yourself (is-dhaliilid) • Blame Allah (Ilaah-amarkiis) • Protection (dhowritaan) • Western medicine (dawada reer Galbeedka) • Traditional healing (dawadadhaqanka) • Mission impossible (ergo aan suurto-galeyn)	*Experiencing* the *causes* of the diseases and *procedures* of *treatment*

[4]The words in brakets are Somali

Figure 2 - Codes and Categories in interpreting data

present brief comments based on the codes and categories presented in (Figure 2) under each sub-heading. We will come to the end with some recommendations and conclusion.

Findings

The research participants socio-demographic characteristics

We interviewed 6 women and 7 men research participants, and one of the men was HIV positive. We also met and discussed informally with unspecified number of men and women about the themes of this research. Thus their views were included in the interpretation of the data. These subjects lived and came from very different regions of Somalia, i. e; North-Eastren region of Bossasso, Central regions of Mudug and Galgaduud, and Sothern regions of Banaadir (Mogadishu city) region, Lower-Jubba and Bay. They also belonged to different clans. However, they could be traced back to the same geographical areas of Noth-Eastern and Central regions of Somalia. They shared the *Maxaa* dialect, as well as the Somali sub-cultural modules of nomadic pastoralists.

Sex education and heterosexual relations

Sex - something invisible

In Somalia there was not a formal *sex* education institution for children due to cultural and religious barriers. Thus, they not only learn sex information through an informal socialising process but also it is not allowed the names of the *sex* organs being pronounced other than to be used as metaphors (sarbeeb) i.e., as woman's piece (cadka gabadha) and man's piece (cadka ninka). This was described in the following quotation by a research participant.

> In the Somali culture it is not allowed to pronounce the names of these organs rather it is allowed to use *metaphors* (sarbeeb).... the background of these restrictions is the religious culture. The still unmarried person is not supposed to be involved in these issues and to not have sex... Therefore, while children are little and until they reach puberty it was not supposed to be mentioned to them such issues. (A religious man).

Codes identified under this sub-heading were all mirroring something latent, not easily discovered, actively concealed or almost unconscious. Sexual behaviour is for sure something the Somali people do not speak to strangers about, not even to relatives of different ages or sex. Because of this, sexuality is *hidden* and the discourse of *sex* education is left in the hands of youngsters of a similar age. This process of *hiding* and not communicating issues on sexual relations has culturally created a situation in which people are not even able to mention sexual attributes and patterns of behaviour. All this is taboo and the words possible to use are regarded as *unmentionable*. Instead, metaphors, paraphrases and associative terms and expressions flourish. The category given by these codes are *invisible*, and the consequences for the rising generation are ignorance and prejudices concerning sexuality and sexual relations.

In addition many individuals and focus group research participants agreed that Somali girls unlike their age group males, grow up in a very hostile socio-cultural environment from early childhood through adulthood. They are humiliated, disrespected and often verbally abused by their family members saying for example "you are worthless female". One reason for this maybe due to that they do not increase the number of their family patriarchal system and they may offend their clan/family honour through sexual transgression sometime during their lifetime. They are physically abused and subject to female circumcision or infibulation or female genital mutilation (FGM), visible virginity control by her mother or her female caretaker as well being treated like a temporary member in her family until she gets married and brings home the customary dowry. All these mistreatment and similar others

obviously *degrade* their *self-esteem* and self-confidence. The ultimate aim is to control their sexuality, prepare them mentally to be *obedient* and submissive to the patriarchal system. They are subjected to a very extensive form of social control, which is especially pronounced on issues regarding sexuality. All this contributes to reproducing the patriarchal features of the traditional society. The following quotation was given by an interviewed Somali mother.

> There were girls who experienced infibulation operation more than 3, 4 times due to failure of the 1st, 2nd, 3rd attempt and so forth. When the mother suspect something and her daughter do not respect her expected time and place then she says show me it [duu]!! Because she knows the original measure of it (the visible virginity). This is the mothers way of checking up of the integrity of her daughter's visible virginity. (A mother interviewed).

The still unmarried girl visible virginity check up is not only a private issue between mother her daugther but also can happen between rival girls who challenge each other about who has got the smallest vaginal opening as a result of infibulation. Sometimes still unmarried girls fight and accuse each other of being prostitute [dhillo or sharmuto] and consequently exhibit their visible virginity publicly. The following is the reaction from a male colleague about this issue that I asked to read my manuscript.

> ...a very moving example. I was subjected once to that exhibition. I was may be 8 or 10 years old, I will never forget. Two girls bigger ones fought and accused each other of being prostitute (dhillinimo) and offered to check up the integrity of their visible virginity [feedasho] in front of everybody. I was shocked so huge crowd. It is still there in my mind.

Instead boys are encouraged to check their manhood rather than being their virginity checked up. The following is a just one of many examples that we were told about this issue by a research participant.

> The young man who reached puberty wanted to check his sexuality, this was one reason to visit the brothel [guri dhillo]. Many teenagers went there... (A man interviewed)

Risk perceptions

The most perceived of the STDs by the individual research participants was gonorrhoea [jabto]. Two women and three men also mentioned that they heard that gonorrhoea can cause infertility in both women and men. They also perceived that the gonorrhoea [jabto] could be caused by different factors (Figure 3). First, gonorrhoea [jabto] could occur due to Allah's will. Second, it could occur in both women and men if they make use of a temporary hygienic article after urinating, with sun-heated stones, soil, and wooden sticks in the bush, on sunny days particularly when water for personal hygiene is not readily available on the spot. The same was valid if people, particularly men, walked without shoes for long hours on the sun-heated ground during dry season. Third, they mentioned that gonorrhoea [jabto] could also be caused by a prostitute [sharmuuto].

[Gale] which caused a serious backache and a pain on the sex organs of both men and women was the second most perceived by the interviewed individuals. [Gale] may and may not be sexually transmitted according to different individual research participants. It could be caused by different factors such as to sit a sun-heated stone, and working while bend for long hours. One woman mentioned that [gale] is contagious like gonorrhoea, while one man argued that [gale] is not contagious like gonorrhoea because both infected men and women do not shy away to discuss it publicly. This is not possible in the case of gonorrhoea due to a strong social stigmatisation.

One woman mentioned chlamydia and fungus infection (Figure 3). Similarly one man mentioned oral-vaginal candida albicans [umuloow] and scabies [isnidaamis]. Another one mentioned syphilis [xabbad]. Only one woman and three men had heard about AIDS before they came to Sweden. However, the interviewed individuals gave the following different Somali metaphors which they used indiscriminately for HIV and AIDS, such as the

savage [bahalka], the disease [cuddurka], the bad disease [cuddurka-xun], bovine-pest [dabakaruub], the 4 numbers disease [cuddurka 4ta lambar], sliming [caateeye].

The diseases of stigma and embarrassment

Individual research participants from urban areas of Somalia, as well as religious people, described STDs as the diseases of prostitution [z-sinno] which implies *embarrassment* and social *stigmatisation*. They also felt and expressed their common worry about the sex-free attitude of Europeans. The following two quotations were taken from two interviewed individuals.

> Anyhow, in summary the STDs are called, for example, the diseases of prostitution [z-sinnada] or *embarrassment* [fawaaxishada]. According to what I have heard from other people... some have said, you know, that HIV/AIDS is a *sin* or *punishment* [cuquubad] which *Allah* sends to *punish* those who have sex without marriage the [z-sinno]. Then, in addition to that there is, Prophet Mohammed's tale [xaddiith] which said "at the end of this world there will be some people who will adapt sex without marriage [z-sinno] who spread it, who are very proud of it. If they do this they will get tragic *punishment* and diseases which never ever have been seen, never ever have been known, they will get infected with that." Thus, the best cure is to ask Allah for pardon and to leave the well of HIV/AIDS which is fornication [z-sinno]. (A religious man)

Perceived STDs	Causes	Procedures of treatment of STDs	
		Modern	Traditional
Gonorrhoea	• Allah's will. • Sun-heated stone. • Sun-heated wood. • Sun-heated soil. • Prostitute. • Borrowed underpantes.	Medicine without prescription: antibiotics Aspro	Allah's *will* To have sex with a prostitute Applying discharge from one's penis on money and leaving it in a road, so that the disease will move into the person who takes it.
Chlamydia	• By sex	Hospital	No suggestion
Gale (backache and pain on sexual organs of men and women)	• May or may not be sexually transmisibile • By working while bend for long hours • By sitting on a sun-heated stone	No suggestion	Burning lumbosacral region of the body with metal rod: two frontal and two posterior points, drinking camel milk, and ghee from a sheep fat and eating its meat. Drinking, or steaming or applying on the body herbs and resin.
Oral & vaginal Candida albicans	• By Allah	No suggestion	Eating a half-done caw tongue, and drinking and steaming a mixture of herbs and resin (local names: malmal[5], xabaghidi[6], xulbad, dacar[7], and xaddiid).
Syphilis, and Scabies	• By Allah	No suggestion	No suggestion

[5]Malmal: Myrrh (Bursoraceae family).
[6]Xabaghidi: commiphora guidotti Chiov.
[7]Dacar: Aloe microdonta Chiov.

Figure 3: Major causes of perceived STDs and suggested *Procedures of treatment*.

> In reality, the easy sex started when there was an exchange between urban rural areas... When I came to study in a town, it was a big town which was the capital town of some regions... At that time, no one was able to date an ordinary good girl, but there was a *brothel* [xaafad dhillo] ... This *brothel* was where people spent their evenings and that was where the dangerous STDs spread from. The young man who has reached puberty wants to check his sexuality, this is one reason to visit to the *brothel*. It had its surprises! We immigrant groups from the countryside who moved to Xamar (Mogadishu) we thought that STDs were because of the new environment, of the coastal climate, and so forth, you know, we said we suffered from homesickness [daltebyo], we thought it was homesickness [daltabyo!]
> (A man interviewed)

However, several members of the focus group discussion disagreed with the view of previous interviewed individuals who said that the HIV/AIDS is Allah's *punishment*, and it infects only non-Muslims and those people who have sex in unnatural ways. They pointed out that whether you are or not a Muslim the important question for everybody is how to prevent it. According to the focus group participants, HIV/AIDS should be evaluated and judged as a health and social problem rather than valued only as a spiritual and religious priority problem.

> We should not confuse the religious point of view of HIV/AIDS and the real facts of HIV/AIDS, thus, we should tell people the crude reality of it. (From the focus group)

Codes identified under this sub-heading mirror people's perceptions of STDs as something dishonourable, and this is especially true for HIV/AIDS. The category chosen for these codes is *stigma*, which has been used by a great many researchers when analysing these diseases. Because STDs are sexually transmitted and sexuality is taboo in the traditional Somali culture, STDs *stigmatise* and are perceived as very *embarrassing* and as a *punishment* for *sins*. Of course, this tendency of *shying off* the problem leads to ignorance of how to behave, which in turn decreases the risk perceptions and, in extension, may also increase the risk of being infected.

Who is mad? The doctor or the client: An important choice

There has been some misunderstanding and even mistrust in the encounter between immigrants and the Swedish medical care professionals. The following four quotations that are from four different men interviewed may illuminate some of these cultural meetings and consequent communication problems between the two parts.

> I was present once with a family composed of a man and a pregnant woman. I did not see them so I did not know what they looked like as I interpreted for them by telephone. Originally, the man was HIV positive and had infected his wife but the child was healthy on the day that we talked by phone. When I interpreted for them by phone, they were with the doctor, and they both agreed and said that the doctor was mad, we are not HIV positive. Therefore, it is difficult, as we mentioned before, to convince Somalis ...about the existence of the disease, and the person who is discovered having it ...says, "This is written by Allah" ...Particularly the religious people strongly believe that they will never catch it (HIV). However, we saw people like Sheikh or Muslims who got it without being in sex entertainment places. (An interviewed man)

> There was a Somali man who was diagnosed as having the bad disease (HIV) which is transmitted through sex, then he was informed that he could marry, but if he does, he could only marry a HIV positive woman. Then the man bought a ticket and travelled to Africa and get married with a young girl who was 20 years of age ...he came back with her while she was pregnant. It was discovered that she was HIV positive and when she was

asked whether or not her husband told her about his being HIV positive and did she agree to marry him despite that. She said that neither did he inform her nor did she know anything about this. " Since I came in this country he used to isolate me from others to communicate with me and to give me information. He was my translator, he knew the Swedish for me, and I did not know anybody else. I loved my husband and I love him but I wonder what you are telling me". (An interviewed man).

Recently, I have interpreted for a Somali girl from home country, and on the same day she gave a blood test. When I was called again for a follow-up meeting, the doctors told me that the girl was HIV positive, but she was not there because she had already travelled to another country to get married to a Somali man who lived there. I could not do nothing as an interpreter, but the man that she was going to marry was facing a deadly danger. (A man respondent).

Codes identified under this sub-heading express the suspiciousness of people, especially those with traditional values, of western medicine and Swedish medical doctors. To accept help from the Swedish healthcare system is an important step. It is a crucial *choice*. When it is about accepting preventive information regarding risks of getting HIV, all these taboos which have been described above are important impediments. The *denial* is many times comprehensive. It is about the disease itself. It is about sexual risk behaviour. All of these are secrets and *hidden* from close relatives and friends. Without any doubt these "trenches" should be abandoned in order to obtain sufficient knowledge and understanding for fighting the disease.

Suggested health actions against HIV/AIDS/STDs

Experiencing the causes of diseases and procedures of treatment

Many research participants mentioned that their fellow countrymen and women often *shy away* and *hide* their disease events particularly those diseases associated with social *stigmatisation* including STDs and Tuberculosis. Nevertheless, two women and two men were able to describe, in detail, with regard to the causes of diseases and suggested *traditional* and *modern treatment* of gonorrhoea [jabto], Backache [gale], chlamydia, and oral and vaginal candida albicans [umuloow] (Figure 3). But all the rest of the interviewed had some limited knowledge of this, three men said that STDs were not curable in Somalia at all. The research participants did neither suggest any modern treatment for backache [gale], oral and vaginal cadida albicans, syphilis [xabbad], and scabies [isnidaamis], nor they did suggest traditional treatment for chlamydia, syphilis (xabbad), and scabies [isnidaamis] (Figure 3).

Marriage as a tool to prevent HIV/AIDS/STDs

Several men interviewed suggested that marriage may be used as a method to prevent HIV/AIDS/STDs. With this they meant clan and rural family-based marriage system. The following quotation is taken from one of these men.

I believe that the person should use marriage as a preventive measure. The person who wants to marry should follow the old Somali culture of an Islamic marriage. The culture was that, one should marry a pure girl from a pure and well-known family, that the girl knows the man, knows his history, the history about his known identity... Often this will be a prevention. If the person marries a person of that quality, then the next step will be that he stick with his wife rather than, you know, going other places. (A religious man)

Some of the interviewed individuals discussed the possible link between polygamy and the spread of HIV/AIDS/STDs. This was also emphasised by the focus group participants. One female focus group participant argued that the danger of polygamy in spreading HIV/AIDS/STDs is a reality and she backed her argument with the following statement:

When we interviewed men in Mogadishu in 1989 about HIV/STDs, 40% of the married men told us that they had been involved in extramarital affairs [gogoldhaaf]. In addition to this, some married women who participated in our research in Hargeisa (Somaliland) and Bossasso (Somalia) in 1997 and who were HIV positive said that their husbands had been involved in polygamy situation with more than two women for each man. (From the focus group session)

The condom as an anti-marriage or fornication tool

Some research participants argued that the use of condoms by married couples would be difficult because the proponent will be suspected by other side as having a hidden agenda, i.e., that he is engaged in other sexual relations. Some others pointed out in the following quotation that a condom use is incompatible with proper *sex*.

...most people believe that a person who wears condom cannot have proper *sex* ...many people believe that *sex* with a condom is not *sex*. (An interviewed man)

On the other hand, the religious group see condom use outside marriage as an fornication tool. Thus, they might not accept its use systematically as a safe *sex* technology not only against HIV/AIDS/STDs but also for family planning. This is emphasised in the next quotation by an interviewed religious man.

I do not believe in the idea which purposes that, you know, fornication is free and people are allowed to use a condom as *protection*. (A religious man)

The condom as a tool to prevent HIV/AIDS/STDs

Some individual research participants argued that most Somalis may not accept the idea of condom use due to a misunderstanding of this technology, as described in this quotation by a interviewed man.

In places where I interpret and doctors explain it and I translate it for the client, I look around me and ask myself how I can pronounce the word "condom" and similar other words while girls are looking at me. It is easy to educate the younger generations about how to use it. But it is difficult to convince the adult ones and they will not accept it. They will not accept it, because there never was a girl who accepted that her husband put on a condom and approached her nor was there a man who has said, "I used condom with her". It is an ***embarrassment*** for them. (A man interviewed)

The focus group discussion seemed to welcome about condom use positively, in general, but when they were asked whether or not the teenagers should be informed about condoms as a tool to prevent HIV/AIDS/STDs they instead preferred to use unspecified metaphors like [sarbeeb] than to pronounce the word "condom" directly. The following statement summarised the focus group participants' views on this issue.

Somalis are a male dominated society like many other societies, thus, the children should be told about condom use through the use of metaphors [sarbeeb]. (From the focus group discussion)

Codes identified under this sub-heading are about perceptions of what causes the STD diseases, and perceptions of what to do about it. Regarding the first issue, the category which sums up the codes, is *blame*, and the main question is: *Who is to blame*. A more modern attitude here is that the *blame* should be put on the individual *blame yourself* who has behaved in an irresponsible way, or on some characteristics in the social structure of the society, i.e., its patriarchal features *blame somebody else*. Among traditional people, on the other hand, there is a pronounced preference to look at problems as caused by the will of Allah *blame Allah*, an attitude which casts off the responsibilities from the individual and obstructs preventive measures intended to change sexual risk behaviour. Sometimes there are also indications of fatalistic attitudes, when people *plead bad luck* in attempts to explain the fact that they have been infected.

As a consequence of the individuals' different understanding of the causes of these diseases, there are also different opinions about how to cope with them. Two categories appear on this issue: *experiencing the causes* of diseases and *procedures of treatment*. In general, people know that the possibility of curing AIDS is not real but that it can be kept it in check for a while. This means that the attitude to the possibilities of curing the killer disease is ne-

gative both when using Western medicine and *traditional healing*. *Mission impossible* is a code, which we think well covers our interviewees' evaluation of the situation. What can be done is to prevent and *protect* people from the disease and most people support education/information about risk behaviour. As concerns *protection* as a preventive measure, the attitudes vary. The traditionalists have argued that condoms increased the possibility of promiscuity, while young and more modern people saw condoms as something good.

Discussion and conclusions

We have demonstrated that the Somali immigrant parents have never had a modern culture of *sex* education for themselves and this has important implication for giving proper information to their children about *sex* organs, human sexual development and preventive measures against HIV/AIDS/STDs. Most of the time there is a communication barrier between the children who speak native Swedish and the parents who immigrated to Sweden as adults with no knowledge of any language other than their mother tongue. It is a daily occurrence that in these Somali immigrants' parents and their kids communicate through combination of some words of mixed linguistic origin, facial expression, mimic and body language. This may lead a communication break down and the need arises for a interpreter who may or may not be available at the time. The focus group participants argued that "in many circumstances many Somali parents are less educated than their school children". Moreover, we have been told and witnessed during this study fieldwork that " Somali parents tell their children to cover their eyes when there is a film on TV in which two people kiss each other." Because they think this will show their children the wrong path. Although these parents have been given some information against HIV/AIDS/STDs by Swedish agents using Somali collaborators they still seem to shy away from discussing this issue properly among themselves. Similarly they shay away to talk to their children about HIV/AIDS/STDs and its preventive measures due to the taboo on *sex* organs and sexual relations.

Therefore, immigrant Somali parents should be helped in giving a proper answer to their children with regard to *sex* and *sex* education. It is necessary that there is a Somali Counselling and Resource Centre (SCRC) which could give advice to parents about the children's questions related to sex organs and human sexual development as well as the two cultures in which the children are involved (the Somali home culture, and the Swedish school and social systems and norms). The SCRC should also bridge the gap between Somalis immigrants in Sweden, and Swedish institutions with regard to social and healthcare related issues, such as offering comfort and counselling to those people who are HIV infected and are in a crisis situation. This Somali SCRC should collaborate with Swedish institutions, in planning, organising, and implementing its activities. It SCRC should seek financial and technical support from the Swedish local and national authorities. It should organise, whenever there is an opportunity to do so, cultural sensitive public debates and meetings in which its participants should include religious people, Somali intellectuals, Somali parents, school children and teenagers, child development experts and researchers on the current issues.

The religious groups and leaders should support the campaign to raise the awareness of the community against HIV/AIDS/STDs. They should condemn the Somali traditions which mistreat females systematically, when compared to males. They should come out and join the campaign for children's and women's human rights.

It might not be easy to describe teenagers' sexuality and related HIV/AIDS/STDs health problems, particularly when these teenagers belong to a male dominated society, such as the Somali one which is subjected to both

horizontal and *vertical* conflicts and maybe frightened by foreign attitudes, behaviours, and values transmitted by different actors in Swedish social institutions and social environments. However, we strongly recommend that this innocent group of the society be studied with regard to not only their knowledge, attitudes, and practices relating to HIV/AIDS/STDs, but also their relations with their parents in this ambivalent world, and the double morality that the Somali teenagers may be trapped due to the two cultures that they are in, particularly the females who experienced FGM practice and plan intervention programmes accordingly.

Both men and women that we talked to formally and informally may have heard mainly about gonorrhoea [jabto], backache [gale] and HIV/AIDS in one way or another (Section, 5.3 and Figure 3). However, many of them could not distinguish between HIV and AIDS due to *sex* related taboos. More importantly, none of these research participants admitted to having used a condom as a tool to prevent HIV/AIDS/STDs or for family planning. Instead we were informed that many Somalis believe that condom use is a barrier to proper sex and its use legitimise spread of fornication. Because they say that "it will encourage the spread of fornication or sex without marriage". Maybe for this reason, we have been told that some Somali adult women use IUDs for family planning. We have also been told that the divorce rate among this community in *exile* is very high. Some of these divorcee might have been involved in polygamy sexual relations. Thus, we may conclude that the safe *sex* attitude of these male-dominated immigrants is very questionable. Therefore, there is a need to undertake specific and deeper community studies on gender structure, and safe *sex* perceptions and condom use attitudes and to plan follow-up community intervention.

We did not meet and talk to enough people of both males or females who are HIV positive due to a lack of funds, thus, we do not know about their awareness, attitudes and practices concerning HIV/AIDS. However, we did hear that both male and female HIV infected Somalis may live in painful self-imposed cultural isolation. Thus, they may need to communicate with their fellow Somalis particularly someone who could understand their situation, their feelings, and who is willing to share with them some of their socialising network activities, and who could, finally, offer them advice and crisis management within their socio-cultural framework. In addition, the narratives that we have managed to collect from interviewed individuals indicate an urgent need on the part of the Swedish decision makers and health care authorities to initiate further research in order to improve our knowledge of these unfortunate peoples' condition, as well as to plan a culturally sensitive education and communication programmes aiming to ameliorate their situation.

We fully support the ongoing project against HIV/AIDS administered by the City of Gothenburg Immigrant Services Administration and aiming to educate people against HIV/AIDS. However, different immigrants in Sweden have different socio-cultural understandings of HIV/AIDS/STDs and health action. Therefore, some of these immigrant communities such as those we present here need sincere understanding, attention and support due to their socio-cultural situation, especially with regard to health promotion programmes and to plan activities according to their needs with long-term commitment as has also been pointed out by other researchers (10). Finally, we recommend a cultural meeting study which could describe the meeting between these Somalis in *exile* and the Swedish healthcare professionals, in general, but particularly with regard to HIV/AIDS/STDs in order to find out and describe the hidden dynamics of these cultural meetings, barriers and potential in the communication process.

One more remark is that people in developing societies have their own sense of the world, one

which is very different from that of the industrialised countries (12). Somalis often have an effective and inclusive communication network which should be taken into account in any development programme. When two Somalis meet on a country road, even if they do not know each other, they normally exchange greetings, and news, by enquiring about each other's respective localities and even about people's health, farming, livestock and rain situation, as well as about matters of security. Person to person communication at the water-hole, while going to and from field work, at meetings, at the marketplace, in the streets, at a cafeteria, and wherever they meet and get chance to talk, is part of the life of an oral society like Somalis. In this way news spreads rapidly.

Summary

Since 1989, the City of Göteborg Immigrant Services Administration has been making efforts to inform about HIV/AIDS. The purpose has been to ensure that even immigrant residents of the City of Göteborg (Gothenburg) have access to relevant information about HIV/AIDS. The administration's efforts have been a part of the collected efforts of Gothenburg to prevent the spreading of HIV. This paper attempts to discover and describe experiences against HIV/AIDS/STDs of Somalis in *Exile* in Gothenburg, Sweden. A qualitative sociological in-depth interviews with 13 individuals (6 women and 7 men) and with semi-structured and themetized emerging design was carried on. A follow up focus group interviews with 10 individuals (2 women and 8 men) was also performed.

The paper reveals that the general understanding of subjects on the issues under discussion is almost the same though details may vary from one research participant to the other. They have described this through narratives. STDs and specially HIV/AIDS was perceived as something dishonourable by the subjects. The HIV/AIDS is perceived as a sin which Allah sends to punish those who have fornication or sex without marriage (Zinna). Of course, this tendency of shying off the problem leads to ignorance of how to behave, which in turn decreases the risk of perceptions and as a result may also increase the risk of being infected. As concerns protection as a preventive measure, attitudes vary. The traditionalists have argued that condom increased the possibility of promiscuity or fonication, while young and more modern people saw condom as something good.

We may conclude that Somalis who have arrived in Western world and in Sweden as adults did never have a modern sexual education for themselves due to socio-cultural reasons and this has important implication for giving proper information to their children about sex organs, human sexual development and preventive measures against HIV/AIDS/STDs. These immigrant parents should be offered culturally sensitive communication and educational programmes aimed at raising their awareness about teenagers sexuality and the preventive measures against HIV/AIDS/STDs.

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