



SUDANESE CULTURE



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BACKGROUND INFORMATION

Sudan is the largest country in Africa and bordered by 9 others, including Ethiopia, Eritrea and the Congo. Since independence from Egypt and Britain in 1956 military dictatorships favouring Islamic governments have dominated politics, and the country has been ravaged by civil war (since 1972) and wrought by strife. The people of Sudan have been experiencing persecution, famine, plagues, oppression and atrocious human rights violations for decades.

The religious struggle between the Islamic fundamentalists in the North against the diverse ethnic groups in the south (including many Christians) resulted in a genocidal campaign led by government militia leaving the country chronically unstable, both economically and politically, and rife with atrocities. Rape as organized onslaught is pervasive, and famine has been used as a weapon of power with international aid being withheld from the South by corrupt military leaders, resulting in widespread starvation. Since South Sudan's independence in 2011 fighting between different factions has kept this country at war, devastating communities and leaving over 2 million people in humanitarian crisis by 2014. It is estimated that the war and famine-related effects have created more than 2 million deaths. Sudan is now one of the poorest countries in the world and has one of the lowest literacy rates.

In 1993 more than 5 million people fled the countryside, some into the towns in Sudan and many to neighbouring countries of Ethiopia, Uganda, Kenya and Egypt. It is estimated that over a million of these people died in flight. Many refugees are from the minority ethnic groups in the South, some are political dissenters from the North who fled to escape forced conscription and the fundamentalist oppression. Sudanese began arriving in small groups to New Zealand from the late 1990s and continue to arrive as they flee the deteriorating humanitarian crisis. Most of the refugees who have been accepted into New Zealand come from the Nuer and Dinka tribes, and some from the Zande, Hadendowa (which includes the Beja), Nubs, Lwo and Fur tribes.

There are considerable differences between cultures from the North and South. Differences are highlighted throughout; otherwise the information applies to most Sudanese.

Photos: by kind permission of Refugees International, www.refugeesinternational.org, and flag from Wikipedia.

COMMUNICATION

Greetings

Hello greeting	<i>Salaam aleikum</i>	'Peace be upon you' (Muslims)
Goodbye greeting	<i>Ma'a alsalam</i>	'God be with you' (Muslims)

Main languages

Sudan is linguistically and ethnically very diverse, particularly in the South. However **Arabic** is spoken by most Sudanese as well as their particular **tribal language**.

Arabic Juba is a dialect commonly understood by a number of ethnicities in southern urban areas. **English** is spoken more in the South, and mostly by those with education. (English was the official language before independence in 1956). As literacy is very low it is recommended not to use written material for health education or treatment purposes.

Gestures and interaction

- It is appropriate to **shake hands** with the same gender (using the **right hand**) but **not** culturally appropriate with Muslim women
- Pointing a finger is considered rude, and both hands should be used for passing objects between people
- Traditionally, **direct eye contact** is considered rude. Lowering or averting the gaze is a sign of respect. Most Sudanese in New Zealand accept direct eye contact from the host culture, but may decline to return this out of respect
- The eldest man in the household holds **authority** and should be treated with respect
- **First names** and 'Mr' or 'Mrs' can be used
- The wife does not traditionally take the husband's name. Records may need to be adjusted to accommodate this
- **Respect** is also age related; those who are older are afforded utmost respect
- Showing an **interest** in the culture and practices will likely enhance relationship with the practitioner and compliance
- Health practitioners are generally highly regarded and deference usually accorded to their opinions. It would be helpful for Practitioners to **invite client's** to share their opinions and questions

FAMILY VALUES

- Families are extended and live together with all children treated equally
- Males are heads of households and dominate the economic and social domains
- Traditionally women are responsible for childrearing, the sick, old and mentally ill. However, after resettlement fathers may become more involved because of lack of family support
- Gender segregation for eating and socializing is traditional. Resettled young couples may live more like westerners
- Divorce is acceptable as a last resort after families have failed to assist in resolving problems. Often dowry's have to be returned

- After divorce, children irrespective of age, always live with the father's family

North

- In some families the groom's family pay a dowry, usually money
- Marriage is arranged and seen as a contract between families. Sometimes the final decision is made by the woman
- Preference in marriage is given to cousins and relatives

South

- The groom's family pay a dowry, usually with heads of cattle (Dinka and Nuer), or with pigs, goats, crops or money depending on resources. In resettled countries this may be paid in money, or with stock to families in Sudan
- Men may take more than one wife and the number is indicative of wealth
- Marriages are usually outside the tribe, clan, or social group
- Children are raised in distinctive gender roles with girls learning about home management and boys being encouraged to develop endurance, valiance and strength in order to protect themselves and their families later on
- Girls are seen as sources of wealth

HEALTH CARE BELIEFS AND PRACTICES

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

Factors seen to influence health

- **Western** biomedical concept of disease causation is established and practiced in the urban areas although other attributions of ill health may co-exist along with western concepts.
- **Spiritual/supernatural**
Beliefs in spiritual and supernatural causation are common. However different tribes have different beliefs about which spirits cause which illnesses. In some tribes (e.g. the Dinka) spirit possession is more rare and considered less dangerous). So generalizations should not be made about Sudanese beliefs.
 - Relatives or neighbours can function as 'witches' and harm individuals
 - Spirit possession can cause both mental and physical illness:
 - '**Zar**' spirits can affect both Muslims and Christians (sometimes considered as '*red jinn*' by a northern Islamic tribe) and have long-term affects
 - *Spirits* known as '**Jinn**' in Islam can cause some illnesses. '*White jinn*' are benign, and '*black jinn*' can inflict serious illness for which exorcism may not even be effective (See Jackson Ch. 11 2006 for more information about Sudanese beliefs)
 - Belief in the '**evil eye**' is common and it is believed that an individual can put a curse on others by looking at them. This mostly affects children and is associated with physical illness, in particular epilepsy (See Jackson Ch.2, 2006 for more information)
 - **Sorcery** and witchcraft is believed to occur as a result of the actions of people and evil spirits working together
 - Ancestors can cause ill health if offended
 - Punishment from God for sins committed, and God's will are also attributions of practising Muslims

Traditional and current treatment practices

- **Western medicine**

This is more commonly practiced in urban areas. However, Western health care and medicines are scarce and for some, 'traditional' or herbal remedies are relied on out of necessity rather than choice. Herbal and biomedical remedies are often used together

- **Traditional/complimentary practices**

There are many *herbal* and 'traditional' remedies used by the Sudanese. Some of these are ingested and others applied externally (see Kemp and Rasbridge Ch. 35, 2004) for examples. These are less commonly used in New Zealand due to lack of availability. However, substitutions may be found and this needs careful exploring by the practitioner in view of possible drug interactions.

- **Magico-religious articles** and religious/supernatural **rituals** may be used.

Important factors for Health Practitioners to know when treating Sudanese clients:

1. As many Sudanese who enter New Zealand have arrived as refugees, extra sensitivity and care in treatment is necessary given the possibility of extremely difficult pre-settlement conditions.
2. Due to low literacy and education levels, and to limited exposure to biomedical care in Sudan, many Sudanese experience difficulty in accessing health care in New Zealand.
3. Since birth certificates are often lost in the chaos of flight and war, and due to the low literacy levels, there can be problems with variations in records (names and birth dates) from one agency/practice to another.
4. Due to the scarce health care situation in Sudan many resettled Sudanese will present with previously undiagnosed conditions. Kemp and Rasbridge (2004) alert us to the most common which are: diabetes, hypertension, food allergies, severe depression, vision and hearing loss, parasitism and dental problems.
5. As a result of severe shortages of medical supplies in Sudan it is not uncommon for Sudanese to share medications for the same symptomatology.
6. Sudanese tend to discontinue medications when symptoms have abated. It is important to counsel about completing medication and treatment courses.
7. Particularly in the South many herbal and traditional remedies are used and practitioners may need to assess for drug interactions or to incorporate the traditions within the current treatment plan where possible.
8. Muslim clients will fast during Ramadan, which may affect medication and/or dietary compliance.
9. Compliance with prescriptions can be affected by language difficulties. Interpreters can assist with providing written instructions in the client's own language.
10. Great diplomacy is required when dealing with gynecological issues. Many

Sudanese will avoid the topic, particularly if there are language difficulties. Same-sex practitioners are preferred (particularly by the Muslim women) in general, but are imperative for gynaecological examinations for all women.

11. Female Genital Cutting (FGC) is common in Sudan. Literature reports that Type III (infibulation) is practiced more in the South. However, local resettled Christian Sudanese report that this practice does not exist amongst the Christian community. Respectful handling of the issue is crucial with assistance and or education as needed. For those who have undergone the procedure, it is part of the culture and is accepted as such by many women.
12. Although fathers hold authority in the family, mothers usually have more information about children's health and can provide information on this.
13. It is appropriate to inform patients of terminal illness although the family elder should usually be approached first.
14. Teeth filing is part of male puberty rites for some tribes, especially Dinka. As many as 6 front teeth may be missing. After resettlement some men will request cosmetic dental care so as not to stand out in the new culture.
15. The *Beja* in particular are customarily reliant on their families and clan and it will take considerable time to establish trust and rapport.
16. When doing HOME VISITS:
 - Give a clear introduction of nature of service, of roles and purpose of visit
 - It is usually appropriate to remove shoes before entering the home
 - It is customary to address the male adult of the household first
 - Food or drink will usually be offered. It is acceptable to decline politely, although accepting would be appreciated as offering food is a gift of hospitality
 - Modest dress is appropriate, particularly in Muslim homes during Ramadan
 - Be aware that no food or drink is consumed during sunrise to sunset during Ramadan

Stigmas

- Mental illness is stigmatized and sufferers may experience shame. However, families will usually take care of the person if they are not harmful to themselves or others, and the community is expected to support the family
- Rape is highly stigmatized. Single women are not able to marry, and married women are not likely to speak about the experience openly as it would bring dishonour to the family. They are likely to be rejected by the husband for this reason. It is believed that pregnancy resulting from rape is not normal and therefore indicates consensual sex. The children of rape are often abandoned. It is noteworthy that rape is common in Sudan and that many women therefore carry the burden not only of the experience but also of the consequences
- Suicide would be stigmatized for Muslims since it is forbidden in Islam

Diet and Nutrition

Sorghum is the most common starch, sometimes used fermented (especially for the ill and elderly), and also millet and maize. Family members could provide this for

hospitalized clients. Vegetables and greens constitute a substantial part of the diet and meats (beef, goat, sheep, chicken and fish) are also consumed, as well as eggs. Pork will not be part of the Muslim diet and 'halaal' food will be necessary for hospitalized Muslim clients. Malnutrition is common in some areas.

Death and dying

Muslims

- Traditionally Muslims need to bury their deceased within 24 hours
- After death the male body is washed by a male relative or Imam (holy man), and a female by a female relative or midwife
- The body is taken to the Mosque for cleansing and ritual preparation by the Imam (cleric) before it is taken to the cemetery
- Burial in a cemetery is required, not cremation
- Mourning lasts between 3 to 7 days
- Women wear black indefinitely but may remarry

Southern Sudanese (Christian)

- The community and relatives gather around the deceased, segregated by gender (children do not view the corpse)
- Traditionally the body is washed by the family and wrapped in a mat of woven grass or a cow skin and buried. Sudanese in New Zealand may have developed different methods
- Burial in the local family site, is traditional. Bodies are not usually cremated
- Mourning is in isolation in the family home for 40 days and is usually ended by a ritual sacrifice to cleanse the mourning spirits
- Husbands are free to remarry, sometimes the deceased's sister so she can care for the children
- The widow remains part of the husband's family and may be taken as wife by the deceased's brother, but the children will take the name of the deceased husband

HEALTH RISKS

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

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

Social issues affecting health

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

Mental Health issues (particularly PTSD and depression):

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

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

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

In addition, the incidence of malnutrition is extremely high resulting from prolonged war and severe famines.

WOMEN'S HEALTH

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

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

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

Female Genital Cutting (FGC) occurs extensively in Sudan (65%). Whilst the sources consulted do not make any differentiation between Muslim and Christian women, local resettled Christian Sudanese report this to be a Muslim practice only. Other literature sources report that Type III (infibulation) is practiced by Muslims and Type I by Christians. There are extensive initiatives to eradicate the practice, and although it is not illegal in Sudan, The Orchid Project (2013) states that the Government of Sudan publicly opposes Type III.

For more information on the types of FGC see Chapter 3, Introduction to MELAA Cultures, pg 6.

Traditional fertility practices and Pregnancy

- In Sudan it is customarily expected that women should bear as many children as possible, beginning within a year after marriage, and imperatively a son to secure the family's future. Contraceptives are therefore not commonly used
- Traditionally childbearing begins earlier in some parts of Sudan than in the west. However the age level is raised in resettled communities and local members reports that 18-20 is the youngest age to be expected in New Zealand
- Women are well supported by female relatives during pregnancy, this support may be absent for resettled women

- A special kind of clay is chewed during pregnancy to increase appetite and decrease nausea. It is not known whether a substitute is used in New Zealand

Labour and Delivery

- In villages in Sudan most deliveries are at home with midwives assisting with the birth. In resettled countries people are becoming accustomed to hospital deliveries
- Traditionally men are not present during labour or at the birth

Postnatal care

- Most children are breastfed for about 2 years with weaning taking place as the child is walking or ready
- Soft porridge made from Sorghum and soups of boiled meat are believed to stimulate milk production (sometimes a cow is slaughtered to secure enough meat for the post-partum period)
- Cow's milk and a soft traditional porridge is used to assist weaning

Religious Ceremonies Related to Birth

- A cow or goat is traditionally slaughtered (for those families who are wealthy enough) so that enough meat is available during the post-partum period

YOUTH HEALTH

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

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

Newborn & Child Health

- First-born boys are given special attention and usually raised in the maternal village
- In Northern Sudan circumcision for males is practiced soon after birth, and for some tribes in the South
- FGC is usually done between 4 and 12 years but depends on customs of the area

Adolescent Health

- In Southern Sudan puberty is a rite of passage and marked for both sexes with rituals
- For girls it begins with menstruation when they begin preparation for motherhood and receive body decoration on the torso done by cutting (scarification) or tattoos with henna (Dinka)
- Boys also receive scarification lines across the forehead (particularly Dinka and Nuer) and some practice teeth-pulling and filing
- Circumcision of males at puberty is practised in the Equatorial region
- Menses, genital malformation, urinary infections and chronic pelvic complications can occur as a result of the FGC. An infibulated woman/girl must be cut on marriage to allow for intercourse or for others before delivery
- Young girls are equally as exposed to rape and sexual abuse as the adult women
- Given the low literacy levels in Sudan, many children and adolescents may have received little or unreliable education. In such cases they may suffer considerably within a new education system, and need added assistance and support
- Most resettled adolescents will be faced with:
 - role changes at home
 - pressures from peers to integrate more quickly than they or their families may be comfortable with
 - the stigma of 'difference'. Assistance and sensitivity from authority figures will be helpful in the schools
- Many young refugee children and adolescents have been subjected to violence or have been witness to the atrocities leveled at their families and communities during war, and in refugee camps. They may bear their experiences unnoticed. Parents managing the challenges of resettlement as well as their own pre- and post-relocation traumas are often unable to attend to, or to manage the distress of their children adequately. Sometimes children do not tell their parents in order to avoid added stress on the family, out of respect, or because they believe they are in some way to blame. Symptoms of trauma may present as behaviour problems, withdrawal, learning difficulties, poor concentration and motivation as well as with various somatic complaints. These presentations may mask post-traumatic stress, depression, anxiety and other mental health conditions. Practitioners and teachers need to be alert to the possibilities of pre-relocation trauma

SPECIAL EVENTS

National holidays follow the Western calendar, while Islamic holidays follow the lunar calendar.

In the north:

Independence Day	1 January
Unity Day	3 March
Labour Day	1 May

Islamic days:

Id-al-fitr (feast at the end of Ramadan)

Id-al-Adha (feast of the Sacrifice)

Ramadan is celebrated by Muslims in the 9th month of the lunar Islamic calendar and is regarded by many as the holiest time of the Muslim year. During this month Muslims fast from dawn until sundown (including no water or other liquids). Those with ill health are exempt from the fast although many nevertheless like to partake and clients may need to have the possible consequences explained, or to be assisted through the period. Young children, menstruating, pregnant and nursing women are also exempt from fasting. In addition to fasting, the following are prohibited: putting eye drops in the eyes, saliva leaving the mouth and re-entering, sex, listening to music and harsh words or arguments.

In the South:

Christians will celebrate Christian festivals as well as some of pagan origin, and these are shared by many of the minority ethnic tribes as well.

SPIRITUAL PRACTICES

About 70% of the population is Sunni Muslims who predominate in the North and central Sudan, about 25% follow indigenous or animist traditions and about 5% are Christians. Both of the latter groups are scattered throughout the South with Christians practicing across a number of different tribes. Some Pre-Islamic beliefs and practices have been incorporated into Islamic practice. Religious affiliations play a significant role in Sudanese politics.

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

DISCLAIMER

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

REFERENCES AND RESOURCES

1. Khalidi, S. Revised by McIlroy, F. (2003). *Cultural Dictionary of People from Culturally and Linguistically Diverse backgrounds*. Project of the Migrant Resource Centre of Canberra and Quenabeyan.
2. Dei Wal, N. (2004). *Southern Sudanese Culture*. Migrant Information Centre, Eastern Melbourne. Retrieved January 2007. Available at: <http://www.miceastmelb.com.au/documents/pdaproject/CulturalProfiles/SudaneseCulturalProfile2012.pdf>
3. Jackson, K. (2006). *Fate, spirits and curses: Mental health and traditional beliefs in some refugee communities*. New Zealand: Rampart
4. Jok, M., Sudanese Community Facilitator RASNZ and interpreter. (February 2007). *Personal consultation on culture and practice of Sudanese resettled community members in New Zealand*. Auckland.
5. Kemp, C., Rasbridge, L. (2004). *Refugee and Immigrant Health. A handbook for Health Professionals*. Cambridge: University Press.
6. No author. *Orchid Project. Female Genital Cutting*. Retrieved February 2015. Available at <http://orchidproject.org/wp-content/uploads/2013/02/Sudan.pdf>
7. No author. *Refugees International: Issues, Stories and Photos*. Updated February 2015. Available at: <http://www.refugeesinternational.org>
8. No author. (2014). Sudan Major Infections Diseases. Retrieved February 2015 from: http://www.indexmundi.com/sudan/major_infectious_diseases.html
9. Perumal L. Health needs assessment of Middle Eastern, Latin American and African people living in the Auckland region. Auckland: Auckland District Health Board, 2010.
10. Yarnell, Mark. (2014). *South Sudan: On the Precipice*. Retrieved February 2015. Available at: <https://www.refintl.org/sites/default/files/052214%2520South%2520Sudan%2520On%2520the%2520Precipice%2520letterhead.pdf>
11. Walrond, C. (September 2006). *Africans: Te Ara - the Encyclopedia of New Zealand*. Updated 17 September 2014. Available at: <http://www.TeAra.govt.nz/en/africans>

Useful Resources

1. RAS NZ (Refugees As Survivors New Zealand) can provide assistance to mental health practitioners on clinical issues related to refugee and cultural needs, and contacts for community leaders/facilitators. They can be contacted at +64 9 270 0870.
2. ARCC can provide information on resettlement issues and contacts for community leaders. Contact +64 9 629 3505.
3. Refugee Services can be contacted on +64 9 621 0013 for assistance with refugee issues.
4. A number of health fact sheets can be found in **Dinka** and **Nuer** for download in pdf. at: <http://www.healthtranslations.vic.gov.au/>
5. The <http://www.ecald.com> website has patient information by language and information about migrant and refugee health and social services.