Congolese and Sudanese Refugees

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Abstract

This paper is an attempt to educate healthcare providers on treatment and management of refugees of Sudan and The Democratic Republic of Congo who have immigrated to the United States. Each section explores different aspects of living including history, health status, disparities and barriers, health traditions, and cultural competencies that healthcare providers in the U.S. should be aware of in order to provide appropriate health care to a sensitive population.

In the Congo and South Sudan many have immigrated to the United States due to an ongoing battle with the Lord's Resistance army, but since coming to America these refugees have encountered difficulties surviving and obtaining equal opportunity. It can also be a challenge for researchers to obtain pertinent information about the refugee's health due to etiquettes and taboos that must be considered. When looking at Congolese and Sudanese refugee's status and health in the United States they are correlated in a negative way. Congolese and Sudanese refugees have increased health issues due to their social status in the United States, impacts from a war torn country, and everlasting fear for themselves and their loved ones.

The Democratic Republic of Congo, South Sudan, the Central African Republic, and Uganda has been impacted by the Lord's Resistance Army since 1987 (Schomerus, 2007). The Lord's Resistance Army or the LRA is one of the most notorious rebel armies in the world by committing numerous abuses and atrocities, including the abduction, rape, maiming, and killing of civilians, including children which has caused many to leave the country (Schomerus, 2007). The soldiers of the LRA see themselves as "fighters for their people, the Acholi, whom they believe to be marginalized, abused, and excluded from Uganda's development by an oppressive regime" in the words of Mareike Schomerus. According to The United Nations High

Commissioner for Refugees (UNHCR) (Clayton, 2015), over 2.25 million people have been displaced in Sudan alone. 1.5 million have been internally displaced, and 730,000 have fled to outside countries like Australia, Great Britain, andthe United States. A survey done by The United States Census Bureau (2013) showed approximately 42,214 Sudanese Refugees were present in the United States as of 2013. The cultural Orientation Resource Center (2016) estimates almost three million refugees have fled to the U.S.in the last 35 years. For Congolese and Sudanese refugees, the LRA has been an extreme influence for migrating out of their country due to their fear for themselves and their families.

A research study was conducted in a refugee camp of Congolese men and women in Rwanda that questioned the meaningful life experiences of the refugees and how this impacted their lives. According to the study "women's experiences revealed themes of leaving the good life behind, worrying about their daughters, feeling ambivalent about marriage and lacking hope (Pavlish, 2007)." Men also held similar experience of "leaving the good life behind, having no peace in the heart and fearing the future (Pavlish, 2007)." Many of these experiences had a negative impact on their health because they were saddened and worried, but the research also attempted to create better health programs for the refugees. When conducting such research, researchers must take into consideration the taboos and etiquettes they must follow when studying such cultural groups (Mulumba, 2007). For example, it is extremely important for researchers to ask the head of the household for permission to conduct such a study on their family and respect their religious beliefs. By doing such, the researchers will have better results and show their respect for the refugees concerns and beliefs.

In the United States, to identify educational access, economic stability, and social membership for recently arrived immigrants and refugees from war-torn African contexts one

must look at the range of social, political, and historical factors (Warriner, 2007). For Congolese and Sudanese refugees immigrating to the United States it is difficult for them to be economically stable and socially active due to their losses in their home countries. This is extremely relevant for those form the Congo and Sudan because they are coming from a war-torn country. Education is extremely important for becoming more sociable in a community for refugees because with learning the language immigrants feel belonging and have more social relationships (Warriner, 2007). It is important for the refugees to become more socially prevalent and educated in their communities for their health and a better understanding of the communities they are a part of. A study was conducted about how discussed processes and products from health programs are relevant to other communities aiming to reduce cardiovascular risk and negative health behaviors among immigrants and refugees (Wieland, 2016). It was evident in the research that only the refugees that were more socialized and involved in the community could be aware of the participation and necessity for health in their community (Wieland, 2016).
The health of refugees in the United States is directly correlated to social, political, and historical factors, but can be improved through research and outreach programs across the US. When coming to the United States with nothing refugees are immediately put into a lower class and it is more difficult for them to exceed and maintain certain health standards. Coming from a war torn country, Sudanese and Congolese refugees are faced with traumatic history and a new environment in the US which does not help their health.

Many health problems that the Sudanese refugees face are compounded by the fact that many have little to no access to proper medical treatment. This can turn what we would call in the western world a quick fix into a morbid disposition, things like hypertension, and diabetes. These diseases are very common in the U.S and can most of the time be kept under control with

one or two medications. Of all the health problems faced by the Sudanese refugees. The most common was “Malaria (45%) this was followed by long standing chronic conditions such as Diabetes (29%), and Hypertension (25%)” (Eltinay, 2007). Also included where the most common medical complaints among refugees “constipation (54%) was the most common, which is higher in prevalence (24-37%) among american elders” (Eltinay, 2007). From this information we can see that this elderly population faces many of the same problems we do in america and while these diseases may have many different factors that led to its manifestation I think that it's important to evaluate their access to health care. “In Regarding medication use, the majority (87%) of the Sudanese were found not to take chronic or recurrent medications in contrast to 90% of Americans over 65 years who take at least one prescription drug daily and the majority take two or more medications. However, only 17% of the Sudanese patients take their medications regularly and this is attributed to not remembering the dose timings of the drugs, and relying on a caregiver to administer these medications.”(Eltinay, 2007). This shows a huge disparity between the U.S and Sudan. And while their are many complex problems in sudan I think, that the elderly refugee community would benefit greatly from educating themselves and their care providers on symptom recognition, chronic diseases, and medication treatment.

Congolese refugees face many health problems and concerns that are similar to those in sudan but during my research many of the academic studies done on this population were mainly focused on the area of mental health and more specifically Post Traumatic Stress disorder (PTSD), and Depression in relation to many violent conflicts that plague the Democratic Republic of Congo. In a study done of non-displaced refugees “the estimated prevalence of disability (with severe difficulty) was 3.6% and 13.4% for disability with moderate difficulties. No gender differences were found in disability prevalence. Almost all participants reported

exposure to at least one war-related traumatic event. The result of a hierarchical regression analysis showed that, for both men and women, exposure to traumatic events, older age and living in a polygamous marriage increased the likelihood of having a disability" (Mels 2010). This study was surprising to me because I thought the rates of disability would be higher, but this also could be due to a lack of studies in general done on this population.

The result of these brutal and vicious wars left many children orphaned and as a result programs were organized in order to resettle youth in the United States. This created a number of barriers and disparities. In 2002, a study was conducted researching how Sudanese boys were resettling into society. These "Lost Boys" migrated to Boston, Massachusetts in 2000-01. A primary concern for many of the refugees was their education. They felt that their resettlement would bring them education that they wouldn't have been able to experience before. Obtaining an education was a struggle for many refugees. "One Sudanese youth expected to go to school on the same day that he arrived. He was initially disappointed but finally made it into school after living fourteen months in Boston (Muhindi, 2002, p. 9)." Others were never able to attend school because they were above eighteen and had to make a living before they had enough money to attend school. Ursula Burgoyne and Oksana Hull highlight the importance of education in Sudanese integration saying "education is expected to play a role in the psychological, cultural, economic and social adjustment of adult refugees" (Burgoyne & Hull, 2007, p. 52).

Another barrier that the Sudanese refugees face is placement due to age and development. Many Sudanese adults literacy levels cannot qualify for secondary level schooling or attend a university because of their English language proficiency. Both men and women are limited in education and employment without Basic English foundations. The Australian Government developed an Adult Migrant English Program [AMEP] providing TAFE College, which teaches

basic academic foundations to learn English and trade skills (Hebbani, 2012, p. 7). Language proficiency carries significant weight in the integration of refugees. When the University of Queensland interviewed men and women refugees in both sessions, language proficiency was a major barrier for them to overcome. For men, many felt that they had been discriminated against in the workforce and not given certain jobs; not because they didn't speak correct English, rather they did not speak with an Australian accent. On the other hand women would often be corrected by their children, because English was their children's first language and they would speak it more proficiently. This diminished their confidence but also made them feel that their children were losing their cultural identity.

Refugees came from a very traditionalistic society where women were responsible for the children and home while the men were "breadwinners." They were each placed into their own roles and dependent on each other. These traditionalistic views make it difficult to immigrate into a more contemporary society. Most refugees struggled coming from collectivism to an individualistic society where it's more about self rather than culture. These conflicting ideals created drama for the refugee's attempting to integrate with their new worlds yet preserve their culture in their minds (Muhindi, 2002, p. 6).

The Congolese and Sudanese refugees in the United States have many barriers and disparities. From education to gender roles the refugees face many challenges in order to integrate into a different culture. Acculturating from traditional collectivistic views to more individualistic ideals while maintaining their cultural models, instilling their values into each generation and adapting into their new societies.

Like other cultures, Congo and Sudan have health traditions that are practiced among the population, many of these being unique traditions and practices that are rarely seen within other

cultures outside of Africa. Although many of these practices are no longer practiced by refugees who have immigrated to the United States, it is important for health care providers to be educated and have a prior knowledge of these practices so they will know how to properly treat those who might have had these procedures performed on them prior to moving here to the United States. Among these unique traditions are the practices of female circumcision, skin burning, teeth removal, and uvulectomies. Other health traditions that are also relative to the population but are not nearly as extreme as those stated prior, include the use of healers and medicinal plants as cures and treatments for sickness.

Female circumcision, also known as infibulation, is where the entire clitoris, labia minora, and most of the anterior parts of the labia majora are removed (Ackerman, 1997). According to Ackerman (1997), female circumcision is practiced by communities in my many parts of Africa, Sudan and Congo included. This practice has become a controversial topic and is highly debated. To most it is seen as mutilation, while to others, such as the Sudanese themselves, it is merely an expression of culture and traditional practice (Turshen, 2000). Effects of this practice are found to be mainly harmful and not beneficial in regards to a female's health. As stated by Ackerman (1997), Circumcised women experience, in addition to an immediate risk of sepsis, profound long-term psychologic and physical consequences, including painful urination, intercourse, and labor, as well as perinatal difficulties.

According to Ackerman (1997), "Skin burning for pain relief and uvulectomy or tooth removal for upper respiratory infections are common traditional treatments." A uvulectomy is the practice of a removal of the uvula when a person is seen to have problems that involve their throat such as coughing and vomiting. Other reasons for performance of this procedure include the belief of the uvula blocking the passageway for food to travel down the throat or that it is a

cause for blockage of respiration which can lead to swelling of the throat (Kunii, 2006). It is mostly performed on infants and children by traditional healers (Kunii, 2006). In a study conducted within a Congolese Refugee camp in Tanzania, researchers aimed to uncover the perceptions of traditional healers on whether or not this procedure is beneficial. When surveyed on their views of the procedure, Kunii (2006) found that "More than half of the respondents did not know whether uvulectomy was effective or harmful." Teeth removal is another procedure that is performed for similar symptoms.

Skin burning or removal is a method used by the refugees of Congo and Sudan in treatment of pain. According to Kunii (2006), "If someone is suffering from local pain, the skin in the painful region is cut with a razor blade or knife and then the resin of a tree is applied to the bleeding site." This is supposedly a practice that will help ease the person's pain even though it is extremely painful at the time of treatment. To many of these refugees, it is believed that it is an approach to curing diseases although it may cause severe scarring or bleeding (Kunii, 2006). Another health tradition that many populations of Africa including Congo and Sudan use the practice and usages of traditional medicines. In countries like these, Wilcox (2004), states that "This is because traditional medicines and traditional health care are easily accessible to the majority of the populations whether urban or rural. In addition, because traditional healers live within and are part of the community, they have a higher distribution and a lower patient-healer ratio in rural areas than modern medical practitioners." Many patients use these methods choose to be treated by healers because they are more familiar with the culture and situations. Modern medicine is found to be foreign and practitioners of modern medicine are not seen as competent because they are usually unfamiliar with the area in which they are working in, therefore trust in

treatment and cures is more often than not, put into the hands of the healers found within the community (Wilcox, 2004).

The existence of major conflicts occurring in countries of central Africa, including disease, oppression, and many civil wars, has resulted in a major efflux of displaced refugees. Most of these external refugees have fled to surrounding countries. A small margin have fled to countries like Australia, Great Britain, and the United States. A survey done by The United States Census Bureau (2013) showed approximately 42,214 Sudanese Refugees were present in the United States as of 2013. The Democratic Republic of Congo has had internal turmoil for decades. The cultural Orientation Resource Center (2016) estimates almost three million refugees have fled to the U.S. in the last 35 years. These refugees have many health-related issues to be handled during their post-migration journey. It is important for healthcare providers to be aware of the health related concerns of these refugees, and how best to manage their care in an understanding and compassionate way.

A major issue for Sudanese refugees is the mental health related complications many face due to the stress of pre-migration life, as well as post-migration adjustments. A study done by the Australian and New Zealand Journal of Psychiatry (2006) conducted an interview of 63 sudanese refugees which included “questionnaires assessing socio-demographic information, pre-migration trauma, anxiety, depression and posttraumatic stress, post-migration living difficulties and perceived social support.” (Schweitzer, Melville, Steel, & Lacherez, 2006, pg. 179). In this study, they used a series of tests to determine the overall mental health of refugees, and found that “Less than 5% met criteria for posttraumatic stress but 25% reported clinically high levels of psychological distress.” (Schweitzer, Melville, Steel, & Lacherez, 2006, pg. 179). The overall conclusion showed that the majority of these refugees had problems with anxiety and depression.

Congolese and Sudanese Refugees

A healthcare provider who is working with refugee patients should be cognisant of their mental health issues and manage them appropriately. Appropriate care from mental health care providers such as social workers, psychiatrists, and counseling psychologists should be considered to best manage mental health related issues.

Another interesting point this study found was that "social support ...play(s) a significant role in predicting mental health outcomes." (Schweitzer, Melville, Steel, & Lacherez, 2006, pg. 179). They discovered that refugees who had a strong level of support from other minority groups in their community thrived better in their new environments. This shows that it is important for healthcare providers to encourage refugee patients to seek out social support from loved ones, other refugees, and from the community as a whole.

A major health concern for Sudanese refugees is the existence of Infibulation, or female circumcision. Rose Oldfield Hayes, who conducted a major study on infibulation, described it as, "A widespread practice in Sudan. It involves cutting away most external female genitalia and almost completely closing off the vaginal opening...and is found to be functionally interrelated with marriage practices, norms of female modesty, women's roles, family honor, and the patrilineage." (Hayes, 1975, pg. 617). There have been many known health concerns for women who have undergone infibulation. There are direct complications like excessive bleeding, tissue swelling, urination problems, and infection. More chronic and indirect problems can arise including HIV, menstrual problems, obstetric problems, as well as psychological consequences. Many have wondered how this practice has continued in the sudanese culture, or why it hasn't been deemed illegal. The practice is still a deeply rooted in the society as an indication of female modesty and Sudanese honor, which has affected bills passed to attempt to deem the practice illegal. Though the practice is rare, it is important for healthcare providers to be aware of it and

its potential complications. Many women who have undergone infibulation will have surgical procedures to repair it, but can suffer complications for the remainder of their life. Healthcare providers must be considerate when treating a patient who has undergone infibulation. It is important to be trained on not only how to help a women heal physically, but also psychologically from complications with infibulation.

There is a high level of stigma on mental illness in the Muslim communities of Congo and Sudan. Many of this religion believe that mental health related issues stem from the supernatural in a way to punish those who have lived sinfully. Many people who suffer mental illness in these countries are scrutinized and banished, as opposed to treated for the mental suffering. The Islam religion believes in being called "Jinn." Jinn is believed to be a spirit who possesses the individuals and causes them to behave in demonic ways. Refugees who enter into a new world of health care will have to be introduced to a new perspective on mental-health related issues. It's important that health care providers educate individuals on mental health management while being sensitive to their religious beliefs. One thing healthcare providers can do is make an attempt to implement many approaches to mental illness management for refugees. Educating them on how to implement cognitive and behavioral therapies into their prayers and meditation can benefit a patient's mental health.

Western culture and medicine is very foreign for many refugees who come to America. It is imperative that healthcare providers do their best to accommodate these individuals who are already in a very vulnerable state. As healthcare providers become more competent in the cultures and traditions of various religions and ethnicities, they can come a step closer to better serving the sensitive population of immigrating refugees.

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