"I am South Sudanese!": The cultural construct of health among southern Sudanese in central Iowa

by

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PREFACE

I discovered my interest in medicine after I dropped out of college. It was the late seventies and I had become disillusioned with anthropology. I left school and found the counter-culture in central Iowa filled with alternative life-styles. I fell in with the "healers"; homeopathy, reflexology, midwifery, Bach flower remedies, massage, kundalini yoga, natural foods, herbs, rolfing, chiropractic, osteopathy, women's health issues, as well as psychic reading expanded my understanding of what I had (until that time) understood as "medicine".

Raised by German immigrant parents, my six siblings and I went to the doctor when we needed cuts stitched or broken bones cast. My parents lacked an American perception of medicine. Though their medical understanding reflected German attitudes towards, health, their beliefs were also a consequence of living through the Hitler era, WWII, and post war Germany. My grandmother died in a tuberculosis sanitarium when my mother was eight, taken from her family when my mother was five. The horrors of war and its effects produced self-reliant medical treatment, because there were few with the training to help. We used aspirin sparingly, induced sweats when we had fevers, and drank hot honey-sweetened lemon juice for sore throats. Growing up with the assumption that illness was a part of every day life, and that a person would usually recover without any assistance from the doctor were principles we lived by. Therefore, I was taught to eat well, work hard, and stay away from the doctor.

My perception of a health system changed a great deal once I left my family and went to college. I found people going to the clinic for cold and flu symptoms, something I had never considered. The discovery of an on-going relationship with the medical community

was truly a revelation to me. I was also shocked by the amount of drugs taken for the sake of a quick fix to health situations, and the medical community's support in such actions.

When I left college, I found a diversity of ideas about health, what it is, how to maintain it. Yet, everyone was always aware that, legally, there was only one health system recognized in the United States. This was a reality that affected the training and practice of many people around me. I felt at the time and still do now, that the American Medical Association held too much unquestioned unrestrained power that undermined its ability to investigate viable avenues of research and grow as a healing institution.

Yet, the definite benefits of biomedicine were never questioned. These included an excellent methodology for handling conditions of physical trauma, aseptic techniques in medical treatment, and use of the scientific method in diagnosing illness. What was at issue in the community of healers of which I was a part was the inability of biomedicine to deal with or recognize the importance of alternative practices that focused upon healing rather that treatment. For example, we questioned the value of perceiving childbirth as a medical condition instead of a natural stage of life in which assistance is necessary, but flexibility in how that assistance is given should be determined by the mother to be and her family. This is not to say that childbirth cannot become a serious medical situation.

What is of importance to this research is the structure of health systems in the U.S., particularly of central Iowa. My experience, starting twenty some years ago, formed my perception of health systems in the United States as blanketed by biomedicine. Underneath that system, were many techniques and philosophies available to individuals.

I decided to focus my research in Iowa. What led me to the southern Sudanese was a curiosity about their perceptions of health and what they do to treat illness or maintain health.

I also wondered if the southern Sudanese felt that the biomedical community of central Iowa was meeting their health needs. The fact that the southern Sudanese had gone through tremendous changes, both in their home country and in the process of acculturation in Iowa, drew me to them. Personally, I felt some connection with their plight, having grownup as a first generation daughter of German immigrants. Though there are many dissimilar circumstances in my family's history and that of the southern Sudanese, there are some commonalities – war and its unspeakable events and the necessity of learning a new language and culture.

CHAPTER 1. INTRODUCTION

It is the purpose of this research project to add to the arena of multi-cultural understandings of health, illness and health systems. Because of the fact that humans do become sick, disabled and die, health care systems are a universal in every society. These systems, however, are diverse in approach and method. Due to the increased cultural diversity in the United States, the need for cultural knowledge and consideration in the health field is growing. Within the last decade over 2000 southern Sudanese have immigrated to central Iowa. Because of their complex history and distinct traditional cultures, the southern Sudanese share concepts of health dissimilar to the predominant society in Iowa. The focus of this research is to determine a cultural construct of health of the southern Sudanese. How the biomedical community of central Iowa is involved in this construct is of vital importance. Because it is the legal and accepted standard for health care, the possibility for misconceptions and inadequate care is very real.

Significance of the Study

> A growing number of Iowa communities are experiencing what I call "rapid ethnic diversification." That is, they are experiencing rapid influxes of immigrants and refugees. Towns that once counted their minority residents in the dozens now do so in the hundreds or even thousands. School districts that had virtually no immigrant students ten years ago are now "majority minority" districts, with more than 50% of their enrollments made up of immigrant children. A bipartisan panel appointed by the governor to determine a vision for the state's future found that Iowa's population needs to grow...To reach this goal, ... (the panel felt) we should welcome 'diverse new residents, including immigrants.' The panel even went so far as to propose making Iowa an 'immigration enterprise zone' with immigration targets that are not constrained by federal quotas (Grey 2000:9).

The goal described in the paragraph above is one particularly important reason to focus upon understanding diverse concepts of health and health systems. Though biomedicine is practiced and understood globally, disparities in understanding and method

are evident throughout the world. These differences in cultural practices make it difficult to communicate and to understand information in situations such as medical assessment, prescription of treatment and concomitant compliance to that advice.

People in every culture have notions about what one has to do to stay healthy. Every culture has systems for health care maintenance pertaining to those conceptions. The ways in which people perceive and construe illness, health, and disease is bound up with cultural norms, beliefs, and values reflecting social structure and environment.

Arthur Kleinman (1995:23) states there is "no essential medicine. No medicine that is independent of historical context." This view is of particular importance in research investigating the application of biomedical techniques to individuals of complex histories (such as refugees from southern Sudan).

Though there is no "essential medicine," health systems are universal in every culture. Because of the influence health systems have in defining illness and disease, it is important to address their purpose within society. Kleinman (1980:70-71) identified five core functions of a health care system. These include the cultural construct of illness as a psychosocial experience, the establishment of general criteria to guide the health care process, the management of particular illness events through labeling and explaining, healing activities, which include all types of therapeutic interventions, and the management of all therapeutic outcomes.

What is of importance to this research is the historically and culturally complex experience of the southern Sudanese, and the role the biomedical health system of central Iowa performs in dealing with their health needs. It is at this point that cultural relativity

must become a part of the research approach, and a definition of culture will describe what this type of relativity is.

Kleinman (1995:58) defines culture:

> not as shared canonical meanings that are distributed equally throughout a community, but rather as lived meanings that are contested because of gender, age cohort, and political difference: meanings that are actualized differently in everyday social transactions so that they exert a partial, uncertain effect are really practices, ways of being-in-the-world.

This definition illuminates how culture can be seen as an emergent force in certain social interactions. Therefore, culture is seen as a process of action, a mode of collective experience, and a force in local relationships (Kleinman 1995:59). Culture, when seen in this perspective, adds interpretive dimensions to situations involving a biomedical health system.

Biomedicine has structural arrangements that incorporate many societies, and is seen as a global system of care (Loustanau and Sobo 1997:46). This global system then affects health care at macro and micro levels of social-structural arrangements to form distinct local histories or stories of health care. Macro-level systems regulate how, where, what, to whom, and by whom care is delivered. Factors include ethnicity, class, or gender and affect health-related experiences at the micro or personal interactive level, which involves a web of interpersonal relationships. The impact of global health systems becomes apparent when considering human processes such as travel, war, trade, and introduction of new foods to other parts of the world.

Biomedicine occupies the professional sector of Kleinman's (1986:29-47) tripartite scheme in which many health systems are divided by defining who provides care in certain contexts. Biomedicine occupies the legally endorsed official system of health care in

Western societies. A plurality of medical systems results from the overshadowing of biomedicine over diverse health systems.

Biomedicine in advanced capitalist nations reproduces structures of class relations (Baer et al. 1997:28). A profit-making orientation caused the evolution of biomedicine with a focus on high technology, massive use of drugs, and the concentration of services in medical complexes. Corporate involvement in the health system is made lawful by the state, and this is accepted at both national and international levels. Throughout the world, biomedicine retains a dominant status over heterodox and ethno medical systems. This status is legitimized by laws granting biomedicine a monopoly over some medical procedures and restricts or bans the practice of other types of healing (Baer et al. 1997:29).

It is this inability on the part of biomedicine practitioners to recognize the influence of culture and its expression in alternate methods of health care that can produce circumstances of miscommunication and frustration to individuals in positions of health care provider and recipients of that care. The aim of this research is to determine the cultural construct of southern Sudanese medical beliefs. Though each individual has their own story culminating in living in central Iowa, there are commonalties, which produce a certain characteristic southern Sudanese identity and cultural form. This cultural climate is distinct from the general culture of central Iowa. Disparities in cultural practices make it difficult to communicate and to understand information. This is particularly exacerbated in the area of medical assessment. And it is here that an understanding of southern Sudanese traditional beliefs, as well as their complex history, is pivotal in achieving satisfactory results in giving medical advice and in achieving compliance with that advice. The purpose of this research is to differentiate misconceptions from cultural differences, which sometimes prevent the

southern Sudanese from gaining effective medical care. These misconceptions arise from both the health care community and the Sudanese.

Introduction to the Research Environment

The research for this study was conducted in Des Moines and Ames, Iowa during June through August of 1999. During this period I spoke with a number of adult southern Sudanese refugees of both sexes. Interviews were arranged through key members of the Sudanese community, and through referrals. Though many issues were discussed, all interviews were carried out with the purpose of gaining a complete picture of a southern Sudanese construct of health.

The southern Sudanese started immigrating to central Iowa in 1992, when three individuals arrived in Des Moines. Since that time close to 2,000 southern Sudanese have moved to central Iowa. Refugees in general face "special considerations" in the area of health. These include such problems as cultural disparities in assessment which include obtaining and interpreting clinical data, the possibility of being misunderstood when adhering to traditional beliefs, and dealing with the ramifications of violence and the state of victimization (U.S. Department of Health and Human Services 1991:56-72).

The study of diverse peoples entering the increasingly multi-cultural United States is of growing importance to many institutions, especially the health care industry. Maintenance of ethnic identity through continuity in lifestyles of the past and the present are essential in sustaining health. Thus when an expression of illness comes from outside this system, diagnosis and concomitant health care may be misdirected or even unable to progress in a way satisfactory to either or both health care practitioner and the ill one. The southern Sudanese of central Iowa are people with a complex history. Their recent past

consists of traditional beliefs and lifestyles quite different in practice from Western habits. Development processes, comprising of missionaries, colonial British influences, and emergence into the world trade market, have had profound influences on every aspect of their culture. Further compounding the situation is the fact that the Sudan has been locked in an economic/religious war for over two hundred years, dividing the Muslim north from the non-Muslim south. Finally, the state of being refugees with all the associated difficulties of such a condition adds to the complexity of their situation. The combination of these factors has produced a distinct southern Sudanese culture in central Iowa.

Brief Review of Sudan

Sudan is the largest country on the continent of Africa (Figure 1). It was formed during the colonial period in Africa, joining two distinct regions with extremely different ideologies. Because of these differences, the country has been dichotomized into north and south. This process is linked to the Arab societies of the north and the resistance to those

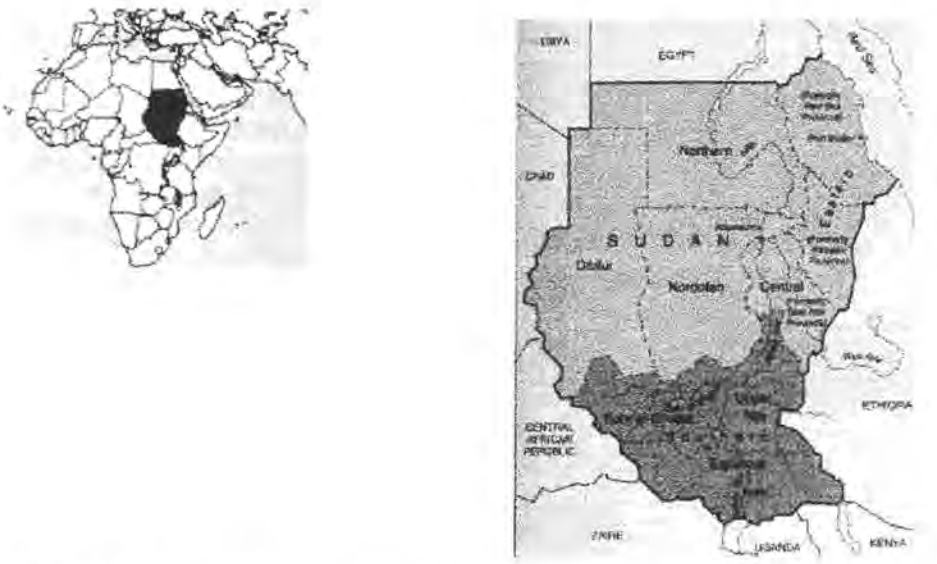

Figure 1. Map of Africa and the Sudan

forces in the south (Deng 1995:9). Deng (1995) claims that without the confrontation from the north there would be no reason for a politically unified entity in the south.

Invasion of northern Sudan by Arab Muslims occurred during the seventh century AD. Intermarriage among these cultures produced people who adopted the Arab/Muslim identity, replacing matrilineal succession with patrilinity and patriarchy. Natural barriers and the resistance of the warrior Nilotic tribes prevented the easy migration and settlement of the south by these same forces (Deng 1995:10). During the early part of the nineteenth century, Turkish and Egyptian forces conquered the northern Sudan. They were interested in establishing northern Sudan as a base of slave trade for their incursions into southern Sudan. Both south and north united to successfully resist foreign domination, and in 1885 the Mahdi (leader who unified the resistance) used Islam as a tool to raise support in the north. The south, though not accepting Islam, saw unification with the north as a means of liberation from foreign powers. However, as the Mahdist government gained control, slave raids from north Sudan continued to scourge the south. Islam became the divisive element in determining treatment in the south, and the south would not accept Islam.

The Reconquest of 1898 was a result of British colonialization, and produced the Anglo-Egyptian condominium. The British adopted a policy of separate development for the north and south, concentrating considerable political, economic, and social programs in the north. The south remained isolated with minimal development brought mainly through Christian missionaries. Interaction between the north and the south was strongly discouraged, and the slave trade was halted. These processes led to reinforce Arabism and Islam in the north, and, after independence in 1956, resulted in ruthless attempts by the north

to Arabize, Islamize, and dominate the south (Deng 1995:11). This struggle continues to this day.

The people of the south can be identified as consisting of two general groups: agriculturalists inhabiting the equatorial region and parts of Bahr al-Ghazal, and the seminomadic pastoralists, Nilotics in Bahr L-Ghazal and Upper Nile regions. The Dinka and Nuer are seminomadic pastoralists living in the Bahr al-Ghazal and the Upper Nile regions (Deng 1995:186). Development, started during the colonial period (1899-1955), was intensified after independence in 1956. The people of southern Sudan were introduced to education systems, labor migration to urban centers, increased exposure to other cultures and countries, and intense cross-cultural interaction between themselves. Because of these influences southern cultures adapted and developed a southern Sudanese identity (Deng 1995:188).

Modern Nilotic people live in rural and urban situations and have joined various political, economic, social, and cultural organizations, which have little in common with their traditional pastoral economy. The liberation movements have had radical influences in changing and reorganizing southern society while preserving and developing the integrity of the southern Sudanese identity (Deng 1995:188). This identity includes the "pursuit of permanent identity and influence through procreation and ancestral continuity, communal unity and harmony as expressed in idealized concepts of human relations, and principles of individual and collective dignity and integrity" (Deng 1995:189).

Summary

This study identifies general health concerns, knowledge of alternative treatment, and ideas of perceived control of one's health, as well as an overview of southern Sudanese

culture as expressed in central Iowa. This information will be juxtaposed against the cultural background of biomedicine.

In order to place the results of this research in the proper framework, a review of literature concerning traditional Sudanese lifestyles, historic influences in the Sudan, and historical processes of the progression of biomedicine as a global health care system will follow. Though much has been written in the arena of medical anthropology, this study will have practical impact for health care practitioners in the central Iowa region.

CHAPTER 2. REVIEW OF THE LITERATURE

This chapter provides a review of the relevant literature pertaining to the southern Sudanese of central Iowa. It includes historical and traditional backgrounds of the Sudanese and the biomedical community as well as a presentation of the theoretical stance of this thesis. As stated earlier, biomedicine has a distinct history and methodology. Of particular importance to this research is the legal position biomedicine maintains throughout the world, and how this situation promotes the formation of plural medical systems within the framework of biomedicine. In order to understand this plurality it is important to become familiar with the history of the southern Sudanese, and how biomedicine became a part of that experience.

Statistics

Sudan (Jumhuriyat as-Sudan) is the largest African country (equal in size to the United States east of the Mississippi) with an estimated population of 3,000,000 for the year 2000. The country has over 570 ethnic groups (Instituto Del Tercer Mundo 1999:522-24). Arabs account for nearly half the population, who along with the Nubians occupy the central and northern part of the country. Nilote, Nilo-Hamitic and Bantu groups are the primary groups inhabiting south Sudan. Roughly 400,000 refugees from neighboring nations (Chad, Uganda, Ethiopia and Eritrea) also reside in the south. Islam is the primary religion practiced among the Arabs and Nubians, while traditional African religions are observed in the south as well as Christianity. Christian groups live throughout Sudan. Arabic is the official language of Sudan while there are over 100 languages spoken by the different ethnic groups. Communications indicate much about a people. As recently as 1994, the Sudan had

20 newspapers, 258 radios, 80 TV sets, and 2 main telephone lines per 1,000 people (Instituto Del Tercer Mundo 1999: 523).

Sudanese History and the Emergence of a South Sudanese Identity

It is not within the scope of this research to repeat the excellent work done by others (Spaulding and Beswick 2000; Petterson 1999; Anderson 1999; Wondu and Lesch 2000; Deng 1995 to name a few) in writing the history of Sudan. A brief history, nevertheless, is imperative to understand the findings of this research.

Sudan has been host to one of the world's and Africa's longest civil wars (Spaulding & Beswick 2000:xiiv). Two hundred years of strife have been attributed to ethnic and religious diversity in a country with European-drawn borders (Spaulding & Beswick 2000:xiiv). "In reality, the heart of the Sudan's incessant conflict is the continual transference of wealth from the country's extremely wealthy southern heartlands into the hands of an elite few who reside in the impoverished north" (Spaulding & Beswick 2000:xiv). In the nineteenth century Sudan became a dichotomized country where the Arab/Muslim north developed a thriving slave business through raiding the south, to accompany the well-established ivory trade. (This attitude of exploitation by the north is apparent in present day policies of the Sudanese government.) Many southerners believe their relatives were sold as far away as Zanzibar, Saudi Arabia, the Yemen and Libya. More than two million southerners were carried off by Arab slavers during the nineteenth century (O'Balance 1977:20). Slavery has remained a facet of north/south relations to the present.

During the Anglo-Egyptian Condominium (1898-1956), the British brought a new colonial regime to the Sudan and the only period of peace in the past two hundred years (there was a short period of peace from 1972-1983 through the Addis Ababa Agreement).

The authorities in Khartoum brought social change through slow and peaceful processes by introducing the money economy and the gradual introduction of Christianity. Most importantly, the transfer of southern wealth into the north was halted (Spaulding & Beswick 2000:xv). This was accomplished by the restriction of movement of people and separating the north from the south administratively.

Independence for Sudan came in 1956 on northern terms, causing instability in central and southern Sudan. The previous limited rights of southerners were withdrawn and southerners were treated as inferior and incapable of representing themselves. From that point to the present, southern wealth and its transference into the north has been an inflammatory issue. Conversion to Islam was then added by northern politicians to the economic issues of development in the Sudan. Since 1983, Muslim fundamentalists representing the needs of the Islam north have held power. This process has served to unify the many ethnic groups of the south into a common identity of South Sudanese. The proclaimed holy war of the north against the recalcitrant southern populace is not understood as such by the south, but seen as the desire of the north to exert political and economic control over a land perceived to be rich in land, water, and agricultural and mineral resources (Spaulding & Beswick 2000:xvii).

This exploitation is documented by the Sudanese government's misuse of land for economic gain (for the north). Commercial hunting, overgrazing of grasslands, deforestation of artificial and natural forests, and management of Nile waters have all been manipulated to the benefit of northern Sudan. Coupled with a policy of ethnic cleansing to gain access to natural resources, the Sudanese government has consistently striven for the benefit of Arab Muslims (Majuk 2000:51). The Southern Peoples' Liberation Army (SPLA,

formed in 1983) while waging war on Khartoum also has established policies of defense for the southern environment (Majak 2000:46).

Southern Sudanese cultural traditions include a perception that human beings form an integral part of the natural world (Majak 2000:51). Humans are linked to nature for example, through bonds of practicality (food and shelter), patriotic affection (homeland), and in a metaphysical sense (some communities experience a kinship with a certain species of living thing, which forms an important part of their collective identity).

The North/South division overshadows the ethnic multiplicity in the south, thus the southern Sudanese do have a unified identity (Deng 1971:xxvi).

Traditional Practices Related to Health and Biomedicine

> Finally, the very fact that it (medicine) has been recognized and studied as a cultural system has placed a particular bias on the anthropological study of medicine in society. This happened because most earlier interest in this subject grew out of an anthropological study of religious systems. As a result, the non-sacred aspects of sickness and treatment received little attention until fairly recently...This bias, I predict, will not be found in most future medical anthropologists (Kleinman 1986:47).

Perhaps the most prolific anthropological researcher of Nilotic tribes in the Sudan is E. E. Evans-Pritchard (1956, 1965, 1968, 1971, 1974). However much of Evans-Pritchard's work relating to health was focused upon magico-religious beliefs. This was done because healing and magico-religious practices are one and the same for many societies living in southern Sudan. When events (such as dances or sacrifices) or certain items (witch doctors' hand bells or rattles [Evans-Pritchard1971:102], shrines and other "objects" [Evans-Pritchard 1971:99]) were mentioned, their role in maintaining or achieving health was not assessed or recognized.

Traditional beliefs among the southern Sudanese are varied in emphasis and form, but there are striking similarities throughout the south. The identification of a single God and ancestor worship through practices of prayer, sacrifice, and oaths and curses are common themes. Medical practices or beliefs fall within this sphere of life. These attributes were a part of traditional life in Shilluk, Dinka, Nuer, Azante, and Lango to name a few of the tribes studied (Seligman & Seligman 1932).

Powers of the ancestral spirits include the ability to produce illness in animals and humans. Men and women able to see and communicate with these spirits are responsible for the diagnosis and treatment of sickness in the form of predicting what old and mighty dead is to blame for the illness and how to cure the patient. In the past, these people also gave advice concerning lost cattle and other accidents of daily life (Seligman & Seligman 1932: 187). The words of kinsmen in the form of curses and blessings are powerful for good or evil (Seligman & Seligman 1932: 192). "A father by saying his son shall be ill can cause him to sicken, while a parent's blessing is held to be so efficacious that it may cure severe illness" (Seligman & Seligman 1932: 193). Sacrifices were made for the ancestral spirits in instances of seasonal change, times of stress such as smallpox epidemics, and rites of passage. Sacrifices are used quite often to nullify curses. The vitality of the sacrificial beast is transferred to the subject of the sacrifice. Medicine people often had herb lore or specialized in certain conditions (for example, barrenness, yaws, constipation, or headache).

Deng (1971:14) explains that certain conceptual entities are of great concern to the Dinka. These entities are referred (by Deng) as mythical participants that include divinities and the dead. Though the Dinka believe in one Supreme Being, they also believe in a complex system of spirits. Everyday life is spent concerned with "clan divinities" and "free

divinities" (Deng 1971:14), which manifest themselves through human experience. Some are known to inflict specific types of pain or illness, or have certain likes and dislikes, and can be identified by the peculiar aberrational behavior induced in their victims (Deng 1971:14-15). Such behavior has a relationship to a certain clan and is often traced to a mythicized incident in the history of the clan (Deng 1971:15). Through this relationship, divinities represent specific aspects of human experience. Experience and its memory are "projected from the mind or interior of the remembering person to form an image which acts upon him, as he sees it externally" (Deng 1971:15). These experiences have the effect of producing a unity between self and image, but also producing a unification of diverse experience within the self. This is an important attribute of southern Sudanese people in general, an ability to cope with change, while retaining an ethnic sense of who they are. "Thus born and bred, he is a Dinka whatever his new cultural acquisitions" (Deng 1971: 20).

Deng (1971:22-24) addresses the relationship the ancestors have with the living members of their family as a continuance of one's identity and influence in this world even after one's death. Existence of a next world and a continued participation of the dead with the living form an interdependent relationship that produces a physical and social immortality. Affection expressed through kin or fictive kin ties is the foundation of social dependences in Dinka relationships. Affection for the ancestors is communicated through the dedication of cattle for them, and the eventual sacrifice of those animals for them (Deng 1971:117).

Deng (1971:279) describes Dinka conceptions of disease as resulting from discord. Well-being in a person is associated with the spirit of life. Since personal experience is

linked to lineal identity and clan divinities, disease and misfortune are likewise linked through lineages.

Biomedicine was first introduced to southern Sudan by the British and later by missionaries. Due to missionaries' association of medicine and religion, missionary medicine was accepted (Deng 1971:290; Deng 1972:160). Biomedicine became highly valued, and "it is now common for a diviner, as a curer, to administer his traditional cure and then advise his patient to see a doctor as well in order to achieve maximum effectiveness" (Deng 1972:160). This view was common in the 1970's when Deng reported the acceptance of biomedicine among the Dinka, and was standard throughout the south.

"The problem for the Dinka today is not superstitious dependence on magico-religious concepts, but lack of modern medical facilities" (Deng 1972:160). This problem is exacerbated by the government's (led by Arab/Muslim leaders of the north) control of resources for development and the civil war.

Refugees

The Sudanese government (controlled by northern Arab peoples) has used many tactics to bring the people of the south to compliance of their demands. Famines induced by hoarding of food, destruction of transportation routes and vehicles, and destruction of homes and farms are some measures used to weaken the defenses of the south. Control of health programs and water deeply affect the well being of southern Sudanese. These situations are further intensified by natural disasters such as drought.

Thousands of southern Sudanese have emigrated from Sudan to all parts of the world by various methods. Some leave by entering refugee camps in surrounding countries (The complexity of Sudan's situation must be stressed, for example, it shelters around 400,000

refugees from neighboring countries like Chad, Uganda, Ethiopia and Eritrea, who also are besieged with internal political conflicts [Instituto Del Tercer Mundo 1999:523]). Many leave on their own, if they have an education and abilities to make them employable. Others immediately contact the United Nations to start the immigration process by declaring their status as refugees. The UN then decides when and where people will go.

Health Care Systems and Biomedicine

Health Care Systems

Humans in every culture view the body and its workings in diverse ways. This includes conceptualizations of illness and health care systems. Throughout the world there are various approaches to healing and categories of healers. In order to understand health systems cross-culturally, it is necessary to use classification schemes. It is essential to remember that these schemes fragment reality, when in fact these conceptualizations are a part of a whole, part of a continuum. People perceive and organize the experience of illness and disease in an assortment of culturally defined ways. The following is a summary of theoretical schemes used by health care systems.

Arthur Kleinman (1986) first drew attention to the tripartite scheme of popular, folk, and professional medicine health care sectors. The crucial determinants in this scheme focused on who provides the care and in what context. Shared cultural understanding is the foundation of the popular sector where nonspecialists provide care. Members of the folk sector are specialists who practice traditional methods and philosophies (Loustaunau and Sobo 1997:74-75). The professional sector includes any legally endorsed official system, for example, the biomedical system in the United States. Problems with this system are

evident; some cultures have no professional sector, religious specialists may treat illness, and notions of distinct health systems are culture bound (Loustaunau and Sobo 1997:74-75).

Young, (1983) by acknowledging that biomedicine was not a universal, developed a system of classification that divided all health systems into those that accumulate formal teaching and those that promote the fragmentation and diffusion of medical knowledge. Biomedicine, Chinese medicine, Ayurveda, and homeopathy are all examples of accumulation systems. Some shamans and magical healers use differing systems in which, knowledge is guarded and seldom shared. This type of classification is simplistic in scope, but offers a new angle in which to look at health systems cross-culturally.

Newer theories of studying health systems cross-culturally are focusing on the understanding cultures develop of the workings of human anatomy and physiology. Human bodies are generally the same throughout the world, but cross-cultural ideas of how they work vary greatly in construct (Loustaunau and Sobo 1997:78). Observations of the laws of physics have organized explanatory systems into such concepts as "flow, blockage, and cleanliness" (Loustaunau and Sobo 1997:79). Concepts, which stress flow and balance, include imagery of containers and channels. Blockage becomes of importance in such a system, and health practices promote the maintenance or reestablishment of flow.

Technology of a culture reflects the views people hold. For instance, with the introduction of industrialization, our society has increasingly envisaged our bodies as factories, a system of inputs and outputs. What people do in everyday life affects how they envision their bodies work, for example, people who slaughter animals regularly view the body as cavities full of bags (Loustaunau and Sobo 1997:79).

Many cultures focus on balance through the maintenance of a sort of equilibrium. Biomedical practitioners relate to balance when referring to hormonal imbalances, vitamin deficiencies, and bacterial imbalances in the intestine (Loustaunau and Sobo 1997:80). In many Latin American, Caribbean and southern European countries, illness occurs when the body becomes either too "hot" or "cold". These states refer to actual thermal conditions of the body or treatments and/or metaphorical properties that exemplify "hot" or "cold" states. Treatment is focused upon regaining equilibrium with either hot or cold remedies (Foster 1994). Sometimes specific body fluids (such as blood) are balanced through application of notions of wetness and dryness, thick or thin, bitter or sweet, high or low in the body (Loustaunau and Sobo 1997:82).

For some peoples, health is a consideration that includes body, mind, and soul. Ideals for body shape and size determine a culture's construct of health, by implying the moral stance of the individual. Loustaunau and Sobo (1997:86) state the "two dimensions of experience – mental and physical – are inextricably interconnected." Therefore, improper treatment of a physical body has ramifications upon the mind, and the reverse is also true, improper treatment of the mind affects the body.

The function of health systems is healing and curing through care. How care is provided is, again, different in ways and means. Different systems have different definitions of what the well person looks and feels like, as well as, how that person is to be treated (Loustaunau and Sobo 1997:91; Rhodes 1996:165-180; Waldram 2000:605). Often the physiological impediment of health is seen as having one of two types of sources. It must be stressed that there are continuums between these systems; they are not exclusive in practice. The first type of treatment, personalistic, focuses upon the cause of disease originating from

the active, purposeful, interference of an agent, human, nonhuman, or supernatural (Foster and Anderson 1978:55). The sick person becomes the object of aggression or punishment, but the sickness concerns that person alone. Naturalistic systems find causality through the imbalance of some feature of the body/mind (Foster and Anderson 1978:56). Another system introduced by Young (1986) is the externalizing – internalizing models. Young felt that internalizing models evolved from externalizing models. Externalizing models are linked to other domains, such as religion, and focus on social and cosmological relations (Loustaunau and Sobo 1997:93). Young (1986:143) finds autonomy the distinguishing factor between externalizing and internalizing models. Externalizing systems have low autonomy while internalizing systems are very autonomous. This autonomy stems from the division of labor in more complex societies, where cultural realms are divided.

These models of understanding health cross-culturally are concepts to be combined and seen as a continuum of experience and knowledge. Many health care systems involve several of the theories previously mentioned. Sometimes one idea may be dominant, and at other times another idea will take precedence within the same health system.

Biomedicine

> Biomedicine differs from ... most other forms of medicine by its extreme insistence on materialism as the grounds of knowledge, and by its discomfort with dialectical modes of thought. Biomedicine also is unique because of its corresponding requirement that single causal chains must be used to specify pathogenesis in a language of structural flaws and mechanisms as the rationale for therapeutic efficacy (Kleinman 1995:29).

Medical care can be divided into micro, macro and global systems and institutions (Loustaunau and Sobo 1997:46; Anderson 1996:190). The impact biomedicine has upon health systems globally are of primary interest because of its influence at the macro level.

Baer and colleagues (1997:27) see this effect originating from capitalist development and expansion that has reshaped social life throughout the world. Institutional social-structural arrangements (macro) control how, when, what, to whom, and by whom care is given on the basis of ethnicity, social class, or gender (Loustaunau and Sobo 1997:46). These institutions affect health related experiences at the micro-level. Biomedicine is an example of a global health system, which involves incorporation of the structural arrangements of more than one culture. The combination of global and macro health systems have a profound effect upon experiences at the micro-level "impacts often far greater than those that culture per se may have"(Loustaunau and Sobo 1997:46). Global influences such as travel, development, war, and trade interface with macro structures such as government policies, problems of poverty, education levels, food supplies, and employment impact people at the micro level (Loustaunau and Sobo 1997:46). It is at this juncture that problems arise unforeseen.

Growth of the scientific medical model is a combination of significant discoveries and events.

> Pasteur's germ theory of disease, the founding of the American Medical Association, Abraham Flexner's Report on the State of American Medical Education, and the development of the hospital system, plus later rapid growth of technology after World War II, had major cultural impacts upon treatment modalities and the context and delivery of health care in the United States (Loustaunau and Sobo 1997:114).

With the discovery of the germ theory, great advances in disease causality, classification, and contagion, health/illness connections emerged. However, focus upon the nature of the organism and not of the individual became predominant.

The formation of the American Medical Association in 1902 initiated the professionalization process by determining membership qualifications and enforcing

conformity. Goals striving for the development of the scientific approach and, consequently, the scientific basis for medicine were adopted. Another objective was to consolidate power in the AMA and facilitate its interests, including economic gain for doctors. This involved the right to define and enforce restraints as well as set standards on medical practice with no checks to that power coming from outside of the medical community.

Further support for the professional dominance of biomedicine came with the publication of the Flexnor Report in 1910. Results such as the education of the public to the benefits of scientific medicine and standardization of medical education were beneficial to the public and the medical community. However, the report negatively impacted the entry of lower and working class individuals into medical school through high costs for education, lengthy training, and the self-imposed right of the medical profession to monitor who was allowed to become a physician. Discrimination against Jews, Blacks, women, and immigrants became policy through the competition for placement in medical school.

Hospitals provided a laboratory for scientific medicine and for physician's practice. The American hospital system reflected (and continues to do so) class relations linked to social and economic forces and historical events. With the success coming out of World War II, "scientific medicine became associated with victory, the conquest of infectious diseases, prosperity, and leadership of the free world—biomedicine was American" (Loustaunau and Sobo 1997:120).

The effect of monotheism upon medicine in Western societies also has an effect of intolerance to alternate methods (Kleinman 1995; Unschild 1988). "The idea of a single god legitimates the idea of a single, underlying, universalizable truth, a unitary paradigm"

(Keinman1995:27). Kleinman (1995:29) concedes a single-minded approach is advantageous in "pushing medical ideas to their logical conclusion, uncovering layers of reality to establish with precision what is certain and fundamental, and establishing criteria against which orthodoxy and orthopraxy can be certified," but finds the reductionistic value orientation of biomedicine as ultimately dehumanizing (1995:31). This is done by the non-recognition of suffering by the sick person and his/her family, thereby producing concepts of disease that do not include suffering and a focus on treatment not healing.

Plural Medical Systems

A plurality of medical systems results from the overshadowing of biomedicine on diverse health systems. Biomedicine in advanced capitalist nations reproduces structures of class relations (Baer et al. 1997:28; Thompson et al. 1999; Miewald 1997). A profit-making orientation caused the evolution of biomedicine with a focus on high technology, massive use of drugs, and the concentration of services in medical complexes (Baer et al. 1997). Corporate involvement in the health system is made lawful by the state, and this is accepted at both national and international levels. Throughout the world, biomedicine retains a dominant status over heterodox and ethnomedical systems. This status is legitimized by laws granting biomedicine a monopoly over some medical procedures and restricts or bans the practice of other types of healing (Baer et al.1997:29). Plurality of medical systems emerges through resistance to the process of legitimization. Groups struggling to retain ethnic identity characterize defiance to biomedical systems. Recognition of biomedicine's ineffectiveness in treating some illnesses is also a factor in producing a layered medical system.

Applied Anthropology

Because of the legally endorsed position of biomedicine and its global impact upon health systems, anthropological theory and data are important factors in implementing health care in societies. "Anthropology finds that people everywhere are intelligent and have good reasons for what they do" (Anderson 1990:169-186). This stance encourages a collaborative effort between anthropology, biomedicine and public health in understanding health issues. Anthropology's contribution emerges from a holistic concept of culture. Culture is seen as the "centering concept that must be reconciled with the realities of human biology and of ecosystems at all levels" (Anderson 1996:208). This broad strategy holds great potential for medical research.

Summary

Millions of people have been affected by the ongoing civil war in Sudan. Not only has Sudan suffered immense inner turmoil, but it has also been a pawn of colonial powers for a major part of its recent past. Its boundaries were chosen by colonial powers, uniting very diverse ethnic groups.

The country is split into two essential groups; the Arab/Muslim peoples of the north and the Christian and traditional groups of the south. Because of the desire of the northern population to appropriate the wealth of southern Sudan for their own economic development, a broad group of ethnic peoples in the south have been joined together to fight for their own voice in how those resources should be utilized. The northern Sudanese have practiced an ongoing exploitation of the peoples of the south through their slave trade. This has gone on for centuries, and is still carried out to this day. Adding to the complexity of the confrontation, the north has claimed this war's purpose to be religious in nature. They have

declared a holy *jihad* against the tribes of the south, insisting that conversion to Islam, by the south, be a part of the peace process.

This sequence of events has done what perhaps nothing else could have achieved; unification of diverse ethnic groups, some of whom were enemies. A South Sudanese identity has emerged that transcends differences in language, ethnic loyalty, and traditional political tactics.

Individuals who leave the Sudan leave as South Sudanese. This transformation includes many changes. Adoption of Christianity and entrance into a world economy and development are major factors in the employment of biomedicine among the southern Sudanese. Through the influence of missionaries, biomedical practices were introduced into Sudan. Because health and religion were inseparable to many in southern Sudan, the missionaries were able to influence beliefs about health through their positions as religious leaders. By the end of the 20th century in southern Sudan, an evolution of traditional beliefs incorporating a trust in biomedical technology had emerged.

Biomedicine has become a global system, achieving a dominance in certain situations as the legal option for aid in health issues. Because biomedicine was developed to promote the scientific method and the careers of health personnel, biomedicine also supports the continuance of class differentiation. It is within this system that the pluralities of social life are revealed and recreated.

The southern Sudanese of central Iowa participate in a distinct cultural climate, which incorporates their history, their ethnic identity (both as South Sudanese and as members of distinct ethnic groups), and evolving beliefs about economic development. This includes an outlook on the biomedical system of central Iowa as an extension of other areas

of their lives. The focus of this research is to determine what the cultural construct of health for the southern Sudanese is while expressing itself within a biomedical health community.

CHAPTER 3: METHODOLOGY AND DATA PRESENTATION

Research Setting

This study, which occurred from June through August 1999, focused on the non-Muslim people of southern Sudan who are refugees of an on-going civil war taking place in that country. The setting of the investigation took place in both Des Moines and Ames, Iowa. Central Iowa is predominantly a Euro-American area, although, there have been some influxes of ethnic peoples such as, Laotian, Cambodian, Sudanese, and recently Bosnian.

Central Iowa has been the location of immigration for the southern Sudanese since 1993, when three southern Sudanese moved to Des Moines. Presently, close to 2000 southern Sudanese live in the area. Although a refugee is not allowed great preference as to where they can move, if they have family in a certain area the United Nations does favor resettlement there. Through this process, individuals from Nuer, Dinka, Shilluk, Juba, Balanda, Jur, and other tribes have relocated to Des Moines. Once a refugee makes it to the United States, the process of finding family and friends begins.

Methodology

Data collection procedures included a variety of anthropological techniques. Informal conversation, unstructured, semistructured and structured interviews, and a review of pertinent literature were methods used in this study. All data were collected during appointed interviews made in advance with the individual involved, and took place in their homes, in offices and in my house. Several individuals were interviewed multiple times.

The research techniques were quite straightforward. Some informal conversation (chit-chat) occurred, but most individuals were contacted for the purpose of an interview. An interview schedule (an explicit set of instructions for the interviewer in administering an

oral questionnaire [Bernard 1995:210]) was followed. Therefore, every informant was exposed to the same set of questions in the form of a close-ended structured research schedule. However, the interview schedule revealed many ideas and matters that were not included in the responses to the questions. These insights added tremendously to the overall representation of southern Sudanese health. Major concerns addressed in the interview schedule included determining medical beliefs through knowledge of alternate treatment/therapies, general health concerns and status, how one stays healthy, and perceived control of one's health.

Some individuals were queried further using unstructured and semistructured interviews (interviews with a clear plan in mind or a written guide [Bernard 1995:209]) with open-ended questions. These interviews were always conducted with the purpose of clarifying the cultural construct of southern Sudanese beliefs on health, but, at times, focused upon the war, gender roles, religion, and other aspects of Sudanese culture.

Purposive or judgmental sampling was used in finding informants, since the process of obtaining informants was a system of referral (Bernard 1995:95). No overall sampling design was employed because units of analysis (people, court records, whatever) emerged in the field as the study proceeded (Bernard 1995:95). This type of sampling is especially applicable to anthropological research where little is known until the study is begun.

Several key southern Sudanese men were contacted by approaching the Immigration and Naturalization Services in Des Moines. These individuals had positions of responsibility within the Des Moines community (teacher, translator, INS employees, for example) and were seen as spokespeople for other southern Sudanese. An initial meeting with these men was arranged in April 1999, and the purpose of the research was explained.

It was agreed that such a study would be mutually beneficial to both researcher and individuals interviewed, and that the research would begin in June 1999. Other contacts with southern Sudanese were made through the Des Moines Area Community College and personal acquaintances.

Adult members of the southern Sudanese community of both sexes were interviewed. All interviews were carried out in English. A Nuer translator was used during three interviews. The same translator translated each time, and after having participated in the study herself. The duration of these formal interviews lasted from an hour to two hours.

At the end of each interviewing day, field notes were also recorded. These went beyond the interview schedule and included topics such as location, other people present, clarification of responses, and interpersonal interactions.

Sample Description

The southern Sudanese involved in this sample lead very busy lives. Most were engaged in schooling or training of some kind, had jobs, and were concerned with the care of immediate family members. Some volunteered their aid to fellow refugees by translating during consultations with doctors and other social service circumstances. Over half of the sample was composed of very sophisticated world citizens. Many had lived outside of the Sudan, in the Near East, and Europe or Canada. Several individuals traveled throughout North America as part of their endeavors associated with settling the dispute in the Sudan.

A total of fifteen people were formally interviewed and provide the descriptive part of this study. They ranged in age from 27-52 years of age. Seven men and eight women had an average formal education of twelve years. Three individuals had no formal education. All but one were Sudanese citizens, the one individual having become a

Canadian citizen since leaving the Sudan. Languages spoken by this sample included; Arabic (the official language of Sudan), Swahili, English, French, Dinka, Nuer, Baria, Lingola, Luo, Zande, and Amarik. Most people knew at least three languages. One individual spoke only Nuer (she also had no formal education), while the person with the most education was also working on his ninth language. All but three individuals could speak English fluently. There was no typical route of immigration to Des Moines other than applying to the United Nations for aid as a refugee. If the location of a relative was known, the UN would try to relocate people in close proximity to them. Once refugees arrived in the States, the process of finding relatives and friends would begin. For southern Sudanese, locating acquaintances was of primary importance, not only for social reasons, but also because of core beliefs tying health status to daily association with significant individuals in one's life[1]. Some southern Sudanese also initiate the procedure of tracking down relatives in Sudan and bringing them to the U.S.[2]

Family ties played important roles in how southern Sudanese responded to my questions. Sometimes I brought one or both of my children to an interview. Presence of family changed the way I appeared to several interviewees, especially when I brought my son. I was told for a woman to have children was a true gift from God. Women responded well when my children were present. It was naturally easier to speak with the women because we shared many roles and beliefs. However, most men were more difficult to question because the traditional role of women in Sudanese culture occupies a distinctly

[1] Discussed in data presentation and conclusion.
[2] A woman in the sample had not known the whereabouts of her mother for nine years. When I spoke to this young woman, she had just succeeded in bringing her mother to the states.

separate sphere. The line of interrogation in the interview schedule may have been more difficult for southern Sudanese men when questioned by a woman.

Data Presentation

Having provided a general description of the people in the sample, it is now appropriate to discuss the variables of relevance to this study. In order to describe the cultural construct of health of the southern Sudanese, it is important to understand the interaction of certain variables that form that worldview of health. These variables include type of practitioner preferred, perceptions of "self" related to health, how does one stay healthy, how does one become ill, what kind of control does an individual have over general health, how much influence does a health practitioner have in maintaining/recovering health. These specific variables are then intersected with more general issues, such as, biomedicine as practiced in Sudan, gender roles, southern Sudanese identity, the war in Sudan, being a refugee, and traditional health practices.

Choice of Health Practitioner

One of the most interesting responses was the answer to the question of what type of practitioner would they normally seek for their health needs (see Table 1). Out of ten choices[3], the unanimous preference was seeing an allopathic physician. No allusion to the use of traditional practices was identified or claimed, which was what was expected. This can be explained through identification of the process refugees go through to live in the United States. For many individuals this includes physicals conducted by biomedical doctors, and instruction in how to seek medical advice in the U.S.

[3] Choices were; 1. physician (allopathic) 2. relative-spouse 3. relative-parent 4. relative-non-specific 5. auto-cure 6. pharmacist 7. physician-other 8. home remedies 9. God 10. other.

With further questioning, an understanding of biomedicine emerged. A belief in biomedical practices became apparent when informants were asked if they would use alternative treatments/therapies. The alternatives as well as their use are detailed in the following table.

Many individuals claimed that while they no longer used some of the methods mentioned, their parents had. This applied particularly to treatments regarding folk curers, herbalists, injectionists, and spiritualists. Two individuals reported that their parents had been folk curers. All respondents reported that these types of healers were of the past, and that these positions were being filled by trades that held similar beliefs and functions.

Table 1: ***Knowledge of alternative treatment/therapies (n=15)***

	Have tried in the past.	Would try in the future.
Acupuncture	0%	20%
Chiropractor	7%	27%
Folk Curer	7%	13%
Herbalist	13%	40%
Hypnotist	7%	20%
Injectionist	13%	20%
Masseuse	13%	47%
Midwife	60%	40%
Dermatologist	20%	47%
Spiritualist	7%	20%

The table above indicates knowledge of medical alternatives. Midwifery is the most prevalent technique used. Sixty percent of the sample had employed a midwife in the past, yet 40 percent also claimed they would not use one in the future. When examining the other categories of alternative treatments, 87 percent or higher claimed they had not used these therapies in the past. Yet people seemed more inclined to try them in the future, anywhere from 13-47 percent. This is indicative of the southern Sudanese in general, who can be described as people that possess a willingness to consider options in many areas of life. When comparing methods that were tried in the past and what individuals claimed they would try in the future, all categories indicated an increase except midwifery. Massage, dermatology, and herbal remedies especially were methods in which interest was expressed.

Another interesting component to emerge from the interviews was the general impression of personal good health (see Table 2). When asked to describe their health, 20 percent chose "excellent", while over half felt their health was "very good". The rest determined their health as "good". None felt their health was "fair" or "poor".

Table 2: Impressions of personal health (n=15)

Valued impressions of health	Percent of sample
Excellent	20 %
Very good	53.3 %
Good	26.7 %
Fair	0
Poor	0

Another important element of impressions of health was the comparison of state of health to the past. When comparing their health at the present to that of the previous year, 80 percent felt it was either the same or improved to some degree.

Health Maintenance

Much of the interview schedule focused on how individuals could control their health. There were two themes. The first focused on what the individual felt they could do (or if there was anything they could do) to maintain good health. The other examined the efficacy of western medicine.

Health maintenance was determined by asking such things as: were regular checkups essential if good health is to be maintained; should treatment concentrate on the "symptoms" rather than on the "whole" person; and whether good health depends on putting effort into trying to stay healthy (i.e., diet, jogging, etc.). Everyone felt that regular checkups and taking care of oneself were important in staying healthy and maintaining one's health. Eighty percent felt that medical treatment should focus upon symptoms rather than the whole person[4]. Daily practices of preventative health included noticing health care recommendations in the media, monitoring the nutritional value of food, and use of prescription drugs. No specific pattern of observance of health practices promoted by the media could be ascertained, however. Monitoring the nutritional value of food, adjusting the diet to state of health and excluding preservatives in food was practiced by over half the people in the sample.

[4] This response is of interest when comparing biomedical and traditional belief systems, which will be discussed in the conclusion.

By stating in several ways that doctors play a key role in helping their patients feel better and asking interviewees if they agreed, it was possible to understand the position doctors have in southern Sudanese beliefs of health. Informants were asked whether seeing a doctor for regular checkups is a key factor in health, if doctors rarely can do anything for ill people, and if doctors can almost always help their patients feel better. Ninety three percent answered that doctors and regular checkups are essential in health matters.

When asked if they could question their doctor about medicines, all felt they could. Whether people actually do investigate options with doctors cannot be proven in this research. But this inquiry serves to illuminate a frame of mind, especially when the complete sample expressed this belief about them. This observation, along with the other findings, helps form a distinct cultural climate regarding health care practice. An emphasis upon biomedicine as the foundation of physical health care, a robust view of personal health, belief in personal maintenance of health, and the conviction that one has the right to question authority in order to understand treatment are the main variables involved in a cultural climate of health among the southern Sudanese.

General Issues of Southern Sudanese Living in Central Iowa

Observations made thus far are further illuminated with data gathered from non-structured and structured interviews. This information reveals where misconceptions by the Sudanese and the health care community interfere with achieving compliance with medical treatment and even the formulation of proper medical advice.

South Sudanese Identity

"I am South Sudanese!" I had referred to this particular individual as Sudanese, and was promptly corrected. Many individuals referred to this specific type of identity. If not

directly alluded to, its cohesiveness was apparent when they spoke about themselves. The South Sudanese identity is very important to an understanding of their culture, and, consequently, is an avenue to prescribing appropriate medical advice for the southern Sudanese.

The source of the South Sudanese identity stems from the forced defensive stance southern Sudanese must adopt in order to withstand pressures from northern Sudan. Religious freedom formed a major impetus to unite among the southern Sudanese. The belief that religious choice is an individual decision separates the Muslim north from southern peoples. Exploitation of southern Sudan's natural resources for the benefit of northern Sudan has had an inflammatory effect in dividing the north from the south. Thus the formation of this identity emerged from recognition of many similarities in tribal societies of the south. A Nuer woman spoke of this identity and explained that Nuer and Dinka cultures were basically the same. Language was the essential difference between the two cultures.

The southern Sudanese describe their identity in the following ways; they are people who are rich in natural resources, there is a close association with the land, and they are people who can always depend upon the bush to support them if crops fail or they are forced to move for political reasons. Strength and independence mark the personality of the southern Sudanese. This is coupled with adaptability to diverse influences, such as, developmental, cultural, political, and finally geographical. Though the southern Sudanese of central Iowa do not have land resources to fall back on, these qualities of independence, strength and adaptability are a part of their self-perception.

This self-image can be of particular importance when dealing with the southern Sudanese in medical situations. Southern Sudanese questioned in the interview schedule revealed an impression of their health as "excellent" to "good". Without understanding how these southern Sudanese view themselves could affect how a health practitioner would interpret situations described to her/him, including the depth of conviction of illness in a southern Sudanese individual.

Importance of family and friends

When asked to define good health, one female respondent replied "exercise and good food help you to stay healthy, as well as, being happy and not frustrated or sad, staying active, making a lot of friends and talking to different people." Not only were friends and family stated as important factors in maintaining health, but also one could clearly observe the importance of these ties. Invariably people would drop by during an interview, or someone would call on the telephone. During the period in which research was conducted, a large party was planned for a member of the Nuer community who had finished some schooling. Much preparation was involved in this, including braiding the hair of all female members of families. This was the opportunity in which I was able to interview a couple women, while hair was being braided.

Once a person from southern Sudan arrives in the United States, the important process of locating family and friends starts. A young woman from Ames finally was able to bring her mother from Sudan after nine years separation. During most of that time she did not know where her mother was or if she was alive. Another woman said her health was impaired because she did not have any of her family around her. She felt alone, isolated and

vulnerable. Others, when asked for ways they maintain good health, spoke of the need to speak to many people and to make lots of friends.

The concept of communication with family and friends involves speaking to the familial ancestors and influences the maintenance of good health. Death does not separate an individual from continuing a relationship with the people they know. A lifestyle in which the ancestors guide and teach through their experiences has been passed down many generations. One individual claimed the relationship has existed for thousands and thousands of years. When problems or conflicts regarding changing beliefs, depressions, or problems in relationships arise, their actions may include a dialogue with the ancestors along with visiting with living friends and family to help them through their crisis. The ancestors are entreated to help, to wash over the petitioner with their presence. Depending upon the form of Christianity a person has adopted, many people will talk with, pray to, and sometimes have feasts for the ancestors. During any important situation in a person's life, the ancestors are always involved. Commemoration of the dead is an influential event in and of itself that lends stability to daily life. Therefore, the continued participation of the dead with the living affects the southern Sudanese in physical, social and cultural expressions, one of which is health. Recognition of the impact of relationships, which could be considered the foundation of southern Sudanese life, has profound effects in association with medical diagnosis and compliance to that advice.

Misconceptions

Hesitancy by southern Sudanese to open up to non-southern Sudanese is an integral part of preserving and protecting themselves from judgment by the general population of Des Moines and the biomedical community specifically. Because of the nature of this

research, some were very vague in answering questions, for example, about their ancestors. This is not to imply that those suspicions are unfounded and unhealthy. To the contrary, members of the Sudanese community are wise to demonstrate these characteristics.

An example of a practice, which produces, at least initially, suspicion among the southern Sudanese is drawing blood for medical tests. In the Sudan, as in the United States, clinics draw blood for a variety of reasons. In the Sudan these tests are executed right at the clinic. Some southern Sudanese claimed that U.S. clinics needed much more blood for tests and ran more tests that demanded blood samples than their experiences in Sudan. Some Sudanese, when having tests done in Iowa, felt the amount of blood drawn for these tests was excessive. Several stated a suspicion, initially, that surplus blood was sold illegally.

Others felt that they would prefer working with doctors who had had professional medical experience in Africa. Such a doctor would understand the diseases and conditions southern Sudanese people lived in, and would require less explanation during consultation for current situations. Some expressed the belief that a doctor's knowledge of malaria and other endemic health situations in Africa greatly influenced their trust in medical advice given by a practitioner residing in the U.S.

Documentation of key events in life is haphazard at best in southern Sudan. Such occasions as births, deaths, and marriages are usually not recorded. Therefore, medical records may simply not exist. Inoculations, treatments used in the past, even names of physicians are not registered. This can cause many problems in providing a continuity of treatment for southern Sudanese by health personnel in the U.S.

Some of the southern Sudanese interviewed were sophisticated travelers with a broad knowledge of the world. When they were asked if they knew if such diseases related to

witchcraft or evil eye existed, most said such things did not exist. One individual claimed that as a child a woman had used the evil eye on her. Everyone in the sample, however, was familiar with the terms witchcraft and evil eye.

Towards the end of the research, I met a southern Sudanese man who had lived in the United States for at least 20 years. He mentioned some of the roles witches had in Sudan, and how basic concepts related to witchcraft continue to be used among southern Sudanese living in the United States. For example, when discussing the choice of marriage partners for southern Sudanese, the topic was intertwined with many variables including the importance of family, health, ancestors and witches. Choice of a marriage partner involves an investigation of the whole family. If anyone in the family had been caught stealing, it marred the character of the future marriage partner. Murder committed by anyone in the family is a very significant determinant. The spirit of the murdered person is thought to haunt the murderer, his/her family and children, and children's children. A serious disease, such as tuberculosis or leprosy, among the family is cause to question continuing with a marriage contract. Finally, it was especially important to find out if anyone in the family was a witch.

Witches take advantage of people, and are available for hire in situations of poor health, influencing other's decisions, or helping to form a love match. They are known to do unusual things. For example, they dress strangely, and they eat or relieve themselves in strange places. This is done to intimidate others or to make the witch look unique. This unusualness or uniqueness was also important for keeping their image as a witch in the foreground, that this impression was very important for business. Usually, it is the elders and

those individuals who have not received a formal education that believe in witches and associated beliefs such as evil eye, curses and oaths.

Witchcraft is not routinely practiced here in the U.S., but southern Sudanese recognize the importance of individuals who perform the same function as witches do in Sudan. These services include counseling offered by trained professionals of various fields. Therefore, younger people do not adopt witchcraft as a trade but become, for example, psychologists instead. Ideas of maintaining social and psychological health are/were achieved through recognizing this link between western and traditional Sudanese methods. This also demonstrates the ability of southern Sudanese to adapt preexisting ideas to new situations.

Gender Roles

The roles of men and women in southern Sudan are quite different to those in the U.S. Sometimes the distinction is in degree (such as subordination), whereas, in other areas, the differences are striking. Consultation with a doctor can be a frustrating circumstance for all concerned due to communication rules of gender roles of the southern Sudanese.

Southern Sudanese traditionally have different spheres of activity for the genders. In Sudan, men and women have separate sections of a house where the other gender does not enter. The family shares a common room, but women have and own a certain part of a house, as do the men. Boys live with their younger siblings and their mothers and other female relatives until they are about the age of twelve. It is at this age that young men are initiated into manhood. After this time they are expected to stay with their peers and the older men. This process is seen as producing respect for each gender.

Men and women are believed to have different abilities, and therefore are responsible for specific daily jobs according to gender. Women fetch water, gather wood, care for the young children, cook, and other household tasks. Men herd the animals, cultivate the fields, and transact business.

The importance of women in society varied in description. A young southern Sudanese man stated that women were less than third class citizens in his society. An older man claimed that women are the most respected people in the country. That women are the ones remembered when they die. Both statements relate to perceived values of women's roles, and of problems that arise from influences such as war and formal education.

In the past, women in Sudan married between the ages of 16 to 20. By the time they reach their mid to late 30s, women "retire" from an active sexual relationship with their husbands. By this time in their lives their children are adults and are married with children. It is considered shameful for a woman of this age to give birth to children when their own children also bear children. It is this time when women own their house, and their grown children come often to visit. They also are needed as child-care providers for the grandchildren.

Along with separate gender roles the southern Sudanese have distinct physical areas in which only one gender may inhabit. In the Sudanese countryside, male household members have their own tree as well as a living room and a bathroom just for their use. Women also congregate in the kitchen or their living spaces. In cities, houses generally have two living rooms and two bathrooms, one for each gender. If people spend the evening gathered about a fire, there is always a side for women and one for men. The practice of

living quarters with assigned gendered areas causes problems for southern Sudanese families in the U.S. where there is usually one common room for all individuals.

This concept of separateness is carried into other aspects of relations between the sexes. Many topics are taboo between genders. Men and women do not divulge much of their lives to each other. People feel shy about private matters heard about the opposite sex. This has a great influence during doctor's visits. A woman will not disclose personal information about her health in the presence of any man from her country. The same is true of men. People in Sudan also prefer same-gender nursing care. In Sudan, members of the family supply food and physical care if an individual stays in the hospital. Though women prepare food, only members of the same gender provide physical care. This can cause problems for southern Sudanese in matters of privacy when a person from the opposite sex attempts to supply this aid. Concomitantly, southern Sudanese also prefer to consult doctors of the same gender as themselves.

Gender roles are changing in urban settings of the Sudan and especially here for refugees. In the Sudan, many people are not raised in traditional rural compounds with their relatives because of the war. Many grow up with an army training. An informant described this upbringing consisting of moving in lines, obedience to orders according to rank, and other influences such as the non-ritual use of alcohol. Urban settings with a corresponding market economy also tend to muddy distinct traditional roles. Though urban housing in the Sudan does include separate living spaces for men and women, confusion occurs when women who traditionally are responsible for heat, water, and care of the children must pay for heat and water while providing childcare. That money must come from employment of women, not men. This is difficult to do while watching children.

Another problem emerges through the failure to disclose income by men. No longer can a woman see the fruit of a man's labor by inventorying the harvest, they must trust that all income is revealed. This sometimes does not occur, and when discovered adds tension to marital situations.

The same problems emerge in the U.S. along with housing that does not supply living spaces for both genders. Great stress occurs when both genders in a family cannot maintain those areas of privacy, as well as, the confusion of reconciling changing roles through a money market. Many individuals in the sample stated these two stresses were present in their lives, and claimed these stresses affected the health of their family in adverse ways through susceptibility to colds and flus and other conditions.

Use of Traditional Methods

Though biomedical practices have been used in Sudan for many years, there are certain traditional practices and concepts that the southern Sudanese of central Iowa employ. Their actions, from an outsider's view, have the appearance of conformity to biomedical concepts, but much of their traditional ways have remained important and continue to be expressed. It would be more accurate to say that biomedicine has conformed to the southern Sudanese worldview.

The adoption of Christianity played an important role in the acceptance of biomedicine through the dual role missionaries had as both people of God and as healers. For the southern Sudanese everything is tied to spirit and honoring the ancestors. Respect for memories of the dead and celebrations for the dead are avenues in which they are appealed to wash over those who remain alive. They represent the other world and whenever southern Sudanese pray, the Sudanese mention the names of their ancestors.

Informants described this action as invoking the dead to "wash" over their progeny. It is believed they also help their family and are considered more powerful than the living. This practice provides strong psychological aid to the people.

Because the introduction of biomedicine initially took place via Christian missionary activities, the traditional understanding that physical well being as a facet of spiritual health was not disrupted. The branch of Christianity adopted by certain tribes also affected the degree of traditional practices retained. The Roman Catholic Church allowed for a greater retention of traditional forms of worship. Worship and healing are intricately associated in southern Sudanese society, some similarities of Catholicism to southern Sudanese religious practices allowed the retention of certain rituals such as sacrifice.

No form of Christianity could suppress the relationship with the ancestors, but the expression of that kinship was affected. Traditionally, the ancestors were included in major decisions, were placated during times of illness and famine and their experiences were remembered providing a continuity of identity with the past. Dialogue with the ancestors took place through prayer, feasts, and sacrifices. Catholicism allowed for a synthesis of traditional beliefs with Christian and biomedical beliefs. Through the presence of saints and apostles in the Church hierarchy and practices such as burning incense, Catholicism was perceived as similar to traditional religions. And Catholics tolerated southern Sudanese beliefs and rituals associated with the ancestors. Expression of their dialogue through prayer, feasts and sacrifices were also allowed. People would pray in church then pray to the ancestors in traditional ways for the same cause (for example, infertility). Protestant Christians were less flexible in tolerating the expression of a relationship with the ancestors. Though prayer and feasts were allowed, sacrifices were banned.

Several people mentioned that in the U.S. they could no longer have sacrifices, but would simply buy much meat and have a feast. Any function, for example, a birth, a graduation from school, would always include mention of the role ancestors have in influencing their lives. The range of impact the dead have upon their living relatives is extensive throughout every aspect of an individual's life.

Kinship to the ancestors is but one aspect of the importance of relations in general. The recognition of family ties is paramount in structuring one's life and, therefore, is a strong force in maintaining health. All life centers on family and friends. Southern Sudanese are very social people. They will go a long way to visit each other. People understand themselves through the groups they belong to and like to be with. Kinship and religious beliefs are the foundation of a health system, which has incorporated biomedicine into its structure.

Summary

As previously stated, an emphasis upon biomedicine as the foundation of health care, a strong view of personal health, belief in personal maintenance of health, and the conviction that one has the right to question authority in order to understand medical treatment are specific beliefs that emerged in this study. Woven into the belief that biomedicine is a primary source for health care are aspects of southern Sudanese culture which form a distinct climate separate from the general population of central Iowa.

Strength, affluence, adaptability, and courage are perceived collective traits of a South Sudanese identity. The friends and particularly the family in which one belongs form personal identities. Ancestors are considered an important part of the family, and influence people in their daily lives.

Because biomedical techniques differ from those practiced in Sudan, the southern Sudanese are wary of those practices. They also demonstrate a hesitancy to speak of certain topics, known by them to produce judgmental and negative responses from people such as doctors. These topics include witchcraft, the ancestors, and evil eye. Personal suspicions of the researcher were revealed when people were allowed to meet the children of said researcher. Actions by southern Sudanese revealed a relief to be allowed to observe the researcher and some of the people who make up her family. This further exemplified just how important family ties are in interpersonal relationships.

Gender roles are extremely important in direct communication with medical personal. People feel shy about private matters heard about the opposite sex. This is very uncomfortable to southern Sudanese when they use translators who are not of the same gender as them. Many misconceptions and miscommunications occur through a lack of understanding this important expression of gender roles.

Religions, family relationships, which include the ancestors, form the foundation of a medical system that has recently adopted biomedicine. The war, immigration to new lands and cultures, redefinition of gender, as well as, individual roles are but some of the influences that challenge the health of the southern Sudanese in general. The identity of southern Sudanese has had a profound effect on how they cope with new lifestyles.

CHAPTER 4: CONCLUSION

> "I assume the unity of the human species such that I take all human beings to be constructing their notions of health and illness and how to handle these phenomena with reference to an essentially similar biological base" (Stacey 1986:11).

Because all people are physiologically the same, every culture uses some sort of health system to identify health conditions and to treat recognized circumstances of disease, however they are defined. The universality of health systems allows anthropologists and health care personnel a common thread with which to relate definitions of health, illness, disease, and methods of treating those conditions. Kleinman's (1980: 70-71) core functions of a health care system are a guide for carrying out such a comparison cross-culturally or (such as the southern Sudanese of central Iowa) in situations of complex histories including acculturation and immigration. These five functions are: a cultural construct of illness as a psychosocial experience, the establishment of general criteria to guide the health care process, the management of particular illness events through labeling and explaining, healing activities, which include all types of therapeutic interventions, and the management of all therapeutic outcomes (Kleinman 1980:70-71).

The purpose of this thesis is to examine the cultural construct of health of southern Sudanese refugees in central Iowa. Because of government policies in Iowa, many Iowa communities will continue to experience "rapid ethnic diversification" (Grey 2000:9). In order to understand and implement medical care that aids immigrants to Iowa, defining a cultural construct of health is a necessary concern to all parties involved. This thesis endeavors to begin the process of such an understanding.

Because health, illness and disease are concepts deeply affected by cultural variables that interact and combine to form a specific worldview, it is necessary to discuss those factors. When working with the southern Sudanese, those variables include the; civil war in Sudan, emergence of a South Sudanese identity, traditional values and beliefs, adoption of biomedical health values during the British/Egyptian colonial period, and misconceptions in understanding that arise both in the biomedical health care system and among the southern Sudanese. Identification of general health concerns, knowledge of alternative treatment and ideas of perceived control of one's health form the general background for the cultural construct of health as related to biomedicine.

Because biomedicine reproduces class relations and claims a status as the legal and legitimate course for medical help in the United States, a layered structure of medical systems has evolved, which progresses from the legal accepted form to distinct systems including ethno-medicine, other traditional forms of medical beliefs and "alternative" methods. Medical pluralism can also exist in serial or simultaneous utilization of different types of medical systems and practitioners (Waldram 2000:615). Though biomedicine occupies a sanctioned position in western health systems and inhabits a sphere of its own making, it does not address humans as a whole, nor does it accept people occupying lower income statuses through the commodization of health care. This inability to respond to individuals and suffering in order to discern disease causality, classification and contagion, and the merchandizing of medical care, forces some people to employ alternate avenues or to turn to traditional methods.

For most cultures, including the southern Sudanese, biomedicine is contained in a complex web of relationships and methods, which form their health system. Therefore, the

Southern Sudanese claim the benefits of biomedicine while employing procedures with which they have been raised. Though biomedicine's qualities are recognized, it has been incorporated into a potent, vital, and existing health system in which biomedicine can and does add to its effectiveness. Because traditional southern Sudanese paradigms about health included the association of health to spiritual and emotional relationships, differentiating between professional, folk, and popular sectors (Kleinman 1986:29-47) can be done, but, for the purposes of identifying a cultural construct of health, may be misleading. Health sectors within southern Sudanese culture can be divided into professional and lay concepts, though I feel that by doing so an understanding of the whole is lost. That entirety is of essential importance when describing their health system.

The foundation of the southern Sudanese health system is based upon associations made through family and friendship. These relationships encompass both the living and dead, as well as, spiritual ties. Physical health is not separated from the emotional and spiritual aspects of an individual. Deng (1995:190) explains whereas the Muslim north of Sudan is based upon a centralized and universalized religion, the southern Sudanese practice religions that follow autonomous and personal linkages with God through the ancestral spirits. Therefore, religious freedom allowed for a degree of flexibility and permitted the southern Sudanese of the past to adopt aspects of foreign cultures selectively. Change is perceived as a process of adoption and adaptation of desired elements, which ensures the continuance of southern Sudanese worldviews. "Continuity in intergenerational succession thus has deep emotional ties to the legacy of the ancestors but is able to adjust to changing conditions" (Deng 1995:190). To keep a sense of constancy with the past and yet adapt to

very different situations is an integral attribute of the southern Sudanese of central Iowa and of primary importance when considering a cultural construct of their health system.

Therefore, the South Sudanese identity, which incorporates notions of independence, strength and adaptability, is based upon a foundation that relies upon a "continued participation of the dead with the living" (Deng 1995:191). This participation is intertwined with notions of the existence of the next world, and allows for individual expression of spiritual beliefs. Perceptions of health are directly tied to these principles. General impressions of the personal health of respondents appear to replicate the awareness of strength and adaptability through their replies of feeling in "excellent", "very good", or "good" health as expressed by individuals during the interview schedule.

Biomedicine was introduced to southern Sudanese cultures through missionaries during the British/Egyptian Condominium. The dispensation of medicines by religious individuals mirrored southern Sudanese beliefs that health was achieved through spiritual means. Though missionaries were eventually restrained from actively proselytizing in the Sudan, and the British government endorsed a separation of church and state, biomedical paradigms were bound to spiritual beliefs. The acceptance of biomedical practices is reflected in the choice of health practitioner among the southern Sudanese in central Iowa. Though other forms of treatments were known, all informants in the sample claimed they would prefer seeking the advice of an allopathic physician first.

The entire sample felt that regular checkups with the doctor were essential for the maintenance of health. Daily exercise, monitoring nutritional intake, and taking note of health care recommendations in the media were recognized methods for self-maintenance of health. An acceptance of certain biomedical paradigms was evident when 80 percent of the

sample stated that medical treatment should focus upon symptoms rather than the whole person. This is an interesting development when considering the holistic outlook of the southern Sudanese health system. It could be that this is an expression of an understanding of biomedical beliefs as practiced in this country as opposed to their practice of maintaining health through a system of spirituality, kinship and biomedicine.

That spiritual and kinship relationships, as well as other health practices, are used adjuvant to biomedical procedures by southern Sudanese raises important questions for biomedicine in general. Most important of all is how does biomedicine help people who have a sense of health systems, which are broader in scope than its traditional boundaries. Allopathic medicine as it is practiced in Iowa is transforming itself by several processes. One avenue of change comes from within the profession itself. Doctors are including techniques that have, until recently, been considered "alternative". Biomedical doctors are practicing, for example, acupuncture, massage and nutrition. The fact that doctors are recognizing techniques outside the traditional realm of biomedicine can be attributed to the general public, which has actively sought "alternative" methods when facing procedures and treatments considered unsatisfactory within the biomedical paradigm. Finally, influences from immigrants and refugees as well as travel throughout the world by U.S. citizens are altering approaches to health and its maintenance.

Though biomedicine is itself undergoing changes, the system of human services, of which biomedicine is an important facet, influences refugees through a system based upon methods, often bureaucratic and patronizing (Whiteford & Manderson 2000), to aid individuals in positions of need. Health care personnel influence the direction of southern Sudanese health maintenance through means that can be deleterious rather than beneficial

because a lack of cultural understanding of people from the Sudan. Certain positions within the human services web have the function of "gatekeeper". Social workers, teachers, and health care personnel are examples of professionals who fulfill such a role. People who are assessed by such specialists are directed to proper avenues of help in the form of education, vocational training or personal care. These "gatekeepers," however, are trained in culture bound practices that become inadequate when dealing with individuals from other cultures. People from elsewhere also have suspicions of these specialists when certain practices are not accomplished in familiar ways. This is a frustration elucidated by the southern Sudanese about aid in the form of medical advice and the unfamiliarity of procedures.

Gender relations is an area where many problems can and do arise. This becomes a problem in matters of communication, specifically when translation is necessary. Women wish for women to interpret during a consultation with a doctor, and the same with men. Misconceptions can arise quickly, especially on the side of the health care provider. A physician's assistant who worked with southern Sudanese related a very heated pronouncement of the chauvinism of Sudanese men. She claimed the men simply refused to translate, and that they were disinterested in the health of their female family members. This is not to say that every health care professional has this view, but it is a demonstration of one way a lack of knowledge of southern Sudanese gender roles can affect diagnosis of and compliance to medical practices. Strong emotions about medical clients can also inhibit proper judgment of medical situations.

Changing gender roles in relation to shifting economic responsibilities have the potential for grave consequences in kinship relationships among the southern Sudanese. Traditionally, women were responsible for childcare, heat and water. Gathering wood and

hauling water could be accomplished while watching the children. But in a money market where heat and water are to be paid for, women must leave children in order to gain the wages to pay for these utilities. This is just a simple example of change that could have drastic effects upon kinship relationships and finally upon health in often unforeseen ways.

Once southern Sudanese immigrate to the United States, it is to be expected that they will acquire problems endemic to the area. Traditionally, women controlled harvests produced by men. They could see the result of men's labors, and determine how best to benefit their family. With the introduction of currency, which can be hidden, full disclosure of earned amounts and who controls that income are glaring problems for southern Sudanese refugees. Southern Sudanese in my sample reported divorce and physical abuse increased once people settled in the U.S. Again this is an oversimplification of an extremely complex situation for many southern Sudanese. Variables such as an army upbringing, length of stay in refugee camps, formal schooling, personal family logistics, and urban vs. rural settings all have influences in how refugees act in the U.S., and, therefore, affect health status. It remains to be seen how these influences will test the adaptability of southern Sudanese kinship and spiritual ties along with their perceptions of Sudanese strength and acclimation.

The past of the southern Sudanese can serve as an indication as to the strength of their ability to survive adverse conditions, but cultural awareness on the part of Iowans who deal with the southern Sudanese plays an integral part in aiding that adaptation. This can be achieved through understanding certain key elements of southern Sudanese individuals.

Perhaps the most important detail that anyone attending to the southern Sudanese is the complexity of their past and the depth of effects that past has upon their status as refugees in Iowa. Though the southern Sudanese have traditional roles as tribal herders and

agriculturalists, this does not describe their political stance in defending themselves against peoples who wished to enslave them and steal their resources for hundreds of years. The colonial British Condominium served to soften the Muslim north and southern Sudanese relations, but British interests did come first. That the diverse groups comprising southern Sudanese peoples have unified and kept certain key concepts that identify them as people of South Sudan speaks to the strength of kinship ties to the living and the dead and the expression of their spirituality in religions of their choosing.

Because health is affected by how people identify themselves, the South Sudanese identity and kinship relationships are key elements in health status for southern Sudanese individuals. This knowledge, as well as, an understanding of record-keeping problems in the Sudan and technical differences in similar approaches to gathering medical information can enable a health care practitioner to ease misunderstandings that southern Sudanese individuals may have. An understanding of inherent biases in the biomedical paradigm is useful for practitioners to comprehend when dealing with individuals who operate within different patterns of beliefs and situations. Southern Sudanese in the sample expressed a preference for health-care practitioners who had some experience with health conditions in the Sudan.

Concluding Statements

Though the stated purpose of this thesis is to identify the cultural construct of health among the southern Sudanese of central Iowa, a more discreet objective has been the underlying force for this research. This theme may be identified as applied anthropology. What is of importance, no matter the title, is the use of anthropological knowledge, training and methodology in fields where such information can make a difference upon the lives of

those being studied. Kleinman (1995:96) cautions professionals in especially biomedical and anthropological fields that research is not experience-distant, that ethnographies should not be caricatures of human conditions. With this in mind, this thesis is important as a guide to understanding groups with cultural affinities. The southern Sudanese are composed of a number of tribal affiliations, but share a common identity. A cultural construct of a group of people is vital in understanding not just medical issues, but all day-to-day matters.

What was accomplished in this study is just a beginning in determining a construct of health. Two directions in questioning are essential if further research were done. The first of these would be how kinship roles influence health. Because of the emphasis southern Sudanese place upon kinship and friends, ascertaining how these roles facilitate health through such directions as what kin are most beneficial or most deleterious, what actions are seen as helpful, and especially the influence of gender relationships in affecting good health.

The second direction would include a more comprehensive investigation of what health, illness and disease mean to the southern Sudanese. Much can be revealed through a thorough investigation of these concepts and how they are applied in their daily lives.

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