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Understanding Reproductive Health among Burmese Refugees in Greeley, Colorado: An Ethnographic Account

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Abstract

In the past four years, over 1,000 Burmese refugees have settled in Greeley, Colorado, but little is known about their conceptualizations of health or experiences with medical institutions. This paper investigates Burmese women's reproductive health beliefs and interactions with biomedical professionals. Ethnographic interviews and participant observation shows that a lack of mutual understanding between the two groups leads to difficulties in communicating and promoting healthcare. Medical anthropological research recognizes that culture critically impacts the experience and outcome of illness, the utilization of medical services and the likelihood of successful treatment and recovery. Burmese women and biomedical professionals carry cultural constructions of health and illness that impact patient-doctor relationships as well as health professionals seeking culturally inclusive treatment. Greeley's healthcare system must understand Burmese perceptions of health in order to establish culturally relevant treatments and to engage refugee populations at preventative care levels.

Keywords: refugee, cultural competency, Burma, Karenni, biomedicine, ethnomedicine, medical professionals, reproductive health, belief systems of health and illness

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Introduction: Small Town, Global Community

The purpose of this paper is to acknowledge the experiences of health and illness as understood by Burmese women within Greeley, Colorado. Reproductive health is an especially relevant paradigm to approach culturally competent care because it automatically integrates elements of infant, child, family and sexual health within a larger population context. The key issue that motivated my research includes the relatively recent influx of Burmese refugees migrating to Greeley in search of access to jobs as well as opportunities to reunite with family members. According to an average estimation of population numbers from multiple non-profit and governmental organizations, including the Global Refugee Center [GRC], Lutheran Family Services [LFS] and the Colorado Department of Public Health and Environment [CDPHE], over the past four years, approximately one thousand Burmese refugees moved to Greeley. This group primarily consists of individuals from the Karenni, Karen, Burman and Chin ethnicities. These ethnic groups vary culturally, geographically and linguistically though they share the experience of the refugee journey. The Karen and Chin comparatively access more formal education due to primary schools supported by Buddhist monasteries, rates of western colonization and Christian missionizing in areas of urban Burma (UNESCO, 2005). The Karenni have higher rates of illiteracy with less than 10% of the population having attended school at least once (Lwin, 2002). However, youth resettled in the U.S. are expected to transition into local public schools.

Burmese families participate in a system of traditional healing practices and beliefs, making the population uniquely significant to the field of medical anthropology. Much of the medical community, both providers and policymakers, are unaware of the experiences the Burmese have had during their refugee journey. All of these components have compounding effects on the success of patient care and treatment outcomes within the clinical relationships developed between refugees and medical professionals, especially those related to Burmese women's reproductive health.

From Burma to Greeley—Understanding the Refugee Journey

The U.S. Citizenship and Immigration Services [USCIS] (2013) provides a list of refugee status requirements:

Is located outside of the United States; Is of special humanitarian concern to the United States; Demonstrates that they were persecuted or fear persecution due to race, religion, nationality, political opinion, or membership in a particular social group; Is not firmly resettled in another country; Is admissible to the United States.

The journey and experiences of the refugee community are most effectively portrayed through a snapshot of an individual's migration story. Pha Meh, 63, lived in Burma for 20 years before she fled to the Thai border out of fear for her family's safety. As a child, Pha Meh was sent to a school for two years near her small Karenni village but was forced to flee seven times from fear of the military junta's genocidal efforts. The military junta in Burma is known for human rights violations such as forced labor, executions, torture, and rape, destruction of residence, political imprisonment, ethnic displacement and genocide (Human Rights Watch, 2013).

Pha Meh served as a medical helper to Thai physicians and nurses, gaining significant exposure to reproductive health and peri-natal care in her refugee camp. When I asked Pha Meh to compare her life in Greeley to her experiences in the Thai refugee camp, she said that she is much happier and will never leave her new home. Pha Meh remembers the challenges she faced without access to medical care, even as an employee at a clinic in the camp. Pha Meh told me about one pregnant woman who she believe miscarried during her pregnancy because she was “poisoned” by drinking unclean water while gathering plants in a nearby forest. Pha Meh explained that the physical exertion required of women to sustain the needs of family members within the camp was exhaustive and often dangerous. For example, women, including those who were pregnant, would carry tremendously heavy loads of water, food and supplies hanging from each side of a large wooden plank that would be placed over the shoulders.



Figure 1. Mae Sot Garbage Dump in Thailand. Refugees pick through trash that can be exchanged for money. These conditions are representative of camp sections that house Burmese refugees in Thailand and Bangladesh. Photo: Sally McBeth.

Pha Meh estimates that she was in Thailand for about 15 years before she was resettled to New Jersey. Pha Meh lived there briefly until she was able to save up enough money to move some of her family members to Iowa where she was reunited with her daughters and grandchildren. From Iowa, Pha Meh’s family migrated to Greeley to reunite with other family members and to gain employment.

Literature Review: The Framework of Medical Anthropology

Culturally distinct groups, like Greeley's Karenni population, may not understand the host population's western health system, which diminishes the capacity to exercise power over their bodies in relation to the implicit authority of treating physicians. Medical anthropology lends well to understanding such cultural healthcare issues because it maintains that experiences, explanations and understandings of health and illness are culturally constructed and are woven into the biological expressions of individual environments and beliefs.

The concept of culturally constructed health leads to the assertion that medical professionals working with migrant groups can more effectively approach patient care when they confront the structures of a society that contribute to the health experiences of refugee populations (Cook, 1995). Furthermore, medical professionals can positively transform their outlook on diverse patient relationships by identifying the cultural assumptions that inform biomedicine.

Medical professionals in Greeley overwhelmingly subscribe to principles of biomedicine, understood as the dominant system of healing in the western world and defined as clinical expressions of health and illness (Foster & Anderson, 1978). Many Burmese participate in a personalistic healing system that relies on understandings of health and illness in the context of supernatural elements separate from the western, scientific world view (Foster & Anderson, 1978). For example, Lou Meh explained that a lack of eating a root vegetable grown in Burma that has essential "powers" could result in issues like low birth weight.

In Foucault's (1975) *Birth of the Clinic*, he addresses the term clinical gaze which defines the development of biomedicine to emphasize the biological properties, systems and pathologies of an individual as opposed to a holistic approach that seeks to understand the experiences and explanations of each particular patient. Foucault's clinical gaze also relates to the term medicalization, which represents the domination of scientific and biological structures on the social, psychological and bodily experiences of individuals (Singer & Baer, 2012). Historically, the hospital developed as a regulating institution that presently seeks to manage and structure expressions of the body (Foucault, 1978). Biopower is one notable mechanism through which medical institutions can exercise power and is defined as the clinical surveillance of the body as well as the medical procedures and techniques used to control populations (Foucault, 1978).

To achieve a thorough understanding of community health, it is important to consider the social determinants of health, which include all factors of one's experiences that impact their lifestyle (World Health Organization, 2013). Notable social determinants of health surrounding Greeley's displaced Burmese population include job insecurity, low income and an overwhelming marginalization from biomedical facilities. Human displacement has a significant impact on the health status of individuals, especially when a particular system of healing is marginalized (Kleinman, 1985). Consequently, health policies and resources must account for refugee groups as they relocate to the U.S. and encounter unfamiliar lifestyle expectations that impact inequalities related to variables like nutrition, community safety and occupational health (Patil, McGown, Nahayo, & Hadley, 2012). Multiple forced migrations deliver a challenge to providing effective and complete medical histories which leads to shortcomings in realizing thorough treatment plans for chronic diseases as well as building doctor-patient relationships that are often essential when realizing sexual and reproductive health needs (Patil et al., 2012).

Realizing the needs of refugee women on an individualized basis through discourse and community involvement allows for the overall push towards inclusion of the refugee population in the agenda of policy-makers (Refugee Women's Association, 2003). Culturally produced gender roles impact refugee women's experiences with local healthcare services and medical

professionals must be prepared to respond to a spectrum of beliefs regarding areas of sexuality and pregnancy (Rumbaut and Weeks, 1986). Host countries must develop comprehensive understandings of refugee's systems of beliefs and family practices in order to effectively serve the preferences and needs of women who interact with medical professionals of different cultural backgrounds (Kaddour, Hafez, & Zurayk, 2005).

Medical professionals encountering women who subscribe to an ethnomedical system must reevaluate their definitions of normative health experiences and the contexts through which they understand reproductive practices (Foster, 1976). The most common cultures subject to resettlement often include matriarchs with exclusive roles in group life that provide mediation between genders and additional social relationships (Nyanzi, Manneh, & Walraven, 2007). In a research study conducted in The Gambia, Nyanzi et al. (2007) uncovered critical examples of women serving as leaders in their communities through the role of a traditional birth attendant [TBA]. Nyanzi et al. (2007) identified that TBA's fulfill key health roles including serving as a cumulative pool of ethnomedical health knowledge and treatments applicable to all illness experiences. Nyazi et al. (2007) asserts that having an outlet for such sensitive health knowledge is a positive avenue for social relationships to be preserved because TBA's help manage emotional and psychological expressions of illness that impact friendships, marriages and families. Burmese women are customarily trained to determine reproductive illnesses. Many of the younger generations in Greeley, ages 18 to 45, indicated that due to displacement, they were unable to gain this traditional health knowledge.

Medical professionals cannot fully grasp the realities of a patient's illness and sickness expression without applying cultural knowledge in clinical settings (Kleinman, 1985). Kleinman (1985) portrays biomedicine as a representation of a culturally dependent and historically assembled expression of a particular socio-cultural population. Recognizing the context that surrounds refugee women's health histories is vital to understanding the current health issues and experiences that take place within a host community (Farmer & Rylko-Bauer, 2002). For example, many women do not have access to medical services during relocation, and they may struggle to adjust their health and that of their children's to the host population's standards due to malnutrition, previously unresolved traumas and, specific to the Burmese, the oral use of carcinogenic substances like betel nut. Some women may have had limited or no access to family planning information which calls for an in-depth discussion between medical professionals and patients who are learning about new medical treatments for the first time (McGinn, 2000).

In resettled refugee communities, shared knowledge about sexually transmitted diseases and healthy pregnancy practices may also be founded in misinformed discourses that dominate in places of refugee origin (Leiter, Suwanvanichkij, Tamm, Lacopino, & Beyrer, 2006). Because refugee populations that come from politically conflicted regions may have higher rates of exposure to sexual violence, biomedical reproductive health services should account for medical histories beyond physical health in order to provide necessary psychological care (McGinn, 2000). Taking into account the cultural practices found in a refugee's place of origin is also critical because women may have participated in or been subjected to ritual body modifications like neck traction or female circumcision in particular regions (Obermeyer, 2003¹). By giving

¹ Neck traction is a body modification technique used by Karenni women where brass rings are secured to the neck for elongation over a period of time. Neck traction is not practiced among the Burmese community in Greeley. Within Greeley's East African and Somali refugee community, one form of body modification includes female circumcision. This is a common practice in Somalia though it is a controversial practice among Somali families in

consideration to female refugee life histories, medical professionals can pull from their clinical insights and modify patient care to accommodate specific reproductive health disparities and experiences within the host community.

Methodology: An Ethnographic Approach

The goal of this paper is to identify understandings of reproductive health among Burmese women and the nature of the relationships they are building with the medical community. I wanted to examine experiences of the Burmese population in conjunction with Greeley's medical professionals' perceptions of Burmese patients and their opinions on the status of care currently being offered. I employed ethnographic research methods to conduct one on one interviews with individuals from both groups in order to produce a foundation for understanding the intersections of culture and health in Greeley. Qualitative research was gathered, including generational comparisons of female reproductive health, experiences in refugee families and accounts of visits to Greeley's biomedical institutions. In-depth interviews were used to establish understandings related to daily lifestyles of refugee women that include intersections of the environment, economic status, diet, self-care, reproductive health histories, responsibilities in public and private roles, overall health statuses, and access to medical resources and beliefs about healing.

The medical professional participants were asked to discuss overall interactions with the refugee population of Greeley, especially the Burmese women. Specifically, interviews were conducted with two family medicine physicians that work closely with refugees at multiple biomedical sites in the Greeley-Evans region. One interview was conducted with a translator who works closely with refugees at a biomedical clinic in the Greeley-Evans region. My research findings are supplemented with information from community stakeholders from the GRC. I was able to interview 17 Karenni women ranging in age from 18 to 70+. Eight of the 17 women were interviewed in a group format that proved effective at making each woman feel more comfortable with regard to answering questions about reproductive health.

Results & Discussion I: Stories of Health, Healing and Illness

The first question I asked during my first interview with Che Meh, 30, was how she felt when going to visit her doctor in Greeley. Che Meh told me that she feels anxious and uncomfortable when she needs to go to the doctor because she is forced to recruit two to three different members from her family or group of friends to go with her in order to bridge the language barrier from the English speaking physician, to Karenni speaking Che Meh. Che Meh wishes she could speak with her doctor privately. Che Meh explained that after leaving a doctor's visit, she is usually given several documents in English that she keeps in a special folder but that she has never been able to use². Upon reading these documents, I realized that they were

Greeley. Many men and women are proponents of ending the tradition to improve female sexual and reproductive health; however, some women maintain that they want the tradition to be continued on their daughters because it represents a rite of passage into womanhood.

² It should be noted that documents detailing medical information that have been translated into at least one dominant language among the Burmese community in Greeley would still prove to be useful even for illiterate patients. This is because illiterate patients can ask a literate family member or friend to read the information to them. However, if the documents only come in English, they are forced to find an English speaking community member, which is rare if not sometimes impossible.

homecare instructions for peri-natal and post-natal needs. At one point during the interview, Che Meh indicated she felt the translators were frustrated because she was slow to understand and answer questions. I asked her the following:

A: Do you feel like sometimes if you were to go to the doctor's office with the translators, if you didn't understand what they were saying fast enough, they would get upset with you?

C's Translator: Yes, because we don't know what she say, so we just have to like stay quiet.

This same frustration with the current system of translation was expressed throughout my interviews with the Burmese women. In another interview, Lo Meh, a Karenni mother of three who recently resettled in Greeley, told me about challenges in communication she faced during a birth experience at a hospital. Lo Meh said she was expected to use a language line³ in her patient room in order to communicate with her medical team. However, Lo Meh was unable to use the translation service to connect with a Karenni translator. During Lo Meh's delivery, the medical team was under the impression that Lo Meh was able to understand everything communicated to her through the language line, though she was only able to infer basic information. I found that while all of the women I interviewed had visited a physician in Greeley on multiple occasions, many of them even having given birth at the hospital, the women's knowledge about the biomedical system of healthcare was virtually nonexistent.

This experience revealed that biomedical words, as well as concepts, are not reproduced within the Karenni dialect or ethnomedical framework. Teeh Meh explained that she had never been asked by her physician if she understood her medical treatments or basic biology and anatomy that inform the biomedical system. Two women interviewed said that they had been asked if they understood but that they did not know how to respond and thought it would be more convenient to simply agree. These stories indicate that a primary reason why refugees are unfamiliar with the intricacies and processes of the biomedical system is because medical professionals have not made the effort to accurately assess the patient's level of understanding. Che Meh shared a recent birth experience where, upon arriving to the hospital in labor, she incorrectly visited the primary care area first. She ended up progressing through labor more rapidly than she expected and gave birth in one of the patient beds. Che Meh said she didn't know that she had gone to the wrong place but that even in light of the surprising experience, the nurses and physician that worked with her eased the situation and showed her kindness. Che Meh was most receptive to their willingness to ask her questions like, "How do you feel today? Do you need something different to eat? Are you comfortable? Do you want or need anything? Do you understand?"

Fifteen of the 17 women that I interviewed had been on a birth control injection they called "Depo," short for Depo-Provera. Lu Meh, 27, explained to me that she was first administered Depo-Provera at a refugee camp in Thailand some years ago. Lu Meh said, "People with the shots came around camp and say we need it if you want to not get pregnant and

³ Language lines used by hospitals are telephones that connect a patient and a medical professional to a centralized resource of various individuals who can speak the patient's language. They generally look like two telephone receivers; the patient holds one while the medical staff member holds the other. This system of communication is ineffective for many of the Burmese women because one of the most prominent dialects spoken in Greeley, Karenni, is not an option on most language lines.

the doctor say it's better to have more time between babies." Pray Meh told me a similar story that included a discussion about the injection being provided in large group settings throughout the camp. When the women left the refugee camps, they were instructed to ask their next physician in the U.S. to continue their injections. These stories and ones similar to them leave a lingering question of motivation behind providing this particular health service in refugee camps freely and actively compared to other critical health needs.

For many Burmese women, motherhood is the most rewarding, enjoyable and meaningful experience, and medical decisions that alter this reproductive potential are entered into with extreme caution. Many of the women I spoke with refuse to take medicine to alleviate menstrual cramps, headaches and stomach aches because they believe that treating such symptoms of pain with drugs can cause infertility. The high importance of motherhood among the Burmese suggests that female patients should be well informed about potential side effects and risks that accompany reproductive and sexual health medications prior to being treated. It stands to reason that without the relevant biological information about their bodies and medications, a woman cannot be expected to provide an informed consent about reproductive health decisions. Ultimately, when the ability for a woman to produce life is at stake, her wellbeing should not be overshadowed by cultural differences or disparities.

The women shared a common experience of sadness and guilt in the refugee camps because when they would do something "wrong" during pregnancy, contradicting doctor's orders, they ran the risk of being "yelled" at. For medical professionals, it is critical to acknowledge these past experiences in different health systems because they impact the behaviors, expectations and beliefs that refugee women bring into Greeley's biomedical facilities. The women I spoke with were relatively unaware of preventive care measures they could discuss with a physician to increase their health through stages of female development. By volunteering a surplus of information regarding available patient services, Greeley's medical community can better communicate biomedicine's scope and relevance to individual refugees. For example, many of the younger women indicated that they would not visit a gynecologist unless they became pregnant, regardless of age or unprotected sex. Adult women, including those who claimed to have visited a clinic or hospital in Greeley, spoke of infertility, joint pain, chronic sore throats and digestive issues but were unaware of corresponding medical therapies or that they should express these issues with their physician.

The Burmese community in Greeley is extremely active in practicing traditional healing through select elders. The women in the community serve as the most important means of transmitting ethnomedical health knowledge to future generations, especially knowledge related to reproductive health. Some themes that were uncovered throughout my interviews with the women included the importance of hot and cold states of the body, the purifying elements of vegetables, the significance of the chicken's body, especially the bones and blood, appetite as the most important health indicator, categories of female health and traditional birthing positions.

Che Meh told me a story about a baby that she gave birth to in a Thai refugee camp that illustrates some of the Karenni's ethnomedical beliefs about health and illness:

A: Can you tell me why you think the baby didn't survive?

C's translator: The little insect that live on leaf or tree is like bite her.

A: Like a caterpillar?

T: It did not bite but when she touch it was like all your body, everything get hurt. When they touch you the little things like come out and you feel like you don't remember anything. She fell and she didn't really remember anything and hurting all the body and they think that is how the baby gets hurt too and she just like die after one week.

Che Meh also noted that she believes that the ultimate cause of her baby's death was due to a very hot and painful rash that resulted from touching the insect. Pha Meh, a grandmother and important matriarchal figure in the Greeley community, told me that one of the most important health practices she recommends to other women is to keep one's head warm and to not touch too cold of water. Pha Meh also emphasized the importance of eating specific types of vegetables during pregnancy in order to ensure both the mother's and baby's health. Pha Meh and the translators told me that women actually have two different "periods."

P's T: Sometimes, the period can build up, too heavy...the white period might eat all the red, the woman has two periods, so when red stops the white is eating all the red and so it stops...If the white one has more, they have more problems with the health, you are having white when red one stops, cause the white period ate it all...When they have white period, their body not look healthy, they look pale. Women, they only get it sometimes. Then they need to get medicine from the vegetables. It is not painful but dizzy and headache.

A: Where do red and white periods come from?

T: Most of women have period, but some never have it...if 1,000 people, one percent don't have the red period...If 10 years old or 13 have period then they have to have the period—it's just what happens, you are old enough to turn into a woman,...but it's not good to have baby yet cause everything isn't strong enough, then the baby will take all your powers.

A: What do you mean by powers?

T: Like strength.

A: Have you ever had a white period?

T: No. But I know someone who did. She just look white, skin white. But she eat a lot of vegetables and it's okay.

Regarding traditional birth practices, Teh Meh explained to me that the most familiar birthing position for Burmese women includes kneeling and holding a something similar to a tree stump while the baby slides onto the ground without being touched. To treat labor pains and complications during delivery, Teh Meh believes the most effective treatment is to spill fresh chicken blood onto the mother's back and shoulders while other women massage it in. Teh Meh said she has experienced this treatment before in Burma and that compared to her labor experience and medications in the U.S., she still believes the chicken blood alleviated her pain more effectively. Teh Meh also explained that in her Burmese village, the placenta was washed with extremely hot water, dried, and then placed into a bamboo shoot that would be admired as it blossomed. Based on these illustrations of therapeutic practices, medical professionals might be encouraged to acknowledge the significance of the traditional healing employed by patients in

order to empower self-care while incorporating patient preferences for effective treatment. It would be beneficial to indicate to Burmese mothers that placentas can be taken home after birth or that, in most cases, a woman can personally develop a birth plan incorporating preferred delivery positions.

The importance of the chicken in the Burmese culture was revealed to me through many different versions of the same story. Hseh Meh's version of the story began with three brothers who each represented one nation, the U.S., China and Burma. The "American" brother wrote down all of the knowledge from the world and gave it to the Chinese brother who nailed the paper to a tree in the forest. Eventually, the paper fell to the ground and was eaten by a dog. The dog excreted the paper, and a chicken came along and ate the waste. Through these series of events, the Karenni believe knowledge has been absorbed into the physical elements of the chicken. When a Burmese community member falls ill, many families will come together and host a ceremonial party in honor of the sacred chicken. An elder man will take the live chicken to a corner of the room and begin to ask questions about the proper decision and course of action regarding the health concern at hand. The chicken's throat is cut and the man interprets the pattern of the spilled blood as well as the orientation of the chicken's bones. He relays this information, which is integrated into the treatment of the ill individual, but the ceremony alone is said to be beneficial for healing. This anecdote is an example of a traditional practice that supports Burmese community healing using specialized interpretations of natural elements. By making medical professionals aware of the systems and beliefs that inform perceptions of healing, they can become more engaged in their patient's explanations and solutions regarding sickness and disease. As a result, medical professional will be able to improve treatment outcomes by situating biomedical concepts within the framework of explanatory models that are relevant and thus more likely to be integrated into the Burmese community.

Employing a culturally sensitive approach to patient care in clinical settings is significant and impactful on the effectiveness and successful outcome of medical treatment because it establishes a basis for trust (Kleinman & Benson, 2006). According to Kleinman and Benson (2006), clinical relationships are greatly affected by cultural beliefs, expectations and behaviors. Kleinman and Benson (2006) list relevant clinical topics that emerge in physician-patient relationships: "Culture factors are crucial to diagnosis, treatment and care" (p. 1673). Even more, Kleinmen and Benson (2006) argue that, "Cultural processes include the embodiment of meaning in psychophysiological reactions..." (p. 1674). Using tools to identify culture within a clinical setting improves medical professionals' ability to understand, treat and communicate with patients. By acknowledging the psychophysiological expressions of illness experience, physicians can alleviate unnecessary health complications in the clinical setting (Kleinman & Benson, 2006). Kleinman and Benson (2006) set forth "The Explanatory Models Approach" for medical professionals to utilize in order to insert ethnographic tools into their patient interactions to uncover culture (p. 1674):

- What do you call this problem?
- What do you believe is the cause of this problem?
- What course do you expect it to take? How serious is it?
- What do you think this problem does inside your body?
- How does it affect your body and your mind?
- What do you most fear about this condition?
- What do you most fear about the treatment?

Kleinman (2006) expects that medical professionals will adapt this model in order to strategize treatment options and communication methods with patients who subscribe to a different ethnomedical system. Kleinman (2006) says, "...explanatory models ought to open clinicians to human communication and set their expert knowledge alongside (not over and above) the patient's own explanation and viewpoint" (p. 1674).

Results & Discussion II: The Biomedical Perspective

To better understand and gather data for comparison to the Burmese refugee community, I interviewed two family medicine physicians, Dr. Collins and Dr. Grant, as well as a translator who often accompanies Burmese patients during doctor's visits, Neh Ru. One aspect that I wanted to investigate by interviewing physicians is how culturally constructed ideas about health impact clinical relationships that form between diverse groups. I wanted to begin the interview with an insight into Dr. Collins' personal definition of health and healing in order to appreciate the individual influences among practitioners who make up the broader system of biomedicine:

A: So if you would share with me, what do you believe healing and health is?

C: I think that health encompasses the entire person and there is physical, spiritual and emotional health and the bio-psyche-social model and all of those parts play into overall health. So healing is what is done to make sure that all those pieces of health are being nurtured to their fullest potential. So if you can't heal a physical ailment, you can help with the other aspects so they can live out their fullest potential.

At first glance, the biomedical system may not appear to garner much room for cultural factors. However, it is evident that the system is composed of individuals, like Dr. Collins, who bring distinct and meaningful perceptions of health to their overarching subscription to biomedicine. Underlying norms that inform biomedicine are worth recognizing in order to humanize both sides of the patient-doctor relationship while acknowledging the impact the union of different beliefs has on health outcomes. When asked to share any challenging moments with a Burmese patient, Dr. Grant responded with the following story:

G: A recent one was a patient who was in labor and she was about twenty and her husband was there (I assume he was her husband). So she was in labor and I showed up when she was ready to start pushing and we had to do all of our interpretations through speaker phone and the whole situation was very frustrating because it was hard since the interpreter was male and she wasn't very receptive to hearing the male voice on the phone that wasn't her husband. This is my perception but they were both very flat and stoic so it was hard to know if she was in pain, or what she was feeling and regarding the communication barrier, we couldn't get through to her that she had to push as hard as she could for this amount of time and she was getting tired and we couldn't get any rise out of her. When she finally had the baby they were both still very flat. So I chalked it up to cultural differences but I don't know if it was just them as a couple.

Dr. Grant explained that during the birthing process, there is a great amount of information that must be communicated urgently between the medical staff and the patient. Dr. Grant shared a story related to a Somali woman's birth experience. The excerpt from the

interview illustrates the relevance of women's health among the refugee community as a whole in Greeley and how significantly different each culture's experiences have been.

G: This is a Somali patient, she was having a baby and this was one of my fellow residents, not me personally. She was having a baby and we broke her water for her so she could progress more quickly, and we do that all the time, but the umbilical cord started to come out before the baby and that's a medical emergency so when that happens we are supposed to get the baby out as quick as possible by a C-section, but the patient must consent, and this woman absolutely refused and said let my baby die, I do not want to have the surgery. Well in our minds, that's horrific, how could you ever choose that? But culturally they're so used to mothers or babies dying during birth and we were beside ourselves trying to get her to consent and telling her the baby was going to die. And she said fine, that's God's will...she said let my baby die. So everyone is waiting around, just waiting for the heartbeat to just go flat and, luckily, the baby did not die, but it's just one of those situations where you can't force it. They have to consent to it and even the other Burmese lady I was talking about, for us to get her baby out we had to put a vacuum on the baby's head and pull it out. And that can cause damage to the baby but we had to ask her and make sure that was okay and through the translator she said yes but we didn't know if she actually understood what was going to happen but in those situations we have to do what we think is best to get the baby out quickly and safely.

Depending on the clinic or hospital, medical professionals rely on translation from an in-house native speaker or a language line. Dr. Grant considers the use of an in-person translator to be an extremely important component of medical interactions with Burmese patients. Dr. Grant characterized the translator as an important language bridge but also described Neh Ru's position as having similar qualities to a cultural broker. Neh Ru is functioning far beyond the role of a translator and is given the power to determine what levels of understanding are acceptable for the physician and for the patient since using exclusive knowledge about the reality of the relationship. Both Dr. Grant and Dr. Collins acknowledged that their patient time is limited to 15 minutes and that they do not feel that they have enough time to fully engage with patients in general, especially those from different cultures and language backgrounds. Dr. Grant and Dr. Collins expressed that they would like to know more about the different cultures of their patient population, and that they would be willing to incorporate traditional healing preferences into treatment plans if they had more information.

One barrier that Dr. Grant expressed is not feeling as though the trust of the refugee patients has been gained enough to make them feel comfortable expressing requests for traditional healing practices. Dr. Grant and Dr. Collins both acknowledge that using more images would be a useful method of conveying medical information. In addition, they supported the idea of a group health class that would complement traditional Burmese healing knowledge and practices with critical biomedical information about reproductive and sexual health and preventative care. Dr. Grant expressed an incredible appreciation for Burmese patients when I asked, compared to other women, are there any distinct differences between your patient relationship with them and the Burmese women?

G: All of the Burmese patients I have had, I just have this feeling of love for them and I wish I could communicate with them better and I want more of them as my patients and they are just beautiful people. Maybe because they don't have that sense of entitlement and they are happy to see you and appreciate their time with you versus many of our non-refugee neighbors.

Dr. Grant and Dr. Collins are examples of an impactful, positive and new medical asset that the Burmese community has in Greeley. Both physicians provide a high quality level of medical care to a diverse patient population and are positively receptive to the idea of learning about traditional healing and engaging with patients at a cultural level. Even more, both Dr. Grant and Dr. Collins acknowledged the importance of assessing the extent to which a patient “feels” healed or healthy and significance of personalized treatment options based on an individual’s culture. Greeley’s health community must build bridges between medical professionals and the various cultural groups that make up the patient population in order to satisfy the demand that is being expressed by both patients and doctors for cultural information. One Burmese woman’s experience that illustrates the importance of medical professionals being aware of the impact of the refugee journey on a woman’s reproductive health needs includes a severe case of emotional trauma related to pregnancy. Upon returning to Greeley after an arranged marriage, Kay Kay became pregnant and severely depressed. Unhappy with her pregnancy, Kay Kay threatened to end her pregnancy because she wanted to leave and return to her family. However, with the encouragement of her husband, Ba Kaung, Kay Kay maintained the pregnancy and gave birth to a daughter, Le Meh. Le Meh was born underdeveloped, and overtime, showed symptoms of developmental challenges associated with a seizure disorder. I asked a staff member at the GRC to help me understand how Kay Kay’s experience was expressed to her doctor:

Well the Burmese are really quiet and just the lack of knowing what’s wrong or how to say what they’re feeling, they’re not ones to have problems but it’s hard to penetrate that culture because they are so quiet and they aren’t needy people. They don’t show the need that they have. I think they’re just isolated mostly so I don’t think doctors know much of their needs because they don’t present unless it’s drastic.

Kay Kay’s story exemplifies the significance of the refugee journey that must be understood by medical professionals in order to ask questions and tailor treatment plans that are relevant to emotional, psychological and cultural needs associated with a refugee status and resettlement journey.

A difference in biomedical knowledge between the Burmese and medical community of Greeley transcends the patient doctor relationship. This difference in biomedical knowledge impacts the way that Burmese women understand health resources available to them in their community. This includes a variety of health resources that are often necessary complements to successful reproductive and sexual health, like psychological care, nutrition and pediatric care.

Conclusion & Application: Cultural Competency and Awareness in Medicine

Critically examining the systems of healing and health that inform Greeley’s refugee community supports the promotion of cultural sensitivity and empowerment of refugee women in biomedicine. Accessibility to health services is significant to human development and a person’s social participation is largely defined by their health status and experiences (Cook, 1995). Therefore, health communities that serve culturally diverse groups must recognize the power that is informally exercised over different groups through exclusionary systems of knowledge about health resources. Medical professionals are an invaluable asset to a refugee community, especially women who require diverse and complex forms of care. Medical professionals that are more aware of their patient’s culture, belief systems of health and healing,

life histories, preferred traditional healing practices and illness explanatory models will provide more relevant and effective care. Members of Greeley's academic, non-profit and governmental arenas can complement healthcare services to advance cultural competency by gathering information about the journeys and perspectives of migrants.

During my fieldwork in the Burmese community, I came to realize that many of the Burmese youth were also being exposed to biomedical reproductive health knowledge for the first time in their life. Though the Karenni and Karen cultures generally do not permit intimate premarital relationships, refugee youths cannot afford to be excluded from critical information about sexual and reproductive health because they typically do not interact with physicians as frequently as adult women in their community. Refugee youths are an important demographic that should be targeted with a specialized promotion of community health that increases accessibility to knowledge and resources about reproductive and sexual health while acknowledging the cultural value of encouraging an interest in practicing and maintaining traditional family health practices.

One way to ensure this reciprocal form of collaboration would be to incorporate cultural leaders from different groups into the development of health curriculum and teaching. Medical professionals can immediately begin to actively acknowledge cultural and linguistic differences in the clinical setting by implementing more relevant modes of communication with patients. For example, physicians can utilize "The Explanatory Models Approach" referenced earlier to begin cultural dialogue with patients (Kleinman & Benson, 2006, p.1674). Rather than relying on ineffective verbal and written modes of communication, medical professional can also employ primary usage of anatomical models, visual images and diagrams to convey unfamiliar biomedical concepts to refugee patients. The structures of traditional healing underpinning the beliefs of Burmese women in Greeley uncover opportunities for the medical community to complement and grow with a rapidly transforming population. Ultimately, Greeley's medical practitioners and newcomer population represent a key point of cultural convergence and are both uniquely positioned to mutually define and uphold community health.

References

- Cook, R. J. (1995). Gender, health and human rights. *Health and Human Rights*, 1(4),350-366. doi: 10.2307/4065247
- Farmer, P., & Rylko-Bauer, B. (2002). Managed care or managed inequality? A call for critiques of market-based medicine. *Medical Anthropology Quarterly*, 16(4), 476-502. doi: 10.1525/maq.2002.16.4.476
- Foster, G. M. (1976). Disease etiologies in non-western medical systems. *American Anthropologist*, 78(4), 773-782. 10.1525/aa.1976.78.4.02a00030
- Foster, G.M., & Gallatin, A.B. (1978). *Medical Anthropology*. New York: John Wiley and Sons.
- Foucault, M. (1975). *The birth of the clinic: An archaeology of medical perception*. New York: Vintage.
- Foucault, M. (1978). *The history of sexuality, vol 1: An introduction*. New York: Random House.
- Human Rights Watch. (n.d). World Report 2013 [Website]. Retrieved from <http://www.hrw.org/world-report/2013/country-chapters/burma?page=1>
- Kaddour, A., Raghda, H., & Zurayk, H. (2005). Women's perceptions of reproductive health in three communities around Beirut, Lebanon. *Reproductive Health Matters*, 13(25), 34-42. doi: 10.1016/S0968-8080(05)25170-4
- Kleinman, A. (1985). Interpreting illness experience and clinical meanings: How I see clinically applied anthropology. *Medical Anthropology Quarterly*, 16(3), 69-71. Retrieved from [http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1548-1387](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1548-1387)
- Kleinman, A. & Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. *PloS Medicine*, 3(10), 1673-1676. doi: 10.1371/journal.pmed.0030294
- Leiter, K., Voravit, S., Tamm, I., Lacopino, V., & Beyrer, C. (2006). Human rights abuses and vulnerability to HIV/AIDS: The experiences of Burmese women in Thailand. *Health and Human Rights*, 9(2), 88-111. doi: 10.2307/4065403
- Lwin, T. (2002). Burma Studies Conference [Website]. Retrieved from <http://www.thinkingclassroom.org/Education%20Papers/4.%20Issues%20Surrounding%20Curriculum%20Development%20in%20the%20Ethnic%20Minority%20Areas%20of%20Burma,%202002.pdf>
- McGinn, T. (2000). Reproductive health of war-affected populations: What do we know? *International Family Planning Perspectives*, 26(4), 174-180. doi: 10.2307/2648255

- Nyanzi, S., Hawah, M., & Walraven, G. (2007). Traditional birth attendants in rural Gambia: Beyond health to social cohesion. *African Journal of Reproductive Health*, 11(1), 43-56. doi: 10.2307/30032487
- Obermeyer, C.M. (2003). The health consequences of female circumcision: Science, advocacy, and standards of evidence. *Medical Anthropology Quarterly*, 17(3),394-412. doi: 10.1525/maq.2003.17.3.394
- Patil, C. L., McGown, M., Djona P., & Hadley, C. (2012). Forced migration: Complexities in food and health for refugees resettled in the United States. *Annals of Anthropological Practice*, 34(1), 141-160. doi: 10.1111/j.1556-4797.2010.01056.x
- Refugee Women's Association. (2003). Empowering and assisting refugee women. *Feminist Review*, 73, 123-125. doi: 10.1057/palgrave.fr.9400081
- Rumbaut, R. G., & Weeks, J. R. (1986). Fertility and adaptation: Indochinese refugees in the United States. *International Migration Review*, 20(2), 428-266. doi: 10.2307/2546043
- Singer, M., & Baer, H. (2012). *Introducing medical anthropology: A discipline in action*. Maryland: AltaMira Press.
- UNESCO Asia and Pacific Regional Bureau for Education. (2005). First language first: Community-based literacy programmes for minority language contexts in Asia [Website]. Retrieved from <http://www.literacyportal.net/china/resources/manuals/English/010/firstLanguageFirst.pdf#page=96>
- U.S. Citizenship and Immigration Services. (2013). Refugees [Website]. Retrieved from <http://www.uscis.gov/humanitarian/refugees-asylum/refugees>
- World Health Organization. (2013). Social Determinants of Health: Key Concepts [Website]. Retrieved from http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html