

Appendix D

Burmese Refugees

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British Rule

- 19th C British Invasion
- 1883 Annexed to India for:
- Economic potential
- Empire expansion



British Rule

- Colonial infrastructure
- Became major rice exporter – largest in the world
- Also exported teak and gems
- One of the richest country's in SE Asia
- 1937 separated from India
- WW II Burmese National Army formed for independence (by Aung San)
- After WW II British agreed to give independence

Union of Burma

- 1948
- Each state was somewhat autonomous
- Made up of ethnic groups, some more wealthy than others



Socialism

- After 1962 became poorest country in SE Asia
- Xenophobic military leaders
- People had no control, became desperate
- Formation of armed resistance groups (ethnic and religious)
- 1988 student-lead protests (3000 killed, 10, 000 fled)
- Tumultuous ever since with thousands of refugees leaving a year

National League of Democracy

- Formed in 1989
- Aung San Suu Kyi
- Gained huge support
- House arrest by State Law and Order Restoration Council (SLORC)
- 1991 Given Nobel Peace Prize
- 1995 Released temporarily



Military Government

- 1989 SLORC changed name to Union of Myanmar
- 1997 SLORC abolished, State Peace and Development Council (SPDC)
- Current government with Prime Minister – General Thein Sein
- Thousands of refugees leave atrocities of military
- Rape, village destruction, forced labor, extrajudicial killing, arbitrary detention

Current Status

- Population: 46 million
- 68% Burman
- 9% Shan
- 7% Karen
- 4% Rakhine
- 3% Chinese
- Official language:
Burmese



Refugees: Composition

- Presently, there is not a lot of information available about the composition of the incoming Burmese refugees (e.g., family size, household structures, etc.). We do have a sense of what ethnic groups are included in this population. The preliminary numbers from the state department indicate that 50% of the group of newly arriving refugees are Karen, 25% ethnic Burmese, 15% Mon, and the rest are a mix of other ethnic groups from that region.
- Initial information from the cultural orientation classes indicates that about 20% of the refugees have finished high school in Burma. Many have had 6-9 years of formal education, and only about 1% possess college degrees. A small number have had no formal education whatsoever, and are illiterate.

Information taken from an e-mail from the Cultural Orientation Listserv dated August 6, 2004.

Cultural Considerations

- An individual's head is considered the highest part of the body and should not be touched by another person. However, exceptions are made for medical examinations.
- It is impolite to sit in a seat higher or at the same level as an older or more respected person.
- Pointing fingers, hands, or a foot at another person is considered rude. It is also considered insulting to call another person with upraised index finger.

Interview with a Refugee: Cultural Considerations

- It would be more typical in Karen culture to give something, than to praise through words. For instance, in school in Burma, a clever student would be rewarded by eating with the teacher at a party, but a student who was not doing well would not be invited to eat with the teacher. We do not show affection in the same way as here. When we come home and see our children, we wouldn't hug them.
- In Burma, a typical greeting would be "Good morning, Grandma," not, "How are you?" Here, when someone asks, "How are you?" it is hard for the refugee answer. In the U.S., eye contact is very important, but in Karen culture you don't look someone in the eye so much, especially with elders. In Burma if you see someone you don't know, you would not say hi, but here you talk to others even if you do not know them. Back home, we would never call elders by their names. Instead we would call them only by a title—like "Auntie," or "Grandfather," or "Teacher"—as a sign of respect. So, most Karen people will not recognize someone by name, especially if you only ever referred to that person as "Grandfather."

Interview with a Refugee: Cultural Considerations

- Some parenting differences between Burma and the U.S. are that in Burma, many parents beat their children with a stick if the child does not listen to you. This can cause the children to become afraid of older people. So here, it is a wonderful thing for me because I have to use my good ideas to teach my children. We don't use the stick anymore for discipline.



Interview with a Refugee: Cultural Considerations

- For couples where the husband does not speak English, the wife still asks the husband for advice. There is more responsibility for husbands. There are the same opportunities and rights for husbands and wives, but it is a little different—the husband has the final say.
- Our family roles have changed a little bit in the U.S. In Burma, husbands did not help with the housework, but here both of us can wash dishes or clean the house. I help with cooking, laundry, taking care of the kids, but in some families mostly the wife does it. In my hometown, the man is the head of the house, but here it seems like the woman is the head of the house.

Interview with a Refugee: Cultural Considerations



Important values from Karen culture that I want to pass on to my children include respect for elders, teachers and parents, even if you are a teenager. In Karen culture, if children don't show respect, people will say that it is a bad family, that you are not teaching your kids to respect others. For Karen people who have been here for several years, their kids are not showing respect to elders. They begin acting like American kids and calling people by their name rather than their title.

New values that I like here are independence. When a teenager is over 18, they think for themselves without their mother taking care of them, they can live by themselves. This is a wonderful thing, but Karen youth cannot stay by themselves—they don't use their own ideas; they need their parents' help. Here, youth over 18 years old are independent and can take care of themselves. If my kids can live and work by themselves, I will be happy.

Klee Thoo, a Burmese Father

Health Issues and Related Factors

- **Pre-Migration:** Drug use and abuse, HIV/AIDS, malnutrition and lack of education
- **During Flight and Refugee Camps:** Iron deficiency anemias, micronutrient anemias, adolescent sex trafficking, hepatitis B, STD's, lack of water and sanitation, lymphatic filariasis, and a marginalized population
- **Post-Migration and Resettlement:** Malaria, increasing susceptibility to chronic diseases, problems and stressors of resettlement, and mental health problems

Infectious Diseases

- Infectious diseases are the leading cause of morbidity and mortality among the Burmese. Average life expectancy at birth is 54.6 years for males and 59.9 years for females.
- Some of the most common infectious diseases found in the Burmese include: Hepatitis B, tuberculosis, malaria, scabies and parasites.

Hepatitis B

- While the exact prevalence is unknown, research shows that the Burmese typically have a 15% infection rate.
- Hepatitis B surface antigen carrier rates in the tropics are 40 times greater than in the west.
- Persons from Southeast Asia are also at high risk of perinatal transmission



Protect babies from hep B!

Tuberculosis

- Estimated incidence in the general population in Thailand is 141 cases per 100,000 however the rates among the Burmese are unknown.
- All refugees 15 years of age and older will have a chest x-ray; those younger than 15 years will be tested depending on history and risk factors.
- If a refugee tests positive for active TB, they are immediately treated and are not allowed to travel until the TB is no longer active.
- Note: There has been a recent increase in the number of TB and H1N1 infections.



Malaria

- The region along the Thai-Burmese border, where Mae Sot is located, is an endemic area plagued with multi-drug resistant malaria.
- The CDC recommends that all Burmese refugees undergo rapid diagnostic testing for malaria due to travel.
- To date, only Burmese refugees living in Bangkok have been screened, however, the number is expected to increase once refugees from Mae Sot begin to ready for departure.



Scabies

- Scabies poses a significant problem in the Burmese population.
- Treatment occurs before entrance into the United States.



Parasites

- Due to their living conditions, refugees are often at high risk for parasitic infections.
- Treatment occurs before departure to the United States.
- Refugees are treated with Albendazole (a broad spectrum antibiotic treatment).
- Regardless of the presence of symptoms, it is recommended that all refugees be tested.



Oral Health Care

- Most refugees have never had any dental health care. Additionally, many of the men chew beetle nuts (a stimulant similar to dipping snuff).
- Many face such conditions as gingivitis, calculus, tooth decay and periodontal disease.



Mental Health

- Burmese refugees generally arrive for resettlement with a substantial health burden secondary to their pre-migration experience and life in the refugee camps.
- Epidemiology of infectious and parasitic diseases, psychiatric disorders and chronic diseases can be said to proceed in stages based on the context of the forced migratory experience.
- Infectious and parasitic diseases are associated with pre-migration experiences and exposure to risk factors in the country of origin.
- Chronic diseases are associated with pre-migration experiences and exposure to risk factors in the host country (in this case, Thailand).
- Mental health problems, and some psychiatric disorders, can be thought of as linking pre- and post-migration experiences with the experience of migration itself.
- Refugees have experienced forced labor, forced relocation, and killing of family and community members. As a result, many show signs and symptoms of post traumatic stress disorder, depression and anxiety.

Mental Health

- Psychosocial risk factors for poorer mental health and social functioning outcomes were: insufficient food, higher number of traumatic events, previous mental illness, and landmine injuries.
- Despite extensive traumatic experiences and high rates of anxiety and depressive symptoms, refugees appear to be functioning relatively well as a whole.
- An important finding was the self-identified important coping mechanism of talking to family and friends.
- It is also possible that the refugees would not reveal their actual struggle with coping to “outsiders”.
- Recommended modifications in refugee policy may improve social functioning, and innovative mental health and psychosocial programs should be implemented, monitored, and evaluated for efficacy, particularly community-based programs rather than health-facility programs.

Malnutrition

- Malnutrition is a common problem among refugees and is a major contributor to a variety of health problems.
- *Acute or Severe Malnutrition:* Acute malnutrition or wasting is a result of a relatively recent decline in nutritional intake. Acute or severe malnutrition is generally characterized by the following illnesses :



Malnutrition

- *Marasmus* is due to inadequate caloric intake and is characterized by failure to gain weight, and weight loss resulting emaciation. Indications of the condition include the loss of subcutaneous fat, which causes poor turgor and wrinkling of skin.
- *Kwashiorkor* or protein-calorie malnutrition (PCM) may be due to inadequate intake or absorption of protein in children. Kwashiorkor is most commonly seen in children around 2 years old and/or who have recently been weaned.



Malnutrition: Effects

- *Chronic malnutrition:* Chronic malnutrition is generally a result of perinatal, childhood malnutrition or prolonged periods with insufficient intake. While many individuals who experience childhood malnutrition survive and reach adulthood, these individuals are more likely to have specific, long-term, developmental problems such as loss of intellectual potential, incomplete physical (stunting) or mental development. The greatest concern with chronically malnourished individuals is their increased vulnerability to illness due to an impaired immune system.
- *Micronutrient deficiency:* Micronutrient deficiency is another form of malnutrition that is potentially a significant issue for most refugees. This is particularly common in groups with little or limited diversity in diet. Children and women are severely affected by deficiencies in iron, vitamin A, iodine, and folate that can lead to low-birth weight, stunting, blindness, mental and developmental delay, and birth defects. In particular, iron deficient anemia is common.

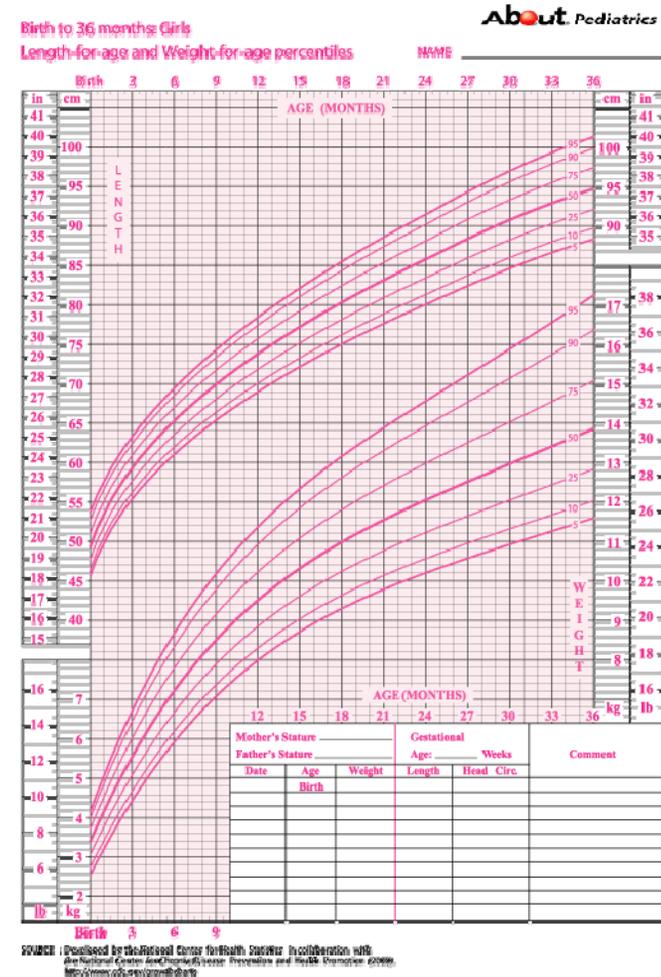
Malnourishment

Age	Average Calorie Needs Each Day
0-5 months	650
5-12 months	850
1-3 years	1300
4-6 years	1800
7-10 years	2000

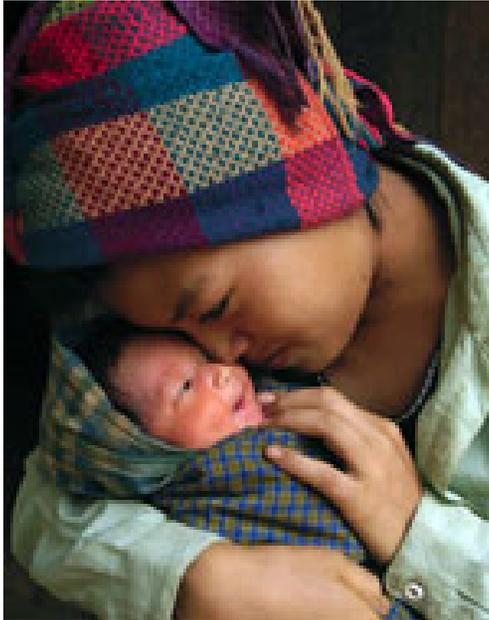
- How do we determine if a child is malnourished?
- For younger children, calorie recommendations and average energy needs depend on their age. The amount of calories that allows a child to grow normally is likely what is 'enough' for him.
- Most Myanmar refugees will not be familiar with the idea of calories.
- Instead, focus on weight gain over a series of checkups.

Feeding from the Family Pot

- A United Nations University study graded the nutritional status of children in four villages in the Kharar Community Block of the Ropar District of Punjab, India by comparison with the Harvard Standards, the fiftieth percentile being regarded as 100 per cent according to the classification system proposed by the Indian Academy of Pediatrics.
- Children were visited at home by a health worker. The 452 children (85 percent) were graded as normal or grade 1; 81 (15 per cent) were graded as having either grade 2 or grade 3 malnutrition. Of these 81 children, 76 comprised the sample for this study.
- The problem in these villages had been the lack of a means of persuading a mother of the need to feed her child more, particularly when she is already breast-feeding. This obstacle can be overcome if the mother can monitor the child's growth and learn that a failure to gain weight from one weighing time to another means that more food is necessary.



Exclusive Breastfeeding



•According to the social workers in the Denver area who are interfacing with the Burmese refugee population, Burmese mothers are exclusively breastfeeding their children for the first two years.

- These social workers also express concern that these Burmese children are malnourished.
- According to one study, “Prolonged breast-feeding, breast-feeding over 12 months, is said to be “insufficient by itself for the rising nutrient needs (and declining stores) of the rapidly growing infant”. It has been found to be associated with clinical malnutrition in Indonesia and with anthropometric malnutrition in Kenya” (Victoria, Vaughan, Martines, Barcelos, 1984).

Feeding from the Family Pot

- Governments and voluntary organizations have employed a number of strategies for the prevention and treatment of malnutrition. A review of several nutrition supplement programs conducted under the aegis of the United Nations International Children's Emergency Fund (UNICEF) showed that most of these interventions had met with only limited success and were not cost effective. The most disappointing aspect of such programs was that after the program no residual impact on the subjects' health or food habits could be demonstrated.
- The use of foods from the "family pot" for the rehabilitation of malnourished children supports the conviction of many health workers that, in principle, this is the most practical approach to the prevention of malnutrition among pre-school children, even in impoverished families. The small shifts in food distribution within the family that are required with this approach are of negligible significance for the other family members, but of critical importance for the young child.



Feeding from the Family Pot



- A nutritional demonstration program was initiated. The 76 children were visited at home three times a week for two weeks and then once every two weeks for eight weeks. During visits the health worker informed a mother that the low weight of a child could be corrected with food cooked for the rest of the family. In the presence of the mother she broke a baked chappati into small pieces and mashed it into a half cup of cooked pulses (legume gruel). These ingredients form the staple diet of the population in rural areas of Punjab. The health worker then fed the mashed chappati to the child by hand and encouraged the mother to do the same. The procedure was repeated on every visit. No other food supplement was supplied nor were any other nutrition education messages offered. The mothers were gradually encouraged to take over the feeding of their children.

Feeding from the Family Pot

- In the study population 14.26 per cent of children were found to be suffering from grade 2 or grade 3 malnutrition. Within six months this figure had dropped to 5.63 per cent, and within the next 12 months, only 2.06 per cent of the children in the population had grade 2 or grade 3 malnutrition. This finding strongly suggests that although the nutrition demonstrations ceased after ten demonstrations, the subjects continued to gain weight and to improve their nutritional status as a result of improvements in feeding practices.



Feeding from the Family Pot



- Another noteworthy fact is that eight subjects who were not included in this study because their nutritional status was grade 1 in the beginning declined to grade 2 status over a period of 18 months. This finding is in sharp contrast to the improvements noted in the demonstration group and suggests the possibility of preventing the onset of malnutrition in vulnerable pre-school children from poor families by nutrition demonstrations.
- The researchers in this study were convinced that in every developing country large segments of the population whose children are malnourished are simply unaware of the fact that their children can digest family food and thrive on it. There are few families so indigent that they are unable to afford even half a chappati and half a cup of pulses (legume gruel) per day.

Feeding from the Family Pot

- The approach employed was very economical. The total salary of two health workers was 1,200 rupees (US\$100) per month, which, when divided by 76 children, amounts to US\$1.30 per month per malnourished child. Even if the total cost of employing the two workers were attributed to this program (ignoring their role in surveillance and primary care), it would still turn out to be less costly than any other nutrition supplement program being run in the country at the present moment. The researchers estimated the cost of treatment of a malnourished or marasmic child in the hospital ranged from US\$95 to US\$950 per child and in a nutrition rehabilitation center from US\$25 to US\$70 per child (at that time).
- The researchers also suggested that illiterate parents should not be confused by talks on the caloric content of foods or on their essential amino-acid content. A simple demonstration that a child will eat family food if given the chance and will grow strong on it speaks far more eloquently than laboriously prepared academic lectures. The solution of the problem of prevention and treatment of malnutrition lies in offering to the child the food that is already in his own home.

(United Nations University, 1985)

Rationale for Supplemental Feeding

- In working with the Burmese mothers, it will be important to explain the benefits of supplemental feeding.
- By providing additional food to these growing children (thereby treating or preventing malnutrition), the mothers will be:
 - Ensuring healthy brain growth and development
 - Ensuring healthy physical growth and development
 - Protecting against increased vulnerability to illness due to an impaired immune system

What about breastfeeding?

- We do not want to discourage breastfeeding in any way. We simply want to encourage these mothers to begin transition foods to ensure the nutritional needs of their children.
- **Increase feeding frequency as a child ages**
- Children from 6-8 months old should have complementary foods, 2-3 times per day in addition to on demand breastfeeding.
- Children from 8-24 months old should have complementary foods 3-4 times per day in addition to on demand breastfeeding.
- Caregivers should also offer food 1-2 times per day for children older than 8 months in addition to breast milk and complementary foods.

(Aide Medicale Internationale, 2007)



- These families automatically qualify for WIC because they are on Medicaid.
- We can improve the “family pot” of Burmese refugees in the United States by getting these families connected to a WIC program and WIC nutrition consultants.



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