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“You have to have children to be happy:” Exploring Beliefs About

Reproduction with Burmese Refugee Women in the United States

by

Kara E. McGinnis

A thesis in submitted in partial fulfillment
of the requirements for the degree of
Master of Arts
Department of Anthropology
College of Arts and Sciences

and

Master of Public Health
Department of Community and Family Health
College of Public Health
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ABSTRACT

Burmese refugees are entering the US at record speed. Resettlement agencies focus on immediate needs, and ethnic community-based organizations (ECBOs) fill any service gaps through community-driven programs. The Tampa Bay Burmese Council (TBBC) is an ECBO in Tampa, FL dedicated to the Burmese community. This research explores the reproductive beliefs of the women in the community, paying particular attention to any differences that arise due to beliefs specific to their ethnic group. Findings include the importance of menses for women's health, the preference for both male and female children, a lack of knowledge about family planning methods, a tendency to use family planning only after the ideal family composition is reached, and periods of food and activity prohibitions during pregnancy and the postpartum period. The recommendations offered will be used by the TBBC to apply for grants to fund needed community-based services.

CHAPTER 1: INTRODUCTION

INTRODUCTION TO CHAPTER 1

Refugees are people who have been forced to flee their country because of persecution, war, or violence. The US accepts more refugees than any other country, but there is little work done by scholars to help service providers and communities share their needs with each other and find solutions to the many issues refugees face. Burmese refugees are currently the second largest group of refugees being admitted to the US each year, yet little is known about the various Burmese ethnic groups that are entering the country, nor how they are managing the resettlement process. In this context, it is necessary for researchers to help the Burmese describe their health beliefs and their health needs, specifically regarding reproductive health. This is particularly important as most refugees accepted by the United States are of reproductive age (United States Department of State 2011).

The Tampa Burmese community is currently home to twenty-three adult women; however, they are varied in their ethnic makeup, and include the Chin, the Karen, the Kayah, the Kayaw, and the Bama, of whom (two of the three Bama women in Tampa also identify as half Indian). This study includes 16 women from the first four ethnic groups. Seven of the sixteen research participants have already given birth in the United States, and many plan to have more children. While the resettlement agencies in the Tampa area provide basic health and living needs to their clients, lack of information about Burmese pregnancy and childbirth norms and practices and their family planning needs creates an important service gap. This thesis hopes to give the resettled refugees' voices, and provide recommendations for

reproductive health education that will help the Burmese adapt their pregnancy and childbirth experiences to life in the United States. This chapter will provide an overview of the issue of reproductive health among resettled refugees, an introduction to a local community organization that serves the Burmese refugees and has requested this study, and an overview of the research study.

REPRODUCTIVE HEALTH OF RESETTLED REFUGEES

Anthropologists have long been a part of the discipline of refugee studies. Applied medical anthropologists are situated in an ideal position to provide needs assessments, assess the similarities and differences within and between cultures, and provide appropriate recommendations to service providers who find themselves struggling to accommodate multiple new cultures. Additionally, medical anthropology's important recognitions of the impact of structural factors on health cannot be ignored when speaking of refugees. The political economic circumstances that have resulted in internal displacement, illegal migration, and refugee status are important aspects of understanding the refugee condition and the potential negative health effects. However, the lived experiences of individuals whose local and now global realities are the struggle of everyday survival deserve just as much attention in the literature. This thesis recognizes the injustice that creates refugees, but focuses on the current reproductive understandings of Burmese resettled women refugees.

The minimal literature that does exist on the Burmese is limited in scope or focused on the horrific needs created by the ongoing human rights abuses. Although important, authors often fail to appreciate the differences between ethnicities when discussing the population. This aggregation of many communities under the title of "Burmese" has most likely done disservice to the potential helpful information that could be gleaned from understanding the beliefs, experiences, and needs of different

ethnic groups. With the limited information available about the knowledge and beliefs of different ethnicities, which have undoubtedly been molded through decades of violence, uncertainty, and displacement, it becomes imperative to explore more closely how different ethnicities are managing and describing their lived experiences and emerging cultural models regarding reproduction.

This thesis will contribute to the anthropological literature by exploring how people from one culture adapt to another. This study specifically looks at how Burmese refugees are adapting to life in Tampa, by exploring their reproductive beliefs, practices, and needs. Anthropologists are trained to distinguish different cultural patterns and beliefs that communities recognize and use to create their own identities. When communities are uprooted and placed in new circumstances, exploring the beliefs that they hold close is important to help individuals adapt to their new lives (Delgado-Gaitan 1994; DeVoe 1992). Refugees are important populations for anthropologists to look at, because of the many issues that arise for families regarding their reproductive health. These include difficulties such as limited knowledge of general reproductive health, prior gender-based violence, how to access birth control, and how to reconcile culturally appropriate ideas about birth spacing and family size with a new economic system (Harris and Smyth 2001). This research provides the stories of Burmese women refugees navigating their changing reproductive beliefs as new residents of Tampa, Florida. It highlights important cultural practices, while describing new reproductive opportunities that both threaten and strengthen women's own feelings towards their reproductive capabilities and family options.

THE TAMPA BAY BURMESE COUNCIL (TBBC)

This research was done with the help of and at the request of the Tampa Bay Burmese Council (TBBC), an ethnic community-based organization (ECBO). ECBOs

are run and organized by local ethnic communities, whose goal is to fill in the service gaps that currently exist in the resettlement process with needs specific to the ethnic group and the local community. ECBOs are often provided grants through programs funded by the Office of Refugee Resettlement (ORR) (Resettlement 2011a). In spring of 2011, a health needs assessment was done by the University of South Florida for a resettlement agency, led by medical anthropologist Roberta Baer, PhD and her students. The TBBC was formed in the summer of 2011, and as a new organization, the TBBC's first goal is to offer educational classes that supplement the orientation classes offered by the resettlement organizations. The TBBC asked me, a student of Dr. Baer's, for help in better understanding the reproductive needs of the Burmese community, as many women in the community are beginning to have children in the US. The TBBC is asking for specific reproductive health education topics, so that they can use the recommendations to apply for an upcoming ORR grant for ECBOs that will be used for community education sessions.

OVERVIEW OF THE STUDY

This is an exploratory study that describes beliefs about reproduction in four Burmese ethnic groups that have been resettled in Tampa, FL. This paper hopes to understand Burmese refugee women's emerging explanatory models of reproduction as they negotiate and make sense of their new roles, new expectations, and traditional beliefs within the context of reproduction in the United States. . As explained by Farmer (1999), the need for a processual approach to truly understand how shared representations of illness emerge is particularly important during the introduction of a disease into a community (p. 159). However, in this instance, it is the introduction of a community into a new system of medical care, access, and beliefs that will be described. Although this research project is limited by the availability of time to work with the community, it is hoped that the results will be

used by other scholars to help describe the emergence of a Burmese (or Karen, Kayah, Kayaw, or Chin) understanding of reproductive health. Although it is impossible in this research to record changing beliefs held by Burmese women over time, this paper can provide a foundation for exploring how beliefs are negotiated and eventually represented within Burmese refugee communities in the United States.

This research builds upon an earlier health needs assessment done with the Tampa Burmese community, and utilizes participant observations and semi-structured individual and group interviews.

RESEARCH AIMS

The objective of the study, specifically focusing on ethnic group differences, is to explore the reproductive beliefs of Burmese refugee women who have been resettled in Tampa. The research aims are:

1. Identify how Burmese women perceive ideal families.
2. Identify Burmese women's knowledge and use of family planning.
3. Identify Burmese women's experiences of pregnancy and childbirth as refugees.
4. Identify Burmese women's pregnancy and childbirth beliefs and rituals.
5. Identify Burmese women's postpartum beliefs and rituals.

TERMINOLOGY

In 1989, Burma's name was formally changed to Myanmar by the military government. The intention was for all peoples from the state to be of *Myanmar* nationality. The dominant ethnic group, traditionally known as *Burman*, would now be referred to as *Bamar* (Barron, et al. 2007). Although most international organizations have recognized the new names, many individuals, expatriates, and

refugees continue to protest the legitimacy of the military government by continuing to use *Burma* for the name of the state, *Burmese* for an individual's nationality, and *Burman* for the ethnicity of the dominant ethnic group (Barron, et al. 2007). Despite this acceptance, it is also important to recognize that the term *Burmese* can have negative connotations to different ethnic groups (Neiman, et al. 2008; Scarlis 2010). Currently, the majority of individuals around the world remain familiar with *Burmese* and *Burman*, and thus these terms continue to be used in most literature, including this paper.

CONCLUSION TO CHAPTER 1

The need to explore the beliefs of newly resettled refugee populations is important to record their changing negotiations between their culture and the US culture overtime, provide a voice to those who are rarely heard, and offer recommendations for health education. This research study hopes to address these issues by exploring resettled Burmese refugee women's reproductive beliefs and practices, and providing recommendations to the Tampa Burmese ECBO, the TBBC, for reproductive health education.

CHAPTER 2: BACKGROUND AND SIGNIFICANCE

INTRODUCTION TO CHAPTER 2

Anthropologists have a long history of describing the abuses, circumstances, displacement, and resettlement of refugees (Harrell-Bond and Voutira 1992; Skran and Daughtry 2007). A recent influx in Burmese refugees into the United States has created opportunities for resettlement agencies and local communities to learn about and help the Burmese, who are in actuality an ethnically diverse group. This chapter begins with an overview of the theoretical frameworks utilized in this thesis through a brief summary of medical anthropology and the anthropology of reproduction. Following this, the chapter explains the rapid increase of Burmese refugees in the United States, the history of anthropology and refugees, a description of the history of the Burmese struggles for independence, and a literature review of known Burmese health needs, specifically regarding the reproductive health of the Burmese within Burma, as refugees, and during resettlement.

THEORETICAL FRAMEWORK

Medical Anthropology

Medical Anthropology became a formal subfield in the 1950s, and established itself strongly in the 1970s through the comparison of various medical systems (Good, et al. 2010). In the 1980s Medical Anthropologists joined the discourse of critical studies, and began to examine the biases in the Western medical system as well as the disparities in health and access to care (Good, et al. 2010). The 1990s created more interest in critically examining technology and science and contributing

to applied work in global health, explorations which have continued through the present (Good, et al. 2010; Lock and Nguyen 2010; Young and Rees 2011).

Important theoretical frameworks have evolved initially from explanatory models of illness and health and later from critical theories which have culminated in the ideas of structural violence and political economy, which see larger societal organization as the systematic cause of poverty and disparity (Good, et al. 2010). Explanatory models recognize the importance of different perspectives in understanding health, illness, and treatment, especially paying attention to the similarities and differences between patients' and providers' beliefs (Young and Rees 2011). This led to a more critical discussion of where these systems of meaning emerged, and how Western biomedical systems are situated in a powerful structure of dominance which can have both positive and negative repercussions, propelled by the advent of biotechnology and its availability around the world (Lock and Nguyen 2010). Furthermore, the idea of social suffering, a chronic and systematic situation of despair due to political economic factors and structural violence, emerged as a call for Medical Anthropologists to reveal the injustices that create a status quo where people cannot realize their health potential (Young and Rees 2011). Increasingly, there is a recognition of the phenomenon Margaret Lock calls "local biologies," the idea that human biology is not static and predictable from birth, but influenced by many factors including personal family history, the environment, lifestyles, cultural understandings, and epigenetics, the ability for genes expression to change in individuals because of events in their lives (Lock and Nguyen 2010; Young and Rees 2011). This moves beyond the traditional Biological Anthropology research where biological responses to environments are measured by adaptations to the environment, and beyond the traditional Cultural Anthropology research where it is assumed that culture impacts the body though health practices, and seeks to

understand the continuous interaction between the environment, genes, culture, and biology.

Although local experiences and explanatory models have never been dismissed in Medical Anthropology, the tradition of critically examining and questioning dominant models of thought and politics has been prominent since the 1990s (Good, et al. 2010; Lock and Nguyen 2010; Young and Rees 2011). Although drawn from ethnographic work examining different communities' systems of meanings and life experiences, the research questions in these studies have focused on the structural conditions that impact these explanatory models, instead of how individuals create and re-create their belief models within these larger structures. The idea of local biologies is promising in that it reminds medical anthropologists that there are important research questions to be asked at the local, as well as at the national and global levels.

Refugee and migrant studies often critically examine the political international structures that create and define marginal populations (Chimni 2009; Harrell-Bond and Voutira 2007; Scalettaris 2007). These oppressive structures come from within their countries of origins, within the aid organizations, (Harris and Smyth 2001), and within their resettlement countries (Keles 2008), and can create barriers to autonomy, rights, and health even when intentions are to help. While there are important research questions that ask how these structural forces create and define marginal populations, this thesis asks how communities and individuals work and define their own cultural beliefs within these larger forces.

The Anthropology of Reproduction

The Anthropology of Reproduction as a subfield of study has followed the major theoretical trends within Medical Anthropology, and has largely been attributed to Brigitte Jordan's 1978 *Birth in Four Cultures*, which provides a cross-

cultural comparison of birth *(Davis-Floyd and Sargent 1997)*. Anthropologists traditionally studied reproduction as only a small and biologically necessary part of the human experience (Greenhalgh 1995). In the 1960's and 1970's, a few anthropologists began to look at childbirth practices leading to a recognition that there were multiple systems of meaning regarding birth that reflected both biological and cultural understandings (see Davis-Floyd & Sargent, 1997 for a good overview of the history of the Anthropology of Birth and Reproduction). The most important line of thought emerging through the 1980s was that indigenous systems of birth and biomedical systems of birth could complement each other if they were considered equally valuable, potentially improving both the safety and the quality of childbirth (Davis-Floyd and Sargent 1997).

The 1990s and forward moved the field from a childbirth focus to include other aspects of reproduction often complemented by critical feminist and political economic movements (Greenhalgh 1995). Some areas that have been explored include but are not limited to family planning, patient-provider discourse and power, infant and child death, structural issues affecting birth outcomes, authoritative knowledge and reproduction, and reproductive technologies (Browner and Sargent 2011; Davis-Floyd 2003; Davis-Floyd and Sargent 1997; Rapp 2000).

The Anthropology of Reproduction often finds itself at the cross-roads of the local and the political. Ethnographic descriptions of the experiences of women themselves are juxtaposed against the popularly accepted biomedical system of birth and health that influences polices and choices. The Anthropology of Reproduction "transforms [reproduction] from a biological event…into a socially constructed process" (Greenhalgh 1995:14). The recent emphasis on political economic structures and critical medical anthropology has resulted in many important studies into the global and national processes that create inequality in health and access (Browner and Sargent 2011; Davis-Floyd 2003; Davis-Floyd and Sargent 2003;

Ginsburg and Rapp 1995). However, the shift towards recognizing how structural violence impacts communities and their health has resulted in an unfortunate dearth of research on local experiences regarding reproduction within the contexts of inequality.

While the purpose of this overview of the Anthropology of Reproduction is not to perform a review of perinatal practices across cultures, it is important to briefly note that pregnancy and postpartum rituals and taboos have been important subtopics in anthropology. One review finds multiple examples throughout the world of postpartum practices, although most of the examples stop mid-1990s (Piperata 2008). A recent study of the cultural and biological importance of postpartum practices notes that the period of rest is significant for both the nutrient intake of new mothers and their social position (Piperata 2008). Research should continue to describe the rituals and taboos that exist regarding reproduction and their biological and social understandings and implications, which are ever more important to comprehend in an increasingly global world.

Theoretical Foundation

The growing recognition within Medical Anthropology that ethnographies can do more than answer questions about larger structural forces, as discussed above, is also important when describing reproductive realties. Researchers cannot ignore the importance of structural forces, including the political violence that creates refugees, which generate the circumstances in which people develop their reproductive beliefs, but the changing meanings of reproduction due to these forces are important in efforts to give voices and agency to individuals. Medical Anthropologists regardless of their sub-specialty will increasingly need to rely on research that asks both local and global questions, and the potential for applying that research to improve health and wellness is immeasurable.

The purpose of this thesis is to describe how Burmese refugee women negotiate reproductive beliefs in the Tampa, Florida after resettlement. It draws upon anthropology's tradition of examining the adaptations made by communities that enable them to survive in new circumstances and still retain unique cultural identities (Delgado-Gaitan 1994; DeVoe 1992; Earle 1994; Markiewicz, et al. 2009; Mortland 1994; Ong 1996; Ong 2003). This thesis seeks to contribute to growing literature of medical anthropology, the anthropology of reproduction, and the anthropology of migrants by exploring Burmese refugee women's beliefs about reproduction in the United States. While recognizing the larger structural violence that brought these communities to the United States as refugees is important, it is the objective of this study to begin an exploration of reproductive beliefs immediately following resettlement as seen by four different Burmese ethnic groups, the Karen, the Kayah, the Kayaw, and the Chin. Additionally, in following the traditions of applied anthropology, this study was conducted at the request of, and with, a local Burmese ethnic community-based organization. The results will be written into a technical report for the organization, with recommendations for educational classes about reproduction based on the findings of the research.

BURMESE REFUGEES IN THE UNITED STATES AND FLORIDA

The U.S. Refugee Admissions Program (USRAP) has admitted more than 2.6 million refugees since its conception (United States Department of State 2010). Historically USRAP admitted refugees from select areas; however, in the past decade, USRAP has expanded its admissions to include a larger variety of ethnicities, especially those in vulnerable situations where repatriation to home and integration into neighboring countries do not exist (United States Department of State 2010). The Office of Refugee Resettlement (ORR), located within the US Department of

Health and Human Services, is charged with helping admitted refugees resettle into different states in the US.

In FY 2009, almost one quarter of all US refugee arrivals (24.38%) were from Burma, totaling 18,202 individuals of the almost 75,000 admitted refugees (United States Department of State 2010) and the Burmese were the second largest refugee group being resettled in the U.S. after Iraqis (Office of Refugee Resettlement 2010). The number of Burmese individuals being settled in the US has increased dramatically since 1983 when the ORR began tracking resettlement. Between FY 1983-2003 only 2,473 Burmese individuals were resettled in the U.S, and in FYs 2004-2006 just over 1,000 Burmese individuals were resettled each year (Office of Refugee Resettlement 2011b). However, beginning in FY 2007 this has radically increased with 9,776; 12,852; 18,202; and 16,693 Burmese individuals being resettled in FYs 2007, 2008, 2009, and 2010 respectively (Office of Refugee Resettlement 2011b; United States Bureau of Population 2010; Office of Refugee Resettlement 2010). As of July 31, 2011, in FY 2011 (October 2010-October 2011), Burmese refugees represent the largest number of individuals being admitted to the United States of any national group (United States Bureau of Population 2011).

The median age of Burmese refugees arriving in FY 2010 was 21, with 13.17% under the age of five, 28.58% school age (5-17), 61.83% working age (16-64), and only 1.02% of retirement age (65 +) (United States Department of State 2011). In FY 2011, the Burmese have access to the USRAP through all levels of priority, Priority 1: individual referrals, for individuals who need resettlement, Priority 2: group referrals, for groups of people needing resettlement, and Priority 3: family reunification, for those who have a family member already in the US (United States Department of State 2011).

Including large numbers of Cuban and Haitian entrants, Florida's refugee resettlement program is one of the largest in the country (Florida Department of

Children and Families 2011b). In Florida, the Department of Children and Families (DCF) is the agency responsible for resettling refugees. DCF receives federal grant money and local agencies compete for grants to help resettle refugees (Florida Department of Children and Families 2011a). After Miami-Dade County, Hillsborough County receives the second largest number of refugees in the state (Florida Department of Children and Families 2010). In FY 2010 Burmese refugees were the third largest nationality resettled in Florida after Cubans and Haitians, and Hillsborough County received the second largest number of Burmese individuals (117) in the state after Duval County (476) (Florida Department of Children and Families 2010). During FY 2010 the Burmese represented the largest non-Cuban and Haitian resettled refugee population in the State of Florida and in Hillsborough County (Florida Department of Children and Families 2010).

ANTHROPOLOGY AND REFUGEES

Modern refugee studies emerged as a discipline in the 1980s (Skran and Daughtry 2007). Prior to the establishment of the field, anthropologists were already studying those groups who were or would become refugees, making anthropology an obvious contributor to the multidisciplinary field from the beginning (Harrell-Bond and Voutira 1992). Anthropological studies on displaced and migratory peoples span the migratory process from the time of displacement, the liminal (or not so liminal) period of camp life or self-settlement, and the repatriation or resettlement process. With its ethnographic and participatory methods, holistic approach, and bottom-up approach, anthropology has been recognized by many scholars as a foundational and important contributor to refugee studies as a discipline (Guggenheim and Cernea 1993; Krulfeld and Camino 1994).

Much of the anthropological research on refugees was conducted in the 1980s and early 1990s with refugee communities who were displaced in the 1960s-early1990s in response to Cold War fighting. Common themes during the initial emergencies include public health and safety in humanitarian crises (Gozdziak 2004; Williams 2001), camp life (Campbell, et al. 1993), life histories and traumas (Rasbridge 1993), and development-induced displacement (Cernea and Guggenheim 1993). Most anthropological studies within resettled communities, including the United States, focus on long-standing refugee communities. Common themes in refugee studies after resettlement have included ethnic, personal, and national identity (re)construction and (re)negotiation (Earle 1994; Krulfeld and Camino 1994; Markowitz 1994; Mortland 1994; Ong 1996) acculturation and adaptation (Delgado-Gaitan 1994; DeVoe 1992), gender roles and change (Benson 1994; Camino and Krulfeld 1994; Dewitt and Adelson 2007; Krulfeld 1994a; Krulfeld 1994b; Kulig 1994), refugee youth, adolescents, generational changes, and school success (Camino 1994; Chatty 2007; Chatty, et al. 2005; DeVoe 1994; Guerrero and Tinkler 2010; McMichael and Gifford 2010; Smith-Hefner 1990), and repatriation (Vrecer 2010) Additionally, some longitudinal ethnographies were completed (Donnelly 1994; Holtzman 2007; Hopkins 1996; Ong 2003).

Beginning in the mid-1990s, most anthropologists discussing refugee studies have been influenced by political economy and globalization. The literature has shifted from ethnographies to a more abstract discussion of moving boundaries of cultural identities and space and the problems of labeling and defining migrants (Mortland 1998). Common topics include transnationalism and globalization (Lewis 2010; Ong 1996; Sargent and Larchanche 2011; Shami 1996), transnational identities (Amat 2005; Dewitt and Adelson 2007; Eisenhauer, et al. 2007; Gordon 2010; Guerrero and Tinkler 2010; Shami 1996), changing ideas of boundaries, space, and place (Earle 1994; Gupta and Ferguson 1999; Ong 1996; Turton 2005),

power and human rights (Krulfeld and MacDonald 1998), life history narratives, violence, psychological effects, and testimonials (Eastmond 2007; Gordon 2010; Kohrt and Hruschka 2010; Omidian 1994), definitions and meanings of the labels of "refugee" or "forced migration" (Amat 2005; Eisenhauer, et al. 2007; Scalettaris 2007; Vertovec 2011), structural, programmatic and policy issues (Keles 2008; Sargent and Larchanche 2011; Vertovec 2011), post-modern reflections on anthropological research and power (Krulfeld and MacDonald 1998), and the history of long-term refugee communities (Boone 1994; Donnelly 1994; Needham and Quintiliani 2007; Omidian 1994; Quintiliani 2009)

The shift from local communities to global processes mirrors a trend within the American Anthropological Association where the study of refugees has slowly been subsumed under larger global processes. Beginning in 1996 the Committee on Refugee Issues (CORI), a part of the General Anthropology Group of the American Anthropological Association, began including all migrants in their research, focusing more on the process of migration than on the different groups of migrants (Krulfeld and Baxter 1997). Furthermore, in 2003 CORI was subsumed under the Society for Urban, National, and Transnational/Global Anthropology. Although anthropologists can be applauded for recognizing that the process of migration has many similarities regardless of the motivations for moving, the literature review reveals that there has also been a decline in applied anthropologists working with refugees and reporting this work back to the field. This is particularly troublesome due to the increase in new ethnic populations entering the United States in the past decade (United States Department of State 2010). Through the use of community-based participatory and rapid ethnographic techniques, US applied anthropologists have the opportunity to aid resettlement organizations that have no experience with these new cultures. With few exceptions regarding policy recommendations, current anthropologists' contributions to *applied* anthropology often remain unclear, despite calls for the

importance applied anthropology to the field (Cernea and Guggenheim 1993; Krulfeld and Camino 1994).

Much of the work that applied anthropologists are doing with refugees is in interdisciplinary and not necessarily in academic settings. As Unterberger (2009) notes, applied anthropologists are so involved with their communities that recording their accomplishments for the wider population is often overlooked. Thus, it is difficult to find scholarly contributions from applied anthropologists in the field. There are some exceptions including authors working with urban health disparities issues and advocacy (Goodkind, et al. 2011), recommendations for structural and nutritional education (Trapp 2010), and special calls for interdisciplinary work in the field during complex emergencies (Williams 2001).

Unfortunately, anthropologists have written relatively little the recent literature on cultural aspects of displaced populations with regard to health (Gagnon, et al. 2002; Williams 1993). Medical anthropologists have done little to assess the resettlement process on health, focusing instead on the emergency situations that attribute to the creation of refugees and the health of refugees in emergencies and camps (Williams 2001). Some exceptions include studies on the impact of dietary changes on resettled communities (Patil, et al. 2010; Trapp 2010) and mental health and the study of suffering due to the trauma and violence that many refugees have experienced (Davis 1992; Gozdziak 2004; Kleinman, et al. 1997; Sargent and Larchanche 2011). Scholarly work that has been published is largely influenced by critical medical anthropologists' analyses of how the political economy has contributed to the creation of vulnerable populations; however, the experiences and needs of the communities and individuals themselves have more recently been overlooked (Sargent and Larchanche 2011; Williams 1993).

US medical anthropologists have spent even less time focused on women's health after resettlement. This is true despite calls for an anthropological contribution

to utilize participatory methods to discover women's ideas about various interventions, health knowledge, health beliefs and health attitudes, and to influence health policy through advocacy (Harris and Smyth 2001; Williams 1993). Other countries' medical anthropologists are contributing much more to the literature of how refugee women interact within their respective health systems; however, these findings are not generalizable to the complex US health care system. For example, in Canada, applied medical anthropological work has been done to learn about the process of resettlement and integration on Cambodian women's lives (Dewitt and Adelson 2007), health communication between providers and Vietnamese refugees (Donnelly and McKellin 2007), and how refugee women create a "healthy space" for their families in their everyday actions (Dyck and Dossa 2007). Despite the current debates on US health care, data on refugee women's health experiences in the US are lacking, frequently outdated or representative of communities with more than two decades of resettlement experience (Donnelly 1994; Hopkins 1996; Ong 2003). It is vital that applied medical anthropologists begin looking at non-traditional refugee populations, such as the Burmese, and their health needs in the United States. Because of the integral part that women play in families and communities, it becomes doubly important to focus first on the health beliefs and needs of women.

Family structures are both products of and guardians of cultural ideals, and can be explored by analyzing reproductive values. By examining Burmese women's reproductive beliefs as they navigate the US economic, health, and social systems, it is possible to reveal the key cultural traditions that will continue to define the Burmese as "Burmese" (or as Karen, Chin, etc.) (Benson 1994; Camino and Krulfeld 1994; Dewitt and Adelson 2007; Krulfeld 1994b). It is also possible to determine which unfamiliar practices available in North American culture will be adapted for use by the Burmese to help them construct new identities that satisfy their emerging definitions of what it means to be Burmese-American. It is intended that this thesis

will be a snapshot of the ongoing implicit and explicit dialogues that occur as the Burmese continue to adapt to life in the United States.

INTRODUCTION TO BURMA AND ITS PEOPLE

Burma Overview

Burma is one of the most ethnically diverse countries in the world with over 130 distinct ethnic subgroups (Barron, et al. 2007). About 68% of the population is Burman/Bamar, who control the current military government (Barron, et al. 2007). As explained by Martin Smith (in Barron et al., 2007:2), pre-colonial Burma consisted of two large subgroups: 1) Valley people, who were frequently wet-rice farmers, Buddhists, literate, and include the Burmans, Mon, Rakhine/Arakanese, and Shan; and 2) Hill people, who were dry-rice farmers, animists, often illiterate and include the Chin, Kachin, Karen, Wa, and others. In post-colonial Burma, most of the hill people converted to Christianity, although remnants from their animist or spirit-based beliefs may persist, and pockets of Buddhists remain (Barron, et al. 2007). The Burmese population in Tampa is dominated by former hill people, specifically the Chin, Karen, and Kayah (Karenni) groups (Baer, et al. 2011).

The history of Burma is riddled with ethnic conflict. Battles between ethnic groups are documented from the 8th century to the Konbaung Dynasty in the 18th century (Barron, et al. 2007). Three Anglo-Burmese wars on the borders of British India culminated in British colonial rule in 1885 (Bureau of East Asian and Pacific Affairs 2011). The British administered power from central Burma where the Burmans were settled, and allowed many hill people to remain semi-autonomous, resulting in strong ethnic ties and furthering ethnic differences (Barron, et al. 2007). The British rule left a large transportation infrastructure, a culture of education, and a spread of Christianity throughout the hill areas (Barron, et al. 2007).

During World War II (WWII), the Burmese Army drove the British out of the country, but switched sides in mid-1945 to fight against Japan (Bureau of East Asian and Pacific Affairs 2011). Led by General Aung San, the Burmese demanded independence from Britain after the war; although a constitution was written in 1947, General Aung Sang and many of his cabinet were assassinated soon after (Bureau of East Asian and Pacific Affairs 2011). Independence was granted in January 1948 and civil war broke out between many different ethnic armies, exacerbated by the various allegiances different ethnic groups had made during the war (Barron, et al. 2007). In 1962 Burman Ne Win took control of the country's military, bashed ethnic opposition groups, destroyed land and villages, cut off the outside world, and imposed the *Burmese Way to Socialism* (Barron, et al. 2007).

Military rule continued for years with major uprisings occurring in 1974 and 1988 that were squashed with harsh military retaliation (Bureau of East Asian and Pacific Affairs 2011). On August, 8th, 1988 1,000 student demonstrators were killed and Aung San Suu Kyi, daughter of General Aung San, became the leader of the pro-democracy fight (Bureau of East Asian and Pacific Affairs 2011). Ne Win was pushed aside, and the military-backed State Law and Order Restoration Council (SLORC) took over (Barron, et al. 2007). A general election was held in 1990 with varying accounts of the freeness and fairness of the elections, and the National League for Democracy (NLD), led by Aung San Suu Kyi, won 60 to 80% of the vote (Barron, et al. 2007; Bureau of East Asian and Pacific Affairs 2011). The SLORC refused to recognize the results, placed Aung San Suu Kyi under house arrest, and had the election results thrown out (Barron, et al. 2007). In 1997 the SLORC changed its name to the State Peace and Development Council (SPDC), but did not change its policies of military control (Bureau of East Asian and Pacific Affairs 2011). Reports indicate that instead of change, the rulers increased the size of the army and continue to spend much of the national budget on military and Burmans (Barron, et

al. 2007). Throughout the 1990s many ceasefire deals were brokered between the government and various ethnic armies, yet human rights abuses, forced labor, and forced displacement continue (Barron, et al. 2007).

In 2003, Aung San Suu Kyi was allowed to travel within Burma, but her group was quickly attacked and she was placed back on house arrest (Bureau of East Asian and Pacific Affairs 2011). In 2007, peaceful protests around the country resulted in the detainment of many citizens. In response, many monks began to peacefully protest in cities around the country, only to be attacked and detained by the military (Bureau of East Asian and Pacific Affairs 2011). The SPDC, following a 1993 plan to democracy, drafted a constitution in February 2008 and planned a vote for May, although people were threatened with arrest if they were found debating or discussing the constitution (Bureau of East Asian and Pacific Affairs 2011). Despite massive devastation and death on May 2-3, 2008 due to Cyclone Nargis, the government still held the referendum vote, claiming a 98% turnout and a 92.4% approval of the constitution (Bureau of East Asian and Pacific Affairs 2011).

In May 2008, the government held closed-door trials which sentenced many of the political prisoners arrested in 2007 to many years in jail (Bureau of East Asian and Pacific Affairs 2011). In May 2009, Aung San Suu Kyi and her assistants were arrested, and later unfairly convicted of violating the terms of her house arrest, sentencing her to further house arrest (Bureau of East Asian and Pacific Affairs 2011). After international disapproval, Aung san Suu Kyi was finally released from house arrest on November 13, 2010.

Manipulated elections were held on November 7, 2010, with many military leaders resigning from their posts so that they could run in the civilian elections (Bureau of East Asian and Pacific Affairs 2011). Prime Minister Thein Sein became the head of the pro-government Union Solidarity and Development Party, which won more than 75% of votes and formally took office on April 1, 2011 (Bureau of East

Asian and Pacific Affairs 2011). Although the SPDC ceased to exist, many of its most powerful members fill powerful political roles in the national and state/regional governments (Bureau of East Asian and Pacific Affairs 2011).

It still remains to be seen how committed the government is to bringing true democracy to Burma, but initial reforms look promising. In October 2011, more than 200 political prisoners were freed and unions were written into law (BBC 2012). In November 2011, Aung San Suu Kyi announced her plans to run in the parliament election, and in December 2011, US Secretary of State Hillary Clinton visited Burma to promise US support if democratic reforms continue, and a law is signed into power that allows peaceful demonstrations (BBC 2012). In January 2012, the last month of this writing, hundreds of the nation's most important political prisoners were released (BBC 2012). In late 2011 and early 2012, ceasefires have also been signed with many opposition groups including the Shan State Army-South, the United Wa State Army, the Karen National Union and the Kachin Independence Organization, yet independent organizations continue to cite many human rights abuses including extrajudicial killings, torture, forced labor, and child soldiers (Human Rights Watch 2012). Elections are set for April 2012, with many waiting anxiously to see the process and the outcomes (Human Rights Watch 2012).

Burmese Economy

The Burmese predominately agricultural economy was stifled by the military rule. After military take-over in 1962, lands and industries were nationalized in an attempt to move towards Socialism (Barron, et al. 2007). Despite opening markets in the mid-1990s, the country still struggles to improve. Most trading is limited to Asian nations and the United States and the European Union have economic sanctions in place which prevent full market abilities (Barron, et al. 2007). It is suspected that most of the regime's money comes from the illegal sale of opiates

(Barron, et al. 2007). Since the introduction of the new 2011 government, Burma has been hosting many foreign diplomats, and discussions of lifting some economic bans have begun, with the hope to spur more democratic reforms (Human Rights Watch 2012).

Chin Culture

The Chin is an ethnic group that consists of many different related groups. The four main language groups are Northern Chin, Central Chin, Southern and Plans Chin, and Maraic Chin, with a total of 20 to 25 different languages that are not mutually intelligible (Barron, et al. 2007). This can pose difficulties when resettling Chin, as many cannot even communicate with each other (personal correspondence, Christy Sui, 2011). The Chin state is located in the Northwestern part of Burma, and the Chin culture extends into India and Bangladesh.

Traditionally ruled by chiefs, after Chin independence from the British in 1948 the Chin chose to instill democratic rule (Barron, et al. 2007). Unfortunately, the Burman military take-over in 1962 forced the Chin to participate in the larger Burmese government, until the uprising in 1988 when the Chin National Front was formed to fight military rule (Barron, et al. 2007).

Most families participate in farming on a full-time or part-time basis. Husbands are head of the household and sons inherit property (Barron, et al. 2007; Scarlis 2010). Women are still valued, but women often have the double burden of farm work and house work, creating gendered differences in labor households (Scarlis 2010).

It is estimated that many Chin have converted to Christianity (Christian Solidarity Worldwide 2006). Western medicine is accepted, although evil spirits will often be blamed if biomedicine fails to work and there is a concept of bad blood (Barron, et al. 2007; Scarlis 2010). Honey, oil, and peppers are common traditional

cures for wounds and colds (Barron, et al. 2007). Illnesses may also be treated using coining and cupping, which both place marks on the skin (Scarlis 2010). Additionally, oxtail soup and chicken soup have been found to be used to increase Chin women's milk production in Seattle (Scarlis 2010).

Karen Culture

The Karen people share a similar story to the Chin in that they are very diverse even within those considered Karen. There are three main Karen groups, Southern (Sgaw and Pwo), Central (Karenni or Kayah or Red Karen), and Northern (Pa-O). There are many traditions shared across these groups, although their languages can be unintelligible (Barron, et al. 2007). Conventionally, most of the subgroups are all considered *Karen* except for the *Kayah*. As there is a population of both Karen and Kayah in Tampa, these groups will be discussed separately.

The Karen (Kayin) State is located in southeastern Burma, but because of the conflicts many Karen are located throughout Burma and Thailand (Barron, et al. 2007). Farming is the main economic activity of the Karen, and hunting is common (Barron, et al. 2007). Much of the Karen people live in the forests where natural resources are used for many household products and traditional medicines (Barron, et al. 2007).

Under British rule the Karen extended their influence and later allied with the British in WWII versus the Japanese and the Burmans (Neiman, et al. 2008). Although many converted to Christianity, some remained Buddhist or animist (Barron, et al. 2007). After WWII the Karen began to push for their own nation, which continues today (Barron, et al. 2007; Neiman, et al. 2008). The major political group is the Karen National Union (KNU) which has a military component called the Karen National Liberation Army (KNLA). The KNU has lost much of its land through conflict with the Burmese army resulting in mass relocation for many civilians

(Barron, et al. 2007). Over time Karen Christians have come to occupy many leadership roles, resulting in Karen Buddhists forming their own group in the mid-1990s called the Democratic Karen Buddhist Organization (Barron, et al. 2007; Neiman, et al. 2008).

Most Karen live in nuclear family units in large villages. Traditionally a matriarchal society, it is common for a newly married couple to live with the female's family until they are able to set up their own home (Barron, et al. 2007). The idea of monogamy is very important to the Karen (Barron, et al. 2007) and household labor is often shared (Neiman, et al. 2008).

It is common for both Christian and Buddhist Karen to still believe in forest spirits and multiple souls (Barron, et al. 2007). However, most Karen are familiar and comfortable with Western medicine (Neiman, et al. 2008). Traditional healers give offerings to appease spirits, and may be more accepted in Buddhist believers than with Christian believers (Barron, et al. 2007; Neiman, et al. 2008). Food is often used as medicine (Neiman, et al. 2008).

There is some evidence that there was a time period where Karen women preferred homebirths in the refugee camps to medical births due to male doctors and a history of forced sterilization (Neiman, et al. 2008), although this trend is most likely changing (Carrara, et al. 2011). During pregnancy and postpartum period taboos exist that prohibit women doing hard work, touching cold water, and eating certain spicy foods exist (Neiman, et al. 2008). In the Karen language there is no difference between the words vitamin and medicine, which could cause confusion when seeking Western medical care and might need to be furthered examined (Neiman, et al. 2008).

Kayah (Karenni) Culture

The Kayah State is located just north of the Karen State and was originally granted the right to secede from independent Burma after ten years, a promise that never came to pass (Barron, et al. 2007). Two main Karenni political groups exist, the Karenni Nationalities People's Liberation Front and the Karenni National Progressive Party, which both have fighting arms and stand on opposite sides (Barron, et al. 2007). There has been significant Burmese army activity in the Kayah State. The Kayah State is also home to the Kayan, Kayaw, Pa-o, and Shan groups who often do not speak languages intelligible to others.

The Kayah's lifestyle and customs often reflect those of the Karen as described above. The Kayah State has both wet- and dry-rice farming, and other economic activities include mining, logging, and cattle trading (Barron, et al. 2007). Most Kayah were traditionally animist, with many converting to Christianity (Barron, et al. 2007). The traditional system is spirit-based and people are believed to have multiple souls (Barron, et al. 2007). Literacy rates tend to be low for the Kayah, although if schooling has taken place there is a high likelihood of understanding Burmese.

In a study of mental health outcomes in refugee camps on the Thai-Burma border, a sample consisting mostly of Kayah participants (76%) found high levels of depression, anxiety, and post-traumatic stress disorder (PTSD) (Cardozo, et al. 2004). Culture-specific symptoms of poor mental health include numbness, thinking too much, and feeling hot under the skin, while coping mechanisms include talking to family or friends, sleeping, thinking about the homeland, visiting the clinic, singing or playing music, and drinking rice wine (Cardozo, et al. 2004).

BURMESE REFUGEE WOMEN'S HEALTH

The knowledge of the reproductive health of Burmese refugees is mostly limited to reports coming from the Thai-Burma border, which is predominantly home to Karen and Kayah refugees. Only one systematic review has been found of reproductive health services in the nine refugee camps serving Burmese women and in the provinces in Thailand where many migrants live (Women's Commission for Refugee Women and Children 2006). Even less information is found about women's health in the Western Burmese states, home to the Chin, or in India and Malaysia, where the Chin predominantly flee persecution and become undocumented migrants (Scarlis 2010). In addition, many reports do not differentiate between ethnicities when discussing traditional beliefs, nor do they provide much detail of how traditional healing or traditional herbs are used. Furthermore, the services available to women in refugee camps can differ greatly from those available to women living as internally displaced persons (IDP) within the Burmese border and those living as illegal migrants in Thailand or other countries, as discussed below.

International standards of reproductive health have been established and do guide current efforts, but more is needed (Women's Commission for Refugee Women and Children 2006). This literature review assesses both technical reports published by non-governmental organizations as well as manuscripts from peer reviewed journals. It attempts to provide an overview of what is known about Burmese women's reproductive health in Burma, in the refugee camps, as illegal migrants, and in the United States.

Human Rights Violations

The context of women's health is inextricably linked to the many human rights violations affecting these communities. These human rights abuses have been well documented, resulting in the categorization of the Burmese as refugees (United

Nations High Commissioner for Refugees 2011). Recent reports have documented violations such as forced displacement, forced labor, beatings and torture, ethnic persecution, and food and livestock theft (Gulf Coast Jewish Family and Community Services 2011; Mullany, et al. 2008; Sollom, et al. 2011; Thailand Burma Border Consortium 2011). Although it is beyond the scope of this investigation to explore how human rights abuses have influenced women's health, it is vital to recognize that there may be underlying physical and emotional issues that emerge in the Burmese over time that directly affect health.

It appears that IDPs face more challenging environments than those who have been able to remain in their home villages, find refuge in a camp, or maintain livelihood as undocumented migrants (Women's Commission for Refugee Women and Children 2006). The military uses a "four cuts" policy to separate ethnic armies from four key resources: 1) food, 2) finances, 3) communications, and 4) recruits; this is accomplished by forcing groups to relocate or live in the remote jungle (Barron, et al. 2007; Women's Commission for Refugee Women and Children 2006). This displacement isolates groups to locations where health services are nonexistent and traditional forms of subsistence and housing are interrupted.

Studies find that within a past 12 months, 43% of Chin households report moderate to severe hunger (Sollom, et al. 2011), 91.9% of Chin households had experienced forced labor (Sollom, et al. 2011), 32.1% of Karenni experienced forced labor(Mullany, et al. 2008), 10% of Karenni faced forced displacement (Mullany, et al. 2008), 40.5% of Chin children were malnourished (Sollom, et al. 2011), and that forced displacement or food security increased Karen likeliness of anemia (Mullany, et al. 2008).

Most women have home births (88%), but only 5.1% have a skilled birth attendant and only 39.3% had any attendant (Mullany, et al. 2008). Services are lacking or inaccessible, with an unmet need for contraceptives at 61.7%, and only

16.7% of eastern Burmese women (Karen, Shan, Karenni, and Mon) able to attend four or more antenatal visits (Mullany, et al. 2008). Furthermore, the odds of receiving no prenatal care are 5.94 times higher among forcibly displaced (Mullany, et al. 2008). Scholars have also explored women's reproductive health in this context specifically in regards to abortion, finding many women forced to make this difficult decision because of lack of options (Belton 2010; Skidmore 2002).

A recent initiative, the Mobile Obstetric Maternal Health Worker (MOM) Project, has been created to provide clinical needs for both routine and emergency deliveries, train health workers (HWs)and traditional birth attendants (TBAs), and provide community organization and empowerment trainings through the use of skilled maternal health workers (MHWs) (Mullany, et al. 2010; Teela, et al. 2009). Initial reports indicate that many of the prior health indicators in eastern Burma are improving after the program, including unmet need for contraceptives, number of antenatal visits, number of women who have a skilled attendant at birth, and number of postnatal visits within 7 days (Mullany, et al. 2010).

Undocumented migrants also live in precarious situations, many due to political policies that offer them no security or rights. Migrants are subjected to fears of arrest and deportation. Access to health care is limited and inconsistent, despite an increasing effort by local and international NGOs in Thai provinces (Women's Commission for Refugee Women and Children 2006). Women are especially at risk for reproductive health complications due to gender-based violence, sex trafficking, unsafe abortions, and malaria during pregnancy (Women's Commission for Refugee Women and Children 2006). Additionally, HIV/AIDS and STI rates appear much more frequently among women migrants or women who are in relationships with migrants, than those who are confined to camp life (Plewes, et al. 2008). Furthermore, Thai policies refuse to legally recognize infants born to undocumented migrants, creating

a generation of stateless individuals that are denied opportunities for education and employment (Plewes, et al. 2008).

Migrants from Western Burmese states, notably Chin State and Rakhine State, may never have the opportunity to enter camps in Thailand, creating different and little reported situations of migration to India, Bangladesh, and Malaysia (Barron, et al. 2007; Human Rights Watch 2009). The limited reports that do exist indicate that police abuse of migrants with and without paperwork frequently occur (Human Rights Watch 2009). Lack of job opportunities and discrimination are also abundant in both India and Malaysia (Christian Solidarity Worldwide 2006; Human Rights Watch 2009). Stories of Chin smuggled across Burma, through Thailand and into Malaysia report abuses not just by the police and army, but also of the agents hired to transport the refugees across the borders (Christian Solidarity Worldwide 2006). Once in Malaysia, Chin are politically recognized as illegal work migrants, not refugees, until they receive the proper paperwork (Christian Solidarity Worldwide 2006). Even with paperwork, there are reports that Chin still face police abuse, detainment, deportation, arrest, poor living conditions, sexual assault, lack of medical care and access, and no legal recourse for abuses because Malaysian policy defines them as illegal (Christian Solidarity Worldwide 2006). Many Chin are forced to pay off police and other citizens to prevent arrest (Christian Solidarity Worldwide 2006).

Camps provide the most consistency and stability to refugees, although opportunities to improve quality of life are lacking. Basic needs including security, shelter, sanitation, food, water, and health care are provided (Women's Commission for Refugee Women and Children 2006). However, conditions and services vary between camps. While overall safe motherhood services are available, family planning knowledge and use remains low and is often limited to HIV/AIDS education which has created stigma (Plewes, et al. 2008; Women's Commission for Refugee

Women and Children 2006). Additionally, domestic violence and rape remain common, and services targeting youth, unmarried couples, and men are limited if available at all (Women's Commission for Refugee Women and Children 2006).

Traditional Illnesses and Women's Health

The Burmese people are generally considered to practice animism, Buddhism, or Christianity, and large groups of Muslims also exist – (Barron, et al. 2007; Neiman, et al. 2008). However, knowledge of traditional medical models is limited in the literature. This lack of information is most likely exacerbated by the large variety of ethnic groups that exist in Burma, the increasing influence of Christianity, the loss of a generation of elders, and the displacement of communities from local lands and known sources of herbs and food. The difficulty of describing traditional medicine is also compounded by the numerous ethnic groups that comprise the "Burmese" and their various interactions with different linguistic, religious, traditional, and political systems. However, there are indications of traditional medicine being reinvented to work within the biomedical system (Bodeker, et al. 2005), and it is likely that some beliefs continue to be influential even if they have lost their ties to their original belief system.

Traditional medicine can still be found in the camps, and the Burmese have been observed using a mixture of traditional (herbs and food) and biomedical treatments (Bodeker, et al. 2005). A local Tampa needs assessment did find that the use of Thai over-the-counter medicines was common (for example paracetamol, which is a pain killer), however knowledge and desire to use herbal medicinal treatments were low and no food treatments were disclosed (Baer, et al. 2011). Bodeker et al. (2005) reported the belief in ghosts, witches, and nats (spirits) within the camps, but noted that they were associated more with Buddhists. While many in Tampa also reported believing in similar beings, individuals seemed reluctant to

discuss those beliefs (Baer, et al. 2011). This could reflect embarrassment and/or the fact that most members of the Tampa community, regardless of ethnicity, identify as Christians. This confusion could lead to problems in communication, and could exist among other ethnic groups as well.

Mental illness may be prevalent and is expected due to the trauma that occurred through displacement and human rights violations. There is a concept of "weakness" that has been argued to be a combination of physical, mental, and social symptoms (Belton 2010) and is associated with distress. In a study done primarily with Kayah in refugee camps, symptoms of trauma-induced depression and anxiety included numbness, thinking too much and feeling hot under the skin (Cardozo, et al. 2004). These symptoms were also found in a local needs assessment, especially "thinking too much" and poor sleep (Baer, et al. 2011).

Few recent studies attempt to describe the beliefs of specific ethnic groups and how this may affect women's health; however, some do exist (Neiman, et al. 2008; Scarlis 2010). Chin women in Seattle have been found to drink oxtail soup or chicken soup to increase milk production (Scarlis 2010). The Chin also believe in the existence of bad blood (Scarlis 2010). Although no literature was found that elaborated upon this, humoral belief systems that place importance on blood could be relevant for studies of reproduction, where menstruation brings women into contact with blood regularly.

For Karen women, there is an accepted one month of postpartum rest where importance is placed on the idea of warmth and husbands are expected to help take care of their wives (Neiman, et al. 2008). Karen households do consider the men to be at the head of the household and to be the breadwinner; however, traditionally the Karen family is matriarchal (in that the larger family structure is led by a woman) and women's opinions are valued (Neiman, et al. 2008). Understanding gender roles could provide avenues for negotiating family planning and reproductive health.

An additional study done within urban Burma describes the importance of blood flow to women's life (Skidmore 2002). A balance between too little and too much blood is important, and therefore menstruation is necessary and important, but excessive bleeding could also be problematic (Skidmore 2002). Skidmore (2002) describes the importance that women place on emmenagogues (herbs and medicines used to start menstruation and bleeding), diet, and the use of birth control injections to restart or strengthen blood flow. The major limitation to this study was the lack of reporting on the ethnicities of the participants in the study, making it unknown which women may have similar beliefs. This study also was focused on women in a major urban area, possibly creating a bias in the sample.

While there has been some examination into the traditional beliefs of different Burmese groups in a reproductive context, the information remains inadequate. Many reports simply report statistics of what is lacking, and few recognize that there could be differences between ethnicities. However, these limited reports indicate that the importance of food, blood, and warmth, possibly analyzed with cultural gender expectations in mind, need to be further explored in the United States.

Availability of Reproductive Services for the Burmese Abroad

Reproductive services vary based on the political status of individuals and their location. However, international standards of reproductive health have been established that guide current efforts, specifically safe motherhood, with available emergency obstetric care, family planning, sexually transmitted infections (STIs) prevention and treatment, and gender-based violence programs (Women's Commission for Refugee Women and Children 2006). Yet, disparities remain.

As noted above, many IDPs lack basic services. Although clinics do exist, many are inaccessible for individuals and they often lack medicines and laboratories (Women's Commission for Refugee Women and Children 2006). Initiatives such as

the MOM Project have been shown to have positive effects in conflict-affected areas of eastern Burma and could possibly be replicated in other areas of the country (Mullany, et al. 2010; Teela, et al. 2009). This project brings maternal health workers, health workers, and traditional birth attendants together to provide both reproductive and basic health services to women. These services appear to be particularly successful reaching women experiencing forced relocation (Mullany, et al. 2010). However, IDPs remain in insecure and fearful situations, which directly affect women's abilities to access services.

Undocumented migrants in Thailand and Malaysia have some health services options, but face unique types of challenges. Many migrants cannot afford to register as a migrant, which prevents them from obtaining Thai health insurance (Women's Commission for Refugee Women and Children 2006). In Malaysia, police corruption results in bribery or detainment (Christian Solidarity Worldwide 2006). Additionally, migrants often face fears of arrest, deportation, and abusive labor practices, including unsafe living conditions and sex trafficking, that result in the inability to access care due to fear and/or restrained movement (Christian Solidarity Worldwide 2006; Women's Commission for Refugee Women and Children 2006). In Thailand, many receive health care through traditional healers, herbs, and/or pharmacies where there are often mixtures of traditional and Western options (Belton 2010; Women's Commission for Refugee Women and Children 2006). In Malaysia, many are forced to pay expensive hospital prices (Christian Solidarity Worldwide 2006). The past decade has seen an increase in NGOs and clinics catering to the needs of migrants, but the undocumented status of most remains a major barrier to care (Christian Solidarity Worldwide 2006; Women's Commission for Refugee Women and Children 2006).

Refugees living in the camps do have access to basic health services. A major limitation within traditional camp services is that family planning and antenatal care

are typically reserved for married couples, leaving gaps in services for youth and unmarried adults (Benner, et al. 2010). Other reports mention that the services provided can be inconsistent (Women's Commission for Refugee Women and Children 2006). Unfortunately, conditions and services vary significantly between camps.

A common trend between both undocumented migrants and camp dwellers is the increase in use of clinics for birth. In the mid-1990s, it was still common for 80% of births to be in the home, but by the mid-2000s, 70% of births are reported to take place in clinics (Carrara, et al. 2011). Familiarity and trust in clinics was also found during the Tampa Needs Assessment (Baer, et al. 2011). These could have implications for what women expect from care in the United States and what they will find acceptable and comfortable.

Despite the grim statistics, many successful organizations on the Thai-Burma border contribute positively to reproductive health. For example, the Mae Tao Clinic located in Thailand near the border serves migrants, refugees in the camps, and IDPs who manage to cross the border (Women's Commission for Refugee Women and Children 2006). Shoklo Malaria Research Unit (SMRU) has also contributed to reproductive health through malaria screening in pregnancy and infancy, antenatal care, and safe motherhood programs, and HIV/AIDS/STI education in camps (Women's Commission for Refugee Women and Children 2006). The Karen Women's Organization and the Shan Women's Action Network are an ethnic CBO and NGO respectively that provide many different programs for women including health, jobs, and education (Women's Commission for Refugee Women and Children 2006). The Women's Commission for Refugee Women and Children's *Thai-Burma Border Reproductive Health Assessment* provides further examples of local and international groups attempting to provide care to the Burmese. Fewer NGOs/CBOs are known to

exist in Malaysia and/or India, and often cannot focus solely on reproductive health (Christian Solidarity Worldwide 2006).

Reproductive Health Knowledge

The knowledge that Burmese refugees possess regarding reproductive health is very varied and underreported. No report was found that assessed the knowledge of IDPs; however undocumented immigrants in Thailand were found to not understand menstrual cycles, fertility, and most birth control options (Belton 2010). Furthermore, camp education services concerning reproductive health are inconsistent and reserved for pregnant or married couples (Women's Commission for Refugee Women and Children 2006). Even married adults in the camps were found to have extremely limited knowledge of STIs and other reproductive health functions (Benner, et al. 2010; Plewes, et al. 2008).

One recent study of Karen youth (both male and female) ages 15 to 24 in camps assessed reproductive health knowledge (Benner, et al. 2010). Although marriage was strongly associated with more knowledge, most individuals were uninformed. The study found that only 19% knew that first sex could lead to pregnancy, 23% knew that sex half way between periods could lead to pregnancy, 37.8% knew the role of condoms, and 35.2% knew where to get condoms (Benner, et al. 2010). Overall, only 20% of young adults could answer even one in five questions correctly, with high numbers of “I don’t know” (Benner, et al. 2010).

Known Reproductive Health Issues for Burmese Refugees

Specific reproductive health issues for refugees have been recognized internationally as safe motherhood, family planning, STI/HIV/AIDS, and gender-based violence (Women's Commission for Refugee Women and Children 2006). Regarding safe motherhood, IDPs have the least options for safe care and delivery,

although undocumented migrants also face challenges regarding fees and paperwork when attempting to use clinics (Carrara, et al. 2011; Christian Solidarity Worldwide 2006; Mullany, et al. 2008; Women's Commission for Refugee Women and Children 2006); both groups face challenges having a skilled birth attendant available during delivery. Furthermore, all women risk poor pregnancy outcomes related to malaria infections (Carrara, et al. 2011).

Family planning services are limited to married couples and seem to offer only the most basic information. The unmet need for contraceptives has been noted as high, and illegal abortions are widely reported and could cause later fertility and health issues (Belton 2010; Mullany, et al. 2010; Women's Commission for Refugee Women and Children 2006). Many individuals claim they are embarrassed to use condoms (Benner, et al. 2010). Early marriage is also common, and could be tied to a lack of contraceptive education and early pregnancy (Benner, et al. 2010; Women's Commission for Refugee Women and Children 2006). Additionally, a 2001 study with the Karenni reported that despite interest in family planning, there were political activists in the camps who wanted to increase the population size of the ethnic group (MacArthur, et al. 2001). Although no similar reports were found in the literature, political pressure to increase ethnic populations in the face of ethnic cleansing campaigns could be a very real pressure for families.

It appears that STI and HIV/AIDS rates remain low among refugees residing in the camps, although knowledge of STIs and their transmission is low overall (Plewes, et al. 2008; Women's Commission for Refugee Women and Children 2006). Two reasons for this have been hypothesized, expectations of monogamy and faithfulness and that some camps are isolated and strict about movement inside and outside preventing the spread of disease (Plewes, et al. 2008). It is known that the likelihood of STI/HIV infections in women increases with husbands who work outside of the camps, being migrants, having multiple husbands, having a husband who has

had prior wives, a history sex work, or intravenous drug use themselves or their partner (Plewes, et al. 2008).

Gender-based violence includes rape, political rape, trafficking, and domestic violence (Christian Solidarity Worldwide 2006; Women's Commission for Refugee Women and Children 2006). These abuses have been well-documented, despite a lack of official reporting (Women's Commission for Refugee Women and Children 2006). It remains to be seen how these abuses translate to the overall reproductive health of the Burmese.

Although not directly a reproductive health issue, poor mental health outcomes have been found similar to other conflict areas. In a study with a majority of Kayah respondents, researchers found high levels of depression, anxiety symptoms, and post-traumatic stress disorder (PTSD) (Cardozo, et al. 2004). Risk factors for poor mental health include insufficient food, multiple trauma events, previous mental illness, and landmine injuries. Risk factors included insufficient food, multiple trauma events, previous mental illness, and landmine injuries (Cardozo, et al. 2004).

Men and Reproductive Health

Discussions of men's role in reproductive health are almost absent from the literature. The results of the STI knowledge survey with young adults and teens did assess both males and females (Benner, et al. 2010), with the major indicator of more knowledge being marital status. A second study reports that Burmese men feel that contraception is something that women should deal with (Belton 2010). A final report noted that in many provinces and camps few men accompanied women to prenatal visits and most services do not target men (Women's Commission for Refugee Women and Children 2006).

While many researchers and international agencies call for more investigation into men's reproductive beliefs and their roles in family planning (Peacock, et al. 2009; United Nations Department of Public Information 1995), most research still focuses on women, who are seen to have the most control over reproduction. Although this study would have liked to include men's perspectives, due to time constraints and the desires of the TBBC, it was decided to focus on women first. It is recommended that the TBBC include men in reproductive education, and continue the research to identify important needs and perceptions of men regarding reproduction and family planning. This may be particularly important if men and women have different concerns and desires regarding contraceptive use, family size, and family composition.

Knowledge and Beliefs from other Southeast Asian Populations

Although it can be dangerous to homogenize Southeast Asian (SEA) cultures, it can be useful to recognize similarities recorded in SEA communities first resettling in the United States. Cambodian women in the 1980s were found to understand a humoral system in regards to reproductive systems; birth control is hot and ovulation is cool (Kulig 1988). The Cambodian women believed that it was necessary to be cool to get pregnant, but also did not believe it possible to get pregnant each month (Kulig 1988). Furthermore, Cambodian women had limited knowledge of birth control types, and did not comprehend the permanence of tubal ligation (Kulig 1988). A separate study comparing the beliefs of five SEA cultures in the 1980s also found a very limited understanding of family planning methods and how they worked (Minkler, et al. 1988). Minkler et al. (1988) recommended both small counseling groups of couples and individual information sessions, being sure to include methods that may be more realistic for some couples such as withdrawal and abstinence.

THE BURMESE IN THE UNITED STATES

Refugee Concerns in the US

Large waves of Burmese refugees only began entering the United States in 2007, and these individuals are often very different than the wealthier and educated political asylees who contributed to the bulk of resettled Burmese in the past (Markiewicz, et al. 2009). Therefore, limited literature exists on the resettlement experiences of the Burmese, although there is increasing recognition of this growing population.

Overall concerns of resettling Burmese in the United States include disappointment in the lack of support from organizations, language and transportation barriers, limited employment opportunities, importance of education for children, concern on how to discipline children, lack of money, and limited access to health care especially due to interpretation issues (Baer, et al. 2011; Mitschke, et al. 2011; Swe and Ross 2010). Mitschke et al. (2011) also found that refugees were having trouble buying food even with food stamps, although the needs assessment in Tampa found the opposite (Baer, et al. 2011).

Burmese Refugee Health in the United States

A chart review of the Karen in Minnesota and a review of data from Burmese entering the US as asylees note the importance of continual screening for hepatitis, TB, and parasites, even in young adults and teens (Markiewicz, et al. 2009; Power, et al. 2010). Smoking and drinking has mostly been reported in men, but it is likely underreported (Power, et al. 2010). In a Seattle Chin community, alcohol and smoking are seen as status symbols (Scarlis 2010). Smoking among men was observed in Tampa, and key informants mentioned that drinking and associated domestic violence were ongoing issues (Baer, et al. 2011). Additionally, the use of betel nut, a popular stimulate that can cause tooth decay and oral and pharyngeal cancers was prevalent in Minnesota (Power, et al. 2010). Dental problems in both

children and adults were a major concern during a needs assessment in Tampa (Baer, et al. 2011). Although high cholesterol, hypertension, obesity, and diabetes are rarely found in the Burmese population, concerns over rapid diet and lifestyle changes indicate that these health indicators should continue to be monitored (Moore 2010; Swe and Ross 2010).

Common use of Thai and Malaysian over-the-counter medicines, antibiotics, and pain killers was found in Tampa, Minnesota, and Texas (Baer, et al. 2011; Power, et al. 2010; Swe and Ross 2010); it seems a larger review of what these medicines are and how they are used is warranted. Researchers note the importance of explaining the need to finish medications even when symptoms disappear (Power, et al. 2010). Additionally, it has been reported that due to transportation and especially language barriers, many Burmese are waiting until they have severe health issues to seek medical care (Baer, et al. 2011; Oleson 2009; Swe and Ross 2010).

Traditional medicine has been found in use in the United States, but it seems that these communities have traditional healers present (Oleson 2009). A Karen community in Minnesota reported the use of traditional medicines and prayer as first lines of use before using American medicine (Oleson 2009). Commonly found items regarded as medicinal included turmeric, ginger, garlic, honey, table vegetables, sesame oil, different plants, snake and bear gall bladders, hen-fat, white goat bones, horns, and tongue (Oleson 2009). In Tampa, a health needs assessment did not indicate a traditional healer was present in the community, and it appeared that most traditional knowledge was lost or considered inferior to Thai, Malaysian, and US medicines (Baer, et al. 2011). However, the use of some spices, such as paprika, and possibly some other foods was indicated by a few participants as being healing (Baer, et al. 2011). Contrary to the Karen study in Minnesota that observed a connection between prayer and traditional medicine, two other US-based studies

found that the use of traditional medicines, herbs, or Ayurvedic or Chinese medicines is minimal if at all existent in Christian refugees as opposed to those followers of Buddhism or animism (Baer, et al. 2011; Power, et al. 2010).

Regarding reproductive health, less information is known. STD/STI infections seem rare (Power, et al. 2010), which follows known information from the Thai-Burmese border as discussed above. Depo-Provera injections and tubal ligation were common methods of birth control found in Minnesota, and two cases of Norplant were recorded (Power, et al. 2010). In Tampa, Depo-Provera was widely cited as a known birth control (Baer, et al. 2011). A study in Minnesota found that pregnant women were avoiding the prenatal vitamin because it was so small they did not think it would work and/or because there was a belief that it caused constipation (Oleson 2009); more observations into how women are using and interpreting US medicine is important when thinking about their health and the health of their babies. In a final concerning study of 22 Burmese women who were given a pap smear in Philadelphia, three were found to have abnormal pap smears, and of those two had high-risk HPV (Pickle, et al. 2011). This study indicates that cervical cancer could be a hidden problem in the Burmese population and that more screening and assessment needs to occur to understand how much of an issue this may be.

CONCLUSION TO CHAPTER 2

This chapter describes the history and contributions of anthropology to refugee studies, medical anthropology, and reproductive health, and the history and health of Burmese refugees at home, during displacement, and after resettlement in the United States. Anthropology over the last few decades has made great leaps in its theoretical foundations, beginning by recognizing its own history situated in colonialism and Western bias. Anthropologists working with refugees often assumed roles of applied anthropologists, helping to understand the cultural confusions that

occurred as groups resettled to the United States and advocating for changes in education, institutional organization, and medical practices. A recent trend in Anthropological theory has been to explore and expose structural violence that contributes to social suffering and creates the humanitarian crises resulting in refugees. The importance of this line of theory and its potential application to creating more egalitarian systems cannot be denied, but the importance of using local ethnographies to aid those displaced by these unequal structures in a more immediate fashion cannot be ignored either. New concepts of local biologies and biocultural realities bring the focus of Anthropological theory back to the lived realities and culturally mediated understandings of medical systems, including reproduction. The goals of applied anthropologists in the next decades will include framing research questions to tackle both local issues and global structural issues, while exploring ways to apply this research to create positive change locally and globally.

The recent history of the Burmese people is one of political struggle and unwavering faith in the potential political recognition of ethnic and religious freedom. Literature reviews of academic, governmental, and non-profit organizations offer little differentiation between ethnicities and focus, understandably, on immediate needs stemming from the continual human rights violations. From what does exist, it is apparent that life within the Burmese border may be the most difficult. IDPs face military abuse, instability, and constant fear of forced labor, physical abuse, and resettlement. Undocumented migrants in Thailand, India, and Malaysia are removed from military violence, but continue to suffer from abuses at the hands of police and a lack of security from political policies that deny them political rights and access to employment and health care. Camps, targeting Karen and Kayah peoples, offer the most stability and basic human needs including shelter, food, and health care;

however, opportunities for improving life, advancing education, or learning job skills are inconsistent if available at all.

What is known about reproductive health knowledge and practices seems to be limited to infectious disease surveillance and family planning options for married couples. The literature indicates that individuals' comprehension of reproductive biology and available pregnancy prevention options is inconsistent among different refugee groups based on political identity and location. Furthermore, the removal from homelands and separation of families has resulted in the loss of traditional knowledge. Finally, data about the Burmese after arriving in the United States is even less informative and often focuses on immediate needs such as access to language training, employment, and health care. Because of the recent surge in Burmese refugees this is understandable, but it becomes even more important to supplement the needs assessment literature with information specific to different ethnic populations and their emerging cultural models of health and wellness in the United States.

CHAPTER 3: METHODS

INTRODUCTION TO CHAPTER 3

This Chapter describes the methods used to explore Burmese women refugee's beliefs about reproduction. The research was requested by the local Burmese ethnic community-based organization (ECBO), which had anecdotally recognized a growing interest in their community regarding pregnancy and childbirth in the United States. Because the author had participated in a health needs assessment of the community and specializes in maternal/child and reproductive health, it was mutually decided to focus the investigation on this topic. The author has been given permission by the ECBO to use the research as her Master's Thesis and has promised to provide a technical report with recommendations for educational classes to the ECBO to use in a grant proposal. The objective of the study, specifically paying attention to ethnic group differences, is to explore the reproductive beliefs of Burmese refugee women in the Tampa, Florida. The specific research aims are:

1. Identify how Burmese women perceive ideal families.
2. Identify Burmese women's knowledge and use of family planning.
3. Identify Burmese women's experiences of pregnancy and childbirth as refugees.
4. Identify Burmese women's pregnancy and childbirth beliefs and rituals.
5. Identify Burmese women's postpartum beliefs and rituals.

RESEARCH DESIGN

This study was exploratory and used qualitative methods to describe women's reproductive beliefs, analyzed specifically through their different ethnicities. The methods used, and described in more detail below, were participant observation, semi-structured individual interviews, and a semi-structured group interview.

Language Challenges

Two female interpreters from the community were available; however, language differences were challenging and varied between and within ethnicities. Within the local community, Burmese, Karen, Kaya, and Chin are spoken with varying degrees of proficiency. Additionally, some ethnic dialects are so different that they are not mutually intelligible (Barron, et al. 2007, personal communication Christy Sui, 2011). Language lines, telephone interpretation available at medical providers' offices, is costly and often has long wait times for Burmese language speakers; additionally, many women do not speak Burmese well enough to communicate with that language.

The first interpreter is a local leader who is well known in the community and often used as an interpreter. She speaks English, Burmese, and five Chin languages, and can write in English, Burmese, and Chin. She holds a Business degree from Burma and works at Catholic Charities in the Refugee program. The second interpreter is a young individual who is new to Tampa, but who has family in the community. She speaks Burmese and Karen, and can write in English and read in Burmese. She has her high school diploma from the United States and she is newly employed as an interpreter.

While there are pros and cons to using local interpreters, the variety of languages involved and the lack of female English-Burmese speakers available presented no other options. Due to the exploratory nature of the research and a lack

of available information on the topic, these limitations are acknowledged, but it is still believed that this design offers the best available solutions for the circumstances.

IRB Approval

The University of South Florida's Institutional Review Board approved this study. The two community members who participated in recruitment and advertisement of the study participated in the ethics training module available at the University of South Florida. These two individuals were also the interpreters for the project, although they did not participate in the data collection or analysis.

Informed Consent Procedures

Signed consent had been used during the needs assessment in Tampa (Baer, et al. 2011) and was utilized in this study as well. Consent forms were available to women in Burmese, Chin, and English. Consent forms were only translated one-way, as there were not interpreters available to back translate the documents. Interpreters chose whichever form was most comfortable for them and verbally translated the document at the beginning of each interview. Women were given a copy in the language of their choice, and the signed forms were collected.

Although signed consent forms were used in the past, many women seemed uncomfortable with the process and others struggled to sign their name. As literacy levels are low and women were visibly uncomfortable signing paperwork they could not understand, it is recommended that waivers of signed consent be requested for future studies. Information sheets should still be offered in the language of choice.

PARTICIPANT OBSERVATION

Sampling

Participant observation occurred during the needs assessment done in Spring 2011 (Baer, et al. 2011) and the current interviews. During the needs assessment, each family in the community was interviewed in their homes. Observations were made inside the participants' homes and at two of the apartment complexes of the Burmese on three separate occasions. Additionally, observations of the resettlement agencies and their organizations took place. During the current study, time was spent with sixteen women, seeing many of their homes, and an additional apartment complex where community members live.

Data Collection

Participant observation occurs when an individual spends time with members of the community they are researching to participate and observe everyday life. After each time spent in the community, detailed notes are recorded about all of the physical, environmental, and social observations, both objective and subjective, that occurred during the interview. During the needs assessment (Baer, et al. 2011), the multiple researchers shared their notes with each other. Researchers were asked to describe their setting, including the apartments of participants, clothing, interactions with other community members, smells, etc. One of the researchers (a member of the class and the teaching assistant for the class) took all of the notes and summarized them based on common observations that were found throughout. I used those notes to compare to my current observations during these interviews.

Data Analysis

During the participant observation which was done as part of the Baer et al 2011 study, themes and observations were analyzed systematically through the

notes taken by the research team. The team consistently shared their experiences, observations, and thoughts to contribute to an overall description of the Burmese. During the current study, additional notes were taken and added to the previous observations, based on the previous summarizations that were found consistent across multiple researchers.

SEMI-STRUCTURED INDIVIDUAL INTERVIEWS

Interview Guide

The semi-structured interview guide (See Appendix A) was designed after a conversation with the President of the ECBO and a case worker at one of the refugee services organizations in Tampa, FL, and after consultation with the thesis committee. The interview guide begins with demographic questions and then asks women about ideal Burmese families, pregnancy and childbirth norms and expectations in Burma, in a refugee situation, and in the US, and concludes with women's knowledge about family planning. Some questions include, "what does the ideal [ethnic group] family look like?" "What types of birth control have you heard about?" and "How do women know when they are pregnant?"

Sampling

Due to the small size of the Burmese female population in Tampa (23 women), all women over the age of 18 were invited to participate in the interviews. The interpreters completed investigator education for human research protection through the University of South Florida before recruiting any participants. They were told to make sure that women were informed that the study was voluntary and would not affect their benefits. Because Kayah women did not have a translator available who spoke Kayah, it was decided that only one Kayah woman (who spoke Burmese) would be interviewed for the semi-structured interview. The additional five

Kayah women would be included in the group interview, discussed below. The individual Kayah woman was selected by the interpreters because she spoke Burmese and lived in an apartment complex where another interview was being held. Therefore, there were a total of 18 women invited to participate in an individual semi-structured interview. Thirteen individual interviews were completed.

Data Collection

Interviews were done at each woman's apartment complex and the interpreter introduced me to each woman. Most interviews took place in the woman's home, although in two instances the Karen women had two individuals offer their home for multiple interviews. In all cases but two, the women were the only adults in the room during the interview. Late elementary to high school children were also not present during the interviews, although in many cases young children were playing in the room or sitting on their mothers laps. The two interviews where a second adult was present for a portion of another woman's interview occurred during two Karen interviews. In both instances, a woman had participated in an interview and then offered her apartment to use for the following interview. Those women initially left and were therefore not in the room when the interviews began, but arrived during the middle of the interviews and proceeded to do work in their kitchens. Although the women being interviewed agreed that it was fine for the other women to use their own apartments, it is unclear if this changed any of their responses.

The consent forms were read to the women and they were asked to sign the form, as discussed above. Semi-structured interview guides were used to guide the interviews. The interview guide was designed by myself and approved by my thesis committee. It was very open-ended, and probing was frequent. Extensive paper-and-pencil notes were taken during the interview. Observations noted during the

interview and elaborations of the notes were typed up after the interviews. Each interview lasted about one hour and fifteen minutes.

Data Analysis

The paper-and-pencil notes that were taken during the interview were typed into Microsoft Word 2010 ©. The research was hand coded, aided by Microsoft Word 2010 ©. The constant comparative method was used to find common themes within and between ethnic groups (Glaser and Strauss 1967).Themes were first organized based on the topics set up in the interview guide and analyzed within each ethnic group. Themes across ethnic groups were also created based on importance that the women gave certain topics (for example, menstruation). Data was then compared between and within ethnic groups, as well as between and within ages. Any differences are reported in the results.

SEMI-STRUCTURED GROUP INTERVIEW

Interview Guide

The same interview guide (Appendix A) that was used for the individual interviews was used for the group interview.

Sampling

Of the six Kayah women in the community, two did not speak Burmese at all. In order to include these women's points of view, a group interview was scheduled. One Kayah woman participated in the individual interviews. Originally, the group interview was supposed to have five women with one interpreter translating and the second taking notes; however, on the day of the interview one woman's husband was called into work so she had to watch her children, and another declined because she did not want to travel to a different apartment complex with her newborn. Of the

three remaining women, two spoke Burmese and Kayah, and one spoke only Kayah. Only one interpreter came so that the women did not feel overwhelmed by researchers. The final number of women who participated in the group interview was three.

Data Collection

The interpreter recruited the women for the group interview and ensured that they were brought to the correct apartment. The interpreter met me at the apartment complex and introduced me to the women. While there were other male family members in the apartment, they mostly stayed in the bedrooms. On four occasions a family member came into the kitchen/living area to get something from the kitchen, but did not seem to observe the group and did not linger. On one occasion a different family member came and started watching the interview. They were asked to leave. Two of the women's young children occasionally came and played on the floor or sat on their mothers' laps.

The consent forms were read to the women in Burmese and they were asked to sign their understanding, as discussed above. The two participants who spoke Burmese and Kayah were asked to translate the consent for the woman who only spoke Kayah. The same semi-structured interview guide that was used for the individual interviews was used for the group interviews. Most women answered each question separately, and probes were used to learn about different opinions or examples. The women who spoke Burmese had to be reminded to include the woman who only spoke Kayah. Although this took a little longer, the information from the group was similar with information from the individual interview and consistent with the flexibility of answers being given within other groups. The group interview actually went very well, and the women often shared more experiences because they were reminded of things based on other women's responses. Because

different answers were given to some questions, it is reasonable to assume that the women were able to answer honestly for most questions. I did not transition to new questions until at least two of the three women gave responses for each question, and when possible all three. Extensive paper-and-pencil notes were taken during the interview. Care was taken to note which woman was speaking for each response. Observations noted during the interview and elaborations of the notes were typed up after the interviews. The group interview lasted about two hours.

Data Analysis

The paper-and-pencil notes that were taken during the interview were typed into Microsoft Word 2010 ©. Care was taken to separate the responses from each woman. Consistent with the individual interviews, the research was hand coded, aided by Microsoft Word 2010 ©. Grounded theory was used to find common themes within and between ethnic groups, using both the group and individual interview notes.

CONCLUSION TO CHAPTER 3

This exploratory research design relied upon qualitative data to explore Burmese women refugees' reproductive beliefs. Participant observation, thirteen semi-structured individual interviews, and one semi-structured group interview was used to collect data. Most interviews took place individually, but due to language complications, one group interview was held to include women who did not speak a language with an available interpreter, so that other community members could help translate for them. Extensive notes were taken and written up by a single researcher. The data was hand-coded and grounded theory was used to find themes within and between ethnic groups that were used to guide the analysis of the results.

CHAPTER 4: RESULTS

INTRODUCTION TO CHAPTER 4

This chapter describes the results of the study. First, the demographics of the sample are described. Second, the results of the interviews are presented. The interview results are organized first by ethnicity and second by the themes that emerged during the analysis. Quotes are labeled with the ethnicity and the age of the participant. Some quotes have been collapsed together to form narratives, which were difficult to obtain through interpretation.

DEMOGRAPHICS

Twenty-three women were eligible for inclusion in the study. This number includes all of the women over the age of 18 in the Tampa Burmese community, excluding the two interpreters. The ethnic make-up of the community is five Chin, eight Karen, six Kayah, one Kayaw, one Bama and two half Bama-half Indian women. Sixteen women participated in interviews that lasted about 75 minutes each. These women represented 69.6% of the Burmese women in Tampa (see Table 1).

Table 1: Number of Women Participants by Ethnicity and Interview Type

Ethnic Group	Interview	Group Interview	Did not Participate
Chin	5	0	0
Karen	6	0	2
Kayah	1	3	2
Kayaw	1	0	0
Bama	0	0	3
Total	13	3	7

Burmese Women Who Did Not Participate

Seven women were not able to participate. Two were Karen, two were Kayah, and 3 were the Bama women. The one Karen woman was too busy at work or tired after work to do an interview. The other Karen woman did not live at the same apartment complex as the interpreter and they could not find a time to meet together. The two Kayah women did not want to participate. One Kayah woman did not want to travel with her young infant to the group interview. The other Kayah woman was taking care of her children while her husband was at work and did not want to participate. Three Bama women were not interviewed because there was a misunderstanding between the interpreters as to who was responsible for setting up those interviews. Unfortunately, I did not realize these women were in the community until the analysis stage. It is recommended that the Bama women be asked about their reproductive beliefs in the future, to ensure that educational programming matches their beliefs and needs.

The women who were not interviewed are very similar to the women who were interviewed. All are married, all are between the ages of 25 and 50, and all have between one and four children. Each of the women's husbands has a job, and only one woman (the Karen woman) has a job.

It should also be noted that during the interviews and the analysis stage (between November 2011 and March 2012) an additional Karen family moved into the community and was not included in the interviews, and one of the Kayah families that had not participated in an interview left the state because of a job opportunity for the husband.

Burmese Women Who Participated

Table 2 describes the demographics of the women in the sample. All of the women were married. The age ranges of the women were 23-55, and the majority

Table 2: Demographics

		Karen	Kayah	Kayaw	Chin	Total
Age						
	23-27	3	2	1	0	6
	28-32	1	0	0	2	3
	33-37	0	1	0	2	3
	38-42	0	0	0	1	1
	43-47	0	0	0	0	0
	48-52	2	0	0	0	2
	53+	0	1	0	0	1
	Range	24-52	23-55	26	28-38	23-55
Religion						
	Christian	6	1	1	4	12
	Catholic	0	2	0	0	2
	Baptist	0	0	0	1	1
	Traditional	0	1	0	0	1
Years of Education						
	0 yr	2	1	0	1	4
	1 yr	0	1	0	0	1
	3 yr	0	0	0	1	1
	4 yr	1	0	0	1	2
	6 yr	0	1	0	0	1
	8 yr	1	1	0	2	4
	9 yr	1	0	0	0	1
	10 yr	0	0	1	0	1
	12 yr	1	0	0	0	1
	Range	0-12	0-8	10	0-8	0-12
Job						
	Yes	1	0	1	1	3
	No	5	3	0	4	12
	Occasional	0	1	0	0	1
Husband Job						
	Yes	6	2	0	5	13
	No	0	2	1	0	3
Neither Husband Nor Wife has Job						
		0	2	0	0	2

n=13) were under 40 years of age, and thus are likely able to have children unless they have received a tubal ligation. Four women had no formal education, five women have between 1 and 6 years of education, and six women have between 8 and 12 years of education. No woman in the sample has a college education. Fifteen of the women self-identify as some denomination of Christianity, and one woman identifies as Kayah traditional. Most women do not have a job (n=12), although three do and one has occasional work. Only three women have husbands that do not work, and two Kayah households have neither the husband nor the wife working.

Table 3 shows the migration history of the women in the sample. Women spent up to 40 years living in Burma before leaving, although two Karen women have never lived in Burma, and many women left when they were children or adolescents (n=6). Chin women have spent the most time in Burma (25-35 years), as well as the least amount of time abroad before entering the United States (at most 2.5 years in Malaysia). Karen, Kayah, and Kayaw women spent many years living in Thailand, with a range of 9 to22 years in the border camps. The women have been in the United States up to five years; however the majority (n=11) have been living in the US for two or fewer years. Only three women have lived in another US city.

The family sizes of women are described in Table 4. All of the women in the sample have at least one child, with two women having six children. Six women experienced childbirth in Burma, nine in Thailand, two in Malaysia, and seven in the United States. One woman is pregnant with her sixth child, and this will be her second child in the US. Nine women do not want any more children, two are undecided, and three women who do want more children specifically mentioned that their decision had to do with wanting to have children of both sexes.

Table 3: History of Migration

	Karen	Kayah	Kayaw	Chin	Total
Years in Burma					
0	3	0	0	0	3
0-10	1	2	1	0	5
11-20	1	1	0	0	2
21-30	0	0	0	2	2
31-40	2	1	0	3	6
Range	0-39	4-40	5	25-35	0-40
Time in Thailand					
0	0	0	0	5	5
<1-10	3	1	0	0	4
11-20	2	3	1	0	6
21-30	1	0	0	0	1
Range	9-22	10-20	20	0	9-22*
Time in Malaysia					
0	6	4	1	0	11
< 1 yr	0	0	0	1	1
1-2 yr	0	0	0	3	3
2-3 yr	0	0	0	1	1
Range	0	0	0	10-30 mo	10-30 mo*
Time in America					
<1 year	0	1	1	0	2
1	1	1	0	3	5
2	1	2	0	1	4
3	0	0	0	1	1
4	3	0	0	0	3
5	1	0	0	0	1
Range	1-5	.5-2	4 mo	1-3	4mo-5 yr
Time in Tampa					
<1 year	0	1	1	1	3
1	1	1	0	2	4
2	2	2	0	1	5
3	0	0	0	1	1
4	2	0	0	0	2
5	1	0	0	0	1
Range	1-5	.5-2	4 mo	10mo - 3yr	4mo-5 yr
Lived somewhere other than Tampa					
Yes	1	1	0	1	3
No	5	3	1	4	13

*Range includes only those who have ever lived in that country

Table 4: Family Size

	Karen	Kayah	Kayaw	Chin	Total
Total Number of Children*					
1	2	0	0	2	4
2	1	1	0	0	2
3	0	1	1	1	3
4	1	1	0	1	3
5	1	0	0	1	2
6	1	1	0	0	2
Number of Children in Burma					
0	4	3	1	2	10
2	0	0	0	2	2
3	1	1	0	0	2
5	0	0	0	1	1
6	1	0	0	0	1
Number of Children in Thailand					
0	2	0	0	5	7
1	1	1	0	0	2
2	2	1	0	0	3
3	1	1	1	0	3
4	0	1	0	0	1
Number of Children in Malaysia					
0	6	4	1	3	14
1	0	0	0	2	2
Number of Children in the US					
0	4	2	1	2	9
1	2	2	0	3	7
Want more children?					
Yes	2	0	0	0	2
Yes, b/c want other gender	0	0	0	2	2
No	3	2	1	3	9
No, but want other gender	1	0	0	0	1
Undecided	0	2	0	0	2

*These totals include only children who are currently living

LIVING IN THE UNITED STATES

When the Burmese arrive in the United States they are met at the airport by the resettlement agency directed to accommodate them. Services provided by these resettlement agencies include housing, translation and English language classes, medical and professional referrals, employment services, cultural orientations, mentoring services, case management, and matching federal grants programs to

help refugees become citizens or get work permits (Gulf Coast Jewish Family and Community Services 2012; Lutheran Services Florida n.d.). While services are provided for free initially, the goal of these organizations is to help refugees become self-sufficient, productive US citizens as quickly as possible. Therefore, some services such as emergency Medicaid only last up to 8 or 9 months, while employment and case management services given directly by the resettlement agencies last up to five years after arrival (Lutheran Services Florida n.d.). English language training is complicated, and often supported by church volunteers. Job training can vary widely depending on the location of the refugees and their potential skills. In Tampa, many refugees work in hotels cleaning, as chefs in Thai restaurants, and in landscaping. Because of job needs, the population is very transient, and the community is in contact with friends and family who have been resettled throughout the US, leading to many moves for job opportunities.

Housing in Tampa

For Burmese refugees arriving in Tampa, FL, there are three main apartment complexes that the resettlement agencies use to house refugees. The first was one of the original apartment complexes that housed Burmese. This apartment complex is located in a residential area between many major highways and thoroughfares. The apartment complex is two stories and built like a square, with a central courtyard with a pool. The building is concrete and has the appearance of being worn down and somewhat cold. Access to the apartments is from opposite sides of the building. When you pull up to the apartment complex on the one side, it is often necessary to dodge Burmese children playing in the parking lot with bikes, kicking soccer balls, or just hanging around. Burmese men can be seen congregating on the balconies or stairwells chatting and smoking. Doors open onto a shared balcony and sidewalk on both levels, and sandals and sneakers can be seen resting outside

doorways on mats. As you walk through the apartment complex, past the pool, many residents of the apartment complex are found grilling and sitting in lawn chairs that have been brought outside their apartments. Wonderful smells ranging from Southern US barbeque to complex Thai spices mix with a variety of loud music playing from many stereos. The apartment complex houses many different cultures, and it appears that many get along with each other, even though they cannot speak the same languages.

The second major apartment complex that the Burmese are housed in is located only about half a mile away from the first. It is a longer complex that stretches for almost a block along the main road. In this apartment complex many African-American children are playing outside, and it is necessary to dodge kids on bikes and running in the street. Many apartment doors are open, all facing the main parking lot which stretches parallel to the road, and TVs and stereos are blaring. Residents seem to notice me as an outsider when I arrive, and often heckle me to share the oranges I am bringing the Burmese interview participants. Although I do see a few Burmese children playing, they remain close to their doors. The apartment complex is so long, that many Burmese families are spread out from each other, despite being located in the same complex. There is less of a friendly vibe at this apartment complex, although it may have to do with the fact the Burmese are more of a minority here than the other residence.

In both the first and the second apartment complexes the interiors are similar. Most open into a carpeted living area that also has room for a small dining table. The kitchens are always visible, some opening right onto the living room, with others being just off the living room in a galley style. Most are one or two bedrooms, and family members often prefer to sleep in the same room. Occasionally lone relatives or community members will be given one bedroom in an apartment, while entire families will occupy the second bedroom.

The final apartment complex is about three or four miles from the first complex. It is in an area known for crime and transience; however, the space and updates in the apartments are much nicer than the first two apartments, and come at a much lower price per month. I only was able to see one of these apartments, and it was very nice. The carpet appeared newer, the kitchen and living space was larger, there was more of a formal dining space, and I was told the apartment had three bedrooms. This apartment complex also had many people sitting outside on the curbs, and children playing in the streets, but it was massive compared to the first two complexes. This complex had multiple buildings with multiple stories of units. The grounds were well maintained, but judging by the dilapidated cars in the lots, the income of these community members was probably low.

Regardless of which complex, the Burmese usually have two sofas, a dining table, and some chairs. The furniture is arranged around the walls of the room, and additional rugs and mats are laid on the floor. The apartments have similar furnishings because that is something provided by the resettlement agencies upon arrival. If a coffee table is present, it is often pulled into the middle of the room for the interview. Many Burmese prefer to sit on the floor, and culturally it is appropriate for elders and respected community members to sit above minors. Sometimes I sat on the floor with the participants, and other times they sat on the couches with me, each experience was different and I let the participants lead.

According to staff at the resettlement agencies (Baer, et al. 2011), cultural orientation typically happens immediately upon arrival, and is ongoing, although often informal. Important lessons that are initially taught when the Burmese are introduced to their new residence include how to turn on and use the stove and oven, what a refrigerator is, what different furniture does, and how to operate the air conditioning and heating. Many staff members reported that neighbors were often very helpful to the Burmese in the first few weeks, especially in regards to using the

stove and oven, which is important for being able to eat and for staying safe in the apartment. Additionally, there are some presentations that newly arrived refugees attend, although it is not clear whether they occur immediately after arrival or not, and whether they are with other refugees of different cultures, or with their own community.

KAREN

Karen Demographics

The Karen women ranged in age from 24 to 52, with two women aged 50 and over and the remaining four women between the ages of 24 and 30. Both of the older women had spent 35 or more years in Burma, while the younger women had spent at most 14 years in the country. Two women had never actually lived in Burma, having been born in the refugee camps in Thailand. All of their husbands have jobs, but only one Karen woman herself has a job. One woman had all of her children in Burma, one had children in Burma and Thailand, two had their children in Thailand, one had a child in Thailand and the US, and one had her child in the US.

Observations

The Karen women all seem very close with each other. The women wanted to share their apartments during the interviews and were spending time together before we arrived. Many wanted to do the interviews in groups of two. Their children seemed close and were playing together, either in the apartment where we were doing the interview or just outside. All of the apartments were kept very warm, but women were often wearing light sweaters despite the heat. A few women wore long wraps as skirts, but others wore jeans or other slacks. The Karen women typically had food sitting out on counters and tables under light covers. One woman had two gallons of milk sitting on the floor in an apartment heated to over 80 degrees.

Apartments often had the heat on, even when it was in the 70s outside. It was common to see bags of chips, donuts, and other processed snacks (both US and from the Asian Market) on counters or being consumed.

Importance of Families

The traditional Karen family has lots of children, although many women claim it is better to have fewer. Most families are nuclear, but it is not uncommon to live with or near grandparents. A value is placed on having male and female children, as one of the women stated, *"It's important to have boys and girls because the boys will go off and work and bring in money and the girls will help with the house, cook, and clean"* (Karen, 30).

Overall, it is very important for the Karen to have children, because children are expected to take care of their parents as they age. Additionally, having children gives Karen women a sense of responsibility and a sense of duty towards their family. As one Karen women (24) explained, *"It is important to have children because you have to think about your children's future, your husband's work, and how to take care of the family. If a woman has no children the other women feel so bad because in the future they will have no one to take care of them."*

The Role of Menstruation

Although I did not originally have a specific question about menstruation, I was fortunate that my first participant began discussing menstruation as we discussed getting pregnant and having children. Because of this, I began to ask more directly for it in later interviews, and asked whether women thought menstruation was important, if they could find what they needed to be healthy during that time in the US, and if there were activities or foods that they should or should not eat during this time. Four participants noted that during menstruation it is important for Karen

women to stay warm and avoid cold things. Traditionally, when a woman was exposed to cold things like ice or rain, they would feel sick, have headaches, and medicines would not work. *"I don't know about how it is to have your period in America. When I was in the forest and I had my period I had to farm, so I did everything, even eat the cold foods. Then I would feel sick and have a headache. I was cold in the rain, and the medicine doesn't work"* (Karen, 52). One woman (50) added that it was best to eat rice and chili during menstruation, although it is not good to eat too much or a woman will have stomach pain. No other woman recommended foods to eat during menstruation. The importance of being warm seems to be related to the physical sensation of temperature, not necessarily attributes associated to certain materials, foods, or items. I tried to ask more about this, but unfortunately the translations did not seem to be making sense. 1

The Karen women agreed that it was easy to find what they needed to take care of their menstruation in the United States. One woman (24) said it was common to use paracetamol, a Thai pain killer that is easy to find, for headaches and cramps. She thought women might like to try US pain killers, but she said they are hard to get because the Karen do not speak English.

A younger woman (24) indicated that there may be some changing ideas towards the traditional beliefs regarding menstruation, although it is not known if this is attributed to age or to living in the United States. *"We have everything here; it's the same...Kotex. [giggles] I eat everything during my period, I can do anything."* The prevalence of these ideas in the Karen is unknown, as two other Karen women who are the same age explained the importance of staying warm and avoiding cold things during this time. However, there was a common theme, discussed further in the next chapter, where it appears many women are more actively disregarding previous cultural expectations because of being in the US. This will remain an area to

continue to examine, as individuals react to and respond to new ideas and new surroundings.

Expectations of Family Planning

Women were asked their beliefs about having children, family planning, how family planning was decided in their family, and what they knew of different birth control options. During analysis it became apparent that two themes emerged from these questions, planning the family composition, and knowledge about different birth control methods.

Having Children

Not all of the Karen women gave advice for what women should do when they want to have children, but those that did recommended good nutrition. *"When a family wants another baby they should have mango, orange, and lemon. It's good for the Karen woman"* (Karen, 24). Another woman recommended eating "healthy foods." Many did not think there was anything that could be done to prepare for a pregnancy. However, most Karen women agree that it is best to have your first child between 20 and 22 years of age, although one felt 25 was best.

The concept of being able to control family size and composition is only apparent in younger Karen women. One older Karen woman (50) giggled, *"I never talked to my husband about children, we just had them."* Another Karen woman in her 50s (52) said she and her husband talked about how many children they wanted, but commented *"we only knew that we would see what happened until my period stopped."* In contrast, all of the younger women in the community (between 24 and 30) said they had talked with their husbands about the number and sex of the children they want, and planned to use birth control after they achieved what they wanted. A 24 year old Karen woman who has one son said, *"I did talk to my husband*

about having more children, and we will stop when we have a girl. After the girl I will use the shot. Well, I will have up to three children and then I might stop if I still have no girl. But my husband will have up to four to have a girl." Another woman said she only wants two children, but will have more if her second is not a girl.

Although many participants said that two to four was the ideal number of children for Karen women in Tampa, women explained it was different for different families. *"My husband and I have talked about having more children; we both want one more* [for a total of two]*. …some families they want four though, and for some that's too many"* (Karen, 24). Additionally, the Karen women did not agree as to whether the husband or the wife would end up making the decision to have more children or not, explaining that it was probably different in each family.

A theme of the importance of having both sexes emerged in the interviews. Three of the women in the community only had sons, two having one son each and one woman having five sons. All of these women commented that they were hoping for girls. The woman with five children was pregnant with her sixth, and said, *"If I get a girl I will stop having children, if not I will keep going. My husband wants a girl, too"* (30).

There appears to be no consensus on how long women should wait between children, with some preferring to have them close together, and others further apart. However, all women agreed that there was nothing wrong with either having children too close together or too far apart. However, one woman did comment that there could be unintended consequences of having children too close together, *"It's better to wait because then it's easier to take care of them. And if only 2 or 3* [years old] *that child could point at the baby and something bad happens, it's bad luck, like if it points at the eyes* [of the baby], *maybe they'd go blind"* (Karen, 30). Although I was unable to get more information from the Karen woman about possible bad luck, other literature indicates that pointing is culturally disrespectful for most Burmese

ethnic groups (Barron, et al. 2007). It would be interesting to further explore the ideas of "bad luck" and "good luck" more in regards to reproductive health.

Knowledge of Family Planning Options

Birth control seems best understood by the Karen as preventing children *after* the ideal family size/composition is met. Therefore, not much thought is given to the biology of pregnancy; women simply understand that when they want to stop having children they can take birth control. In line with this view of procreation, women seem unaware that there is a potential to get pregnant soon after having a first child, *"I have a baby* [11 months] *now, so I don't need to think about it* [birth control]" (Karen, 24). Women did not discuss using breastfeeding as birth control, so it is unknown whether they associate breastfeeding with pregnancy protection.

Neither of the Karen women over 50 knew anything about birth control. Four women knew of the injection ("the shot"), three knew of the pill (the "medicine," the "tablet"), two knew of condoms, and one knew of the implant. Because one woman was pregnant and two only had one child (and were hoping for a second) they were not using birth control. *"I've heard of the shots and the medicine [pill]…I don't know about getting birth control"* (Karen, 24).

Most women expressed interest in learning more about birth control, and only one Karen woman in the sample was currently using birth control. This woman had begun the injection in Thailand and was continuing its use here in the United States. When she was asked which birth control Karen women like she explained, *"It's different because of* [their] *blood. Some use medicines better, some like the shot. There are side effects."* One other woman indicated that preferences would be different for different women, but did not elaborate.

Experiences of Pregnancy and Childbirth in a Refugee Situation

Two Karen women had experienced childbirth in Burma, four women in Thailand, and two women in the United States. Only one woman preferred giving birth in Burma to Thailand, and she had given birth in both places.

> "[I] *don't know how often you should see a doctor; I lived in the forest and never saw* [a provider] *until the birth. In Burma, the midwife came and pushes on the stomach to give birth (takes hands and pressed on stomach moving from upper torso down). Your friend and husband and midwife* [are] *there. You are in the house, lying down. In Thailand it is the same except that they don't push your stomach there. They put* [monitoring bands] *on your waist. I like Thailand, but there was no medicine. I preferred Burma because they pushed on the stomach. I have heard in America no one pushes on the stomach, and you have to do it by yourself." (Karen, 50, 5 living children, 2 in Burma, 3 in Thailand, 2 deceased-birth locations unknown)*

All of the other Karen women agreed that birth was easier in the United States.

> *"In Burma, the traditional, women were home when they gave birth, and other woman stood behind them and they pushed the baby out. Sometimes a traditional doctor, they were men. And the Husbands. In Thailand it was the doctor and the husband there. They gave me medicine, a little black pill. I walked a lot, and I knew almost when so I lay down and he was born. In America I hear it is easy, because no pain. In Thailand you have pain for 3 or 4 days. Here, I hear it is so easy, no pain. No one is scared here. Here is better, easy. The hospital is the best place to give birth, and it doesn't matter if the doctor is a man or a woman." (Karen, 24, 2 children in Thailand)*

In addition to the security of US technology, a common concern for food security was apparent in the birth narratives of the Karen women. Many commented that in Burma and sometimes Thailand it was hard to find food, but in the United States healthy food was always available.

> *"In Burma when I was pregnant we had food, but sometimes we had to run away and sometimes I didn't have food to eat. In Thailand it is hard because if you don't have money, you can't buy the food. In the US you have enough food and the husband is working and can buy food for the pregnant wife, but if pregnant in Burma and Thailand, it's so hard" (Karen, 52, 6 children in Burma)*

The two women who had given birth in the United States were pleased with their experience.

> *"It is important to go to the doctor during pregnancy, and you should go 10 times, and before the birth every week. I have heard it was hard to give birth in Burma, so hard. In Thailand they have a hospital, so it is the same like here. Here it was easy because the doctor told me what day and it was good. I got an epidural. No pain, nothing bad about it. I wasn't scared, I was just happy to see*

> *my child. But the language was hard, but my husband can speak English. It is good to give birth in a hospital. I liked the shot, no pain" (Karen, 24, 1 child in the US)*

Karen women felt that it was fine to give medicines during birth and were happy to receive them.

> *"Childbirth is bad…my stomach* [felt] *bad when* [I was] *ready* [to give birth] *and after it feels much better. I don't know about Burma, but in Thailand it is the same. When the stomach hurts you go to the hospital and when* [you are] *ready,* [you] *push and* [the baby] *comes out. I got medicine, but I don't know what kind. It was after birth to help stop the bleeding. In America you get the shot for pain. In America the doctors are better and* [there are] *shots if you feel not strong. I had no fear in America, I was ok… I think they gave me paracetamol and I didn't feel anything and I feel OK with that." (Karen, 30, 4 children in Thailand, 1 child in US)*

It is generally understood by Karen women that childbirth in Burma was difficult. Although Thailand was an improvement because of hospital care, food was scarce, women had to continue to work, and pain medications were only available after the child was born. The United States has healthy food, good facilities, pain medications, and caring doctors that help ease any fears that Burmese women may have. The only challenge women considered to giving birth in the US is the language barrier, but only a few women specifically mentioned this.

Beliefs and Rituals of Pregnancy and Childbirth

All Karen women recognized pregnancy as the cessation of the menstrual period. Additionally, they cited headaches and a loss of appetite as further symptoms that a woman is pregnant. One woman also said that she felt that when she opened her eyes the world was "spinning" (Karen, 24). The loss of appetite lasts the entire pregnancy for Karen women, although there is also an understanding that each woman has an individual experience. *"Women know they are pregnant when they don't get their period, have a headache, and can't eat or doesn't feel like eating"* (Karen, 24). Despite the lack of appetite, cravings are common. Most cravings were

expressed not by specific foods, but by tastes like sour, or bitter, which has been shown to be a common way that the Burmese categorize foods (Barron, et al. 2007).

Furthermore, women must be kept warm and not participate in strenuous activities. One Karen woman explained the importance of warmth back in Burma.

> *"You should eat the warm things, and hot tea. Also, you need wood for* [a] *fire and clothes to keep warm and food to get healthy. Being warm is important. After the birth you have to get a river rock and wrap it in a blanket to make it warm. Then you have to sit on it after you have the baby for 1 day until the rock gets cool again. It's not always used, but usually. My mother got the rock for me. Women in America don't need fire to stay warm because everything is covered, the house is covered." (Karen, 52)*

Although women in the US do not need a fire, they still emphasized that it was important to stay warm, and eat things that were a warm temperature. Additionally, the women who have had children in the United States are quickly learning the expectations that US providers have of proper pregnancy care for women and incorporate those into what women should do during pregnancy.

> *"During pregnancy she can't carry the heavy things, shouldn't climb on things, or cook. For food she should fill out the WIC form, and eat apple*[s]*, orange*[s]*, milk, grapes, juice, and eggs. Everything should be* [a]*warm* [temperature]*" (Karen, 24).*

There was also some indication that women were willing to test the boundaries of traditional beliefs in the US to verify if there were still negative consequences. For example, one woman stated:

> *"A woman can't carry the heavy things,* [but] *I can eat everything, even cold* [foods]*. I am not sure about others. During birth a woman needs blankets and clothes and temper (a type of baby covering). A woman should not eat cold water, you need warm water. Even though I ate cold* [foods] *in pregnancy, it is better to stay warm, but different for everyone." (Karen, 24)*

A second woman added:

> *"It's ok with me* [to eat cold things] *because I feel so hot.* [In Burma] *I didn't eat a pig from the forest. But yes, I will eat cold things, and take a shower in the morning. I eat everything. In Thailand? No, but in America yes, because* [the doctor] *brought me cold water. I was not worried it was bad,* [in the US] *it doesn't matter." (Karen, 30, currently pregnant)*

Beliefs and Rituals of Postpartum Period

The Karen women list many things that are inappropriate for pregnant women to do, and although they occasionally disagree, major themes include no hard work, staying warm, and eating well.

> *"She should not carry the heavy things, work in the sun or rain, get cold, get wet with the rain, do not wash the clothes. The husband needs to do all, like cook, get firewood. She should stay warm. We can eat everything, but it must be warm, like coffee, rice, soup, cakes. You have to heat it up if it gets cold. Yes, you get to rest* [smiles]*" (Karen, 50).*

Another woman also added, *"You should not have sex with the husband"* (Karen, 24).

Women gave different reasons for not getting wet or getting cold, although they all had to do with future health problems. The implications included, *"you will get sick in 3-4 years"* (Karen, 24), *"If you get cold you will get many bad things like sick or headaches, neck will be in pain. Pain in the stomach is a woman's problem"* (Karen, 52), and *"If you make yourself cold, when you get older your hands will be shaking"* (Karen, 24).

Many women also discussed food restrictions, and it appears that most of the foods they cannot eat are fruits and vegetables that are available in the Asian Markets in the United States. Unfortunately no one had any of these foods in their apartments to show me, nor did the interpreter know the English name for the foods. However, there is indication that these taboos are unnecessary in the US.

> *"We did not eat some foods* [in Burma and Thailand]*, but* [we do] *in America. There's a vegetable, they bring it from Thailand so it is* [available in the US]. *When you live in* [Burma there is] *no medicine so you can't eat* [the vegetable]*, but* [Karen women] *will eat* [this in the US] *because they can drink the medicine if they feel bad.* [But] *I don't know what the medicine is."* (Karen, 50)

One of the Karen women who had children in the United States admitted that she eats these foods now that they are in the United States, and another woman said that she would. Additionally, one Karen woman said she is not supposed to eat chili because it will affect her breastmilk and cause her breastfeeding child pain. It is not

known whether this is a Karen belief or something that the woman was told by her US providers. Finally, one woman did give advice for what Karen women should eat, *"warm rice, warm soup, vegetables, and milk"* (Karen, 24).

The length of the postpartum ritual period varied among women, but was always between two months and one year. However, some women think that this time period is changing now that they are in the United States, *"In Thailand it lasts 3 months, in America 1 week. They have enough medicine here"* (Karen, 24). Another Karen woman also agreed that this period only needs to last one week in the US.

Karen Summary

Themes that emerged with the Karen women are the value of having children of both sexes and an importance of warmth during pregnancy and childbirth. It appears that many women in their 20s-30s have retained some of the traditions of the past, but are willing to experiment in the US because of perceived stronger medicines. Women seem happy to have hospitals and US doctors available for their use, as they relate these institutions to safety and personal care. Little is known about birth control, but women seem eager to learn more. At this point in time, birth control appears to be used as a method to stop having children, not as a method to wait before children or space between them.

KAYAH

There are six women in Tampa who are Kayah. Two are unable to speak any Burmese. Four women total were available to participate in the interviews, one of whom could speak no Burmese. The first woman participated in an individual interview. The three other women participated in a group interview. Originally, it was planned for two women to participate in individual interviews, but during the second woman's interview it was discovered that she was actually of a different ethnic

group. Of the two women who declined to participate in the group interview, one woman declined because she had to watch her children while her husband was called into work, and the second declined to participate because she had recently had a child and did not want to leave home with the infant to attend the group interview. It is unsure if they would have participated in an individual interview, but did not want to participate because of the other women in attendance. . During the group interview, one woman did not speak Burmese. The two other participants in the group interview spoke both Kayah and Burmese and helped to translate. Although I was worried that women would hold back because of the other woman in attendance, the group interview went very well. Women seemed willing to agree and disagree with each other; however, women were less likely to give longer narratives than in the individual interviews done with the other ethnic groups. I believe this is because the women wanted to give others a chance to respond. Additionally, the interview did go slower, as I had to make more of an effort to remind the two participants to help translate into Kayah for the third participant who spoke no Burmese. I also had to manage a more talkative woman and try to ensure that each woman answered almost each question. Because of this, the interview was set up much more like individual interviews in a group setting, and not like a focus group. However, the women were able to build on the comments of other women, and sometimes the data was richer as the women helped clarify and explain for each other.

Kayah Demographics

The Kayah women are between 23 and 55 years of age. Their time in Burma ranged from four to forty years, with an average time in Thailand of 15 years (10 to 20 year range). No Kayah woman had been in the United States for more than 2 years. Two reported their religion as Catholic, one as Christian, and one as traditional Kayah. Only one Kayah woman has an occasional job, and two of the

women do not work, nor do they have husbands that work. The number of children that the Kayah women have range from two to six. The oldest woman (55) had three children in Burma and three in Thailand. One woman (35) had four children in Thailand and then received a tubal ligation. The other two women have two and three children each, both experiencing childbirth in Thailand and the United States, and undecided on whether they would have more children.

Observations

The Kayah women live in several different apartment complexes in Tampa, as opposed to many of the Chin and Karen who live in apartments within the same complex. One woman identified as *traditional Kayah* religion and wore a woven necklace. . All of the Kayah women were dressed in pants, zip-up cardigans and as common, wore plastic flip-flops. The Kayah women's teeth and the teeth of a few of the young Kayah children I briefly met showed signs of wear and disease, more prevalently than the other ethnic groups. Plastic bottles filled with brightly colored liquids were common in the homes. The homes were kept very clean, and sparsely decorated. One 3-bedroom apartment, where the group interview was held, was very large and clean, although it is located in a neighborhood known to be unsafe and transient. However, the interpreter told me that the price was very good. The homes were filled with minimal accessories, soft carpets to sit on, and the furniture pushed against all of the walls. Family portraits and school papers were hung on the walls to show off.

Importance of Families

The Kayah women all laugh when you ask them what a typical Kayah family looks like. *"As long as they can keep having children, they will,"* smiles one Kayah woman, 35. Children were a central theme in the Kayah women's definitions of

families. *"It's important to have children because if we have a child we just feel happy,"* (Kayah, 23). She also said that having both a boy and a girl was "better." Women agreed that they would feel sad for someone who did not have children. The women in the group mentioned that sometimes men will adopt a brother or sister's child *"to not look as bad."* If a woman cannot have a baby, traditional Kayah women will pray to the spirits for a pregnancy and sacrifice a chicken or pig. Additionally, one woman (27) explained that it was common for Kayah women to live with the husband's family at least initially after the marriage, if not forever.

Although many children were essential to the Kayah idea of family, there was some question as to whether that would continue in the US. *"In traditional* [Kayah beliefs]*, you have to have children to be happy. And because* [then] *parents will work hard, and it means they will have a future. But in America? It might be different because of the economy here"* (Kayah, 35).

The Role of Menstruation

Menstruation is an important time for the Kayah. *"It's not good if they don't get it because their stomach gets big,"* one woman (27) explained about what would happen to a woman who did not get her period. Another woman chimed in that, *"In traditional* [Kayah beliefs]*, sometimes periods stop because a bad spirit controls a woman, so they have to pray to the spirit to let this woman go, and sometimes it works"* (Kayah, 35). One of the women offered that she has had irregular periods her whole life.

Although the Kayah women said there was nothing they could not get in the US that they needed for their menstruation, there are many activity restrictions associated with this time period. During the group interview the three women brainstormed and mentioned that they cannot wash their hair or they will get a headache, and while one woman (35) will use warm water to bathe, another (27) will

not bathe at all. I was also told about a saying the Kayah have, *"during the period you should not brush your hair because a lot falls out"* (Kayah, 55).

Most of the Kayah women eat everything, but one woman (27) said if she eats sweet her period stops, so she tries not to eat anything sweet. Contrary to the women in the group interview, the woman in the individual interview (23) said that she can do everything on her period and eat everything as well. It is unclear whether this was because she really believed that, whether these restrictions are changing in the United States, or whether she did not feel comfortable with the researcher.

Expectations of Family Planning

Having Children

As discussed above, in traditional Kayah women would pray to spirits or sacrifice chickens or pigs in order to get pregnant. In the United States, however, women did not mention what they would do to get pregnant, but they did say that when planning to get pregnancy couples talk to each other. None of the Kayah woman expressed difficulty talking with her husband about family planning or using birth control, and they all felt that communication was good. Most women said both the husband and the wife together make the decision to have more children or not, but one woman admitted that it was really the woman who makes the final decision.

For traditional Kayah, it was normal for a woman to have her first baby at fifteen. *"Yes,"* agreed the women in the group interview, *"Kayah get married very young"* (Kayah, 55, 27). When I asked if they still wanted to get married young in the United States, I was quickly told, *"no"* (Kayah, 27). However, only one woman offered an ideal age to have a first child, and she recommended 20 years old.

There was no consensus about how long a couple should wait between having children. As one woman said, *"Having another baby too soon can be a problem because if the other is still too young, you will be very busy"* (Kayah, 23). This

woman felt that waiting 3-4 years between children would be ideal. However, she added that, *"there is nothing bad about waiting a long time in between children, as long as you already have two"* (23).

The women in the group interview did not think Kayah women would be interested in spacing their children at all. As one woman summarized, *"Because most women* [in the US], *if they want babies, they want to have* [them] *continuously because they cannot work* [when they have young children], *and* [so] *they want all the children at once, and if they wait* [between children too long], *they can never work"* (35).

Knowledge of Family Planning Options

Most Kayah women knew of the injection, pill (tablet), and condoms. One woman (35) had heard of the intrauterine device (IUD), although she had to describe it ("like an umbrella") as she did not know its name. She also knew of the implant, and knew that these could last 1, 3, or 5 years depending on what the woman wants. The woman who was familiar with many types of birth control also knew about side effects. *"Injection is good, but sometimes woman is allergic and gets headache, and period not normal, so* [it is] *not good for all"* (Kayah, 35). The researcher asked if it was bad for the period to stop, and was told, *"Yes, bad.* [Then] *condoms are best."*

The Kayah woman agreed that condoms were very common to use; however, whether or not men would use condoms really varied. *"Some people like to prevent* [themselves] *from* [getting] *everything, but others don't like"* (Kayah, 35). It is not known whether "everything" includes sexually transmitted diseases as well as pregnancy. Two of the women in the group interview (35 and 27) did not claim to have any trouble asking their husbands to use condoms, and said their husbands did.

It was noted that birth control was only available in the camps, not in Burma. One woman (23) said that she was given some form of birth control in Thailand, but stopped using it and had a third child (which was born in the US). Both she and her husband had liked using the birth control. The Kayah women did not know how to get birth control in the US. *"No, I have no idea where I can go and get it,"* said one woman (Kayah, 27). All of the women seemed interested in learning more about birth control options, and thought that other women would be interested, too.

Experiences of Pregnancy and Childbirth in a Refugee Situation

As discussed above, it is important for Kayah women to have children. Although animal sacrifices were available in Kayah state, in the refugee camps in Thailand, women needed different services. *"I had been married in the Thai camp for four years without having a baby, so I went to a traditional Kayah healer. The healer massaged my stomach and prayed for me, and I was able to have a baby"* (Kayah, 35). That healer is now resettled in the U.S., but the women do not know where. They seemed surprised that I would inquire as to whether they wanted the healer's service in the US. After thinking a moment the first woman responded that in the US, those services might not be needed. *"I am not sure if people are still interested in that kind of healer. In the refugee camp we worked very hard and had to carry heavy things. So the healing would not always work because we had to do hard work"* (Kayah, 35). The implication was that hard work causes harm that needs specialists, but in the US pregnant women are not forced to work, and therefore heal easily without the need for expertise.

Additionally, a Kayah woman said that to prepare for pregnancy, eating well, such as vegetables, fruits, and meats was good, (Kayah, 23). Although the traditional Kayah woman could not think of anything the Kayah did to get pregnant, she did know how to prevent pregnancy. *"We have many things to prevent*

pregnancy. You know the very young banana leaf[s]*? You can boil them in water and drink it. And when you take the umbilical cord you can bury it upside-down and the woman cannot have more children"* (Kayah, 55).

A woman knows she is pregnant if she does not have period, if she becomes sensitive to certain smells and foods, she does not feel like eating, or she vomits. *"You know you are pregnant if you have no period and you don't feel like eating,"* the woman in the individual interview informed me (Kayah, 23). This was agreed upon in the group interview where the women got into a giggling conversation about pregnancy symptoms. *"Some women when pregnant cannot smell certain foods that they don't like the taste or they will vomit"* the first woman said (Kayah, 35). *"I vomit out and I can't smell onion and garlic. I can't smell! I vomit!"* laughed the second woman (27). *"When I was pregnant I got a short temper. I was angry. When I was pregnant I liked to find mistakes"* the first woman replied with a laugh. *"Ah yes,"* the second woman agreed giggling, *"Some people, when they are pregnant, hate their husbands."*

Cravings were also a common experience for pregnant women. *"When I am pregnant I never wanted what we had in the village. I always wanted what was in the forest, what I couldn't have!"* explained one woman (55). It was agreed that although there were similarities for pregnant Kayah women, pregnancy was also different for every woman, and women could have different experiences.

The Kayah women seemed to have mixed opinions and experiences about childbirth in Burma, Thailand, and the US. When describing her memories of women giving birth in Burma, one Kayah woman (35) explained, *"In Burma it was very easy, we just did it. Just put cloth on the floor and women can deliver by themselves!"* She stood up from the couch and put one knee on the ground to squat, pretended to catch a baby with her hands, and laughed. *"I remember that my dad was very scared and ran away, and then my mom just did it all by herself!"* Another Kayah

woman agreed it was better in Burma. *"In* [the] *refugee camp I don't like it, because in the camp they make you lie down, and I don't like it. In the village I like to have one knee on the ground"* (Kayah, 55). She also got up and showed how the Kayah women like to squat with one knee on the ground, leaning her weight on the thigh of the leg that is half erect. The women in the group interview all giggled.

For the Kayah woman in the individual interview, her family had always had access to hospitals whether in Burma, Thailand, or the US. She had two children in Thailand and one in the US and did not feel that the experiences were different. *"When you hurt you go to the hospital. It is good to give birth in a hospital because the nurses and doctors take good care of you. It's good because when you see your baby you are happy"* (Kayah, 23). This sentiment was shared by another Kayah woman; however she felt that the US hospital system was better. *"In the US it was better because doctors are more professional,* [the] *nurses* [are] *better. The way they serve the people* [is better]. *In* [the] *refugee camp they don't care"* (Kayah, 35).

However, for another Kayah woman, Thailand was more comfortable. *"In America it was very difficult because of the language, no transportation, I didn't know how to get there"* (Kayah, 27). We also had a conversation regarding placentas (discussed further below), and in the US, the doctors took the placenta and the family did not know they could ask for it.

For Kayah women who have given birth in the US, familiarity with the number and timing of prenatal visits is common. One woman said, *"I like very much, it is good for the child"* (Kayah, 23). Although there was the story of a man in Burma running from his wife's childbirth, the women agreed that it was good for the husbands to be present in the hospital.

There was not a consensus for the Kayah women regarding the use of pain medication during childbirth. *"I like it,"* said one Kayah woman (27) who had

received a Cesarean-section in both Thailand and in the US. *"If I deliver in the US I don't want to get the medicine,"* replied another woman (35). *"I would have preferred to deliver in the US because it would be easy, because no pain"* said the third woman in the group interview (55).

Beliefs and Rituals of Pregnancy and Childbirth

When a Kayah woman is pregnant she should wear a tight braided string bracelet on her wrist that is removed right after delivery. No one could say why this was important; *"I think it's just a normal custom"* they told me.

The women in the group interview had a lively time recalling what women should not eat during pregnancy. *"In traditional,* [you] *cannot eat frog, iguana,* [you] *cannot look at or eat monkey. And in Kayah, monkey is delicious meat.* [You] *cannot kill snake*[s]*. And* [you] *cannot eat an animal that lives in the ground, like a rat but bigger..."* explained one woman (55). After a short discussion where the women tried to describe the animal, it appeared they were referring to a mole. I inquired, "What happens if you look at the monkey?" One participant (35) replied laughing, *"The children born will be like monkeys! Playful!"* The Kayah women also cannot eat a certain fruit from the jungle. One woman explained, *"I ate this and the baby was shaking and I went to the doctor and the doctor made me vomit it up"* (Kayah, 35).

In the US there are also pregnancy taboos for Kayah women, including no alcohol and no smoking. *"And actually we should not eat the* spicy [foods]*, but no one listens, everyone does"* I was informed. However, I never learned if the spicy rules were new to the US, or if they had always been in existence. The Kayah woman in the individual interview (23) said that she could eat everything. She also said *that "a woman can do more things the first 1-3 months and can do less closer to the birth."* I cannot be sure that these rules are reflective of traditional beliefs, being in the US, or just a changing acceptance of what is appropriate.

The Kayah place special importance on the placenta and the umbilical cord, which are supposed to be buried after the birth.

> *"For Kayah,* [they] *put* [the placentas] *under the soil. Once my father took mine and washed it with warm water and made something with* [it and] *bamboo to keep next to the house in the refugee camp. It is believed that when you put the placenta in soil and keep it you have a good child who is lovely, good, and successful. In* [the] *camp if we went to the hospital we would sometimes have to go back to get* [the placenta] *because they would destroy it." (Kayah, 35)*

The women agreed that burying the placenta and the umbilical cord was important in developing the temperament of the child. One woman saw a big difference between her children born in Burma and those born in the refugee camp.

> *"*[For] m*y children born in Burma in the village, we always put the placenta in the soil. But* [my children] *born in the camp hospital are bad because the placenta was thrown away. And there is a big difference between my kids. And those in the camp are bad, and don't care about their parents, they are very different." (Kayah, 55)*

Beliefs and Rituals of Postpartum Period

There are many rituals of the postpartum period that allow Kayah mothers to rest. *"You cannot carry the heavy stuff and cannot sleep with the husband"* one woman explained (35). *"And you cannot use cold water, you need warm water. Cannot wash your hair"* chimed in another (27). This lasts for at least 45 days. There was also an understanding that things might be different for easy deliveries. *"If a mom and baby is healthy she can begin to do things again right away…although she should not carry the heavy things"* another Kayah woman (23) said.

Additionally, there were many things a woman should be careful not to eat. *"*[She] *cannot eat chili for 3 months.* [She] *should not eat cold things, should drink warm things. If a woman eats cold things it affects the breastmilk"* (Kayah, 23). There is also a fruit women should not eat, and although the interpreter was unsure of the English name, she said it was the same as the fruit the Karen women do not

eat. Women also recognized that there were differences in some women, although some things were avoided by all women.

> "[We] *cannot eat spicy, ho t* [foods]*... and not for others, but for me I cannot eat green vegetables. Also* [Kayah women] *cannot eat bamboo root, no pickles, and in Kayah traditional, from delivery to one year no mushroom*[s]*. I don't know why, but everyone cannot eat* [them]*. Also no fish paste, when I eat* [fish paste] *my whole body is itchy." (Kayah, 35)*

"Is this the same America?" *"No. You can eat whatever you want. Even mushroom...But I still won't eat bamboo root"* (Kayah, 27). "Why do you eat the mushroom?" *"It can depend on people"* a second woman explained (Kayah, 55); *"In some families they teach to not to eat mushroom, and those women follow their mothers and grandmothers."*

The Kayah women also knew of appropriate things to eat during the postpartum period. This seemed particularly important, as many had come from food insecure settings.

> *"In* [the] *refugee camp or* [Burmese] *village you cannot get food easy. So we would have to boil papaya and eat the broth. But in the US you can have a good meal" (Kayah, 35). "The oriental market has everything!" (Kayah, 27)*

> *"Women will eat corn, because it will make them have good breastmilk. And eat a lot of soup. Any kinds of vegetables. Also things, cakes...they are like lady fingers. And cabbage and dry shrimp." (Kayah, 27)*

Kayah Summary

The Kayah women have many ties to their traditional beliefs, but are actively complementing traditional beliefs with their new experiences in the Thai refugee camps and in the US. Having many children are important to a Kayah family, and it remains to be seen whether family size will be adjusted because of the new economic circumstances families find themselves living in as US citizens. While one woman did mention that it was better to have a boy and a girl after being asked, the sex of the children were rarely mentioned by the Kayah. Menstruation is an

important area of women's lives, and women need to stay warm and observe some food restrictions. Having the period every month is important, and thus birth control methods that stop or lessen the period need to be explained clearly.

Methods of family planning are known to the Kayah women, but they seemed interested in learning more, especially about the longer-acting methods. The Kayah women spoke openly about condoms, and these could be valuable methods to continue utilizing. Although there are food taboos during pregnancy and the postpartum period, because of the abundance of food, they do not seem too restrictive. Women are very happy to have the Asian Markets and to have a variety of food available all of the time.

There is a concern about not being able to take placentas to bury them or put them near the home. This may be remedied by talking to the hospitals when a Kayah woman is planning to use one. Although the women are interested in using the hospitals, there was nostalgia for birthing at home, and this could present itself as a barrier to hospital use for some Kayah women.

KAYAW

Kayaw Demographics

Only one woman in the Tampa community identified as Kayaw. This woman spoke Karen and Burmese, and her sister, who is also in Tampa, is married to a Karen man and identified herself as Karen. She is 26 years old and has three children, all of whom were born in Thailand. She had left Burma at the age of five and spent 20 years in Thailand before coming to the US only 4 months prior to the interview.

Observation

The Kayaw woman was unsure of what time we would be stopping by and hurriedly cleaned up her kitchen table which was covered with the remains from her children's lunch. Juice boxes, chip bags, and crumbs were swept away and a quick rub with a damp cloth placed the home back in order. Her two older children ran in and out of the home, and her husband stepped outside with her youngest to give us privacy. The US alphabet was taped to the wall in large letters, as were other written learning tools. Unlike most women, this woman preferred to read her Burmese consent document, and appeared well-literate as she quickly moved through the page.

Importance of Families

Similar to other Karen and Kayah women, the Kayaw have many children. As the respondent stated:

> *"It is important to have children because in the future when you are older children will take care of you. I feel sad for a woman without children because they have no one to take care of them. I feel sad also for men without children, often they drink alcohol because they feel sad so they drink. It is important to have a girl and a boy." (Kayaw, 26)*

It was not clear how many people were usually in a household, and if the household included grandparents.

The Role of Menstruation

The Kayaw woman had been regularly receiving birth control injections in Thailand before coming to the US, but she had not yet had her period in the US so she was unsure of how it would go or if she would need anything. She did share some Kayaw beliefs about taboos during menstruation.

> *"You cannot sleep with your husband. You should not eat orange*[s] *or lemon*[s] *or your period will stop. Like* [if you eat those foods, the period] *might stop a few months." (Kayaw, 26)*

The Kayaw woman was clear that having your period stop because of the foods was not a good thing, although it is unsure if having your period stop for many months is indicative of overall health or of future health.

Expectations of family planning

Having Children

The Kayaw woman though it was best to start having children at 20 years old. She also felt that it was best to wait three years between children. *"It would be bad to have a baby too soon because you are so busy when they are too young, and tired, and it does not feel too good"* (Kayaw, 26). Living in the US seems to have an impact on family size.

> *"I have three* [children] *and I don't want anymore because I live here now, and it is important for me. I have to work and take care of these children, and I will worry if they get sick." (Kayaw, 26)*

However, the sex of a child is still paramount. "If the third had been a boy [her oldest 2 are boys] would you have wanted another?" *"Yes, a girl is important."*

The Kayaw woman and her husband also talk about having children. She says that it is better to be open, but it is common for Kayaw women to sneak birth control when they and their husbands disagree.

> *I talk with my husband about how many kids* [we want]*. If my husband wants, I will say yes, but right now my child is so young. But maybe when she gets older. We talk easily because it's better to talk to my husband. In Kayaw, some talk and some don't.* [If] *they don't* [talk it's] *because they do not want another baby and will keep* [their birth control use] *from him." (Kayaw, 26)*

Knowledge of Family Planning Options

The Kayaw woman was familiar with the injection, condoms, and pills. She was also vaguely familiar with the calendar method, but did not know anything specific about it. She had been regularly receiving injections in the refugee camp in

Thailand, but the US clinic was waiting for her to have her first period in the US before giving her an injection here. She was curious to learn about other birth control methods.

Experiences of Pregnancy and Childbirth in a Refugee Situation

According to the respondent, to prepare for children, the Kayaw women *"stop birth control and eat healthy foods, with vitamins and proteins, also rice."* In Burma, it was acknowledged that women had to work hard, and although there was less work in Thailand, it was in the US that women were really given a rest when pregnant.

> *"In Burma, if in a village or the forest, even if pregnant, you have to work and* [there is] *not enough food. You have to carry the heavy things. In Thailand you do not have to carry the heavy things. In America you can stay home and not work at all." (Kayaw, 26).*

She had prenatal care often in the camp that she liked, and she felt hospital birth was good.

"In the camp I had to see the doctor one time each month and at seven months more often, it's good. In Burma usually babies are born at the house, because we don't have money for the hospital, and the hospital is very far…In Thailand, if you don't go [to prenatal care]*, even when you give birth they won't take care of you…In America it is good because they take care of the child and the mom. Also, for us it is good to give birth* [in the US, you can do] *everything you want." (Kayaw, 26).*

The only thing the Kayaw woman said she would be scared of in the US is not knowing English. But she was adamant that the hospital was the best place to give birth.

> *"It's not good to have birth in the house because of bacteria and blood. The bacteria will get into your blood and could* [give you] *something bad, a sickness. Better in the hospital."*

Additionally, she liked the idea of having medication at birth. With medicines, *"You feel free"* she said.

Beliefs and Rituals of Pregnancy and Childbirth

Kayaw women know they are pregnant when they do not feel like eating, the earth feels like its spinning, and menstruation stops. Cravings are common as well. As the Kayaw woman described, *"You feel different when pregnant, not like normal people. I wanted to eat lemons and oranges too much."*

Additionally, there were some things that a pregnant Kayaw woman should do. *"She should not carry the heavy things, or drink alcohol. Also* [she] *should stay clean."* The Kayaw participant also informed me that there is a vegetable and certain fruits you should not eat or you will "drop" the pregnancy. Unfortunately, the interpreter did not know the names of those foods in English.

Beliefs and Rituals of Postpartum Period

When I asked about the importance of being warm or cold during pregnancy, I was told it did not matter. However, for the Kayaw, being warm or cold did make a difference in the postpartum period, which I was told lasted two months.

> *"Women should not touch the cold water or eat chili. You can eat oranges and lemons if your baby is healthy, but not if your baby is sick. You should not go out because of the wind, and if* [there is] *too much wind, the earth will spin and you might fall." (Kayaw, 26)*

Additionally, for two years, women should have *"no alcohol and tobacco"* (although she added it was better to never drink or smoke). It is unclear when this became a routine part of Kayaw women postpartum care.

Kayaw Summary

Although it is not possible to describe an entire culture based on one interview, there were some important similarities between the Kayaw, Karen and the Kayah people. The Kayaw consider family central and do place an importance on having children of both sexes. Women should begin families around 20 years old.

Family planning knowledge exists, but woman want to know more. There are pregnancy and postpartum food taboos, but with the availability of food in the US it is not a problem to avoid them. Warmth for Kayaw women is important only during the postpartum period. The Kayaw woman noted an association between bacteria and blood if a woman was to give birth at home; it is unknown if there are other important associations with blood for the Kayaw.

CHIN

Chin Demographics

The Chin women have very different backgrounds as refugees than the Karen and the Kayah, as they infrequently stay in Thailand during their refugee journeys. Most Chin refugees enter the US through Malaysia, where they live as undocumented migrants. Because there are no camps easily accessible to the Chin, most have spent far more time in Burma than the Karen and the Kayah. All of the Chin women in Tampa spent time in Malaysia before coming to the United States. The youngest that any woman left Burma was at the age of 25 (two women), giving them much more experience in Burma. The range of time the Chin women spent in Malaysia was 10 months to 2.5 years, so these stays tend to be short, and most likely a means to getting refugee status.

Two of the Chin women entered the US speaking a Chin language that was not familiar to the interpreter (who speaks seven Chin languages), so the interview was done primarily in Burmese with some Chin. There was a long discussion between the interpreter, the family, and the researcher as to whether the husbands should be present to help with the interview because of the language barriers. The interpreter was anxious that the women's Burmese was not very good, but also did not want the husbands to influence the interview. It was decided that the interviews would be attempted without the husbands. The interpreter noted with excitement that the

women's Burmese had greatly improved since entering the US, and that she thought the interviews were very successful.

Of the five Chin women who participated, their ages ranged from 28 to 38. One woman (38) had all five of her children in Burma. Another woman (35) had two children in Burma and one in Malaysia. One woman (37) has experienced childbirth in all three counties, with two children born in Burma, one in Malaysia, and one in the US. Both of the 28 year olds had their single child in the US.

Observation

The Chin families, both men and women, were likely to be wearing long wrapped skirts and t-shirts, and many held their babies or used cloth swings to tie their babies to their sides or backs. Both men and women seemed to share the responsibility of holding and watching the children. Many women ended up with their youngest on their laps during the interviews. The houses were tidy, and many families had portraits of their family printed out on computer paper hanging on the walls. Two of the Chin families had computers in the homes. The apartments were crowded with children and guests often running in and out. Similarly to the other Burmese ethnic groups, shoes were usually removed just outside or inside the door.

Importance of Families

Family is important to the Chin. *"Family means to have a baby and start a family lifestyle. If no child, how can we start a family lifestyle?"* (Chin, 28). Children define both a family and a couple's relationship in Chin culture. As the respondents stated:

> *"To have a child is everything to a couple." (Chin, 28)*
>
> *"Yes,* [children are] *important. If we don't want, better to not marry." (Chin, 35)*

> *"If we have children the wife and the husband's relationship is stronger, if there* [are] *no children, there is no relationship." (Chin, 37)*

Children not only define a family, but also provide future support. As one woman (35) explained, *"We feel bad for* [people without children], *because in Chin culture we don't have any pension or SS income like in the US, when we get old our children and grandchildren take care of us. So if* [a person has] *no children, who will take care of them?"* For childless women specifically, the Chin attribute this "bad fortune" to past health issues from the maternal line. *"We feel bad ...because she gets it from her mother or grandmother's bad health.* [We] *feel sad for her"* (Chin, 28). For men, most agreed they still felt sad for those without children, but that it was not as sad for men to be childless as it was for women. However, one woman shared that "[The Chin] *think* [childless men] *cannot have sex with women, that is why* [they have no children]*. Because their penis is not working"* (Chin, 38).

Some women mentioned that it was common for women to move in with her in-laws after marriage, but it was not clear how frequently that happened, or how women feel now that they are in the US. Although it was common to have many children in Chin State, most Chin women say that ideally a family has fewer, between two and four. However, there is a discrepancy in some cases between what an "ideal" family looks like and how many children an individual actually wants. One Chin woman (28) says that the ideal family is two children, but that she wants three.

The discrepancy seems especially true in regards to ensuring that a Chin family has both a boy and a girl. "[The] *ideal family is two children, one son and one daughter, but we cannot always get what we want. I have one girl and if I have another girl, I will have a third child"* (Chin, 28). Another woman (28) said she will at least have four children in hopes of having a boy and a girl. Therefore, the sex of the children is more important to the Chin than the family size. As the first woman with

one daughter explained, *"My husband wants a son. I think men have to have a son and women need a daughter."*

The Role of Menstruation

"If the period does not come, it means bad health, it's not good health" (Chin, 37). Regular menstrual cycles are important to Chin women, and health is directly tied to having one's period. Therefore, there are many rituals and taboos that are necessary to ensure that women will keep a regular cycle, which is healthy. In general women can eat everything, but some women are adversely affected by bitter or sweet foods.

> *"Women can eat everything. Every woman is different, some say if they eat bitter* [foods] *their periods stop, so they might eat sweet* [foods instead]*. But others when they eat sweet* [foods] *it stops, so they want bitter* [foods]*. I don't have* [any restrictions]*, but my friend likes to eat sour or sweet* [foods] *every time. Like* [with] *some pregnancies, they want things and they* [feel] *better." (Chin, 35)*

> *"We can eat only sweet* [foods]*, not bitter and sour* [foods]*. If you do, your period stops. It's bad, because if your period ends we are sick." (Chin, 28)*

Additionally, every woman informed me that she will not wash her hair during the period, and one woman shared that Chin women cannot sleep with their partner during menstruation either.

> *"They used to say if you washed your hair your period gets abnormal, sometimes there, sometimes not, and that you can suddenly die. Yes, this would happen in America, too." (Chin, 38)*

Because it is unhealthy if the period stops, women will try different remedies to make it start again. *"To make it come we boil sugar and ginger, or something sweet with ginger and drink the liquid"* (Chin, 37). One woman (37) described how she feels when her period does not arrive on time, *"Every time I miss I feel my face full, sweaty, and itchy."*

Fortunately, women did report that in the US they felt that they could get everything they need, such as sanitary napkins. However, many women complained

that they often get headaches, sickness, cramping, and back pain, which makes it hard to work. One woman (37) reported that in Burma there was a pain killer that the women could use, but she did not know its name. No one mentioned using pain killers in the US.

Some of the women expressed curiosity to learn more about why women's periods cease, which can happen to some very young, and others very old. One Chin woman (28) who had her first child five months prior and was exclusively breastfeeding informed me, *"I have a concern because I have not seen my period since my baby, but haven't made* [it] *to* [the] *doctor."* Another woman (37) was very concerned about her period stopping, because *"In Chin we believe that if a woman's period ends when she is young, her life will be shorter than others."* She had a tubal ligation, so her stopped menstruation may be an unexpected side effect.

Expectations of family planning

Having Children

The Chin women disagreed as to when it was best for a woman to have her first baby. *"The Doctor in Chin State says when we are 18 we are able to have a baby. So 18 is good"* explained one Chin woman (35). The other Chin women recommended the following ages to have a first child, 18 to 20, 20 to 25, 25, and 25 to 26. There did not appear to be any pattern based on the age of the woman making the recommendation.

Most Chin women said they do discuss the number of children they want with their husbands, saying, *"Yes, it's good."* Two women (35, 38) indicated that it is the women's ultimate choice if there is a disagreement between couples regarding family size, but also mentioned that it probably depended on the couple. The woman who had all of her children in Burma said they never discussed the number of children they wanted. One of the younger women (28) who only has one child also indicated

that she might be interested in learning how to talk with her husband about birth control.

Three women discussed how many years a Chin woman should wait between children. One (38) said 2 to 2.5 years, another (28) said three years because, *"It can be hard for a family if the kids are too close,"* and the third (35) said, *"I think it's good to have about four years between pregnancies. For a poor family, it's not good to have another baby too soon."*

One woman had recently had her first child. She explained that Chin women do not do anything to time or space their children.

> *"I don't know how soon a woman can get pregnant after her baby. But right now I don't want birth control because I want more children. After that yes, I want [birth control]." (Chin, 28)*

Additionally, women may have limited knowledge regarding how women become pregnant.

> *"You cannot get pregnant every time you have sex. I don't know why. Even myself, after I married I was not pregnant for a very long time,* [but] *some couples marry and after one month get pregnant." (Chin, 35)*

Knowledge of Family Planning Options

The Chin women had heard of different types of birth control, but were unfamiliar with many. Three women had heard of the injection, two had heard of the implant, four had heard of the pill, and one described something that seemed like the IUD. One had received a tubal ligation, and one woman had heard of things like sterilization, but did not really understand the options. The two women who had recently had their first babies were very unfamiliar with birth control. One of them stated, *"I don't know about birth control, I've never used it. Women won't use it as long as they want more kids. I don't know if they use it between kids*" (Chin, 28).

Most women were interested in learning about birth control, especially about longer-lasting options. Additionally, the Chin women indicated that learning from a

doctor would be acceptable. Only the woman who had already had the tubal ligation was not interested in learning more.

Only one Chin woman (35) discussed getting birth control in the United States and uncovered a barrier that may exist for refugee women. *"If we have Medicaid it is easy, but if we don't it is very hard. I don't know about others, but for me, if there is no Medicaid, no way I can get it."* When I asked what would happen if she could not get her birth control on time, she replied, *"I don't know, maybe I might have more children."*

Because the Chin women had indicated that women make the final decision regarding the number of children in a family, I specifically asked one woman (35) if there were times when women secretly take birth control. *"Yes,"* she explained, *"when in Malaysia a lot were doing that."* However, she did not know if women were doing that in the US. *"It's hard. It's going to be very difficult in America, because we can't go anywhere to buy any."*

Experiences of Pregnancy and Childbirth in a Refugee Situation

One Chin woman (38) had given birth only in Burma, one in Burma and Malaysia (35), two in the US only (28, 28), and one woman (37) in Burma, Malaysia, and the US. Every Chin woman agreed that pregnancy was difficult. *"Pregnancy is difficult, I cannot stand up as I wish, I cannot sit as I wish, I cannot eat what I want and I have to eat what I don't want. I don't want to eat but I have to be full for my baby"* (35). Other women agreed, also citing no sleep and swollen legs as common ailments.

Pregnant women in Burma had to continue to work, and women struggled to eat well. In Malaysia women could find food more easily, and were able to use a hospital, but it was very expensive. Additionally, women constantly referred to how nice they think it is for pregnant women in the US. One woman described her story:

> *"In Burma it's very difficult. In America it's* [easier] *because we don't have to do anything, but in Chin State we have to work, go to the farm every day, and cannot eat what we want because we don't have it. Even if we want a vitamin, we don't know where to get it and don't have it at all. Here, I see pregnant women and they sit and sleep and eat whatever they want with the Food Stamp card. In America when they have a baby she can take care of the baby at home, but in Chin State we have to bring them to the farm or the jungle because we have to work. In America the doctor and nurse are taking care of the pregnant women a lot. In Chin State we don't have anyone, just deliver by ourselves. In America you see the doctor every month because they have to see how the baby is doing and every month it's growing and* [the providers] *check the baby and mother. In Chin State* [it's] *very difficult because we cannot see a doctor every time we want to see* [one]. *And we don't know how the baby is doing, don't know if it's a boy or girl. (Chin, 38)*

A second Chin woman shared similar experiences of being pregnant in Burma, Malaysia, and the United States:

> *In Burma when you are pregnant we still have to work and we cannot find the food like we can in America. We have to go to the farm and carry a lot of stuff like rice, corn.* [It's] *much better in Malaysia than Burma. We don't have to work like the way we work in Burma and we can find more food. If we want sour* [foods] *or* [want] *to eat sweet* [foods], *we can find* [them] *in Malaysia. In Malaysia since we don't have transportation it's hard to see the doctor, and no money for taxi fee, so hard. Especially in Malaysia we don't have the* [immigration] *documents, so the private place charges more. In the US I feel, I envy of* [pregnant women] *because they feel lucky. They medicate and they have regular check-ups with the doctor and check the health. They are very lucky. (Chin, 35)*

Childbirth was also a period of difficulty. In Burma, there was no guarantee of even having a midwife available for the birth, and women cited depending on their mothers or a neighbor. When asked about husbands, women always said that husbands should be at the birth, but it appeared more like an afterthought as husbands only came up when they were directly asked. One participant explained:

> *Childbirth is very difficult by yourself.* [In Burma we gave] *birth at home, sometimes our mothers help. Some people used midwives, but we didn't have* [one] *all the time, so the family helps. I feel that having a baby is easy in America.* [The] *hospital is the best place to give birth because* [you] *don't have to worry and* [women] *told me they get medicine and don't feel pain. In Chin State* [there are] *no medicines, so* [we] *cry and shout all night to deliver* [the] *baby and it's very difficult. When* [I] *deliver* [my] *baby in Chin State my whole body is painful, all my back, because we have to try and push it out. (Chin, 38)*

An additional woman added similar experiences of childbirth:

> *"Childbirth is very difficult. In Burma,* [there is] *no doctor. I was at home with my mother.* [It is] *common to have* [your] *mother* [there]*, if not I would call a neighborhood friend. In Malaysia it is difficult as well. But we can relax in Malaysia, not like in Burma. We are in the hospital to give birth, so we can feel relaxed because we are sure we are healthy. But in Burma we are worried about my health and the baby's too. In America it is good—nothing to be scared or nervous about." (Chin, 35)*

Although the two women who gave birth in Malaysia were happier in Malaysia than in Burma, the undocumented status, or temporary documentation, proved a burden for women. This also was a major expense for Chin women. The Chin women were extremely thankful that in the US the prenatal care and childbirth were free. One Chin woman only gave birth in the US, but from her outsider's point of view, the difficulties in Malaysia with documentation and fees were a major negative experience for many of her friends and family.

> *Here it is very good to be pregnant. Here we have a good doctor and nurse, and we don't have to worry for fees, it is free. In Burma if I have no money I can't even call a doctor. In Malaysia it was worse, much better in Burma. To have a baby in Burma we have family and parents who can support you. Even if you have no money we can have a baby at home. But in Malaysia we don't have the proper documents, so if we get pulled over we have to give the police all our money and then we can't pay the hospital. (Chin, 28)*

The cost of care was also evident in other stories. This woman had experienced childbirth in all three countries.

> *Pregnancy is not good, it's very painful. In Burma, it is more difficult, not good. In Malaysia it is not good. In America it's better, because if we're pregnant we receive Medicaid. In Malaysia, no Medicaid. You see the doctor* [in the US] *every month, and if 8 or 9 months* [along] *we have to see* [the doctor] *every week. Childbirth is difficult. It's different in Burma, you're at home. My mom, my husband, and some relative were there. In Malaysia, I was in the hospital. In Malaysia we have to pay the hospital bill by ourselves, but we had paperwork. Still difficult in America, but whenever we see doctor we don't have to pay a single cent because the government pays. (Chin, 37)*

The women who had given birth in the US liked their experiences overall.

> *In Burma it's very difficult, when women deliver its very hard. Here it's easy because there is a doctor, nurse, hospital. In the US it is good because we eat what we want to eat, and we have follow-up appointments with the baby, so I know the baby is fine. In America you see the doctor every month, and close to delivery every week. It's good, I think it's good.* [I had*] one baby in America, I*

didn't feel any pain or anything, I didn't even know I delivered! I liked. I had no fears, because I trust the doctors and nurses. (Chin, 28)

Only one Chin woman expressed concern that in the US her doctor had been a man. Most women said that it did not matter. However, she dismissed it, recognizing that in the US, there were things she would have to get used to.

Childbirth is very difficult. I feel my back is very painful and my stomach very painful and I was almost dying. The doctor is supposed to be a woman, but the man doctor came in too. I think it's kind of American culture. In Burma the men [are] *never in charge of a woman's delivery, but in America they don't care. (Chin, 28)*

All of the Chin women said that they would prefer a hospital delivery to a home delivery except one. This Chin woman (28) said if a doctor was at the house that would be good; however, if they could not provide emergency services she would prefer the hospital. Additionally, all of the Chin women when asked about medication during childbirth agreed that it was good.

The only fears that the Chin women expressed did not have to do with the location of their births, but with the birth itself. *"I'm scared of the delivery"* laughed one woman (37). Another (28) giggled loudly and covered her face with her hands embarrassed, *"I am afraid I am going to die!"*

Beliefs and Rituals of Pregnancy and Childbirth

When a Chin family wants to have another baby, women agreed that the family should talk to a doctor, take vitamins, and stop drinking alcohol. One Chin woman (38) said that the doctor can give a different vitamin to the woman and she will get pregnant. This woman also knew of a Chin person who could check a mother's womb and make it larger if she was having trouble conceiving.

"[This specialist is] *not a doctor, but ...can check* [a] *mother's womb and if* [it's] *small, they can make it bigger. It's a Chin person, but no one in America. It's common in Burma. One of the women had a baby, but her baby womb was small and* [she] *had lots of miscarriages. The Chin person makes it bigger, and it lasts 9 months. We call them "seyah"* [which has a definition] *like a teacher, doctor... More like experienced person. The seyah is male. In America, if a*

> *woman has a small baby womb the doctor and the hospital are good and can fix* [it] *easy. In Chin, the seyah uses his hands to make the womb bigger." (Chin, 38)*

Although most women did not know of things to do to help a pregnancy begin, one woman (35) said she knew of what to drink to *not* get pregnant. They would take a leaf from a certain tree and warm it in water and drink the soup. I asked if she thought people might like to grow that tree in Tampa, and she looked at me a little skeptically and said, *"I don't think they would want to grow that here."*

Women all recognized that pregnancy had begun when their period stopped. Some women also had headaches, vomiting, and different cravings, like for sour stuff. One woman (37) laughed and added, *"Or if at four or five months the baby is shaking in the stomach."* Another woman (35) explained, *"You know you are pregnant if your periods stop coming. For myself, when I was pregnant one week, I* [felt like eating] *different things I do not normally eat. Everyone is different. Some don't know they are pregnant for four or five months. I had a niece who thought she was fat first!"*

All of the Chin women but one said that it was fine to eat everything during pregnancy. One woman (28) said that eating warm foods was important during pregnancy, but this was not shared by the other women. She explained, *"If we eat warm food, it's good for the baby in the womb and mom's health. If we eat cold,* [the] *stomach is upset."*

Although most foods were considered fine during pregnancy, the Chin women named a few things women should stop doing, such as having alcohol, getting vaccines or the injection, taking tuberculosis (TB) tablets, and carrying heavy loads.

There were also things women should try to eat. Vitamins were considered good for the baby and the mother, and both of the women who had their first baby in the US recommended drinking milk. Additionally, there was a meat from the jungle that is considered very good for women. The interpreter did not know what

the animal was called, but said that there were lots at Busch Gardens. It seems like the women were describing a porcupine or hedgehog.

> *"In Chin culture* [there is] *some meat…* [It] *lives in the jungle. And the animal has skin, very sharp. If you eat that, it's very good for* [your] *health. Women would want* [it] *here! It's very good, it's delicious!" (Chin, 35)*

Women gave mixed responses when asked whether being warm or cold was important. In Chin culture, after childbirth women are supposed to be cleaned with water to help heal the wound that forms during childbirth.

> *"Warm* [water] *is important. But in Malaysia, they put medicine on the wound, with room temperature water. In Burma we* [would] *use hot water when we give birth. There is a wound, so clean with hot water. In America* [I think the doctor] *should put water on* [the wound] *too." (Chin, 35)*

However, the tradition of cleaning a woman with warm or hot water after birth appears to be changing as women experience childbirth in the US and place their trust in US doctors and medicines.

> *"Cold water is important, I don't know why but that is what the doctor [in the US] used. In Burma, they used warm or hot water." (Chin, 28)*

Beliefs and Rituals of Postpartum Period

There were many differences in how the Chin women thought about the postpartum period. The only consistent thing regarding this time was that women should not carry heavy things, do heavy jobs, or work too hard. However, there did not seem to be much agreement between the women. Two women (both 28) mentioned that they should not touch cold water or wash clothes. One individual (28) said she could not cook, and another (35) said she could not go down staircases.

Additionally, none of the women agreed upon the length of time this should last. One woman (28) said it should last about a week, but if the woman feels ok, it is fine to do anything. Two women (28, 38) said the postpartum period should last

one month. The fourth woman (35) said it depended on her location and the needs of the family. *"In Chin State, it lasts for about two months, but in Malaysia, it depends on if I can stand up and get up, I can."* Finally, the last woman said it lasted five to six months, but specified this was only regarding lifting heavy objects.

While some of the postpartum rules allow women to rest, the reasons for others do not seem consistent, but look promising to explore further. *"I cannot cook, because the smell might wound or hurt the heart"* said one 28 year old Chin participant. The other 28 year old said, *"Should be warm, because I don't know for sure, but I think if I use cold water it's bad for my blood."* Another woman assured me that it was *"nothing special"* to have a baby.

> *It's nothing special to deliver in Chin State. Just wait 9 months, have* [the] *baby, wait one month* [to] *rest, and go back to work on* [the] *farm. You* [just] *carry the baby and let the other children watch it, and feed the baby rice at one month. (Chin, 38)*

It is unknown whether these differences reflect changing traditional practices or the fact that many of the Chin in this study are from different Chin groups.

The only consistent thing that women agreed upon was that they can eat everything, although two women said they could eat everything *except* spicy foods. However, it appears that the rules to avoid spicy foods are coming from US doctors or WIC centers. *"I cannot eat spicy and hot stuff. No alcohol. We follow what the doctor says, because we have to feed breastmilk to the baby"* (Chin, 28). Another woman (35) said there were lots of rules, but no one follows them. *"Like the spicy, no one should eat, but still eat it."* I asked what happened if you do eat it. *"It's not good for the baby, their skin, eyes, or pooping"* she explained*; "But Chin women eat a lot of hot and spicy."*

Two of the women who had given birth in the US mentioned drinking milk, one of the 28 year olds and the 37 year old. They also said they should eat

vegetables and the vitamin. Another (35) said that just making sure the mother ate was important.

Although not all of the Chin women had delivered a child in the US, it was clear that they were all talking to one another and observing what was being told to women by their doctors. One unexpected change is that infant feeding practices are being altered to follow US providers' rules. Two women mentioned that the doctors and nurses in the US were telling women to wait to start food. One woman (28) said that Chin women usually feed their babies solid foods at three months, but she was told not to do it yet (her child is five months and exclusively breastfeeding). Another woman (38), who did not have a baby in the US, said that in Burma the children were given rice at one month old. When asked if that happened in the US, she explained, *"No here we don't need rice because WIC gives the baby food. But* [the] *doctor said to start food at five months."*

Chin Summary

The Chin consider children essential to a family, defining both the family lifestyle and the relationship between a husband and wife. Having children of both sexes is important, although the number of children a family wants is changing. Regular menstruation is necessary for health, and irregularities can indicate health problems for a woman either now, or in her future. Birth control is somewhat understood, but women are interested in learning more. Also, the Chin seem unaware of how to obtain birth control in the US. Pregnancy restrictions were varied between the Chin women, although most restrictions were with food and not with activities. Postpartum healing is important; however there was a lot of variation in how long women thought they should maintain care. Many Chin women were actively trying to incorporate health recommendations from US doctors and nurses into their own lifestyles.

CONCLUSION TO CHAPTER 4

This chapter discussed the reproductive beliefs of the Burmese women in Tampa. The results were broken down by ethnicity, and major themes were found between the different ethnicities. These themes included the importance of families, the role of menstruation, expectations of family planning, experiences of pregnancy and childbirth as refugees, pregnancy beliefs and rituals, and postpartum beliefs and rituals. Care was taken to keep many of the explanations and stories in the women's words through the use of quotes. Overall, the Burmese women put high importance on children, regard menstruation as an important time period, want to learn more about birth control options, know little about using birth control as a family planning method, are happy to have US medical technology and personnel attending their prenatal care and births, and are mixing provider recommendations for care with traditional belief systems regarding pregnancy and postpartum rituals.

CHAPTER 5: DISCUSSION

INTRODUCTION TO CHAPTER 5

The results of this study support many previous studies about the resettlement of refugees in the United States, as well as important reproductive health themes of the Burmese people. Additionally, this research discovered many similarities and differences between the Burmese ethnicities in Tampa, the Chin, Karen, Kayah, and Kayaw. This chapter will explore the findings in to the context of the relevant literature and in regards to the possible implications for health education and service provision for the Burmese refugees in Tampa.

IMPORTANCE OF FAMILY

To the Burmese, regardless of ethnicity, families are extremely important. Although understanding the Burmese concept of family is necessary for discussing reproductive health beliefs, the literature is almost silent on the topic. Each ethnic group in the study was quick to point out that a traditional family in their home state in Burma had many children. Children are still important for two reasons, first, because they provide security during old age, and second, because they provide a purpose in a couple's life. Children made a family happy, while having no children was a sad situation.

The limited ability to control fertility through traditional means (typically plant-based or illegal abortions) is perhaps the primary reason for the gap in the literature; however the women's narratives in the present research indicate that there is a changing ideal for family size. Women sometimes mentioned that financial

and educational constraints and opportunities limited the number of children that they wanted in the US. However, having both a boy and a girl in the family was extremely important to all ethnic groups, and seemed more important than the final number of children. Despite this preference in all ethnic groups, it seemed less necessary to the Kayah than to the Karen, Kayaw, and Chin. This may have implications for family planning, as discussed below. Although it appears nuclear families were the norm, many women spoke of staying with or near in-laws or parents. This is similar to family descriptions in the literature (Barron, et al. 2007; Neiman, et al. 2008; Scarlis 2010). It is unclear whether those in-laws provided additional support, social, financial, or otherwise, but the influx of working-aged adults into the US for resettlement most likely separates these family bonds, if displacement has not already done so.

THE ROLE OF MENSTRUATION

Having regular menstrual cycles is integral to the health of Burmese women, although the extent of the potential harm from abnormal cycles is different between ethnic groups. For the Karen, Kayah, and Kayaw, any sickness attributed to the menstrual cycle was experienced immediately and related to breaking taboos. For the Karen, getting cold, eating cold things, or working too hard during the period could cause headaches and cramps that would not go away even with pain killers. For the Kayah, washing with cold water, or eating certain types of foods (for example, sweets) could stop the period or cause pain. If a woman's period does not come, her stomach can either get large, or it can be a sign that a bad spirit controls the woman. For the one Kayaw woman, sleeping with her husband or eating lemons or oranges during her period could stop her period for a few months, although she did not describe what would happen if that occurred. These prohibitions indicate the importance of warmth and avoiding cold water and food, which has been described

previously in literature regarding Karen pregnancy and postpartum rituals, although not specifically the menstrual period as found here (Neiman, et al. 2008). The Karen women reported that they used paracetamol, a Thai pain killer, when they had bad headaches or pain from their periods.

For the Chin women, having irregular periods or long amounts of time when the period does not come is directly related to future health problems, as opposed to immediate sickness. Having a stopped period means the Chin woman could be sick or have a shorter life. Therefore, if a woman ate a certain food group (such as bitter, sour, or sweet) and noticed that her period did not come regularly the following month, she would avoid those foods during her period from then on. Women also avoided bathing and sleeping with their husbands while menstruating. Although women said that they had used pain killers in the past, they were unaware of how to get them or where to find them in the United States.

The Chin were very concerned if their periods stopped, because of the implications for future health. Two women specifically mentioned they were worried because they were currently experiencing unexpected amenorrhea. One had received a tubal ligation, and one was still breastfeeding a young child; therefore, while it may be expected that periods stop after these events, the women were not prepared and feared for their health. A study of physical ailments self-attributed to the uterus in northeastern Thai women were shown to cause extreme anxiety and worry in this population (Boonmongkon, et al. 2010). It seems that the direct connection between the menstrual cycle of the Chin and future sickness and/or illness may be similarly affecting the emotional health of the Chin women in the United States. The Chin women also spoke of using different food combinations to start a period that was late or missed. This reflects work done by Skidmore (2002) in a Burmese urban center. Although Skidmore never identifies the ethnic group she was working with, she describes the importance that women place on emmenagogues (herbs and medicines

used to start menstruation and bleeding), diet, and the use of birth control injections to restart or strengthen blood flow, with the goal always to maintain a good balance between a flow that is too heavy or too light. An additional study found that Chin parents in Seattle would sometimes cure illness by pricking a sick child's finger to release the "bad blood" (Scarlis 2010). Unfortunately, the report does not discuss bad blood any further.

It is unclear whether the importance of the menstrual cycle for the Chin is at all related to these concepts, but it is very clear that women are concerned about abnormal cycles. This understanding makes it particularly important to address potential menstrual changes that occur with new reproductive technologies, such as birth control and sterilization, childbirth, and aging. Furthermore, although the ties between abnormal menstruation and long-lasting sickness were not mentioned by the other ethnic groups, this does not indicate these concepts are absent from their belief systems or not important. Therefore, regardless of the ethnic group, it is clear that education regarding pregnancy, family planning, and childbirth needs to include specific side effects that can affect menstruation. This education should also take into account possible traumas that may have occurred while the women were refugees, including malnutrition, muscle injuries from forced labor, and rape. Additionally, a few women of various ethnic groups mentioned that they can participate in all activities on their period; so it is important when designing education to remember that not all women may associate with ethnic beliefs. Finally, being able to find and safely use pain killers in the US may be something important for all of the ethnic groups to be taught.

CREATING THE FAMILY

Women in each ethnic group said that they felt comfortable talking with their husbands about how many children they wanted and using birth control. Only two

women said they and their husbands had not discussed this much, and they were older Karen women who had had their children in Burma before family planning became an available option.

Additionally, in no ethnic group was there a dominant prevalence in the power of either gender to make decisions regarding family planning. Many women reported talking to their husbands about this topic, and most commented that whether the man or the woman made the final decision was probably different in every couple. This seems to reflect what is known about traditional Burmese family structures, where regardless of whether men or women are considered leaders in the community or family, both sexes are highly regarded and respected (Barron, et al. 2007; Neiman, et al. 2008; Scarlis 2010).

However, a few women mentioned that they knew of women who would secretly take birth control because they did not want more children while their husbands did. While none admitted to that, it is important that women in the Tampa community be given an opportunity to obtain birth control without relying on their husbands. This is complicated by the fact many women were unaware of how to get birth control in the US, or were intimidated by language and transportation barriers. Although cost was not explicitly mentioned, it is possible that as women learn more about obtaining birth control in the US this issue will emerge. There could be a role for community organizations to play to ensure that women have private transportation to clinics and/or pharmacies to obtain birth control as needed, and without their husbands if requested.

There were a variety of ages that the Burmese women thought would be ideal to have a first child. Most women believed the best ages were in the early 20s, with all falling in the range of 18-25. In addition, the Burmese women thought it was best to wait about two to four years between children. Women did not see any potential health reasons to have children close together or far apart, but named personal and

financial costs as factors influencing their opinions. For example, most said that it was difficult to have too many young children to raise at once, and it would wear a mother out. Others cited financial costs. Some women thought that for a poor family it would be too difficult to have many children right away. However, some of the Kayah women thought that, specifically in the US, it would be better to have children immediately after each other. They explained that because it is best for women to stay home with their young children, if they spread them out they would never have a chance to go back to work.

Although most women thought it was best to have children two to four years apart, none indicated that they purposively participated in any birth control methods to space their children. Research shows that spacing children can help with the health of the mother (Utah Department of Health Maternal and Infant Health Program 2012). Considering that the Burmese women seem interested in having children a few years apart, it is important to include the potential health benefits of spacing children and how birth control can help to do that, within education about family planning.

The most important theme that emerged when asking Burmese women about their families was the importance of having children of both sexes. With the exception of the Kayah women, the women from all of the Burmese ethnic groups emphasized how they would increase their ideal family sizes in order to obtain a child of the opposite sex. So while the Kayah women expressed interest in having a boy and a girl, none of them indicated that it was so important that they would plan their family size around it. However, many women from the other ethnic groups said that while they would prefer two to three children, they would keep going to obtain a child of both sexes. In fact, one Karen woman was currently pregnant with her sixth baby in hopes of having her first girl, although she said she was not interested in having more children.

Women also mentioned that they liked how ultrasounds in the US made it able to tell the sex of a child before they were born. Although sex identification typically occurs past the date that an abortion is legal, other (non-Burmese) cultures have been shown to select their children's sex through abortions (World Health Organization 2011). It is important to recognize that there is no indication that this is even a consideration for the Burmese women, but it is necessary to point it out in case it becomes a concern in the future.

An important behavior associated with birth control is using it only after the correct family size or composition has been met. Burmese women did not appear to understand that a woman could use birth control before or between pregnancies and still go on to safely conceive more children. In fact, only the Kayaw woman mentioned that to prepare for another child you should stop your current birth control. She was the only woman interviewed who seemed knowledgeable about the mechanisms of birth control. For educators, it is important to know that family composition provides a stronger role in determining when to begin birth control than any other factor. However, it will also be important to help women understand that they can use birth control before ever having children or between children if they want to continue their education or employment. Although women might not agree with using birth control to wait for children or between children, it is important that they learn that is an available option and that it will not create difficulties having children later (unless they wait until they are much older). Additionally, explaining the health benefits for children and the mother of waiting at least two and a half years should be incorporated in family planning education.

The lack of family planning knowledge may also be associated with a lack of reproductive knowledge in general. Undocumented Burmese migrants in Thailand reportedly did not understand menstrual cycles, fertility, or birth control options (Belton 2010). Another study in the refugee camps found that only 19% knew that

first sex could lead to pregnancy, 23% knew that sex half way between periods could lead to pregnancy, 37.8% knew the role of condoms, and 35.2% knew where to get condoms (Benner, et al. 2010). In this study, one Chin woman mentioned that she did not think she could get pregnant every time she had sex, because it took her so long to have her first child. Additionally, the Chin women were especially concerned about irregular menstrual cycles. Although all of the Burmese women associate pregnancy with a missing period, it is unknown how much knowledge exists of the role menstruation plays in pregnancy.

Most of the Burmese women are aware of birth control, but want to learn more about different options and their side effects. Burmese adults' limited knowledge of birth control is congruent with reports from the literature (Benner, et al. 2010; Plewes, et al. 2008; Women's Commission for Refugee Women and Children 2006) and reflects experiences of other southeast Asian refugee populations resettled in the US in the past (Kulig 1988; Minkler, et al. 1988). The most common birth control methods that the Burmese women mentioned include the "injection," the pill, and condoms. Some women were also aware of the "implant," intrauterine devices (IUDs), and the calendar method, but these methods were only brought up by a few women who expressed that they did not really understand them. Other women had received tubal ligations, but it was not clear whether they considered sterilization to be a form of birth control.

Only a few women mentioned that birth control can have side effects, with most implying that because side effects were different for every woman, women needed to find the birth control option that worked best for them. However, most participants did not mention the potential for side effects of birth control options. Additionally, in this study the women who discussed condoms claimed that their husbands used condoms, but admitted that it was different for every couple. This somewhat reflects findings from surveys in the refugee camps that highlighted many

individuals were embarrassed to use condoms (Benner, et al. 2010). Almost all women, in every ethnicity, were interested in learning about all different types of birth control options. The Burmese women would also appreciate learning about the potential side effects of the options, how long they last, and how they can access these options locally.

The knowledge of birth control options is varied even within ethnic groups. Younger and older women have the least amount of knowledge. Younger women, who typically only have one or two children, explain that they do not know about birth control because they are not interested in using it until they have the number and type of children they desire. Older women explain that they had already reached menopause before birth control was available to them, and are not interested in learning about something that they would not use. However, one Kayah woman had been surprised by a child late in life, so even women in their late 40s and early 50s may benefit from learning about birth control and the fluctuations of menopause.

The interview sample consisted only of married women. The literature acknowledges that being married was associated with more birth control knowledge, as many unmarried refugees lack education about contraception (Benner, et al. 2010; Women's Commission for Refugee Women and Children 2006). It appears that the variation of knowledge within married couples may reflect the cultural perceptions the Burmese have that birth control is only something to be used after the ideal family is created. Additionally, as discussed in chapter 2, a 2001 study with the Karenni (Kayah) reported that despite interest in family planning, there were political activists in the refugee camps who were pushing to increase the population size of the ethnic group (MacArthur, et al. 2001). Although no corroborating reports were found in the literature, political pressure to increase ethnic populations in the face of ethnic cleansing campaigns could be a very real pressure for families that extends even after resettlement in the US.

The Burmese women indicated that to obtain birth control they need Medicaid, transportation, and English skills. Not having these three things could prevent them from accessing birth control, especially if their husbands wanted more children and they were hoping to control their fertility privately. Additionally, the importance of menstruating every month could be affected by different kind of birth control. Women should be described the possible side effects of each birth control option, especially side effects that might limit or stop menstruation. Whether this would be accepted by the women is unknown, however they should be made aware of those potential side effects before they determine which option to choose. Working with resettled Cambodian families in the 1980s, Minkler and colleagues (1988) recommended both small counseling groups of couples and individual information sessions, being sure to include methods that may be more realistic for some couples such as withdrawal and abstinence. This advice still seems relevant to the current Burmese population, and could provide women and couples with many means of learning about and discussing their family planning options.

EXPERIENCES OF PREGNANCY AND CHILDBIRTH IN A REFUGEE SITUATION

Most women remember pregnancy and childbirth in Burma as being very difficult. Only the Kayah women retained a nostalgic view of being able to birth easily at home without the complications of beds or technology. Similarly, pregnancy in the refugee camps of Thailand or in Malaysia was difficult, but overall women were pleased with the options of hospital care in these locations. Common complaints of pregnancy and childbirth in Burma, Thailand, and Malaysia include having to continue working, having limited food choices and/or quantities, and sometimes having financial burdens (particularly for the Chin women in Malaysia and the few women who had access to hospitals in Burma).

Chin women specifically were very concerned with the potential costs of pregnancy and childbirth. For the Karen, Kayah, and Kayaw, living in a refugee camp meant that prenatal care and childbirth was free for women using the camp clinics. However the Chin women were migrants in Malaysia, and told stories of being forced to pay for doctors and sometimes even to pay bribes to Malaysian police while en route to care. All of the Chin women in the sample had been in Malaysia within the past four years, indicating this abuse is ongoing. Other literature confirms that these abuses are common and problematic (Christian Solidarity Worldwide 2006; Human Rights Watch 2009). These experiences in Malaysia made the Chin women grateful for Medicaid in the US, whereas the other ethnic groups did not mention Medicaid as an advantage of being in the US, as free care is all that they know.

All of the Burmese women were happy with women's access to prenatal and hospital care in the United States. Women liked getting regular check-ups that gave them the security that they and their baby were healthy. Women who had not experienced childbirth in the US were quick to point out that the women here are lucky. The Burmese women's comfort with hospital care is not surprising due to the long-standing influence of Western medicine in Burma, Thailand, Malaysia, and particularly the refugee camps (Barron, et al. 2007). Clinic use was found to be common and accepted in multiple studies (Baer, et al. 2011; Barron, et al. 2007; Carrara, et al. 2011). In fact, only one Kayah woman said she would not choose to use medications during birth, while every other woman was very pleased at the thought of having a pain-free labor.

A few women were asked if they thought other women of their ethnic group would like giving birth in a house with a provider. The intent was to learn if women might feel more comfortable with a birth center scenario, which is available to Medicaid patients in Florida. However, most women were very skeptical and did not

feel that it would be good. One Chin woman thought home birth might be better, but not if emergency care was not available on location.

BELIEFS AND RITUALS OF PREGNANCY AND CHILDBIRTH

All of the Burmese women recognized that the cessation of the period meant probable pregnancy. Additionally, women spoke of food cravings, headaches, and vomiting as pregnancy side effects. The Karen and Kayaw women also associated a lack of appetite with pregnancy, and explained that it lasts the entire pregnancy. One Karen woman and one Kayaw woman further added “spinning” or a sense of vertigo to their symptoms.

All of the ethnic groups had some food and activity restrictions. Not doing hard work was a common restriction shared by all groups. Although this has some variations within ethnic groups (such as not carrying heavy things, not climbing on things, not cooking), the importance of not overexerting a pregnant woman is the same. Additionally, various women mentioned the importance of avoiding alcohol and smoking, which educators should continue to encourage.

Chin women also mentioned that they should not get vaccines or take tuberculosis (TB) tablets while pregnant. While it is true that most vaccinations are not safe during pregnancy, vaccines for the flu and tetanus, diphtheria, and pertussis – Tdap (after 20 weeks of pregnancy) are available (The March of Dimes 2011). The flu shot is often recommended for pregnant women, especially after the H1N1 outbreak, so it is important that women know there are exceptions to this belief. TB has been an issue with the Burmese refugee population (Baer, et al. 2011; Markiewicz, et al. 2009; Power, et al. 2010), but some TB medications are available for use by pregnant women (University of Maryland Medical Center 2011). Because of the prevalence of TB in the Burmese population, this needs to be directly addressed with women during educational sessions regarding pregnancy health.

The Karen women place importance on staying warm during pregnancy and childbirth, similar to the restrictions recognized during their period. This is particularly true for food, and especially during childbirth. However, women do claim there are some variations based on each individual. Additionally, eating warm foods during pregnancy was also a belief of some of the Chin women. Because the Chin in Tampa represent many different Chin language groups, it is likely that there are differences between Chin women. It is important for providers and educators to respect the importance of warmth, and if refreshments are ever offered during classes or services, care should be taken to have warm items available. Additionally, it is important to note that Karen women might be reluctant to go to jobs or prenatal appointments if they might get wet. Proper raingear should be provided to women if this occurs, although it may be difficult to force women to leave the house. The Kayah and Kayaw did not have any cold or hot restrictions or expectations regarding food or body temperature.

There were no food restrictions for the Chin women, except for the few women that do not want to eat cold foods. For the Burmese women, the importance of cold and warm foods and liquids refers to the physical temperature of items. The Karen, Kayah, and Kayaw women also avoided cold foods, and named other food restrictions, including specific vegetables, fruits, and meats. However, overall the women are very happy that they have many food options at the grocery store and the Asian market. The Burmese women are pleased with the food stamp program and happy to be in a food-secure setting. Therefore, women expressed that they could eat healthy during their pregnancies despite food restrictions, because of the availability of many foods in the US. The Chin also named things women should eat including vitamins. It is not known what these vitamins are, but they may be referring to prenatal vitamins.

During childbirth the Kayah would like to take their placentas and umbilical cords home. This was not a practice found in the other ethnic groups. This is an important tradition that while difficult to continue when in the refugee camp, was still requested. Most hospitals in the US, including the local hospital where most women in the Burmese community give birth, will save the placenta for the family if they are asked in advance. Women should be made aware of this service, and reassured that although the doctors do take the placenta away for testing, they keep it refrigerated or frozen to give back to the woman upon discharge.

For some Chin and Karen women, being cleaned after childbirth with hot water is also preferred. Some women think that cold must be safe because the US doctors use cold water; however, if women prefer to be cleaned with hot water that is something that can most likely be requested during the labor by a spouse, family member, or other companion in the hospital room, is someone is available who speaks English. Language lines should also be requested, as many providers might not consider using them.

The Chin also said that there is a food they miss from Burma that is very tasty and good for pregnant women. Although the interpreter did not know the exact name it is believed to be either porcupine or hedgehog. Although untraditional, the community organization could see if it is legal to raise that animal in Tampa, and perhaps provide an additional food source for women that they are familiar with and enjoy.

Interestingly, when asked about what families can do when they want to get pregnant, more women knew of what to do when they *did not* want to get pregnant than what they could do *to* get pregnant. Abortion should be presented to the women as a legal option for them. Many of the resettlement agencies have religious affiliations, so it is important for community organizations to take leadership in educating women about this option. Even if educators are uncomfortable with the

topic of abortion, women should be told that it is legal in the first trimester, and if they want more information they can speak to a doctor. Additionally, it is appropriate to explain that this topic is very controversial in the US, so that the women are prepared if they hear of objections from others.

BELIEFS AND RITUALS OF THE POSTPARTUM PERIOD

Similarly to being pregnant, the postpartum period is one of labor and food restrictions for the Burmese, with the emphasis on providing women time to rest. There are more restrictions in the postpartum period, but the length of time is usually cited as shorter than nine months. Furthermore, warmth becomes significant in the postpartum period for all ethnic groups, even in the ethnic groups that did not consider it vital during pregnancy.

All respondents except the Kayaw woman mentioned that women should refrain from carrying heavy things or working too much after having a baby. For the Karen, Chin, and Kayah, women cannot work, get cold, get wet in the rain, or wash clothes, and for the Kayah, cannot wash their hair. The Kayaw woman said that women cannot go outside after having a baby, because of the wind, which could cause her to get vertigo and fall. Additionally, the Kayaw woman said that alcohol and tobacco are prohibited for two years. The Karen and the Kayah women also mentioned that they should not sleep with their husbands.

Most women can eat most things as long as the food is physically warm. The Karen, Kayah, and Chin all mentioned that they cannot eat spicy things. While there is evidence in the literature that the Karen have always had a taboo against spicy foods in the postpartum period (Neiman, et al. 2008), the Chin attributed this to something they were told by a US doctor. The Chin women explained that none of them can actually follow this rule, because the Chin always eat spicy things. The Kayah also had a long list of things that they cannot eat, although they said for some

women it was different. They also mentioned a number of appropriate foods like soups and vegetables that they do eat in the postpartum period. For people wo1rking with Burmese women who have recently had babies, it might be a nice gesture to bring them warm things, or double check that whatever they plan to provide for refreshments is something they would like to eat.

Karen husbands are expected to step up and do things like cook and get firewood to keep the woman warm. This expectation is also reported in the literature (Neiman, et al. 2008). If a Karen woman gets cold, it could cause future sickness, headaches, neck pain, stomach pain, or shaking hands. The other women did not talk about how husbands, family members, or other friends might assist them during this period of time, nor what the implications were for not staying warm during the postpartum period. No ethnic group seemed to have a taboo about who can or cannot see a newborn or visit with the mother.

The Chin also mentioned that US doctors have dissuaded them from introducing solid foods to their infants at one month. Traditionally, Chin women began to give their babies rice at one to three months, but the US doctors have said to refrain from feeding babies anything but breastmilk until five to six months. While obesity has not been a problem for the Burmese people yet (Moore 2010; Swe and Ross 2010), there is an association between feeding children adult foods in the US and future obesity, especially if they ever use formula (Huh, et al. 2012). The recommended age to begin introducing solid foods is between four and six months, but preferably six (HealthyChildren.org 2011). This advice should be reinforced, stressing that because the food in the US is more available, women have enough nutrients to create good breastmilk and babies will not need supplemental food until five to six months.

The Karen felt the postpartum period should last about one to two months, although the literature reports it as one month (Neiman, et al. 2008). However, the

Karen women reported that in the US it only needs to last one week. The Kayah said that the postpartum period lasts at least 45 days, while the Kayaw woman said this time period lasts two months. The Chin women had the most variation, with women saying one week, one month, two months, five to six months, or if in Malaysia, whenever the woman is ready to get up again. There is some indication that women believe that because of strong medicines in the US, they heal much faster from childbirth than in other countries. Typical postpartum advice in the US is to relax and refrain from heavy work and from intercourse for six weeks (myMidwife.org n.d.). For women who experienced a cesarean section, more precautions should be noted. These recommendations should be clearly addressed with the Burmese women, and educators should maintain that waiting even longer before returning to daily activities is healthy as well. It is important to debunk any myths that stronger US medicine and better care means that women should not observe a period of rest and healing in the postpartum period.

Potential US Influences on Postpartum Practices

Very few specific beliefs were common between the ethnic groups in the study. The one exception to this was that women should not eat spicy foods either during pregnancy or after the baby was born. Some Chin women specified that the spicy foods were bad for their breastmilk. And both the Kayah, who would not eat spicy foods during pregnancy, and the Chin, who said they did not eat spicy foods after the birth, said this rule was commonly ignored. Although there is not extensive discussion of postpartum beliefs in the literature, only one report found spicy foods were restricted, and this was in the Karen culture (Neiman, et al. 2008). However, there is a common misconception in many US cultures that an infant's health can be harmed if a breastfeeding mother eats spicy foods, because her breastmilk could then cause stomach pains, diarrhea, or discomfort to her infant (Supplemental

Nutrition Program for Women 2012). Although eating spicy foods is neither good nor bad, it will be important to ensure that women have these perceptions due to their own ethnic beliefs and not due to ill-informed providers. Especially for the Chin and Kayah women who enjoy spicy foods, they should be reassured they are not harming their breastfeeding infants by continuing to eat them.

Also, women were taking the advice of their WIC counselors, although still retaining some traditional expectations. As one Karen woman said, *"In pregnancy…for food a woman should fill out the WIC form, and eat apples, oranges, milk, grapes, juice, and eggs. Everything should be warm" (Karen, 24).* Additionally, Karen and Chin women said that milk was good for women during pregnancy and the postpartum period. Although there is no problem with milk being stressed as healthy for women and children, it is important to recognize that lactose *in*tolerance is very common in the majority of the world, and that Asian populations are very likely to have lactose intolerance (Lomer, et al. 2008). Therefore, providers and families need to be made aware that if milk causes abdominal discomfort, diarrhea, bloating, and cramping, women can still get the nutritional benefits of milk from other sources. Additionally, it will be helpful to let women know that children typically can tolerate lactose for a few years before they begin to see symptoms of intolerance, and that they can pay attention to the symptoms to see if they ever arise in their children. Examples of additional food options that do contain similar health benefits to milk should be provided to women by educators.

Implications for Reproductive Health at the Crossroads of Traditional Models of Health and Western Medicine

Although the Burmese people are very accepting of Western medicine, there are still indications of traditional beliefs and practices. This becomes more complicated as we recognize the diversity within the Burmese population, and even

within different ethnic groups. Although traditional medicine has not been found to be readily used in the Tampa community (Baer, et al. 2011), these persistent beliefs remain influential even if their origins have been forgotten. Additionally, traditional practices and beliefs could be un- or underreported to outsiders. In this study, five themes have emerged that tie traditional beliefs and modern health together, and these may influence reproductive health for the Burmese women.

Theme 1: Food as Medicine

Although the original needs assessment done in the Tampa Burmese community did not reveal that the Burmese were using many traditional models of healing (Baer, et al. 2011), the results from this study indicate that food does play an important role in maintaining the health of women. In Minnesota, commonly found items regarded as medicinal included turmeric, ginger, garlic, honey, table vegetables, sesame oil, different plants, and snake and bear gall bladders, hen-fat, white goat bones, horns, and tongue (Oleson 2009). In Seattle, oxtail soup and chicken soup were found to be used by Chin women to increase milk production (Scarlis 2010). Although it was unclear of the perceived medicinal properties, some Tampa community members indicated that some spices, such as paprika, and possibly some other foods, could be used for healing (Baer, et al. 2011). In this study, women often gave advice for what women should eat. For example, a Karen woman recommended, *"warm rice, warm soup, vegetables, and milk"* (Karen, 24). Other women from different ethnic groups also had advice. For every group, rice was a commonly endorsed for use by women, and considered the center of the Burmese diet.

It is possible that the women in this study have not expressed a need for more traditional foods, because the Burmese women in Tampa have been fortunate to enter a community with good Asian markets. During the interviews women often

expressed pleasure at being able to find everything they wanted at these markets and to have the ability to pay for them with Food Stamps. Many of the women were asked if they could find all of the foods they had in Burma in the US, and aside from certain meat products from the jungle and the forest, the women claimed they could find everything. Recognizing the importance of food to the health of the Burmese, the availability of recognizable and desired Asian food products has likely helped ease the transition into the US for many women and their families. This seems particularly true considering that many women complained of food insecurity in their prior refugee situations. Because foods are associated by the Burmese with having good and bad health effects, providers and educators should remain alert and accommodating to women's requests for specific foods, especially during the perinatal period where some food restrictions may be enforced.

Theme 2: Healthy Menstruation through the Lifetime

Menstrual cycles are indications of the health of a Burmese woman and can bring negative short-term or long-term consequences. Therefore, it is vital to explain how menstrual cycles change over time, what experiences (from stress to birth control to age) can affect menstrual cycles, and how menstruation and pregnancy are biologically linked. Some additional gaps in knowledge that have implications for health including a misunderstanding of how and when women can get pregnant, a possible over-acceptance of being safe from harm while pregnant in the United States, and a misconception that postpartum care should only last one week. Women's concerns and fears surrounding abnormal menstruation or uterine pain need to be validated and if necessary medically screened.

Theme 3: Preventative and Well-Woman Exams

The Burmese women never mentioned going to a doctor unless they had a specific reason such as wanting to get pregnant, having a missed period, or experiencing abdominal pain. Even the women who were concerned about their own missed periods mentioned that they had refrained from obtaining care. This avoidance of the medical system was also seen in the Tampa health needs assessment and was attributed to barriers including lack of transportation, health care costs, and English language ability (Baer, et al. 2011). These three barriers additionally keep women from obtaining well-women appointments. Preventative care such as well-women appointments can ensure that women remain healthy and enable them to perform their jobs as mothers and/or employees.

Preventative care may be particularly important for the Burmese. Researchers in Philadelphia conducted Pap smears to obtain a baseline of cervical cancer, cervical dysplasia, and HPV prevalence in their refugee populations (Pickle, et al. 2011). Of the 22 Burmese women in the study, three had abnormal Pap smears and two of those had high-risk HPV (Pickle, et al. 2011). The researchers conclude that refugee women should be considered a vulnerable population for cervical cancer, and recommend that Pap smears should be prioritized for all resettling refugee women, especially those aged 35 and older (Pickle, et al. 2011).

Additionally, research with northeastern Thai women found high prevalence rates of untreated reproductive tract infections (RTIs) (Boonmongkon, et al. 2010). While many RTIs are not life threatening, researchers found they resulted in many negative physical and emotional health implications, including pain, itching, excessive worry and anxiety, indications of marital infidelity, and extreme fear of developing cervical cancer (Boonmongkon, et al. 2010). Uterine problems were considered a "women's problem" for Thai women, and those with recurring RTIs attributed them to past misfortune and associate all lower abdominal pain with the

uterus (Boonmongkon, et al. 2010). Although the Burmese women are not Thai, all of the Karen and Kayah women have lived in Thailand, and it is very possible that they experience similar ailments, lacked similar treatments, and have been influenced by Thai women's fear of uterine diseases. Regular wellness appointments can address any of these concerns, and future research should attempt to discover if the Burmese ethnic groups have any specific areas of the body that they attribute many physical ailments to, similarly to the Boonmongkon, et al. (2010) study.

Theme 4: Mental Health

A study in the Thai refugee camps found that risk factors for mental illness included insufficient food, multiple trauma events, previous mental illness, and landmine injuries (Cardozo, et al. 2004). Women in this study did share stories of insufficient food and trauma (such as being forced to relocate by the army, as well as suffering police abuses), which could be especially stressful during the vulnerable period of pregnancy. Additional traumas directly affecting reproductive health that have been recorded in the literature, such as rape, forced labor, forced sterilization, gender-based violence, sex trafficking, and illegal abortions (Belton 2010; Gulf Coast Jewish Family and Community Services 2011; Mullany, et al. 2008) could also be experiences that the women in this community have faced, but are not prepared to discuss with an outside researcher, if anyone at all.

Although the Burmese women did not reveal mental health concerns during the interviews regarding reproductive beliefs, the needs assessment did indicate that some members of the Tampa Burmese community were experiencing possible symptoms of trauma (Baer, et al. 2011). In a discussion with employees at local resettlement agencies, they revealed that many of their refugee clients do not begin to process their past traumatic ordeals until after they feel secure in their resettled communities (personal communication, Refugee Services employees, October 2011).

Secure in this instance includes both personal safety and financial stability, which can take a few years to obtain. Therefore, symptoms of prior trauma may only become apparent after women have had a few years to adapt to their new surroundings in the US. Most of the women in this study have only been in the US for two years or less, indicating that mental health may emerge as an important area of need for the community in the near future.

Therefore, while none of the Burmese women explicitly described any mental health issues during their childbirth stories, their refugee experiences put them at risk for experiencing mental health problems. In addition, it has been found that women who have experienced traumas can have particularly difficult childbirth experiences (Simkin and Hull 2011). Therefore, it is necessary to prepare women, their families, and their providers for this possibility. The TBBC will have to continue to talk to women in the community about what their mental health concerns are and continue to monitor women's emotional health throughout the perinatal period. It will be important for the TBBC to begin planning in advance for services or group sessions to discuss and manage these potential issues.

Theme 5: Healthy Blood?

Although not common or explicit, the concept of blood did emerge during some interviews, indicating that there could be a traditional concept of healthy blood. Why women are not sharing these explanations may range from this belief is not commonly held, this belief is not considered something to be shared with outsiders, this belief is so accepted by the Burmese that they are unaware it is not known to those in the US, or it is a belief that is being abandoned.

For example, when a Karen woman was asked which birth control Karen women like she explained, *"**It's different because of the blood**. Some use medicines better, some like the shot. There are side effects."* In addition, when the

Kayaw woman gave a unique explanation for why a home birth was not safe, she said, *"It's not good to have birth in the house **because of bacteria and blood**. The bacteria will **get into your blood** and could [give you] something bad, a sickness."* Again this theme of blood emerged, but the context in respect to traditional beliefs is unknown.

One study (Skidmore 2002) in urban Burma did find a correlation between health and bleeding, but the ethnic group is unknown. The researcher found that a balance was needed between too little and too much blood, and therefore menstruation is necessary and important, but excessive bleeding could also be problematic (Skidmore 2002). Skidmore (2002) also describes the importance that women place on emmenagogues (herbs and medicines used to start menstruation and bleeding), diet, and the use of birth control injections to restart or strengthen blood flow.

Further research needs to be conducted to determine if there is a concept of "healthy blood" or a balance of blood in female bodies. As beliefs similar to these could result in self-treatments that result in excessive blood loss, emotional health concerns when menstruation is abnormal, and/or misuse of birth control methods, providers working with Burmese communities need to remain alert to any mention of blood.

CONCLUSION TO CHAPTER 5

As this study has reinforced, the Burmese people are very diverse and have very different beliefs and rituals. However, several common themes emerged that can guide reproductive health education for women and families. First, women need accurate information about menstrual changes during pregnancy, menopause, and birth control use. Additionally, they need to understand that work, nutrition, weight fluctuations and stress can cause changes in addition to actual medical problems.

Women should be advised where to get and how to use US pain killers to aid in any discomfort that may occur during the menstrual cycle.

Second, it appears that many Karen women do not learn much about birth control until after they have the number and composition of children they desire. This explains why many women do not know much about birth control, as they choose not to learn until they are ready to use it. Therefore, educating women about different birth control methods, how they work, their side effects, and when they can be used will be helpful for women deciding when to begin their families. It still remains to be seen how open women are to using birth control as a means of waiting to have children until they reach an optimal age/financial comfort/educational attainment, or between pregnancies to space them. It may be especially difficult to convince women of the health benefits of waiting to give birth or spacing their children a part if women are more concerned with ensuring that they have both a boy and a girl. However, good education will enable women to choose options that work best for them and their husbands.

Third, women are very comfortable with hospital births, and can retain healthy diets and lifestyles through pregnancy and the postpartum period because of the security and food availability that the US offers. Women's affinity towards warmth should be recognized, especially in the postpartum period. Health educators need to emphasize that despite the perceived ease of birth in the US, complications can always occur. Women must take care during pregnancy and at least six weeks postpartum to ensure the health of themselves and their infants.

Burmese women from each of the ethnic groups stressed that many of the menstrual, pregnancy, and postpartum rituals and restrictions could vary depending on the woman. This is reflected in research conducted in other areas of the world that found that postpartum rituals are often neglected as women spend more time away from their villages (Piperata 2008). The research indicates that experiences

and interactions with other methods of postpartum care and systems of belief influence women's choices regarding which ethnic practices they consider appropriate to continue using. The history of the Burmese refugee situation, which has resulted in communities and families being uprooted from their homelands, has placed them in a perpetual re-negotiation of their belief systems as they encounter new challenges and ideas. Exploring reproductive ritual negotiations as individuals from Burmese cultures adapt to North American culture identifies the foundational beliefs of the Burmese cultures and enables service providers to recognize and address areas of gaps and concerns that emerge when belief systems come into conflict.

CHAPTER 6: CONCLUSION

INTRODUCTION TO CHAPTER 6

This study has explored the reproductive beliefs of Burmese refugee women in Tampa. The results from this study will be given to the Tampa Bay Burmese Council (TBBC), an ethnic community-based organization, to help guide health education sessions for their community. This chapter will summarize the findings of the research, the health education recommendations, the contributions to the literature, the contributions to the fields of Applied Anthropology and Public Health, and the limitations of the study.

SUMMARY OF THE RESEARCH FINDINGS

This was an exploratory study that sought to discover the reproductive beliefs of Burmese refugee women resettled in the United States. The study employed participant observation and semi-structured individual and group interviews with sixteen women from four Burmese ethnic groups living in Tampa. The research aims of the study, specifically focusing on ethnic group differences are:

1. Identify how Burmese women perceive ideal families.
2. Identify Burmese women's knowledge and use of family planning.
3. Identify Burmese women's experiences of pregnancy and childbirth as refugees.
4. Identify Burmese women's pregnancy and childbirth beliefs and rituals.
5. Identify Burmese women's postpartum beliefs and rituals.

Children were important to the Burmese women and defined a family, roles and responsibilities of spouses, parents' happiness, and future security. For most

ethnic groups, having children of both sexes was paramount, and women would increase their ideal family size in hopes of obtaining both a boy and a girl.

Menstruation is an important time in a women's life and ritual taboos exist to mark this period. Additionally, the menstrual cycle is a reflection on women's health, which depending on the ethnic group has implications for short-term health issues or future chronic illness.

Family planning is known and accepted, but women have very limited knowledge about it. Birth Control appears to be used only after the ideal family size and composition are met. Women were very interested in learning about different short-term, long-term, and permanent options and their side effects. Barriers to receiving family planning involved not knowing where or how to get it, relying on husbands, and not knowing about different options.

Pregnancy and childbirth are periods where women need to observe some rituals, and access to Western medical care and facilities is seen as positive and desired. Most women spoke of the difficulties of having children in Burma, the financial costs in Malaysia, and the lack of good care in Thailand. Women were comfortable giving birth in US hospitals, happy with their prenatal and labor and delivery care, and pleased with the option of having no pain. Barriers to care include language and transportation issues. Women were relieved that in the US they did not have to overexert themselves in work, could always find a variety of food, and could easily observe any food, temperature, or work taboos that did exist.

The postpartum period entailed observing more stringent prohibitions than any other period. Most women emphasized that being warm and eating warm foods were important for the health of the woman. Additionally, women were supposed to rest, and not participate in activities that could harm them like carrying heavy things, washing their hair, getting cold, or getting wet in the rain. Some women said they did not cook or climb stairs either. Many women also named specific foods that

they should not eat, which did vary between ethnic groups; however, the availability of foods in the Asian Markets in Tampa enabled them to eat any other foods they wanted, as long as the foods were physically warm. The length of the postpartum period varied between ethnic groups and within ethnic groups. Women believed this period lasted from as little as one week to six months.

Overall, women noted that while there were expectations regarding things such as food and activity restrictions, birth control side effects, and menstruation and pregnancy symptoms, these experiences and limitations may or may not be necessary for certain individuals. Many women were already admitting to relaxing their restrictions, believing that in the US they were protected from any negative health consequences.

CONTRIBUTIONS TO ANTHROPOLOGY

The immediate needs of refugees being resettled in the US are so extensive that published data regarding cultural findings and educational points are understandably lacking. The anthropological literature is especially deficient in current ethnographic studies of resettled populations. This is particularly unfortunate as there are many “new” refugee groups being admitted to the US that have little to no family or cultural communities to walk into and are presenting unknown cultural expectations to service providers. Anthropologists’ history, theory, and methods are better suited than any other discipline to explore how these new ethnic groups adapt to US culture and to identify any areas of conflict where systems of belief collide.

Although studies of acculturation and refugees were common in the 1980s and 1990s (Boone 1994; Delgado-Gaitan 1994; DeVoe 1992; Guggenheim and Cernea 1993; Harrell-Bond and Voutira 1992; Hopkins 1996; Kulig 1994; Minkler, et al. 1988; Mortland 1994; Ong 1996), recent work has chosen to focus more extensively on the political economic factors that create refugee situations (Good, et

al. 2010; Keles 2008; Sargent and Larchanche 2011; Vertovec 2011). While this is important, this study hopes to bring the focus back to how anthropologists can study explanatory models of health and wellness, or other topics of need, for new communities in the US.

This research provides a snapshot in time of Burmese refugees negotiating their cultural belief systems while learning to adapt to life in the US. By examining which cultural beliefs are retained by the Burmese ethnic groups, and which beliefs are challenged and redefined, it is possible to identify the gaps in the emerging belief system and provide the Burmese with more information to help them define their own identities as Burmese-Americans. This research returns to anthropology's roots of ethnographic inquiry into the assessment of how migrant groups enter new cultures and negotiate their ever-evolving definitions of what it means to be themselves.

CONTRIBUTIONS TO APPLIED ANTHROPOLOGY

This study is an example of how sound anthropologically-driven research can result in positive recommendations for community-based organizations to use for education. Although studies into structural violence and political economy have been dominating the current literature on refugees, this study is an illustration of how using explanatory models and careful cultural analyses as theoretical frameworks may serve applied anthropologists better for situations where short-term change and programmatic recommendations are needed. These findings can produce immediate results, as well as provide foundational data for larger policy-related advocacy.

For example, this study will provide data and recommendations for the local ethnic community-based organization to use in a grant request for funding for educational classes for the Burmese community. The report is also being shared with local refugee resettlement service providers, who have the ability to use the data to

improve their own services at the local and state level, as well as bring any findings to the national level. Furthermore, because Burmese refugees are both new to the US and information is lacking on the different Burmese ethnic groups and their cultural beliefs, any data that can help inform other resettlement agencies or communities could be used to advocate for better local, state, and national policies for resettling and serving refugees from Burma.

CONTRIBUTIONS TO PUBLIC HEALTH

The research design and the results from this study are important for Public Health practitioners working with Burmese refugees to recognize. Using qualitative methods, which are underutilized in public health studies, can often provide better data than pre-existing surveys that do not take into account cultural nuances. This study can be seen as an example of an alternative way of learning about new refugee groups that may provide insights into how to better serve these communities.

Furthermore, public health practitioners can use this information to better address reproductive needs of Burmese and refugee populations. Although this sample is small and therefore not generalizable across cities, some of the findings can be used as starting points to explore reproductive health beliefs in other localities. Additionally, the recommendations can be used to ask local communities if those are things that may be of interest or needed in those cities.

Finally, increasing reproductive health for women and families of diverse populations is important for fulfilling the mission of public health to improve the health of communities. Focusing on refugees, who are vulnerable populations that need help learning their options, opportunities, and constraints in a new country, is a valuable way to ensure that couples can create healthy families that fit their dreams and abilities.

CONTRIBUTIONS TO REFUGEE LITERATURE

This work brings with it an explicitly applied component, as findings can also help inform service providers how to better serve their patients and clients, and refugees can share what is important for them. The discipline of refugee studies has been focusing more on the processes of migration than on the experiences of those living as migrants (Krulfeld and Baxter 1997). Yet, US resettlement agencies struggle to help new ethnic groups adapt to their lives in the US. Most of the literature on Burmese refugees and their health is coming from state and local health departments and resettlement agencies (Goodkind, et al. 2011; Gulf Coast Jewish Family and Community Services 2011; Mitschke, et al. 2011; Oleson 2009; Power, et al. 2010; Swe and Ross 2010; Trapp 2010). As these resources are very helpful for service providers in different locations across the US, it is important that any research that gets conducted with this population gets shared with the intention of a broad readership. Although this study found that specific reproductive beliefs varied between Burmese ethnic groups, the findings produced recommendations that can be generalized across the ethnic groups. It is hoped that these recommendations are found useful in many resettlement communities around the US.

LIMITATIONS TO THE STUDY

The six major limitations to this study include minimal interpretation services and language barriers, unfamiliarity with the research but relationships with the interpreters and the community agency, limited time, an imperfect interview guide, an inability to interview all of the women, and confidentiality issues in a small community setting. First, the interpretation services were provided by two women who are community members. It is unknown if this affected the quality of the information (for good or bad) that was shared. Additionally, the interpreters have varying skill levels of interpretation, with one being fairly new. Follow-up questions

and prompts occasionally had to be reworded, and the responses sometimes indicated that there was something missing in the translation. Unfortunately, some data was lost, as there is only so many ways it is possible to ask a question. Additionally, it seemed that in some instances the translations were not direct, resulting in the interpreter trying to explain the question to the women based on their own understanding of the question, and not necessarily the meaning that the question intended to portray.

Furthermore, many of the Burmese speak mutually unintelligible languages. For example, although one of the interpreters speaks seven Chin languages, two Chin women spoke two different Chin languages that were not one of these seven. The women were able to participate in the interview in Burmese; however their Burmese has been improved solely because of living in the refugee community in Tampa, not because they are fluent. The Kayah women were also disadvantaged in that two women do not speak Burmese at all, and there was no Kayah interpreter available except the women participating in the study. It will be important to see how and if women change some of their beliefs should their English be improved, an outside interpreter be provided, or new language applications on smart phones be used to provide anonymous or computer-based translation services during an interview.

The second limitation to the study is the inability to know how open the women were with me, especially because I could not speak with the participants one-on-one without an interpreter, and that working with the TBBC may have influenced the responses. In every research study there are costs and benefits to having the anonymity of a stranger versus the comfort of someone who can be trusted. It is always difficult to know whether speaking to a stranger who is not from the community will yield richer or more superficial data than speaking with community members or friends of the community. This becomes additionally

challenging when working closely with a community organization that may sway individuals to or from participation.

In the needs assessment done in the Tampa community, it was found that issues sensitive to the community (identified as drinking, drugs, domestic violence, and divorce) were discussed more openly in the few interviews that were conducted without interpreters present (Baer, et al. 2011). Unfortunately, all of the interviews for this study were done with an interpreter present, and thus it is unknown if any reproductive health topics were sensitive or if different information may have been gathered without the community-based interpreters. Fortunately, many women responded with similar beliefs and experiences, strengthening the accuracy of the data. Also, because the organization that requested the study and the recommendations is community-based, it is hoped that any gaps can be filled in over time through local meetings and service evaluations.

The association with the TBBC could also be problematic if some individuals participated because they were concerned that if they did not they would not get the services. In order to minimize this concern, the interpreters, who recruited the participants, were trained in human subject research ethics through the University of South Florida. Additionally, all recruitment and consent scripts emphasized that volunteering or refusing participation in no way would affect the services they could receive through the TBBC. Some women refused to participate, so it appears that this was communicated well.

The third limitation of this study was time. The TBBC planned to apply for a grant that was due in March 2012, using the data. The interviews, results, and technical report needed to be provided to the TBBC in time to incorporate the findings into the grant. The interviews were conducted between November 2011 and January 2012. One of the interpreters has a full time job working at the refugee resettlement agencies, and is also considered a go-to person for the Burmese

community. Coordinating time with this interpreter to conduct the interviews was difficult, especially when women in the community worked opposite shifts than her. Additionally, the three women who identify as full or partial Bama were not able to participate; therefore, it is unknown if the Bama women have different needs or reproductive beliefs that need to be considered. It would have been nice to have more time to conduct and analyze the interviews, possibly conducting a few follow up interviews after initial analysis.

The fourth limitation of the study was in the interview guide. Although the guide was intended to be very open-ended, with almost no data about the Burmese in the literature it was hard to know what questions to ask or how to word them correctly. This difficulty was compounded by the fact that the Burmese women were inclined to give very short answers to the interpreter, even for very broad questions. Because of this, probes were used often, and it may have given women less room to interpret the question as she desired. Furthermore, asking, "Tell me more" more than once or twice became redundant, and the women seemed more likely to get bashful and respond with, "I don't know." Very often specific questions had to be asked to elicit the needed information. For example, when trying to learn about rules or rituals during pregnancy and the postpartum period, it was necessary to specify "is there anything that [ethnic group] women should or should not *eat*, should or should not *do*, should or should not *have with them?"* because simply asking the women about this period of time, or about "rules" did not provide useful responses. It would be very beneficial to learn how to ask these questions better. It is to be noted, however, that despite the limitations in the question guide, many women emphasized areas that were unexpected to me, such as menstruation cycles and the importance of having children of both sexes. Because of the themes that arose during interviews, the use of the constant comparative method for the analysis was

able to uncover the importance that the Burmese women put on certain reproductive topics that were previously unknown.

The fifth limitation was the inability to interview every woman in the community. Of 23 women over 18, 16 women were interviewed. The three Bama women were left out of the study due to miscommunication between the interpreters and the researcher. It is unknown how similar or different these women are from the other Burmese refugees in Tampa, and if there are certain services that may be specifically needed due to their ethnic beliefs. Two of the Kayah women did not want to participate. One of these women speaks no Burmese, and only Kayah. Especially because the one woman had newborn, valuable information may have been lost by not speaking to her, specifically information about her pregnancy in the US, her childbirth, and how it was to be in the postpartum period. Two of the Karen women did not participate. One woman had a job and could not find time in her busy schedule. Because most of the women in the community do not have jobs, she may have had different insights into family life in the US when the woman has to work. The final Karen woman was unique in that she did not live in the same two apartment complexes that the other Karen live in. This isolation may have resulted in different needs and services regarding families and reproductive needs that cannot be known without talking to her.

The final limitation to the study was the small size of the community, which could result in confidentiality breaches. Unfortunately, it is difficult to conceal individuals' different experiences and family sizes to people who may interact frequently with the Burmese population. To help minimize privacy issues, this study asked women about what was common in their ethnic group, as opposed to their own direct experiences, to avoid some of the more personal details that could identify participants. Family size and make-up is something that is public knowledge, and this thesis attempted to remove family size from many of the quotes unless

pertinent. Additionally, this study does not report names. Although the ages are used to provide some context as to where women are in their reproductive lives, ages are not commonly used within the Burmese community. Dates of births have only become necessary to apply for paperwork, and many women are still reluctant to use ages, preferring year at birth. Also, the community is fairly transient. Many of the families who are settled in Tampa move to other cities where there are available jobs, and new families are consistently arriving. Because of this, the make-up of the community changes frequently. This transience, along with the fact that there were women who did not participate, decreases the opportunity for women to be identified. As a last measure, the technical report which has been made available to the community has further removed possible identifying information, providing more overarching research findings within each ethnic group and focusing on the recommendations.

Although it is ideal for the results to be completely confidential, the small community does present a challenge that many anthropologists face. It is hoped that the measures taken will help to preserve the privacy of the participants. As with many studies, it is always a possibility that those close to the participants will be able to identify individuals, despite researchers' best attempts to de-identify information. Therefore, it is hoped that should any information be identified by a reader, that the benefits the community has received as a result of the study will outweigh possible identification. However, this study has done its best to minimize identifying factors and keep the participants' identities confidential.

RECOMMENDATIONS TO THE TBBC

Educational Classes

The recommendations offered here were designed based on a combination of questions women asked, topics they focused on in their interviews, as well as topics the women did not mention that may be important for life in the US.

1. Basic Reproductive Biology

The Burmese women were very curious about menstruation and changes in their menstrual cycle. They also felt that it was not possible to get pregnant every time that they engaged in intercourse. Women were already using Western biomedicine and placing a lot of faith in it, yet they had never been introduced to basic biomedical beliefs regarding how reproduction works. Women will most likely find this information of great interest. The women would benefit from the opportunity to attend basic reproductive biology classes.

2. Explanation of Annual Wellness Exams for Women

No woman mentioned regular wellness exams for women during the interviews. This was surprising because the women reported that they like prenatal exams because they enable them to feel secure that they and their baby are healthy. Women also mentioned that they had questions or concerns regarding things such as their menstrual cycle, which could be discussed during wellness exams. These exams are also important because cervical cancer has been found in Burmese refugee populations (Pickle, et al. 2011). Therefore, educating women about wellness exams, what happens during them, why they are important, and how they can request and attend an exam will be beneficial to their long-term physical and emotional health. If these exams are acknowledged as uncomfortable, but framed as something that can leave women feeling secure in their health, it is likely women will utilize them.

3. Family Planning Options and Side Effects

Birth control options and their side effects are something that Burmese women minimally understand, but they are very interested in learning more about these options. Women should be advised regarding short and long term options, including sterilization and abortion. Women also need to be honestly engaged in discussing side effects, particularly those that may affect the menstrual cycle.

Although it is unknown if women would alter their behaviors, it is important that education regarding family planning include information about its safety and efficacy if used before or between children. Husbands and partners have a role to play in the family planning discussions. It is recommended that this topic be taught in a multitude of settings, including groups with women only, women one-on-one with educators, and small groups of couples.

4. How to Access Family Planning Services

Many women reported that they did not know how to get birth control in the United States. They were also concerned about language and transportation barriers. This becomes even more complicated if women are hoping to access birth control without their husbands' knowledge. Therefore, informing women how they can access these options is vital to empowering women to have control over their family planning. Different types of teaching methods will be helpful for this topic, including some with only women and some with couples.

5. US Nutrition Services for Pregnant Women

The TBBC and the refugee resettlement services are already working to integrate nutrition education into their educational programming (personal communication, September 2011). Findings from this study indicate that women are (at least by what they say) taking the advice of Women, Infants, and Children (WIC)

services that are offered to low-income pregnant mothers and young infants in the United States. While this has positive outcomes, women also frequently mentioned the importance of milk. Milk can be an important nutritional resource, but high levels of lactose intolerance in adults around the world, especially in Asia (Lomer, et al. 2008), could result in women having negative reactions and side effects to increased milk consumption. The refugee services should work with WIC to assess this, and in the meantime should integrate the concept of food allergies into nutritional programming. This could be particularly important for women with regards to milk, as the Burmese women are trying to do what is best for their babies.

Additionally, the emphasis that WIC places on breastfeeding and waiting to introduce solid foods for six months is an important addition to the education that new Burmese mothers should have. The Chin women mentioned that in Burma is was common to introduce rice and other foods to infants as young as one month old, which is not recommended for women living in the US. Nutritional guidelines for infants, young children, and nursing mothers would be important nutritional information to include in any nutritional programs. With the availability of many foods in the US markets, the Burmese women could be helped to understand what will be healthy for them and their growing children.

6. Postnatal Care Education

Burmese women of all ethnic groups participate in postpartum rituals including resting, refraining from hard work, staying warm, and avoiding certain foods. Although this time period varies between ethnic groups, and even within many ethnic groups, a pattern was noted that women across ethnic groups thought that in the US the postpartum period only needs to last about one week. This is concerning, as women physically and emotionally need to heal from pregnancy and childbirth, and need time to bond with their new infant. Educational classes regarding postnatal

care should be sensitive to women's assumptions that in the US the medicine is stronger and therefore they are more invincible. Classes should also let women talk about what will make their early motherhood experiences better. These classes will most likely go over well in group settings, and with small couple groups to also include fathers.

7. Children's Health Services

Although the purpose of this study was to explore reproductive beliefs of the Burmese women in Tampa, many women were focused on their children, whom they see as their purpose and their future caretakers. Parenting in the US and navigating the US educational and medical services is complicated and challenging. Women would be relieved to learn more about how they can ensure their children are staying healthy and receiving all of the benefits of being US citizens. Classes discussing available services for young families and children and how women can access them are important. Parents should also be given easy to understand explanations of childhood health services and the importance of regular check-ups. Doctors often do not have time to go over many of the important developmental screening and vaccination schedules with parents, especially those who are using interpreters. Therefore, bringing this information to the community can help alleviate some fears.

8. Aging Healthy

Many women were at or nearing the end of their child-bearing years and starting to indicate worry and concern regarding menstruation ending and future health. The TBBC should initiate aging healthy seminars for women, men, and couples, to discuss what opportunities are available in the US for health services past the age of 40. Important possible discussions include menopause, annual check-ups, blood work, and disease screening schedules. It is important to note that this study

did not look at how Burmese individuals may respond to interventions such as blood draws, fasting before exams, or invasive screenings such as colorectal screening; however, keeping the Burmese adults informed of the health opportunities in the US for aging individuals is important. As with the wellness exams for women of reproductive age, is will be important to validate that these exams can be uncomfortable and the results confusing, but also to emphasize that keeping track of one's health can allow for peace of mind.

9. Mental Health Counseling

Although the Burmese women in this study did not explicitly reveal any mental health concerns, they did share stories that involved trauma, such as forced labor, forced displacement from their homes, and the death of family members. Additionally, the health needs assessment done in Tampa indicated that community members may be experiencing symptoms of prior abuse (Baer, et al. 2011). It is recommended that the TBBC prepare for the possibility that more community members will begin to acknowledge their previous abuses as they become more comfortable in their current situation as resettled refugees. Even activities as simple as dances, weaving, talking groups, or movie watching could be arenas where Burmese women and their families allow themselves to process some of the horrors that they experienced and move forward. Because this research did not address mental health concerns directly, it is advised that the TBBC discuss needs with the community before implementing any specific programs

Class Delivery

1. Women Only Classes

Many of the Burmese women were very comfortable with their neighbors and friends, and wanted to participate in the interviews together. Also, the group

interview with the Kayah women went extremely well, and women used each other's knowledge to remember different beliefs and practices. It is likely that small groups of classes for women will be successful. TBBC can vary these classes between ethnic groups, but are also encouraged to have some classes where women from the entire Burmese community get together. Although language barriers remain challenging, the Burmese population is so small that helping the different ethnic groups to learn more about each other could promote new social ties.

2. Couples Classes

Men are also integral to family planning and childrearing. As recommended by Minkler (1988), small groups of couples can be effective for sharing knowledge and retaining community and social relations. In this manner, men's opinions, beliefs, and concerns can be addressed along with women's. It can encourage couples to talk about their own wants and expectations for family planning and raising their children in the US, and can provide a space for those discussions to happen.

3. Women One-on-One

Although Burmese women do seem happy to learn about topics as a group, it may also be important to provide the Burmese women with one-on-one time. It is possible that there are controversial or private topics that the Burmese will not want to share with the entire community, and thus can become a barrier to asking all of their needed questions during group sessions.

4. Couples One-on-One

Similarly to the limitations found in groups of women, couples may have private concerns that they do not wish to share in public. Couples should have opportunities to meet with educators one-on-one to address any of these concerns.

5. Men Only Classes

Although this research did not address Burmese men's reproductive beliefs, it is likely that they are important and influential in the family setting. More research and exploration into men's beliefs, and space for men to discuss the importance of family and reproduction in the changing context of resettlement and US citizenship is important.

6. Community Health Educators

Community Health educators have worked in various settings, and are currently working in health interventions in Burma (Mullaney et al. 2008). The TBBC should consider asking for funds to train and compensate some of the women. While it is recommended to look into this option, it is also cautioned that in such a small community, women and men may not want to share their personal issues with everyone. Additionally, the selection of certain community members to be lay health advisors could become a source of community dissent. Therefore, while community health workers have been successful in other settings, the TBBC should carefully consider the pros and cons of this option for their own community.

FUTURE RESEARCH DIRECTIONS

Although this study provides very good information to direct initial reproductive health education efforts, more research is needed. Recommended areas to research include, 1) Bama women's reproductive health beliefs and if the proposed classes will meet their needs; 2) Burmese men's reproductive health beliefs and needs; 3) puberty, family planning knowledge and relationship expectations of Burmese adolescents and young adults, as well as potential reproductive education needs for them; 4) implications of previous traumatic experiences on mental health in general and their potential impact on perinatal health specifically; 5) a study of

the potential role of blood as an indicator of health or illness in Burmese culture; and 6) if the Burmese have any cultural illnesses and illness symptoms that are specific to reproductive organs that could affect physical and mental health (see Boonmongkon, et al. 2010). Additionally, the reproductive health needs of the Burmese women should be followed to see how their beliefs and needs change as they integrate more into the US culture.

CONCLUSION TO CHAPTER 6

This chapter summarizes the study's research findings regarding the reproductive beliefs of Burmese refugee women in Tampa, Florida, explores the contributions the research has to the larger literature in anthropology, applied anthropology, public health and refugee studies, , and offers its recommendations for the TBBC. In sum, women's health is often directly related to menstrual cycles, and food, activity, and temperature restrictions are found during menstruation, pregnancy, and the postpartum period. The Burmese women are interested in adapting their belief system to the biomedical approaches that they find enhance their reproductive control, such as prenatal visits and hospital care.

Additionally, the contributions that this thesis can bring to anthropology, applied anthropology, public health, and refugee literature are discussed. This study is a good example of how explanatory models of reproductive beliefs can uncover how different ethnic groups adapt to living in a new culture. The findings provide recommendations to a community-based organization, and are a concrete example of how medical anthropology can be applied. Implications for public health include the importance of integrating qualitative data and community perspectives into research. Finally, providing recommendations that address concerns that were found across the Burmese ethnic groups can assist refugee resettlement services around the US to determine if similar educational needs are necessary in their communities.

Finally, this chapter provides nine recommendations regarding educational topics that the Burmese women will appreciate based on the interviews and their reproductive beliefs, and six options for how educational sessions could be implemented. These recommendations consider the internal conflicts that many women have between retaining their own ethnic beliefs and introducing new ideas and medical systems into their emerging identities as Burmese-American. Many of the women remain conflicted about which beliefs to keep, which to adapt, and which to dismiss, and educating women about many of the new reproductive technologies and methods that are available in the US can provide them with the information they will need to decide which options work best within their Burmese belief systems.

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APPENDIX A: SEMI-STRUCTURED INTERVIEW GUIDE

Demographics

ID Code
Age
Ethnicity
Marriage Status (ask about boyfriends/other partners too)
Religion
Education Level
Time in Burma
Time in Camp
Time in US
Time in Tampa
Job
Husband Job

1. Identify how Burmese women perceive ideal families.

- What does an ideal Burmese family look like? (probe: size, members)
- Do you think that it is important to have children?
    - Why?
- How does the community feel about a woman who does not have children?
- How does the community feel about a man who does not have children?
- When should women start having children?
    - Are there any exceptions?
- Do you have children?
    - Where was each born?
- Do you plan to have more children?

2. Identify what Burmese women consider normal about pregnancy and childbirth.

- How do women know when they are pregnant?
- What is pregnancy like?
- Can you describe what childbirth is like?

3. Identify what Burmese women expected during pregnancy, childbirth, and postpartum period while in Burma/refugee camp.

- How was it to give birth in Burma? What was good and what was bad?
    - Can you describe your/another women's experience?
    - Are there special things a women needs during this time?
    - Are there certain things women shouldn't do during this time?

- How was it to give birth in Thailand? What was good and what was bad?
    - Can you describe your/another women's experience?

4. Identify what Burmese women expect during pregnancy, childbirth, and postpartum period while in the U.S.

- Based on what you have heard/know, how is it to give birth in the United States? What is good and what is bad?
    - Can you describe your/another women's experience?

5. Identify what Burmese women fear about giving birth in the U.S.

- Thinking about what you have heard/know, what are women's biggest fears about giving birth in the U.S.?

6. Identify what women would consider an ideal childbirth experience.

- What would an ideal childbirth experience be for you?

7. Identify Burmese women's knowledge about family planning.

- What kinds of birth control have you heard about?
    - Which kinds to women like best?
- Who do you talk with to learn more about birth control? (probe: family, friends, providers, refugee services, etc.)
- Who do you want to talk with to learn more about birth control?
- What is it like getting birth control? (Easy, hard)
    - Are there many months when women miss it?
    - Do you know what happens if you don't get it on time?
- What is it like talking to your husband/boyfriend about having or not having more children?
    - Who gets to make the final decision?
- What is it like talking to your husband/boyfriend about using birth control?
    - Who gets to make the final decision?
    - Is learning how to talk to a husband/boyfriend about using birth control something women would be interested in?