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Hilary Aviela Lerner April 10, 2014

Burmese Refugees in the United States: Resettlement Barriers, Access to Healthcare, and Adjusting to Life in Atlanta, Georgia

by

Hilary Aviela Lerner

Peter J. Brown, PhD

Adviser

Department of Anthropology

Peter J. Brown, PhD

Adviser

Michelle Parsons, PhD

Committee Member

Benjamin Hary, PhD

Committee Member

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Abstract

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The human rights situation in Burma is considered one of the worst in the world, characterized by counter-insurgency operations directly targeting civilians, forced labor, restrictions on farming, and land confiscation. Ethnic minorities have been subject to constant conflict with the Burmese government since independence from Britain in 1948. As a result of the turmoil in Burma, hundreds of thousands of Burmese people have been displaced and forced to flee to Thailand for sanctuary in refugee camps. There are currently over 119,000 refugees from Burma living in Thai border camps and tens of thousands of displaced persons living in Thailand. Refugees face many challenges to living in refugee camps; one of the most serious is getting access to healthcare. Burmese refugees endure a number of health problems while in refugee settlements, including infectious diseases, reproductive health, mental health, and substance abuse. In the refugee camps Burmese refugees begin applying for resettlement in a third country. The process of resettling to the United States is complex and has many steps refugees must go through. This paper looks at the challenges Burmese refugees in Atlanta, Georgia encounter upon resettlement. Through interviews with Burmese refugees and caseworkers at resettlement organizations it explores challenges to receiving healthcare, including the cost of services, interpretation difficulties, cultural differences, and more. The interviews reveal additional challenges Burmese refugees face in daily life, including transportation, the language barrier, lack of resources for refugees, and others. The Burmese refugees further demonstrate that while they face substantial obstacles during resettlement in Atlanta, they have a strong community to rely on which allows them to maintain their cultural practices in America.

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CHAPTER 1: INTRODUCTION

This paper looks at global refugee health concerns and the ways in which refugees struggle to receive adequate health services. In particular, this paper will examine refugees from Burma and the struggles they face, from leaving their home country and fleeing to refugee camps to final resettlement in Atlanta.

Global Refugee Concerns

There are currently 45.2 million forcibly displaced persons worldwide, 15.4 million of whom are considered refugees and only 10.5 million of whom are under mandate of the United Nations High Commissioner for Refugees (UNHCR) (Facts and Figures about Refugees, UNHCR). There are an additional 28.8 million internally displaced persons (IDPs). According to the UNHCR, a refugee is defined as someone who:

> Owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country (Facts and Figures about Refugees, UNHCR).

Internally displaced persons are:

> Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalised violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognised State border (The Definition of an Internally Displaced Person (IDP), IDMC).

Through their work with over 120 nations and more than 10.5 million refugees worldwide, the UNHCR has identified three ultimate goals for the world's refugees: repatriation home once conditions allow or, if return is not possible, either integration in the first country of asylum or resettlement to a third country (Refugees: Overview of Forced Displacement, UN). However, there are a few challenges that hinder these actions.

The first major challenge is "the increasingly protracted nature of many modern conflicts, some of which have dragged on for years or even decades. And as they drag on, so too does the time spent in exile for millions of refugees" (Refugees: Overview of Forced Displacement, UN). More than half of the refugees under support of the UNHCR have been in exile for more than five years (Refugees: Overview of Forced Displacement, UN). One way to ease the burden on less developed host countries is for more developed nations to take some of the most vulnerable refugees for resettlement.

The second challenge is "the increasingly dangerous climate in which humanitarian actors must work today, or what UNHCR calls the 'shrinking of humanitarian space'" (Refugees: Overview of Forced Displacement, UN). Providing humanitarian help in environments of violence is not only difficult but extremely dangerous for aid workers. Humanitarians working in these locations, whose objective is to help the innocent victims of conflict, are themselves increasingly becoming targets.

The third challenge is "the erosion of the institution of asylum," which is "particularly of concern in industrialized countries trying to cope with so-called 'mixed movements' in which migrants, asylum-seekers, refugees and victims of trafficking travel alongside each other" (Refugees: Overview of Forced Displacement, UN). Individuals have different motivations for moving. For example, migrants choose to move, whereas refugees are forced to flee. Many states have adopted measures aimed at preventing those without proper documents from entering their territory. However, if applied indiscriminately, the same measures create obstacles for refugees and asylum-seekers in genuine need of international protection. These challenges hinder the ability for refugees and IDPs to get aid. One way in which refugees may suffer the consequences of these challenges is through a lack of access to healthcare.

It is difficult to provide the world's refugees with healthcare. The UNHCR claims that "the aims and principles of refugee health…are simple, yet pose a substantial challenge to all working in both emergency and long term refugee health care. The context of displacement is complex, and introduces many variables not encountered in 'normal settings'" (Refugee Health, UNHCR). The main objective for actors in refugee health is to prevent excess mortality and morbidity (Refugee Health, UNHCR). The timely provision of effective refugee health care requires a multi-sectoral and preventative approach.

It is important to address the health of refugees because they are among the most vulnerable populations in the world and require improved health services in order to survive. While this paper looks predominantly at the challenges that Burmese refugees encounter seeking healthcare services in America, it also explores the background factors contributing to these challenges. Anthropology, particularly medical anthropology, provides a useful lens to study the health of refugees across their entire journey from fleeing their home country to final resettlement because it takes into account a refugee's history and subjection to structural constraints. Medical anthropology is a subfield of anthropology "that draws upon social, cultural, biological, and linguistic anthropology to better understand those factors which influence health and well being (broadly defined), the experience and distribution of illness, the prevention and treatment of sickness, healing processes, the social relations of therapy management, and the cultural importance and utilization of pluralistic medical systems" (What is Medical Anthropology, Society for Medical Anthropology). This paper attempts to provide an all-encompassing view of refugee health and the experience of Burmese refugees in America.

Burma

There is controversy about whether to call the country 'Burma' or 'Myanmar' based on political-historical events. I will call the country 'Burma,' as it is the title used by the refugees interviewed in this paper.

Figure 1: Political Map of Burma (Maps, Vidiani)

There are over 130 ethnic groups in Burma (Topich and Leitich 2013). The majority of the population (70%) is Burman (Topic and Leitich 2013). The largest minority groups are the Shan, Karen, Rakhine, Mon, Kachin, Kayah, and Chin. Attempts to unify the country have led to the marginalization of ethnic minorities through actions such as military raids, property

destruction, forced resettlement, forced labor, arbitrary arrests, and further civil rights violations. The Burmese military has had a campaign to control areas of the country populated by ethnic minority groups and has caused significant internal displacement of civilians since the late 1980s (White 2002). As a result of this continued persecution many Burmese have escaped and become refugees. While the number of internally displaced persons is not known exactly because the government does not allow outside observers to visit them, an estimated 500,000 displaced persons remain in Burma today (The Definition of an Internally Displaced Person (IDP), IDMC). The overwhelming majority of Burmese refugees in America are members of an ethnic minority.

In 1988 a movement towards democracy in Burma had a significant impact on ethnic minorities. Before 1988 regional ethnic groups had maintained a degree of autonomy protected by surrounding inaccessible jungle and their own military. After 1988 however, the military regime, called the State Peace and Development Council (SPDC), strengthened their forces to control these populations (White 2002). Today troops are deployed throughout the ethnic minority regions and continue to cause destruction and displacement (Topich and Leitich 2013). The army has forced civilians to relocate creating increasing numbers of IDPs. Others have fled after unrelenting abuses and threats by the military. This situation continues despite the fact that seventeen ceasefires were agreed upon between the SPDC and insurgency groups, including the Shan, Karenni, Karchin and others, between 1989 and 2001 (White 2002; Topich and Leitich 2013).

The military regime mandates forced labor of civilians as a control tactic. This causes displacement. Hundreds of thousands of villagers have been forcibly relocated by government troops for the officially declared purposed of "combating insurgency movements" (White 2002:

112). An Amnesty International report found that a total of 1,400 villages in the Shan state alone had been evacuated at one time (Amnesty International 2001). A common pattern used in forced displacement is "villagers are given up to one week's notice to leave their village. Later, government troops reportedly enter the abandoned hamlets to destroy housing structures and food crops and to loot remaining belongings—thus discouraging the people from returning" (White 2002: 112). Civilians are offered no support for their journey to designated relocation sites. While some people avoid moving to the resettlement sites by seeking refuge in the jungle or with host communities outside the reach of the SPDC, they encounter extremely dangerous and challenging conditions.

The human rights situation in Burma is considered one of the worst in the world, characterized by counter-insurgency operations directly targeting civilians, forced labor, restrictions on farming, and land confiscation (White 2002; Burma, Human Rights Watch 2013). There are regular reports of torture, arbitrary executions, sexual violence, forced recruitment by both government and armed opposition forces, and the indiscriminate use of land mines with the purpose of making areas uninhabitable (White; Burma, Human Rights Watch). Displaced persons are extremely vulnerable while in hiding and in relocation sites.

Relocation settlements in Burma are often empty stretches of land where families are expected to create their own makeshift shelters. In these settlements the displaced are offered little means of survival with limited health and sanitation facilities as well as few food supplies. Tight restrictions on the freedom of movement of IDPs only worsen the already dire living conditions. Reports indicate that people scavenging for food outside their relocation areas have been killed (Amnesty International 2001). In some cases, SPDC troops have closed sites due to lack of supplies, but do not allow civilians to return to their former villages, nor do they provide

them with alternative settlement (White 2002). International organizations are not permitted access to displaced populations in Burma and international NGOs operating inside Burma face severe restrictions on their freedom of movement.

Resettling in the United States

The situation is Burma has resulted in hundreds of thousands of displaced persons and refugees fleeing the country. These people most often seek refuge in Thailand or Malaysia. In Thailand there are nine refugee camps managed by the UNHCR and other international organizations. In Malaysia, however, there are no such camps and refugees are forced to find jobs while they wait to be recognized as refugees by the UNHCR. Seeking refuge in Thailand or Malaysia is considered a last resort.

The Thai government implements a strict asylum policy, offering asylum only to civilians fleeing direct fighting. Additionally, crossing into Thailand leads to insecurity and maltreatment of migrants who are not accepted into refugee camps. While in Thai resettlement facilities refugees must depend on the camp provisions of food rations, housing supplies, and healthcare services. They are not allowed to leave the camps because they are considered illegal immigrants and will be arrested by the police if they are found outside camp borders. Living in refugee camps can lead to severe health problems and the spread of infectious disease. Burmese refugees in Thailand face many of these health consequences and cannot always receive proper treatment for their needs.

Once in refugee camps, Burmese refugees can begin the process of applying for resettlement in a third country. However, they must be first recognized by the UNHCR as a refugee. As of July 2013 there were a total of 124,000 Burmese refugee resettlement requests (Burmese Refugees in Thailand & Malaysia, European Resettlement Network). In 2014

UNHCR will submit 14,000 applications for resettlement of Burmese refugees from Malaysia and 3,500 from Thailand (Burmese Refugees in Thailand & Malaysia, European Resettlement Network). The remaining refugees will continue to wait for their applications to be submitted. Burmese refugees will spend an average of seventeen years in refugee camps before ultimately resettling in a third country.

Burmese refugees seek resettlement in a number of countries around the world. Over 19,000 from Thailand have resettled in Australia, Canada, Finland and Japan since 2005 (US Wraps up Group Resettlement for Myanmar Refugees in Thailand, UNHCR). The UNHCR has also resettled Burmese refugees to a number of European countries including Czech Republic, Denmark, Norway, and Sweden. The United States alone has resettled over 100,000 Burmese refugees since 2000 (Refugee Arrival Data, ORR).

Refugees must be referred to the United States Refugee Admission Program to be considered for resettlement in America. Refugees face substantial difficulties upon resettling in the United States. Learning English, becoming accustomed to cultural norms, understanding the process of applying for government assistance, and adjusting to life in a new country are just some of the hardships. Accessing healthcare is another area of concern. Learning how to navigate the American healthcare system, such as how to pay for services, apply for insurance, schedule appointments, fill prescriptions, and other general communication struggles create significant barriers to attaining quality healthcare for refugees and contribute to a trying resettlement process. Through interviews with Burmese refugees living in Atlanta, Georgia, and caseworkers at resettlement organizations this paper explores the challenges that Burmese refugees encounter to resettling in America and the barriers to accessing healthcare services. It

will provide insight into the ways in which Burmese refugees establish a community and adjust to life in America.

Methods

This paper uses a combination of literature review and interview data to portray the resettlement process and barriers to healthcare for Burmese refugees upon coming to the United States, specifically in Georgia. A literature review of refugee health worldwide and in Thai refugee camps provides information on health concerns among refugee populations. Literature is also presented to demonstrate common obstacles refugees face when seeking healthcare services in America. The literature review provides a foundation for understanding health needs and resettlement challenges. The interview data is used to demonstrate first hand examples of barriers for Burmese refugees in Atlanta.

Institutional Review Board approval was required to conduct interviews with refugees. Burmese refugees were asked questions about their experiences fleeing Burma, living in refugee camps, traveling to America, resettling in the United States, and accessing healthcare once in Atlanta.

I used a snowball method to find participants. I interviewed the director of health services at Refugee Resettlement and Immigration Services of Atlanta (RRISA). She put me in touch with a Burmese refugee who works as a contractor for RRISA to interpret for incoming Burmese refugees. I also located a number of other resettlement agencies in the Atlanta area. I contacted caseworkers at World Relief and Refugee Family Services. At World Relief I spoke with the Health Care Specialist, the Burmese Program Coordinator, and a Senior Case Specialist who works predominantly with Burmese refugees. At Refugee Family Services I spoke with two

caseworkers who are both refugees from Burma and now work with newly arrived Burmese refugees.

I also attended services with the Karen Christian Fellowship at the Clarkston International Bible Church. I interviewed a Burmese community leader who then put me in touch with three other refugees. I made contact with an Emory MPH candidate who worked on a cholera study at Mae La refugee camp in Thailand. I conducted a total of twelve interviews: six with refugees, four with case workers, one with a Burmese community leader, and one with the Emory student.

The interviews were informal and conducted one-on-one at locations where the participants felt comfortable. Two refugees were interviewed in their homes, two at church, and two at the resettlement organization for which they worked. All of the caseworkers were interviewed at their offices. I used an open-ended interview style with the participant. I had a number of questions I was hoping to answer, but I allowed the conversation to flow naturally to ensure I received as much information as possible. For a full list of interview questions for the refugees and caseworkers see Appendix A. The interviews lasted no more than an hour and a half; most were between twenty and forty minutes.

Responses from the interviews are used in the paper in a number of ways. Quotes from the refugees were extracted and placed in sections throughout the paper to provide personal stories within the background and literature review sections. The majority of the interview data is used to demonstrate barriers to resettling and receiving healthcare services endured by Burmese refugees in Atlanta. One section examines barriers to healthcare according to Burmese refugees, the next barriers to healthcare according to resettlement caseworkers, with a third section on general barriers that Burmese refugees face during the resettlement process according

to both the refugees and the caseworkers. Finally, excerpts from the interviews are used to show the commitment of Burmese refugees to their community here in Atlanta. The literature review and interview responses are used in complement to provide a full scope of knowledge about the experience of Burmese refugees coming to America.

Paper Organization

This paper looks at the trajectory that Burmese refugees go through, from fleeing their home country to living in a refugee camp to resettling in America. Using a combined approach of literature review and interviews conducted in Clarkston, Georgia, it looks at the processes that make up this movement and the challenges, both health related and otherwise, that these refugees face throughout their journey.

Chapter Two provides a framework for understanding challenges to accessing healthcare for refugees worldwide. It gives context for the difficulties that Burmese refugees face. It covers common health problems of refugees such as communicable diseases, mental health issues, and substance abuse. It then describes four major public health concerns for refugees: health promotion and prevention, adherence, outbreak detection, and the objectification of refugees. Chapter Three provides a comprehensive history of Burma and the reasons that citizens are forced to flee. It then describes the nature of the relationship between Burma and Thailand and the history of Thailand's acceptance of refugees from Burma.

Chapter Four looks at the life of Burmese refugees in Thailand, particularly in refugee camps. It explores the conditions of refugee camps, challenges faced by the refugees, common health problems for Burmese refugees in Thai refugee camps, and challenges to accessing adequate healthcare in the Thai refugee camps. Chapter Five provides an overview of the resettlement process in America. It first describes how a refugee gains acceptance to the United

States including the many steps required before approval to resettle in America. It then explains the procedures for resettlement in America based on the laws and regulations that define the process. The chapter concludes with the specific regulations for refugee resettlement in Georgia.

Chapter Six uses previous literature studies to describe the barriers to healthcare access that refugees face. It provides a comprehensive review of challenges for all refugee populations in America. Chapter Seven addresses specific barriers to healthcare for Burmese refugees in Atlanta according to the refugees and the caseworkers who work with them at resettlement organizations. It finally uses interview data to describe other general resettlement challenges for Burmese refugees.

Chapter Eight discusses characteristics of the Burmese refugees living in Atlanta. It explores the nature of their community in Clarkston, Georgia, a city with a large refugee and immigrant population. It then explores how the refugee experience for the Burmese influences their patterns of assimilation and adjustment to life in America. It also provides suggestions for future study. Finally, Chapter Nine concludes the paper with recommendations for bettering the resettlement process and ways in which refugee access to healthcare and services could be improved.

CHAPTER 2: REFUGEE HEALTH

> In the refugee camp, the hospital is there. But they have no doctors for, like, surgery. They don't have that. Only if you get like fever or something a little bit small. It is not easy to go to the hospital. Because we don't have money. If have money, we can go. The doctor in the camp can help you there and they can treat for free for the people. But just small things. Like the people, they have a surgery, they can't go for that. Many people die first. They can't do anything. (HN on healthcare in a Thai refugee camp).

Common Health Problems of Refugees

This chapter will discuss common diseases and conditions that burden refugees worldwide. Communicable diseases, substance abuse, and mental health are just some of the health problems that affect refugees. While conditions such as infectious diseases may receive more attention from public health campaigns than other health problems, it is important to note the impact that all illnesses play in refugee situations.

Communicable Diseases:

Refugee camps provide abundant opportunity for the spread of communicable diseases. Malaria, pneumonia, and diarrheal disease are the leading causes of morbidity and mortality of children under five in UNHCR refugee camps throughout Africa and Asia. Hershey and colleagues report that "the primary causes of mortality among camp-based refugee children younger than five years of ages were malaria (20%), pneumonia (20%), diarrheal disease (7%), neonatal deaths (11%) and acute malnutrition (10%) (Hershey et al. 2011: 8). Malaria remains a significant cause of childhood mortality among refugees often due to the location of the refugee camps. The authors concluded that risk factors for higher crude mortality included newly opened camps, proximity to conflict regions and increased travel time to referral hospitals. Burmese refugees are susceptible to high rates of malaria, both in Burma and in Thai refugee camps. Pneumonia, diarrheal disease, and malnutrition are also rampant in the Thai refugee camps (Beyrer and Lee 2008; Turner et al. 2010).

Acute respiratory infections are another health burden that contribute to the morbidity of refugees. As Bellos and colleagues explain:

> Diseases that cause a visible impact through dramatic epidemics, such as measles, cholera, dysentery and malaria are usually considered the top threats during humanitarian relief operation…by contrast, acute respiratory infections (ARI) have received far less attention in humanitarian policies and programmes, despite being the largest baseline contributor to disability-adjusted life-years (DALYs) lost and the leading single cause of mortality among children under 5 y worldwide (Bellos et al. 2010: 1).

A number of risk factors lead to ARI, including malnutrition (both chronic and acute); inadequate shelter conditions due to displacement or destruction of houses and resulting exposure to cold temperatures and/or to indoor air pollution, overcrowding, decreased provision of measles, pertussis, and Hib vaccinations; and lack of or delay in diagnosis and treatment due to insecurity and breakdown in health services (Bellos et al. 2010). All of these are indicators frequently found in refugee settlements and difficult to combat due to lack of resources. If left untreated refugees become carriers of disease and can expose unsuspecting populations in their resettlement country to serious disease.

Mental Health:

Refugees are heavily susceptible to mental health problems because of their experiences as displaced persons. Forced migration for refugees "involves a shared set of core experiences of violence, disruption, and loss" (Miller and Rasco 2004: 4). Stressors begin during a pre-flight period, continue through migration, and continue after a refugee's displacement. Some potential stressors during these periods include exposure to violent experiences and destruction of one's home and property, separation from family members and abandonment of one's entire material possessions, and lack of economic self-sufficiency and discrimination, respectively. Throughout these periods refugees are constantly challenged, leading to continued distress and mental health problems (Lustig et al. 2004)

Post traumatic stress disorder and depression are two illnesses that greatly impact refugee populations. The stressful events experienced by refugees affect their physical health and can contribute to the presentation of symptoms such as diarrheal disease, malnutrition, and infection (Lustig et al. 2004). Among refugees, "somatization has been found to be a significant component of symptomatology. Chronic physical complaints may indicate underlying psychological distress" (Lustig et al. 2004: 31). Refugees continue to have worse mental health than other populations due to their life histories, which develop increased morbidity in refugee settlements.

Primary healthcare clinics (PHCs) are where the majority of psychiatric morbidity is encountered (de Girolamo 1994: 266). About 25% of refugees in primary health care settings show some kind of psychological suffering; depression, anxiety, and PTSD are the most common conditions (de Girolomo 1994). Psychological disorders witnessed in refugee health care facilities include depression, which is the disorder most frequently seen in primary health care, somatization and masked depression, anxiety, and fatigue (de Girolomo 1994). Because healthcare resources are scarce in refugee settings, mental health professionals are frequently unavailable to treat psychiatric disorders.

Primary health care practitioners treat these patients instead of specialists because the host countries of refugee camps are predominantly middle and low-income countries without sufficient practitioners. A WHO study identified that a substantial number of psychological disorders in patients at PHCs were unrecognized by primary healthcare providers (de Girolamo 1994). The presentation of psychiatric conditions as physical symptoms is one of the main reasons for the infrequent detection in primary health care settings (de Girolamo 1994). Inability

to recognize psychological symptoms and illness leads to worsened mental health in refugees and can be easily avoided.

The deterioration of one's mental health can continue upon resettlement to a third country. While there may be greater availability of mental health resources in these countries, they are not always accessible to refugees. In the United States, for example, Medicaid will not always cover mental health services. Additionally, refugees can be hesitant to acknowledge that they have mental health problems for fear of stigma. The conditions will therefore continue to go unrecognized and untreated.

Substance Abuse:

Substance abuse is a common problem among refugees and both a cause and effect of mental illness. Alcohol use in populations displaced in conflict remains a public health challenge as "globally, substance use is a important cause of ill-health and mortality-alcohol alone accounts for some 4% of mortality and is linked with a number of mental health problems including depression" (Ezard et al. 2011: 2). Substance abuse can have serious implications for one's health and the health of others. Specific problems from conflict-affected populations include: alcohol related suicides, gender-based violence, injection drug use-related risks such as HIV and other blood-borne virus transmission and TB treatment failure, and disruption to household economy which exacerbates already high levels of poverty (Ezard et al. 2011). Substance abuse can have a wide range of consequences for individuals, households, and the surrounding community.

Refugee settlements influence an individual's substance abuse, often precipitating it. In refugee camps alcohol is readily available. It can be both purchased and home brewed (Ezard et al. 2011). A refugee's past experience may include traumatic events, which can further trigger a

need for intoxication. Living in refugee camps for extended periods, often multiple decades, leads to feelings of restlessness, depression, and obsoleteness. This can trigger the need to imbibe, often for the sole reason of boredom (Ezard et al. 2011).

Substance use in refugee populations is not an isolated occurrence. It is based on underlying factors inherent in the refugee experience. Interventions must be added to other primary care afforded to refugee populations to decrease its prevalence. Substance abuse can be both a cause and result of poor mental health, which is another significant problem among refugee populations. Substance abuse in refugee camps can have lasting effects, including continued addiction after a refugee's resettlement. This prolonged abuse can lead to worse health outcomes and further healthcare needs.

Three Public Health Concerns in Refugee Populations

> We did have free healthcare. Different countries, people would come to help. And the volunteers are our own people. People who were providing the medicine were from different countries to help the refugees. Whenever time get sick, they give you free pills. You tell the reason why you visit for and what kind of healthcare you need and they give you the pills. Its kind of difficult, if you have like a big problem. So you have to, on big surgery, you have to pay a lot of money. The camp doesn't really have the people, they don't have the top doctors to help you for surgery. Some amount that we have, of women's birth and giving babies, we have doctors for that one too." (MN on Mae La refugee camp).

Refugee health is a major public health concern because it affects other populations in a variety of countries through transnational movement. Refugees are susceptible to infection and disease, as well as a host of mental health problems as a result of their precarious living conditions and the stressful refugee experience. According to the UNHCR, less than half of the world's refugees live in settlement facilities. Providing them healthcare is a difficulty faced by the host country responsible for the camps as well as a number of intergovernmental organizations. Three challenges to providing healthcare to refugees include disease prevention

and promotion, adherence to drug therapy, and the objectification of refugees, all of which are further found upon refugee resettlement in America.

Healthcare Promotion and Prevention:

Because of poor health services in refugees' home country they frequently arrive at refugee camps in a second country with significant health problems. These include high rates of tuberculosis, malaria, hepatitis, and HIV, which then become a problem for the host country to handle. (Palinkas et al. 2003: 19). Healthcare promotion and prevention through education is an important strategy to minimize the morbidity of refugee populations and to limit the potential for the spread of disease.

Providing initiatives to educate refugees can be challenging because implementation is "often hindered by more immediate concerns of access to care because of the lack of transportation, adequate translators, and health care providers willing and able to [treat] refugee patients" (Palinkas et al. 2003: 21). Refugee settlements frequently lack ample healthcare workers to provide for the population. Without healthcare promotion and preventive care options refugees develop poor health. It also leads to an increase in emergency health situations. Lack of healthcare promotion and prevention initiatives limits the uptake of health services by refugees when they need them. This translates to life in America where refugees do not understand the benefits of visiting a practitioner for primary healthcare. Instead refugees will not visit the hospital until a condition worsens and they must visit the emergency room.

Adherence:

Adherence to treatment regimens is an ongoing struggle with all populations worldwide. Among HIV positive persons and those with tuberculosis or other infectious diseases proper treatment adherence is necessary to ensure viral suppression and prevent drug resistance.

Conflict affected and forcibly displaced populations, such as refugees and internally displaced persons, "may face unique challenges in sustaining good adherence…and treatment outcomes while the potential for onward displacement presents a risk of pharmacy defaulting and treatment interruptions" (Mendelsohn et al. 2012: 2). The transnational migration of refugees contributes to the spread of infectious diseases across international borders. This movement also provides opportunity for the development and spread of drug resistant patterns of disease. Campaigns to educate refugees about the importance of finishing their treatment course would be a valuable in refugee camps. It also applies to refugee health after resettlement; when a refugee receives instructions to finish a course of treatment by their practitioner they will already understand the reasoning and comply, even if a language barrier exists.

Objectification of Refugees:

Challenges with administering proper health to refugees can result from the ways in which settlement administrators and outside parties perceive them. Aid organizations and governments "deprive refugees of control over their own lives…Refugees have been systematically although implicitly excluded from decision-making that affects their lives at both the levels of policy and operations" (Muecke 1992: 518). Along with a lack of control in their daily lives, broad characterizations of refugees limit their possible access to healthcare as they are constrained into categories. For example, the healthcare characteristics of women refugees are largely based on obstetrical needs. This leads to the defining of women only in terms of reproductive capacity (Muecke 1992: 518).

While looking at the health problems of refugees is important, over-classifying them as chronically *physically* ill beings is a problem: "refugees were so objectified by this perspective that their suffering and manifestations of emotional distress were fundamentally overlooked"

(Muecke 1992: 520). In order to combat this, Muecke suggests that refugees be given a voice in their experience of healthcare, in addition to their life in the refugee settlements. Allowing refugees some agency in their lives will improve their quality of life and lead to additional beneficial health outcomes. It is additionally important to recognize the political-economic factors that influence the health of refugees. Understanding the history of refugee patients is vital to recognizing possible factors leading to their infirmities. Enhanced awareness of this context can lead to improved diagnoses and treatment outcomes. Cultural difference is a barrier that refugees face to seeking healthcare in America. When practitioners are understanding of a refugee's previous circumstances, refugees receive enhanced care.

Challenges to implementing proper health solutions in refugee populations remain a constant frustration in public health. The abundant health problems that surround refugees provide a continuous stream of difficulties in their treatment. Until solutions to the broader public health dilemmas are addressed, individual disease prevention and treatment will be thwarted.

Refugees encounter considerable health problems including communicable diseases, substance abuse, and mental health conditions. With over 45 million persons currently displaced worldwide, refugees greatly contribute to the global burden of disease. Different refugee groups encounter diverse challenges on their journey to sanctuary in camps and ultimate resettlement. Refugees from Burma are one group that has faced enormous challenges as they seek refuge. There are over 1.3 million Burmese refugees worldwide including internally displaced persons still living in Burma. As of January 2014, approximately 120,000 Burmese refugees were living in refugee camps in Thailand along the Burmese border (A Brief History of the Thailand Burma Border Situation, TBC). In these camps, the Burmese refugees suffer from many of the same

health problems as other refugees. They lack adequate resources and healthcare provisions. These individuals, often stuck in resettlement camps for decades while they await the chance to resettle in a third country, are unable to return to their home country due to civil unrest and military persecution.

CHAPTER 3: BURMA

Background of Burma

Burma or Myanmar? Controversy remains over whether to call the country by its previous title, Burma, or rely on the current name of Myanmar. Prior to British colonization there was much internal debate about whether the proper name was Burma or Myanmar. The British officially named the country Burma upon colonization in 1886. After independence from Britain in 1948 the country called itself the Union of Burma, which was subsequently amended to the Socialist Republic of Burma. The SLORC (State Law and Order Restoration Council) military government changed the official name of the country back to the "Union of Burma" in September 1988. They changed the name once more to the "Union of Myanmar" in July 1989, which is still in place today. The name change has become "politically charged" because "while the SLORC claims that is has simply reinstated the original names for the country, its political opponents in particular regard the changes as illegitimate" (Lang 2002: 8). Opposition groups, including the ethnic minorities population, call for a boycott of the name "Myanmar" as a form of protest against the regime's human rights abuses (Amnesty International 2001). This paper will refer to the country as Burma out of respect for the Burmese refugees interviewed who do not support the regime that implemented the name change.

Burma is the largest country in mainland Southeast Asia with approximately 260,000 square miles of territory and a population of 52,797,000 (Myanmar, WHO). It borders China on the north and northeast, Laos and Thailand to the east, India and Bangladesh to the northwest, and the Bay of Bengal and the Andaman Sea to the south and west. The terrain is diverse with lowlands around the Irrawaddy and Chindwin Rivers and rugged mountains and plateaus in the highlands. The lowlands are considered the heartland of Burma and are inhabited predominantly

by the majority Burman ethnic group. Numerous hill tribes inhabit the mountainous area of the country, including the Kachin and Chin ethnic minorities.

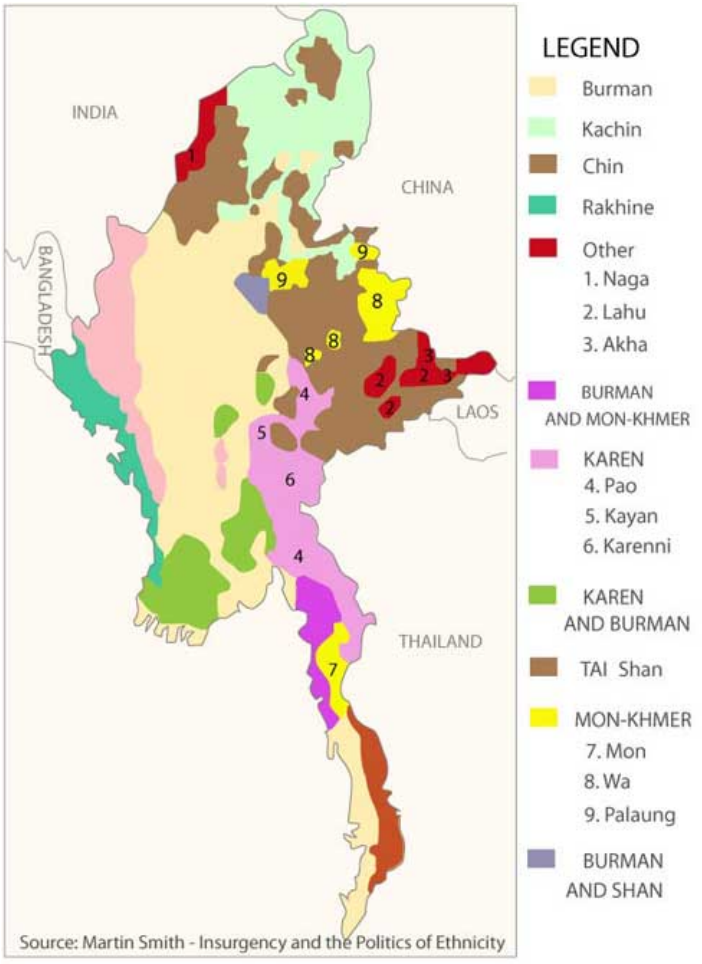


Figure 2: Map of Ethnic Groups in Burma (Burmese Migrants in Thailand, GeoCurrents)

Ethnicity has been a source of constant conflict in Burma. There are approximately 130 ethnic groups in the country (Topich and Leitich 2013). The largest non-indigenous groups are the Chinese and Indian minorities. The Burman are the largest ethnic group in Burma, making up roughly 70 percent of the total population (Topich and Leitich 2013). Shan account for 9%, Karen for 7%, Rakhine 4%, Chinese 3%, Indian 2%, Mon 2% and other 5% of the total population (Topich and Leitch 2013). Other ethnicities are the Kachin, Kayah, and Chin groups.

The Burman people have dominated the region historically and politically for the past 1,000 years (Topich and Leitich 2013).

Since independence in 1948 the Burman have controlled the government by dominating military positions. Minority populations have accused them of trying to implement a "Burmanization" policy throughout the country in an attempt to further marginalize minority groups in economics, politics, language, and education. The government has used violent and repressive tactics in attempts to accomplish their goal of unification. However, in doing so they reject the rich ethnic culture and history of the minority groups; these groups therefore seek political autonomy in order to live freely. Ethnic minorities have been subject to constant conflict and turmoil with the Burmese government since independence.

Burmese is the official language of Burma and is spoken by 80% of the population, often in addition to a preferred ethnic language (Topich and Letich 2013: 7). The ethnic minority populations speak over 100 additional languages. Approximately 70% of the population is involved in agriculture (Topich and leitich 2013). The natural resources include teak and other wood, as well as minerals including petroleum, lead, zinc, tin, tungsten, and precious stones such as jade and sapphire. Burma is the largest mainland producer of oil in Southeast Asia; however, internal conflict has led to the inability to extract these natural resources, which further perpetuates the economic difficulties in the country. The dominant religion in Burma is Theravada Buddhism. Approximately 89% of the population is Buddhist. The Karen minority living in southeast Burma practice Christianity, which accounts for four percent of the population. Islam is practiced in the Arakanese region by an additional four percent. The remainder practice mostly animist beliefs (Topich and Leitch 2013: 9).

In Burma, life expectancy at birth is 63 for men and 67 for women years (Myanmar, WHO), ranking Burma 170 of 223 countries in the world (Burma, CIA). Maternal mortality is high at 200 deaths per 100,000 births (Myanmar, WHO). Health expenditures account for less than 2% of the GDP (WHO), ranking it 189th in the world, better only than Qatar (Burma, CIA). Education expenditures account for 0.8% of the GDP (Myanmar, WHO), ranking Burma 172 of 173 countries (Burma, CIA).

History of Burma

Pre-Colonial Burma:

The first Burmese empire at Bagan was founded in 849 CE and continued with a line of 55 kings ruling over the territory for the next 12 centuries (Topich and Leitich 2013: 25). During the Toungoo Dynasty (1531-1752) Tabinshwetti united Upper and Lower Burma which had been split in past battles. The Konbaung period (1752-1885) was the last dynasty to rule Burma before British colonization in 1886. During this time the empire was expanded, which resulted in the historic conquest of Ayutthaya, the Siamese capital, in the 1760s. During the dynastic period a number of powers, including the Mon, Burman, Shan, and Arakanese kingdoms, competed for control of present day Burma (Lang 2002: 26). The Burmans settled in Burma between 600-800 CE and had conquered the whole of Burma by 1100 (Lang 2002: 26). In the 1300s the Shans entered the territory, which led to a long history of conflict between the Burmans, Shans, Mons, Thai, and Arakanese. Political authority in pre-colonial Burma was based on patron-client relationships, where citizens were to show loyalty and respect to kings, local princes, or military officials. This favored autonomy and allowed for ethnic heterogeneity.

Colonial Burma:

The British conquest of Burma began in 1824 with the first Anglo-Burmese war and continued until Britain won the third Anglo-Burmese war and established Burma as part of the British Empire in January 1886. The war was initiated due to border tension between Burma and Cachar, India, a British protectorate (Lang 2002). Further territorial disputes continued between Burma and British ruled territory until 1824 when the British officially declared war on Burma. The British had little knowledge of the Burmese culture and relied on Indian assistance to infiltrate the culture. This relationship resulted in prolonged immigration of Indian professional class citizens into Burma. Burmese citizens, particularly the ethnic minorities, began to resent the incoming workers as they had increasing trouble finding employment (Topich and Leitich 2013).

Ethnic autonomy continued under colonial rule (Lang 2002). British rule advocated for the rights of minorities, supported ethnic plurality, and attempted to promote equality across the nation. This in turn sparked a nationalist movement with intent to integrate the ethnic minorities into a single national body.

Nationalism in Burma continued to grow during the 1920s, especially after a number of economic challenges, which included shortages disrupting the rice export trade, poor growing conditions that lasted for several years, and the implementation of tax collections. Such issues caused economic and political unrest and led to a more directed nationalist struggle against British colonial powers. In addition, the tendency under colonial rule to respect ethnic boundaries inspired increased tension with the anti-colonial nationalist movement. The nationalists called for an emphasis of Buddhism, Burmese language, Burman cultural values, and the integration of the ethnic groups into a unified nation. In the early 1930s Hsaya San led a peasant rebellion. It was ultimately silenced but demonstrated civilian displeasure with the

current situation. In 1935 Burma ceded from India and became an official colony through the Government of Burma Act.

Post-Independence: 1947-1962:

Burma achieved independence from Britain in 1948. The Panglong agreement, which was "designed to guide the national integration of Burman and minority ethnic groups [and] advocated future ethnic quality and autonomy based on federalism," was introduced in 1947 (Lang 2012: 34). The first constitution, drafted in 1947, created a federal structure of government and attempted to incorporate ethnicity into the independence process. It intended to "address the complex problem of how to construct a state in which formerly separate peoples were brought together into an administrative and territorial union" (Lang 2002: 34). Elections were held in April 1947 and the Anti-Fascist People's Freedom League (AFPFL) became the first party to lead Burma after independence.

On January 4, 1948 Prime Minister U Nu of the AFPFL took over the newly independent Union of Burma. The AFPFL dominated the political system in Burma from 1948 until 1958, despite many interfering conflicts. Many ethnic groups were not happy with the Burman-dominated political system and did not see an advantage to being part of a newly formed Burmese state (Topich and Leitich 2013: 79). Aung San, a political leader, had been adept at negotiating with the ethnic groups and keeping peace. However, after his assassination in 1947, internal conflict had grown and ethnic insurgencies were less easily controlled. Certain groups initiated rebellions in an effort to gain autonomy. The first groups to engage in insurrections were the Karen, Mon, and Arakanese. Within five years the Shan, Kachin, and Chin groups joined in the insurrections. By 1949 seventy-five percent of the towns in Burma had been overtaken by one insurgent group or another (Lang 2002: 24).

Constant conflict between the majority Burman government and ethnic minorities hampered political progress in Burma (Topich and Leitich 2013: 77). At this time the Burmese army ceased recruiting from minority groups and the Army became Burman dominated, further contributing to the "militarization of ethnic perspectives" in Burma (Lang 2002: 33). Karen opposition posed a particular challenge to the Burman dominated government because they believed that the British had promised them an independent state (Topich and Leitich 2013). The Shan, Kachin, Arakanese, and Chin populations also rebelled against strict governmental control.

Elections in 1956 once again led to victory for the AFPFL, but due to internal fracturing, the party finally split in 1958. The political situation worsened after this and led to violence between political movements in August and September of 1958. Prime Minister U Nu asked the military to take over as a caretaker government and granted leadership to General Ne Win, the Commander and Chief of the armed forces. As a result of these initial political challenges after independence, the Burmese military, the *tatmadaw*, began extensive expansion.

Elections in 1960 were held in an effort to return Burma to civilian rule. U Nu ran again for the AFPFL party, this time focusing his campaign on promoting Buddhism as the state religion and promising increased federalist structure. His overwhelming victory was met with opposition from military powers due to his continued attempts for a federalist system. After further government reforms were implemented Ne Win staged a coup against U Nu's government on the grounds that it was "conducting negotiations with minority leaders which would lead to the disintegration of the country" (Lang 2002: 36).

Ne Win: 1962-1988:

General Ne Win exerted military domination through a military-backed socialist government under the name the Revolutionary Council (RC). The parliament was dissolved and

the constitution suspended, and no mention was made about future elections. The Revolutionary Council took measures to ensure total control over the country. Foreign press coverage was restricted in an effort to eliminate independent media. Additionally, universities were put under control of the military to quell political actions from student movements.

Because Ne Win worked to rid the country of any foreign influence, by the late 1970s the Burmese economy was in serious trouble (Topich and Leitich 2013). The isolation of the country had led to significant debt and China began funding the regime. Burma was listed as the least developed nation in 1987 (Topich and Leitich 2013: 92).

Under continued military rule the trend toward a more centralized, Burmanized, and militarized state intensified (Lang 2002: 37). All citizens "were to share a common identity and loyalty" as the increasingly ethnocratic and assimilationist state emphasized that that nationalist culture would be shaped by the numerically dominant Burmans (Lang 2002: 37). In an attempt to suppress ethnic insurgencies, the *tatmadaw* introduced the "four cuts" strategy, which ultimately aimed to cut the insurgents off from their support system. This involved cutting food, funds, intelligence, and recruits from insurgent groups by eliminating and displacing townspeople who were suspected of helping them (Topich and Leitich 2013). This strategy was implemented in an effort to cut ties between insurgents and their villages and included tactics such as displacement and resettlement of villages. These practices kept ethnic groups in opposition with the ruling party and similarly influenced other citizens.

1988 Uprising:

Between 1988-1990 hopes for modernization and democratization inspired by U Nu were crushed under the repressive military junta that controlled the country. In September 1987, the regime decided to get rid of 25, 35, and 75 kyat notes (the currency), sparking protests as many

Burmese citizens lost much of their savings within a few days. On March 16, 1988, the student movement marched in protest and called for the resignation of Ne Win as well as the establishment of a multiparty democracy. The regime blocked the students and dozens were killed and others beaten to death. On Bloody Friday, March 18, both students and ordinary citizens rioted on their way to Soule Pagoda in central Rangoon. So many arrests occurred that police had to send detainees to a prison outside the city. Many citizens fled the country at this time because the government targeted them as political activists.

In September 1988, the National League for Democracy (NLD) emerged as the most significant threat to the regime. They called for the "formation of an interim government that would transition to a true democratic system" (Topich and Leitich 2013: 99). Aung San Suu Kyi, the daughter of the assassinated politician Aung San, became the general secretary of this party.

On Sunday, September 18, 1988, the military staged a coup and established the State Law and Order Restoration Council (SLORC). The platform of the regime was "restoration of law, order, peace, and tranquility; providing security; assisting the population regarding food, clothing, and shelter; and the eventual fulfillment of mutiparty elections" (Topich and Leitich 2013: 101). The previous constitution was no longer in place and military control was re-established. The new junta included 19 high-ranking officials of the military, all of whom were Ne Win loyalists. The military quickly extinguished resistance to the takeover.

The regime immediately expanded the military intelligence capability. They aimed to eliminate political dissent among the civilian population and strengthen operations against ethnic insurgencies along the borderlands. Whereas before the Burmese army would move into an area, cause destruction to local villages, and leave, they were now able to remain in one area and

launch attacks outward for more prolonged periods. They also laid more landmines, forcing people to use the roads where the military would stage attacks (Lang 2002).

Push for Democracy: 1988-2007:

During the spring of 1989 the SLORC changed the name of the country from "the Union of Burma" to "the Union of Myanmar." They claimed that the name Burma carried colonial connotations and wanted to get rid of it. The regime maintained control of the country through the 1990s, stalling calls for political freedom and economic development. In 1997 the regime changed their name from the State Law and Order Restoration Council to the State Peace and Development Council (SPDC) in an effort to reconfigure the regime's image.

On November 8, 1989, the government announced that they would be holding elections the following May 27, 1990. The NLD was the most significant opposition movement in Burma. The SLORC began a smear campaign against Aung San Suu Kyi and her party in an attempt to curtail popularity for the NLD. Despite these efforts the NLD won nearly 60 percent of the vote. However, the SLORC did not make any move towards transitioning to the new party. They declared "transfer of power could not take place until a new constitution was finalized" (Topich and Leitich 2013: 105). All legislative, executive, and judicial powers remained with the SLORC.

The NLD called for negotiations to transfer power to them as well as for the immediate release of NLD leaders and other political prisoners. The *sangha*, the Buddhist religious leaders and monkhood, attempted to help facilitate change by rejecting offerings from the *tatmadaw*, the equivalent of excommunication. The SLORC responded by arresting monks and raiding monasteries, further damaging their legitimacy and trust in the SLORC regime. The junta

responded to increased pressure through internal repression; hundreds of citizens were arrested as the junta attempted to consolidate power once again.

Opposition to the ruling SPDC continued; ethnic insurgencies persisted and the NLD gained more supporters. In 1989 the SLORC had begun negotiating cease-fire agreements with ethnic insurgencies. By 1995 the Mon ethnic group was the fifteenth to sign a cease-fire contract (Lang 2002). However, at the same time the government was promoting peace through cease-fire agreements, they continued to conduct devastating counterinsurgency offensives (Lang 2002). The *tatmadaw* once again implemented the "four cuts" strategy to ensure the success of eradication efforts. During the peak of these efforts 2,500 villages were destroyed and over one million citizens were displaced (Lang 2002).

2007 Protests:

Calls that the SPDC was "drifting further out of touch with the average citizen," intensified when authorities unexpectedly removed all subsidies on fuel and gas prices as well as basic commodities. In some places the natural gas prices went up as much as 500 percent (Topich and Leitich 2013: 126). The increase shocked Burmese citizens and threatened the livelihood of the majority of the population. Protests broke out. On August 19, 2007 hundreds gathered for a march in Rangoon. The government responded by arresting prominent activists and harassing the general population. The "Saffron Revolution" originated on August 28 when monks took to the streets in their saffron colored robes to join the protest. The military launched a brutal crackdown against the monks. They were beaten, apprehended, and imprisoned. This abuse caused a serious backlash against the regime (Topich and Leitich 2013).

By September 23, 2007, protests had turned into a national movement with over 20,000 students and political activists protesting in Yangon. Subsequently over 100,000 people gathered

to call for the release of Aun San Suu Kyi and other political prisoners. By September 25 authorities began arresting public political figures and raiding monasteries during the night. The crackdown became more violent as the military used live ammunition to quell the chanting crowds. By September 30 the remaining protests were subdued. The regime severed the Internet so that western media could no longer follow the brutal suppression of the population. Detention centers were set up and torture and human rights violations became commonplace. The regime crushed any signs of dissent on the surface, but underlying tension remained.

Cracking down against the *sangha*, the Buddhist religious leaders, was a great infraction in the eyes of the country; the SPDC could do little to redeem themselves after their actions in the Saffron Revolution. This uprising and the subsequent government tactics forced many activists and their friends into hiding. Once the government identified a political opponent they would exert pressure on uninvolved friends and family in an effort to arrest them. Tens of thousands of civilians fled the country out of fear, generally hiding in the jungle before seeking sanctuary in refugee camps across the border in Thailand.

Modern Burma:

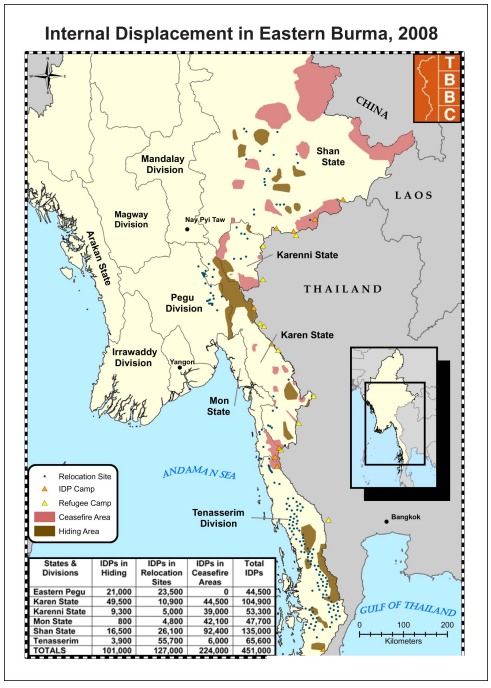
In May 2008 the dictatorship ratified a new constitution as they took steps towards democracy. It created a civilian-dominated government with a two-house parliament. Elections were held in November 2010. The new regime in power, the Union Solidarity and Development Party (USDP), abolished the SPDC, although the military retained substantial power. Aung San Suu Kyi was released from house arrest. Thein Sein came to power in March 2011 and began implementing an ambitious reform agenda. Eventually Aung San Suu Kyi developed a relationship with Thein Sein and seemed convinced that the new administration was sincere in its efforts to move Burma forward. Thein Sein was intent on opening the country once again and

developing the economy. His agenda included reinvigorating the economy, reforming politics, and dealing effectively with human rights issues.

The most significant challenge for the future development of Burma continues to be the ethnic minority situation. Since independence in 1948 there has been constant conflict between the central government and the ethnic minorities. It has caused death, destruction, economic hardships, and the dislocation of hundreds of thousands of civilians. Cease-fire agreements were established in the past but ultimately fell through. Resolving the turmoil between the government and the ethnic groups will benefit the country and bring peace and increased stability to the citizens of Burma.

Displacement: Why People Flee

> I am from Burma. I left because where I live in Burma, in 1994 and 1996, was the time when the Burmese military, fight people. Kill people. And many people are killed by military. Other people fight and burn the rice. Military comes and burns vegetables and farmers land. Cannot stay. Have to move, close to Thailand border. Stay in Thailand border. Live there for 10 years in the Thailand refugee camp. (HN on why she left Burma)



States & Divisions	IDPs in Hiding	IDPs in Relocation Sites	IDPs in Ceasefire Areas	Total IDPs
Eastern Pegu	21,000	23,500	0	44,500
Karen State	49,500	10,900	44,500	104,900
Karenni State	9,300	5,000	39,000	53,300
Mon State	800	4,800	42,100	47,700
Shan State	16,500	26,100	92,400	135,000
Tenasserim	3,900	55,700	6,000	65,600
TOTALS	101,000	127,000	224,000	451,000

Figure 3: Map of Internal Displacement in Eastern Burma in 2008 (Burma Library, TBC)

Because ethnic insurgency and military counterinsurgency have blurred the boundaries between combatants and non-combatants, entire civilian populations have been affected by ethnic strife in Burma. Figure 3 delineates relocation sites and areas of ceasefire and hiding of displaced persons in Burma. Due to the nature of guerilla warfare, civilians are cast under universal suspicion; their response to fleeing from conflict can serve to further identify them as suspects. Guerillas gain support and resources from civilians, which make counterinsurgents assume that civilians in contested areas have aligned themselves with rebel groups. Under these circumstances it becomes impossible for average citizens to live as neutral bystanders. They instead live trapped within the conflict.

In addition to active warfare between opposition groups counterinsurgencies take revenge on local villages through systematic punishments, such as raiding and burning villages, confiscating resources, such as food and livestock, and demanding compensation, through fines and forced labor (Lang 2002: 63). Due to these harsh conditions, fear permeates all aspects of daily life for the ethnic minorities. There is constant uncertainty about when skirmishes will erupt in the area and when troops will seize and destroy villages. Communities become impoverished as able-bodied individuals are seized for forced labor, agricultural land is destroyed, villagers are forced to pay high fees, and civilians are prompted by fear to escape. Figure 4 shows areas in Burma that were controlled by the SPDC and insurgency groups in the 2000's.

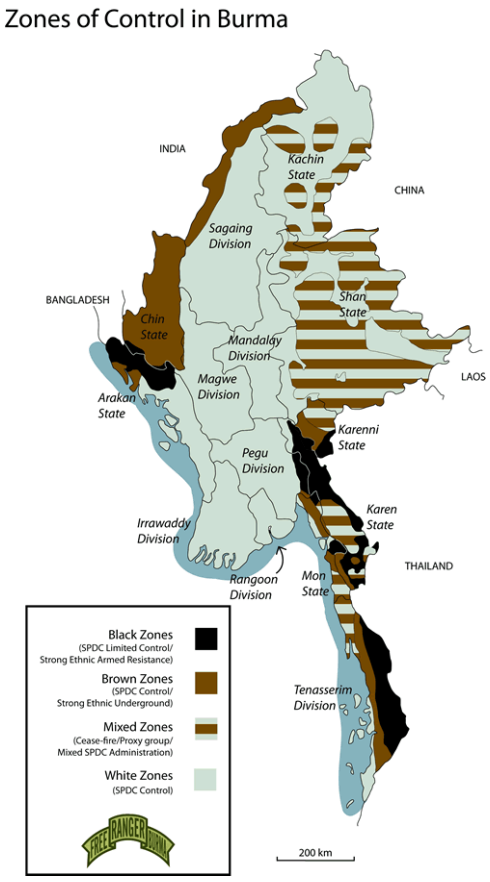


Figure 4: Zones of Military Control in Burma in the 2000's (Free Burma Ranger Report, FBR)

All of these factors cause civilian displacement and population resettlement. There are four main causes of displacement in Burma: the raiding of villages, which includes seizure of food, livestock, and other properties, interrogation, torture, and even killing of villagers; the continued imposition of coercive financial demands for various taxes and fees, extortion, and ransom; the requisition of forced portering for the military, as well as other forms of forced labor; and the forced relocation of villages (Lang 2002: 68).

An estimated 500,000 to one million people are currently internally displaced persons within Burma (Lang 2002: 75). They remain hidden in fear of retaliation by the military and counterinsurgency forces. The UNHCR has noted that people will "flee in absolute silence, not wishing, in most instances to be identified as displaced, in order to avoid persecution and fearing

execution" (UNHCR in Lang 2002: 75-76). Internally displaced persons (IDPs) remain vulnerable to attack, outside physical shelter and border camps, and may be perceived by national authorities "not as citizens meriting protection and assistance, but as part of the enemy, if not the enemy" (Lang 2002: 76). Cross-border refuge is typically the last resort for civilians, who would prefer to remain in their home country. However, those who do decide to seek refuge across the border in Thailand are faced with new challenges.

Thailand shares a porous border with eastern Burma, which has provided opportunity for Burmese displaced persons seeking refuge. Yet because Thailand never signed to the 1951 UN Convention on Refugees, nor the 1967 Protocol, refugees and asylum seekers are technically termed illegal immigrants under Thai law (See Appendices A and B). However, Thailand does honor some of the standards defined for dealing with refugees. They follow the non-refoulment principle, a key element of refugee protection, which reasons that "persons will not be forcibly returned to their country of origin where they are at risk or in danger, both at the border and within the territory of the receiving state" (Lang 2002: 82).

In addition, Thailand did sign an agreement with the UNHCR in 1975 following a large flow of Indochinese refugees into the country. Thai officials maintain that "non-participation in the agreement permits the government greater flexibility in its response to refugees and that, in view of the large refugee burden confronted by Thailand, the standards of the full obligations contained therein are too high and therefore unrealistic and unacceptable" (Lang 2002: 93). Thailand declares that they have been accepting and providing resources for refugees for over thirty years and do in fact comply with the necessary protocols. Despite not signing the 1951 agreement with the UNHCR, Thailand has accepted UNHCR presence along the Thai-Burmese

border to assist with refugee migration. Thailand continues to maintain a flexible approach to accepting and providing sanctuary to citizens fleeing from Burma.

Thai/Burmese Border Politics

Thailand and Burma share a 2,401-kilometer boundary that has been a source of conflict for centuries. The modern boundaries between Thailand and Burma were established during British Colonial rule in Burma in the 1800s. The border demarcation began in the south and was negotiated between Siam and the British East India Company after the first Anglo-Burmese war in 1826. This boundary was subsequently extended northwards in 1852 after British annexation of Lower Burma. The final stretch was marked in 1893 following British annexation of Upper Burma.

The relationship between Thailand and Burma dates back to the Burmese conquest of the ancient Thai capital Ayutthaya in 1767, leading to great animosity between the two countries. A negative image of Burma has remained among the Thai population to this day and has been said to influence Thai foreign policy towards Burma (Lang 2002: 139). Diplomatic relations between the two countries were established following Burmese independence in 1948. Their relationship has since fluctuated as one of cooperation and hostility. A more positive relationship has been maintained since 1988.

Prior to 1988 a key source of conflict between Thailand and Burma was based on Burmese displeasure with Thailand's acceptance of ethnic insurgent forces seeking insurgent sanctuary in Thailand. The insurgents were accused of engaging in illegal arms trade and generating income derived from the black market and smuggling trade from Thailand in the 1960s (Lang 2002). Thailand claimed that they did not allow such activities in an effort to promote a more trusting relationship. Tensions increased when formerly exiled Burmese leader

U Nu left India and was granted political asylum in Bangkok; he was later forced to leave the country after relations improved once again in 1973. The *tatmadaw*, the military forces, also entered Thai territory occasionally resulting in the injury and death of Thai citizens and the destruction of their property, which has led to Thailand's continued distrust of the Burmese.

While ethnic minorities and insurgent armies fighting against the Burmese government originally occupied the borderlands, the *tatmadaw* has since gained a considerable hold on virtually all of their previously controlled territory. This occurred mainly during the large counterinsurgency movements in the mid-1980s through the mid-1990s. This change in control has had considerable consequences for Thailand. Previously, Thailand had tried to balance relations with Burma while dealing with ethnic insurgencies along the border and attempting to maintain an official relationship with Burma. However, these territory changes have led to altered dynamics based on various factors including:

> 1) Thailand's abandonment of its previous buffer policy, which relied on the various non-communist opposition groups to act as a 'buffer' separating Thailand from its historically hostile neighbor and to prevent cross-border links between the Thai and Burmese communist insurgencies; 2) diplomatic rapprochement with Rangoon and pursuit of a 'constructive engagement' policy, the foreign policy concomitant of Thailand's closer business and military relationships with the SLORC, cultivated since 1988; and 3) a new security environment in which the *tatmadaw* is now Thailand's immediate neighbor and cross-border incursions … have complicated the security of the refugee camps and the surrounding territories within the Thai borderland (Lang 2002: 138).

In 1988 Thailand and Burma reached a diplomatic relationship inspired by Burma's new economic policies. Thailand was the first country to develop an association with the SLORC. Their affiliation led to Thailand's gain of 20 logging sites in Burma, 16 of which were in insurgent-held areas. Additional national resources were exported by Thailand from Burma. This was beneficial to Thailand because a nation-wide logging ban had been established in Thailand in November 1988. With the logging concessions granted to Thailand the borderland

forests of Burma were destroyed, transforming security conditions for ethnic insurgent groups. It also challenged the black market business opportunities for the ethnic insurgent armies. In June 1993 after a number of Thai companies secretly purchased additional logging territory from insurgent areas, Burma decided to terminate logging contracts with Thailand.

In the mid-nineties oil and gas became the largest natural resources exported from Burma. Thailand once again became involved in the trade. Thai interest in Burmese resources encouraged the development of military stability in border regions to ensure its continued success. The *tatmadaw* managed to impose control over many of the rebellious border regions. This led many ethnic forces to depend increasingly on Thai support for military supplies and sanctuary.

A significant source of tension between Thailand and Burma has been the frequent cross-border raids by Burmese counterinsurgency groups into refugee camps along the border. The Democratic Karen Buddhist Army (DKBA) has been primarily responsible for the raids. They were a breakaway group from the Karen National Union and backed by the Burmese government. The situation has since stabilized, but in the 1990s a number of camps in supposedly safe areas were subject to regular, violent raids. By April 1995 the attacks had become a serious concern and several long-established refugee camps were completely destroyed and abandoned. These assaults continued into 1998. Additional camps were closed due to proximity to the border and many refugees were forced to flee into the jungle. Other camps absorbed the smaller ones, generating increasingly large populations within the settlements. Mae La camp increased from 5,000 persons in 1995 to around 25,000 by 1996, making it the largest camp on the border. By 2000, there were just 12 camps along the border, compared with more than 30 in 1995 (Lang 2002: 157).

Figure 5: Refugee Camps in Thailand (A Brief History of the Thailand Burma Border Situation, TBC)

Today there are nine Thai refugee camps along the Thai-Burma border, as shown in figure 5. They are arranged into four groupings based on The Border Consortium field office that manages them: Ban Mai Nai Soi and Ban Maw Surin, the two most northern camps; Mae La Oon and Mae Ra Ma Luang; Mae La, Umpiem Mai, and Nu Po; and Dan Yang and Tham Hin, the two most southern camps. There are currently 119,101 refugees living in the nine refugee camps (A Brief History of the Thailand Burma Border Situation, TBC). Karen people make up the vast majority of refugees located in these camps (77.7%), followed by a moderate Karenni population (11.8%) (TBC). A small Burman population (2.9%), along with minimal

numbers of Mon people (0.8%) and a combination of other groups (6.9%), account for the remaining population (A Brief History of the Thailand Burma Border Situation, TBC). All of the camps remaining today are the result of consolidation between smaller camps or the creation of new camps to accommodate displaced refugees from destroyed camps.

Since 2000 relations between Thailand and Burma have remained complex as Burma continues to violate the rights of their citizens and violate their border with Thailand. There is a constant distrust between the nations based on a long history of conflict. Thailand's push towards democracy has widened the gap between the two countries. While economic ties may help to maintain a more positive relationship, unless Burma makes serious changes to their governance policies, tension will likely remain between Thailand and Burma.

CHAPTER 4: THE HEALTH OF BURMESE REFUGEES IN THAILAND

> If we got sick, we go to the hospital. And then, yes, if you have more major issues, they send us to the Thai hospitals. This happened a lot. Like for some complicated situation like when you deliver and also when you have some chronic diseases, like a cancer and some other major, they send you to the Thai hospitals. It's easy to get services there [in the camp]. But for the major issues and emergency stuff sometimes it was a little difficult because of the transportation. They are free services. In the camp, they had primary care services. I'm not familiar with the treatment in Thai hospitals. According to some of the patients they said, yeah, sometimes it is like discrimination because of language. Those people never see you as a person when you are as a refugee there. Especially people from Burma, Thai people are looking down to them all the time because of poor health status, everything I mean. So it is a little bit difficult. And then there is the language barrier thing (JW on healthcare in a Thai refugee camp).

There are currently over 119,000 refugees from Burma living in Thai border camps and tens of thousands of displaced persons, or "illegal immigrants" within the country (A Brief History of the Thailand Burma Border Situation, TBC). Burmese people have been living in Thailand for centuries and are faced with many barriers living there today, both in and outside of the camps. Due to animosity between the two countries Burmese individuals are not always treated kindly and can face discrimination in their daily activities. Living in the border camps can also have detrimental health effects on refugees. The Burmese refugees situated along the Burmese/Thai border suffer many of the same health problems seen in worldwide refugee populations, as well as others more specific to Thai camp conditions.

Treatment of Burmese Refugees and Displaced Persons in Thailand

> The camp was a place, kind of like a trap that you couldn't get out of. You couldn't go anywhere. If you do get out from the camp, you probably might end up with the Thai military. If they catch you they could send you back to Burma or you could be jailed. The camp is like, a place kind of like a jail. You have to stay there, you have to eat there and go to school there. You can't go anywhere, even if you want to go outside. I was there for about seven years (NK on life in a Thai refugee camp).

The Burmese people in Thailand face not only poor health outcomes while in refugee camps but also difficulties in navigating the transition to Thailand. There has been a history of

Thailand closing the border to incoming Burmese refugees many times in the past two decades. This leads to consequences for Burmese migrants. In 1997 the Thai army implemented a new strategy in which it closed the border to all new arrivals, thus denying asylum to those fleeing Burma (Hyndman 2001). They are no longer granted refugee status and are considered illegal immigrants who run the risk of bring arrested or deported if they do not register at a refugee camp. Burmese political dissidents in Thailand have a particularly difficult experience because while they have escaped persecution in Burma, they are still not recognized by the Thai Government as asylees.

Thailand has been faced with an internal debate about Burmese migrants and whether or not they are taking jobs from Thai citizens. In 1998 a new government policy "aimed at freeing up as many jobs for Thai nationals as possible was developed…and the government announced its intention to deport Thailands's entire foreign 'illegal immigrant' workforce" (Hyndman 2001: 42). This included deportation of potential asylum seekers. This decree has led to thousands of displaced Burmese people being in constant fear of arrest and deportation. Increased measures must be taken by the Thai government and international organizations to provide settlement opportunities for these migrants.

Burmese refugees have been living in Thailand for over 20 years. The Thai government prefers encampment as a way to limit the flow and number of Burmese refugees that they are responsible for (Brees 2008). Therefore, strict distinctions are still made between refugees in camps and those living outside of camps. Thailand imposes these regulations based on the assumption that "both protection and assistance are supposedly more efficient in the context of a refugee camp, and that self-settled refugees are assumed to take care of themselves. Refugees thus have the choice either to receive protection and assistance in camp, or to bypass the refugee

camps and self-settle without support" (Brees 2008: 380-381). However, refugees do not always have a choice. Some Burmese migrants must work in order to earn money for their family in Burma, which is impossible in the refugee camps. Therefore, those who may be eligible for refugee camp status are excluded from aid and considered illegal immigrants in Thailand.

Both groups of refugees have a positive impact on the Thai economy through their agricultural work inside as well as outside the camps (Brees 2008). The Burmese work in Thailand in order to survive; however, the Thai government believes that they are stealing jobs from Thai nationals. In fact, Burmese workers do not intend to take away jobs. Their ultimate dream is to return to Burma as soon as it is safe (Brees 2008). The Thai economy benefits from the labor of Burmese refugees and could suffer without their contribution (Brees 2008).

Burmese migrants have been integrated into the Thai agricultural system for centuries. With the more recent flow of immigrants and displaced persons to Thailand, however, the new official position of the Thai government is that refugees are not allowed to work (Brees 2008). In order to improve this situation and allow greater acceptance for Burmese workers, who are contributing to the Thai economy, "the legal framework should be adapted to assist a better realization of refugee potential. Legalizing access to work would merely confirm an existing situation as refugees are already economically integrated in Thailand" (Brees 2008: 392). An improved policy would lead to more equal treatment of Burmese migrants and displaced persons and ensure better living conditions as they adapt to life in Thailand.

Health Concerns for Burmese Refugees in Thailand

> "There was a giant outbreak of dengue fever while we were there. Thailand was having their worst dengue fever season in like 10 years during this past summer. So at the very start of the rainy season is when I got there. While I was there, two little children died in Mae La from it. A bunch of other people got it but they got better. Yeah, there were hundreds sick. In all the camps really. So that's a pretty common problem they deal with. And also while I was there a couple people had malaria; there were a couple

> suspected meningitis cases. They also had an entire section of the camp, called TB village, so when you have active TB they sent you to go live in TB village until you've been treated and are no longer contagious. So they have TB doctors that are really specialized. And TB village is actually much nicer than the rest of the camp because it's not as dense and its quieter. So people don't want to leave once they're done." (AF, an MPH candidate, on conditions at Mae La refugee camp in Thailand in summer 2013).

In addition to migration struggles and restrictive immigration laws in Thailand, Burmese refugees combat serious health concerns in refugee camps. Burmese refugee health studies represented in this paper focus on infectious disease, reproductive health, mental health, and substance abuse. Such examples demonstrate the health challenges of Burmese refugees and the need for greater resources for those living in Thai refugee camps.

Infectious Disease:

In the border regions of Thailand infectious diseases of concern include HIV/AIDS, tuberculosis (TB), malaria, and prevalent neglected tropical diseases including filariasis, anthrax, and Japanese encephalitis (Beyrer and Lee 2008). These diseases are not only a concern within the regional population, but of particular worry for refugees living in settlements that enable the spread of disease. Refugees fleeing Burma leave with abundant health issues before integrating into camps. They are also subject to severe malnutrition, which increases their susceptibility to infectious disease. Additionally, due to the lack of accessible healthcare in Burma, "the Thai side of the Thai-Burmese border serves an ever increasing proportion of Burmese from inside Burma proper who come to Thailand for care unavailable and unaffordable at home" (Beyrer and Lee 2008: 2). This provides increasing challenges to the refugee settlements which already lack adequate funds. The ongoing difficulty in Burma will continue to take a toll on the health of the Burmese, as well as the Thai border populations, unless this changes.

Influenza virus and Acute Respiratory Infection (ARI) are two health concerns for refugees living in settlements. Refugees generally live in crowded conditions and are in contact

with populations from countries where public health infrastructure may be poor (Turner et al. 2010). Influenza is of particular concern due to its contagious nature. Although vaccinations do exist, seasonal influenza vaccinations and antiviral medicine are not readily available among the refugee population Mae La is the largest refugee camp in Thailand. It is considered an ideal location for an outbreak of influenza virus due to its crowded conditions (Turner et al. 2010). A study by Turner and colleagues reported that the incidence of influenza in the Mae La was about five times higher than in the general Burmese population (Turner et al. 2010). Strained resources and poor conditions in refugee camps contribute to the spread of influenza.

Pneumonia contributes significantly to global childhood morbidity and mortality. It is another respiratory infection that poses an especially high risk to refugees, particularly small children (Turner et al. 2013). While the global incidence of pneumonia in children under five is 0.28 episodes per child year, the incidence in Southeast Asia is estimated to be closer to .36 episodes per child year, and even greater in refugee settings (Turner et al. 2010). Turner's study also found that of the participants, roughly half of the children developed pneumonia in their first two years (Turner et al. 2010). Risk factors for pneumonia included crowding, indoor air pollution, and having a smaller living space. Infants in refugee settings are additionally susceptible to opportunistic infections and the development of bacterial superinfections because of their rates of malnutrition. Monitoring the spread and development of pneumonia in refugee settings is very important due to its impact on infants.

Malaria is another significant cause of morbidity and mortality in Burma: "the combination of multi-drug resistant *plasmodium falciparum*, ubiquitous fake antimalarials, and underfunding of malaria control within a health system ranked 190th out of 191 countries by the WHO in 2000, results in more malaria deaths (1,707) in Burma than in any other country in

southeast Asia (Richards et al. 2007). Poor malaria control in Burma contributes to its transmission into neighboring countries. The prevalence of malaria found among Burmese migrants and refugees is 20 times that of Thai locals (4.4% versus 0.2%, respectively) (Richards et al. 2007). Malaria transmission across borders is problematic because it incurs costs for the host country to which it spreads.

Infectious diseases pose significant challenges in refugee settings. In refugee camps, diseases spread rapidly and can lead to possible outbreaks due to cramped living conditions. Tuberculosis, pneumonia, ARIs, and malaria are prevalent in Southeast Asia and pose significant threats within Thai refugee camps. Public health officials must pay attention to indicators of these diseases and develop prevention and containment methods to deal with potential consequences.

Common, preventable conditions seen in refugee camps include malnutrition, lack of childhood immunizations, tuberculosis, and HIV. When Burmese children do not receive immunizations as children, it threatens control of vaccine-preventable illnesses in Burma, particularly polio. Treating migrant populations for HIV and tuberculosis can also be problematic because it is difficult to isolate, treat, and follow up with patients. These preventable diseases are widely found among this population because very few migrants in Burma have ever had basic health education prior to departure, which leads to misconceptions and HIV-related stigma (Suwanvanichkij 2008). These problems will improve only when the Burmese government ends its neglect of the health of its people, which fuels the "health catastrophe and exodus to Thailand" (Suwanvanichkij 2008: 4).

It is important that refugees receive treatment in refugee camps because having an infectious disease can prevent them from resettling in the United States. Before a refugee is

approved for resettlement, he or she must go through multiple health screenings. These are done to ensure that infectious diseases do not cross international borders. Failure to pass these screenings can result in the United States rejecting to sponsor the refugee until he or she is treated.

Reproductive Health:

A refugee with reproductive health concerns must combat suboptimal conditions during her journey when she is unable to receive care. Maternal and infant health have been associated with parental education levels, which can be measured by female literacy (Carrara et al. 2011). Similarly, adult literacy programs have demonstrated a reduction in infant mortality and improvement in health related knowledge (Carrara et al. 2011). In Burma, where the estimated maternal mortality by the WHO is over 200/100,000 births and the literacy rate is low, mothers and children have inferior health outcomes. Education in refugee camps has been shown to positively impact maternal and child health, including a reduction in childhood pregnancies, women who smoke, and malaria or anemia during pregnancy (Carrara et al. 2011). Women are also more likely to give birth in a healthcare facility or with a skilled birth attendant. Increasing educational opportunities will be an important step for further change in refugee settlements and not only for the health of women and children.

Reproductive health education is essential to promoting healthy habits that last throughout one's life. Refugee camps infrequently offer such education and the health of adolescents suffers. This age group is special because they

> Have sexual and reproductive health needs that may differ from adults, but they remain poorly understood and underserved. In situations of conflict, the absence of appropriate services and trained providers is a major barrier to ensuring young people's right to a healthy and productive life (Benner et al. 2010: 1).

A study revealed that over 60% of both male and female refugee youth would like to receive reproductive health information from health workers, but only a third received any (Benner et al. 2010). There is little opportunity for education in settlements, especially health and reproductive education. Lack of education leads to higher rates of teenage pregnancy, lack of family planning, transmission of sexually transmitted diseases, and other unnecessary health consequences (Benner et al. 2010). Increased educational opportunities for young refugees by healthcare workers are important so that safe reproductive behaviors are promoted.

Micronutrient malnutrition is an overwhelming problem in developing countries and can be especially harmful for pregnant women. Iron and micronutrient deficiencies remain prevalent in Thai refugee camps because nutritional intake depends mainly on rice, split mung beans, fermented fish, iodized salt, soybean oil, and dried chilies provided by the government and aid organizations (Stuetz et al. 2011). Thiamine and vitamin A deficiency as well as a high prevalence of anemia have been documented in pregnant and postpartum women in these camps (Stuetz et al. 2011). While additional food rations are provided to pregnant women, micronutrient malnutrition continues to be an issue. Combating micronutrient deficiencies in pregnant and lactating women is a challenge. Lack of funding for refugee resources results in the inability to provide refugees with a nutritional diet.

Women and girls in conflict settings are at an increased risk of sexual violence. This type of violence increases the risk of unwanted pregnancy, unsafe abortion, and sexually transmitted infections (STIs), including HIV (Tanabe et al. 2013). Despite the increased vulnerability to attack, “care for those who have survived sexual violence is limited in humanitarian settings, as service providers are often ill-equipped to treat survivors, and facilities may lack supplies and

trained providers at the height of insecurity. Distance to a health facility and stigma associated with sexual violence are also barriers to accessing care" (Tanabe et al. 2013: 2).

These difficulties result in increased suffering for women who have experienced sexual violence. Not only have they withstood an attack; they are subsequently unable to seek and receive important care. This is of particular concern for Burmese refugees because "local reports from community-based organizations focusing on rape perpetrated by soldiers in Karen State and other locations in eastern Burmese cite sexual assault as a primary concern during displacement" (Tanabe et al. 2013: 3). Not only do refugees lack the proper services to handle the aftermath of their assault, some Burmese women must travel several days across the border into Thailand to get any treatment at all; there is no care available to them in Burma. Providing services to survivors of sexual violence is important as there can be long lasting physical and mental health effects for the women.

Mental Health:

Refugees often flee their home country due to political violence and having witnessed or endured a number of traumatic events. The transition of resettlement in refugee camps is also a trying process that has effects on the health of the population. There is an increased need to consider mental health needs of refugees "given their shared common experience of war-induced trauma and significant stressors related to migrating…" (Hsu et al. 2003: 193).

There are a number of factors that influence the mental health of refugees. After refugees escape their native country they experience compounding stressors, often due to spending extended periods of time in refugee settlements. These are generally unsafe, overcrowded, and poorly sanitized environments with limited resources.

The most commonly diagnosed mental health problems in Southeast Asian refugee patients are depression, somatization and physical disorders, adjustment disorders, anxiety, and posttraumatic stress disorder (PTSD) (Hsu et al. 2003). Additionally, there seem to be gender differences in the experience of mental health problems among Burmese refugees. Women report significantly higher levels of distress than male refugees (Hsu et al. 2003). Family resources and relationships as well as social support tend to be protective against developing a mental health condition. A number of treatment options are available; however these have limited availability in refugee settings. Therapy, medication, and other treatments would significantly reduce the burden of mental health on refugee populations. Yet until this is afforded to them, refugees will continue to suffer.

In a study of the mental health of the Burmese, exiles had experienced a mean of 30 trauma events (Allden et al. 1996). Events during political uprisings in Burma included mass killings of unarmed civilians, torture, harassment, and the need to go into hiding. After the uprising, the most common events were living in the jungle without adequate medical care, without safety, and forced separation from family members (Allden et al. 1996). Over half of the exiled study participants reported their health as fair or poor (54%) and reported being bothered by illness or pain in the past month (53%) (Allden et al. 1996). Less than one third (27%) had medical problems diagnosed by a doctor (Allden et al. 1996). More than one third of the participants (38%) had depressive symptoms, and women reported higher rates than men. Participants also presented with symptoms of anxiety, PTSD, chronic hypervigilance, and fear of arrest and other threats (Allden et al. 1996).

The poor mental health of these participants is expected based on their identities as political dissidents;

> Their traumatic experiences began as the perils of a revolutionary… movement [in Burma], shifted to the hardships of a jungle escape, and now have been transformed into conditions of violence and insecurity that are characteristic of lives of illegal immigrants (Allden et al. 1996: 1568).

Developing a way to treat these individuals is important to the well being of Burmese displaced persons.

Substance Abuse:

Alcohol use among reproductive age men is a significant risk factor for morbidity and mortality among refugees. It is the leading cause of death for males aged 15-59 years old (Ezard et al. 2012). Alcohol consumption is prevalent in refugee situations. The behaviors of alcohol use "are context specific, related to a range of pre- and post-displacement influences such as cumulative exposure to traumatic events" (Ezard et al. 2012: 2). Alcohol abuse has become a significant concern in Thai refugee camps because artisanal rice wine can be made cheaply in the camps and other forms of alcohol, such as beer, wine, and whiskey, can be bought at shops and bars just outside the camp. Limited access to services may exacerbate the harmful consequences. Alcohol abuse is an important public health concern because it leads to gender based violence, physical assault, and suicide.

The use of alcohol among the Burmese people is not unusual and has a cultural basis in customs such as weddings, funerals, and other gatherings. Additionally, ideas about the health benefits of small amounts of alcohol are pervasive. It is only in the refugee setting that alcohol abuse has developed (Ezard et al. 2012). While reports from Mae La refugee camp in Thailand shows a stigma associated with substance use, continued abuse occurs in and creates opportunity for poor health outcomes. There is a common sense of hopelessness that drives alcohol use (Ezard et al. 2012). The pressures of residing in the camp with limited options for entertainment drive men to drink and subsequently engage in risky behaviors.

Alcohol abuse is predominantly seen among male Burmese refugees. Overconsumption is associated with men "having no self-control" while the self-control women exhibited "was driven by strong normative pressures against women's alcohol use and a fear of social exclusion for contravening social norms" (Ezard et al. 2012: 5). Religious norms were also used in explanation for proscriptions of women's drinking (Ezard et al. 2012). Additional explanations for overuse of alcohol included the stress of exposure to new cultures, ongoing population movements, increased social diversity in the camp, and changing social networks (Ezard et al. 2012). Interventions must become available to Burmese refugees in settlements in order to decrease the prevalent alcohol abuse.

Thai refugee camps are full of disease and burgeoning health consequences for Burmese refugees. Illnesses are exacerbated because most refugees live in camps for an extended period of time, on average seventeen years. There is ample opportunity for the spread of disease and a constant lack of public health efforts to bring awareness to the inhabitants. Once Burmese refugees are able to leave the camps they still face challenges gaining access to health services after resettlement in America.

CHAPTER 5: REFUGEE RESETTLEMENT IN THE UNITED STATES

> As a new person, you've never been to the country that you will visit. There's a lot of pictures in your mind so can't imagine. Everything was amazing here. I did like it. Because, I spent my time in a refugee camp, almost 20 years. There is no future, there's no hope. So when I resettled to the United States, there is the hope. And a lot of opportunity. (JW on coming to the United States).

History of Refugee Organizations and Resettlement Process in the United States

The process to officially become a refugee and resettle in a third country is very complicated. There are many international and national, public and private, large and small organizations that work to assist refugees during their long journey to resettlement. Organizations work together across borders and across jurisdictions to assist refugees in the process.

The United Nations High Commission for Refugees (UNHCR) was established on December 14, 1950 by the United Nations General Assembly to provide assistance for displaced Europeans in the wake of World War II (History of UNHCR, UNHCR). The UNHCR was given a three-year mandate to complete their work and then disband. A basic statute was adopted to guide UNHCR's work. However the next year the 1951 United Nations Convention relating to the Status of Refugees gave the UNHCR legal foundation to help refugees worldwide. The UNHCR has been assisting refugees ever since. The Convention Text has since been subject to only one amendment in the form of a 1967 Protocol, which removed the geographic and temporal limits of the1951 Convention. Since its first year in 1950 the budget has grown from $300,000 to more than $3.59 billion in 2012 (History of UNHCR, UNHCR 2014). The UNHCR deals with 33.9 million people: 14.7 million internally displaced people, 10.5 million refugees, 3.1 million returnees, 3.5 million stateless people, more than 837,000 asylum seekers and more than 1.3 million other persons of concern (History of UNHCR, UNHCR). It is the international

governing body for refugee assistance and works with hundreds of countries to help resettle thousands of refugees each year.

The United States works very closely with the UNHCR to ensure refugees receive the assistance they need. The U.S. also has its own federal regulations for handling refugees internally. In 1948 the United States Congress enacted the first refugee legislation, the Displaced Persons Act of 1948, following admission of more than 250,000 immigrants from Europe in the wake of World War II. The legislation subsequently allowed for an additional 400,000 displaced Europeans to enter the United States in following years (1948 Displaced Persons Act, UWBL). The Act aided victims of persecution by the Nazi government and those who were fleeing persecution. It dealt directly with citizens from Germany, Austria, and Italy, the French sector of either Berlin or Vienna, and natives of Czechoslovakia. The individuals were granted permanent residency and employment in America. A displaced person could bring his or her family as long as they were "good" citizens who could stay out of jail and provide financially for themselves (1948 Displaced Persons Act, UWBL).

Later laws allowed for admission of persons fleeing communist regimes in Hungary, Poland, Yugoslavia, Korea, China, and Cuba (History, USDHHS). These refugees were largely assisted by private ethnic and religious organizations in the U.S., which formed the basis for the current public-private collaboration in the U.S. resettlement process today.

The Immigration and Nationality Act was created in 1952. Before this a variety of statutes governed immigration law but were not organized in one location (Immigration and Nationality Act, USDHS). This Act collected and codified many existing provisions and reorganized the structure of immigration law. The Act has been amended many times over the years, but is still the basic body of immigration law.

In the aftermath of the Vietnam War the United States faced the challenge of resettling hundreds of thousands of Southeast Asian refugees. A Refugee Task Force was created and operated with temporary funding (History, USDHHS). Congress subsequently realized the need for refugee resettlement services and passed The Refugee Act of 1980, which standardized resettlement services for all refugees admitted to the United States (History, USDHHS). This Act created The Federal Refugee Resettlement Program to provide for the effective resettlement of refugees and to assist them in achieving economic self-sufficiency (The Refugee Act, USDHHS).

Since 1975 the U.S. has resettled more than 3 million refugees, with nearly 77% of those either Southeast Asian or citizens of the former Soviet Union. Since the creation of the Refugee Act of 1980 annual admissions figures have ranged from a high of 207,116 in 1980, to a low of 27,100 in 2002 (History, USDHHS).

Achieving Refugee Status in the United States

> First, my parents have to apply first to come to the United States. And then, first they call and they interview us and they ask my parents information, like: why do have to leave Burma? And why do you have to stay in refugee camp? And my parents explained the same thing. Like because we have the civil war, we can't live there and we have to move to Thailand. They asked about other dates and asked about my family background also. Then they have to do the medical check and if we pass then we have to, like, go to the training. Like how to ride an airplane. Like do the seat belt. And then we come here. They do tell us in refugee camp that we'll have a caseworker or people that are going to help us. They did say that. They did an orientation…they say when you go to America, you have to learn a new culture. It was kind of helpful, but not too much. (MN on the application process for resettlement to the United States).

Achieving refugee status and entry to the United States is a long, trying process that refugees must go through. According to U.S. law, a refugee is defined as someone who:

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

> include anyone who ordered, incited, assisted, or otherwise participated in the persecution of any person on account of race, religion, nationality, membership in a particular social group, or political opinion. (Refugees, USDHS).

The applicant must be referred to the U.S. Refugee Admissions Program for consideration as a refugee. This is done by the UNHCR, a U.S. embassy, or an NGO. Every year immigration law requires executive branch officials to:

> Review the refugee situation or emergency refugee situation; project the extent of possible participation of the United States in resettling refugees; and discuss the reasons for believing that the proposed admission of refugees is justified by humanitarian concerns, grave humanitarian concerns or is otherwise in the national interest (The United States Refugee Admissions Program (USRAP) Consultation & Worldwide Processing Priorities, USDHS).

After discussions with cabinet representatives and Congress, a proposed determination is drafted for approval by the president. The "Presidential Determination" establishes the overall admissions numbers and regional allocations for all refugees for the upcoming year (The United States Refugee Admissions Program (USRAP) Consultation & Worldwide Processing Priorities, USDHS). The proposed refugee admissions for 2014 are 70,000, with 14,000 from East Asia (Proposed Refugee Admissions for Fiscal Year 2014, USDHS).

Each year "Process Priorities" are established to determine which of the world's refugees are of "special humanitarian concern" to the United States (The United States Refugee Admissions Program (USRAP) Consultation & Worldwide Processing Priorities, USDHS). These priorities, once established, enable the eligible refugees to interview with a United States Citizenship and Immigration Services (USCIS) officer. In most cases, refugees must be outside of their country of origin to be considered, unless the President authorizes certain individuals from within their home countries. There are three Process Priorities currently in use:

- **Priority 1**: Cases that are identified and referred to the program by the United Nations High Commissioner for Refugees (UNHCR), a United States Embassy, or a designated non-governmental organization (NGO).

- **Priority 2**: Groups of special humanitarian concern identified by the U.S. refugee program.
- **Priority 3**: Family reunification cases (spouses, unmarried children under 21, and parents of persons lawfully admitted to the United States as refugees or asylees or permanent residents (green card holders) or U.S. citizens who previously had refugee or asylum status) (The United States Refugee Admissions Program (USRAP) Consultation & Worldwide Processing Priorities, USDHS).

When a refugee is referred for resettlement in the United States the case is first received and processed by a Resettlement Support Center (RSC). The United States Department of State's Bureau of Population, Refugees and Migration (PRM) funds and manages nine RSCs around the world. Each center is operated by international and nongovernmental organizations and one U.S. interests section (U.S. Refugee Admissions Program, USDS). The PRM guides RSCs to prepare eligible refugee applications for resettlement consideration in the United States (U.S. Refugee Admissions Program, USDS). The RSCs collect biographic and other information from the applications for security screening. The Department of Homeland Security, in participation with multiple U.S. Government security agencies, is responsible for enhanced security screening of each refugee (U.S. Refugee Admissions Program, USDS).

Finally, a USCIS officer will review the information that the RSC has collected and conduct an interview to determine whether or not the refugee is eligible for resettlement. Eligibility is established case-by-case. It is based on an individual's refugee claim and other relevant testimony to determine if the applicant is "qualified under a designated processing priority; meets the definition of a refugee; is not firmly resettled in a third country; or is otherwise admissible under U.S. law" (Refugee Eligibility Determination, USDHS). In addition, the USCIS officer considers the conditions of the country of origin, the individual's credibility, and confirms the completion, review, and analysis of their security checks (Refugee Eligibility Determination, USDHS). If the applicant passes these steps, he or she will be approved as a

refugee and begin the process of resettlement to the United States. There is no fee to apply for refugee status and none of the information collected by the United States officials is shared with the applicant's home country. The total processing time of each refugee application depends on the applicant's location and other circumstances, but the average from the initial UNHCR referral to arrival in the United States is between 12-18 months (U.S. Refugee Admissions Program, USDS).

Traveling to the United States

The International Organization for Migration (IOM) provides resettlement services for approved refugees who will travel to the United States. These services include Case Processing, Health Assessments and Travel Health Assistance, Pre-Departure Orientation/Integration, and Movement/Travel Operations. Case processing services are designed to help applicants complete applications properly, which assists governments by providing detailed and objective information in standard formats to streamline the interview and selection process (Resettlement Assistance, IOM). Health Assessments and Travel Health Assistance works to ensure that refugees are fit to travel and meet the requirements of the resettlement country. They are performed prior to a refugee's departure for resettlement.

Pre-Departure Orientation/Integration provides a number of services, including Cultural Orientation, Pre-Departure Orientation, Language and Literacy Training, and Pre-embarkation Briefings (Resettlement Assistance, IOM). The Cultural Orientation prepares refugees by teaching cultural practices and providing practical information on the destination country. Pre-departure orientation assists refugees in developing realistic expectations for their future resettlement. It also provides information on topics such as housing, healthcare services, money management, the role of settlement service providers, education, cultural adaptation, rights and

responsibilities, and more. Language and literacy training teaches refugees basic language and communication skills to help them become more independent and increase their chances for employment (Resettlement Assistance, IOM). Pre-embarkation briefings prepare refugees for their flight, including what to expect at the airport, in flight, while in transit, and upon arrival at their destination.

Movement/Travel operations ensure that refugees are transported without difficulty from their initial location to their final resettlement destination. These services include assisting refugees obtain travel documents, providing them with information on flight schedules and air travel rules and regulations, ensuring all necessary accommodations are made for the trip, and arranging for the refugee to meet with their sponsor upon arrival (Resettlement Assistance, IOM).

Resettling in the United States

> RRISA [Refugee Resettlement and Immigration Services of Atlanta], they helped me come to America. They apply for food stamps for us and give us money to buy food and teach us how to do things. It was hard when we first came. Because where I came from, I didn't know where to go. I don't know how. They teach us. They teach us how to go, where to go, to take MARTA and go places, to the RRISA office. I don't know these things by myself. Only because they teach how to go, where to go, and how to live. I didn't know all this. But I lived it. I worked. All the time and I have experiences and now I know how to go. (HN on adjusting to life in America).

Many organizations work together to make it possible for refugees to resettle in the United States. After United States Citizenship and Immigration Services approve applications for refugee status, the Resettlement Support Centers request sponsorship assurance from a U.S.-based resettlement agency (U.S. Refugee Admissions Program, USDS).

The Department of State's United States Reception and Placement Program (USRPP) provides fundamental assistance to newly arrived refugees. Their Refugee Processing Center is

made up of nine domestic resettlement agencies that provide resources and assist with refugee resettlement (Refugee Council USA).

Once a refugee has been approved for resettlement in the United States, these nine organizations meet to review the biographic information and other case records sent by the RSCs to determine where a refugee will be resettled (The Reception and Placement Program, USDS). At this time, the resettlement agencies match the needs of each incoming refugee with the resources available (The Reception and Placement Program, USDS). If a refugee has relatives in America, he or she will likely be resettled with or near them. Otherwise, the agency that agrees to sponsor the refugee decides the most favorable match between the refugee's needs and the community's resources. The Department of State has agreements with the nine domestic resettlement agencies to resettle refugees, mostly specifying the services that the agency must provide each refugee. Additionally, the nine domestic agencies have another 350 affiliate agencies that they monitor throughout the United States. These smaller organizations offer resources to the refugees at the local level.

An agreement between the Department of State, the nine resettlement agencies, and the connected affiliates requires that a number of services be provided to refugees. All refugees must be met at the airport by the affiliate upon their arrival in the United States. The refugees are then taken to their apartment, which is already furnished with basic amenities including appliances, clothing, and typical food from the refugees' country of origin. After their initial arrival refugees receive help starting their lives in the United States. This includes applying for a Social Security card, medical assistance, and food stamps, registering children in school, learning how to access shopping centers, arranging medical appointments, and connecting with social and language services (The Reception and Placement Program, USDS).

The United States Reception and Placement Program supplies resettlement agencies a one-time sum of $1,875 per refugee to help cover a refugee's costs during their first few months in America (The Reception and Placement Program, USDS). Most of these funds go towards rent, furniture, food, and clothing, as well as to support some of the resettlement agency's costs. Assistance from the USRPP is limited to the first three months after a refugee's arrival. After that time, the Department of Health and Human Services' Office of Refugee Resettlement works through the state and nongovernmental organizations to provide longer term monetary and medical assistance, as well as language and social services. Refugees are able to become employed immediately upon arrival and are encouraged to do so as soon as possible. Within one year refugees are expected to apply for permanent residence. After five years refugees are eligible to apply for U.S. citizenship.

The Office of Refugee Resettlement (ORR) provides refugees and other new arrivals with opportunities to become comfortable and productive in the United States. They provide benefits and services to assist the resettlement and local integration of refugees and other eligible populations (ORR Benefits at a Glance, USDHHS). Some of these benefits include:

- Refugee Cash Assistance, which is available for up to eight months from the date of admission to the U.S. for those who are not eligible for federal cash assistance
- Refugee Medical Assistance for up to eight months from the date of admission to the U.S for those who are not eligible for Medicaid
- Refugee Social Services, which are available for up to five years from the date of admission to the U.S., and includes employment and employability services, job training, skills recertification, job-related day care, job-related transportation, translation and interpreter services, and case management (ORR Benefits at a Glance, USDHHS)

Six divisions operate within ORR, three of which are crucial to providing resources to refugees. These are the Divisions of Refugee Assistance, Resettlement Services, and Refugee Health.

The Division of Refugee Assistance (DRA) was created to oversee and provide guidance to State-administered programs that provide assistance and services to refugees. It monitors

program planning, provision of services, and provides technical assistance to ensure compliance with federal regulations governing the delivery of refugee assistance and services, including cash and medical assistance (Divisions - Refugee Assistance, USDHHS). DRA provides direction to the states to ensure that refugees are provided assistance and services through state-administered programs that enable them to become employed and economically self-sufficient as soon as possible after their arrival in the United States (Divisions - Refugee Assistance, USDHHS).

The Division of Resettlement Services (DRS) provides assistance through public and private non-profit agencies to support the economic and social integration of refugees (Divisions – Resettlement Services, USDHHS). The Division of Refugee Health (DRH) "oversees the Refugee Medical Assistance and Refugee Medical Screening programs in collaboration with the Division of Refugee Assistance" (The Division of Refugee Health, USDHHS). DRH works with federal, state and non-governmental partners to promote refugee health through six key strategies: prevention and early intervention, health education, community-based health initiatives, language access, resource mapping and evidence-based activities.

Refugee Medical Assistance (RMA) is a federally funded program that provides up to eight months of healthcare coverage to refugees in the form of Medicaid. It is a special provision of Medicaid for refugees that can be applied for based on refugee status not income. The coverage begins on the date the refugee enters the United States. Refugees are not able to renew the assistance. To be eligible for RMA, refugees must meet the following conditions:

- Be ineligible for Medical Assistance
- Have one of the immigration statuses of: Refugee, Asylee, Cuban/Haitian Entrant, Amerasian immigrant, a Dependent child of any of the above, trafficking victim, or Iraqi and Afghan Special Immigrants.
- Provide the name of their resettlement agency to the county human services agency.
- Not be full time students in an institution of higher learning, unless their enrollment is part of a state-approved plan. (Refugee Medical Assistance (RMA), MDHS)

This service assists refugees with paying for any health visits in the first eight months in the U.S. After the first eight months, refugees can reapply for Medicaid. However, they are often ineligible based on their income bracket. They are required, instead, to sign up for insurance through their employer if this is a possibility. If a refugee is eligible for Medicaid when he first arrives based on low income or another qualifier, he will not be eligible for RMA, but may receive benefits beyond the eight months. Children living in refugee families are eligible for Medicaid until they are eighteen years old regardless of the family income.

An additional form of medical assistance for refugees is the provision of interpreters for medical visits. According to Title VI of the Civil Rights Act of 1964 and further Executive Orders, refugees and individuals with Limited English Proficiency (LEP) are to be provided with interpreter services (Chen, Youdelman, and Brooks 2007). While all federally funded entities are mandated to provide such translation services, there are different regulations for different healthcare settings. The Policy Guidance for the Executive Orders

> Attempts to balance the requirement that federal fund recipients must take reasonable steps to ensure LEP people have meaningful access to programs and activities with the agency's reluctance to impose undue burdens on small business, local governments, or small nonprofit organizations (Chen, Youdelman, and Brooks 2007: 363).

Despite the federal right to language access for LEP patients in healthcare settings, the reality is that many healthcare providers are not aware of their responsibility, have not prioritized the issue, nor are they held accountable through consistent enforcement of these laws (Chen, Youdelman, and Brooks 2007).

Resettlement Services in Georgia

The Office of Refugee Resettlement oversees public and private groups at the state level of refugee services. Each state has a State Refugee Coordinator, assisted by six Project Administrators, who is responsible for coordinating public and private organizations. Refugee

services in Georgia are directed through the Refugee Program Unit (RPU), which is run by the Georgia Department of Human Resources, Division of Family and Children Services, Office of Family Independence. The RPU is federally funded and manages both public and private resettlement organizations. The goal of the unit is "to encourage effective resettlement and economic self-sufficiency of refugees after entrance to Georgia. This means the refugees must become self-reliant in utilizing existing community resources to meet their basic needs, within the shortest possible period" (Refugee Resettlement Program Overview, GDHS).

Twelve public and private organizations operate in Georgia to provide social services to refugees. These services include: employment services (job development, job orientation, and placement services), vocational training, English language instruction, social adjustment services (emergency services, health-related services, and translation/interpreter services), domestic violence services, youth services, and parent/school involvement services (Refugee Resettlement Program Overview, GDHS). Six private organizations in Georgia work with the RPU; Refugee Resettlement and Immigration Services of Atlanta, Jewish Family and Career Services, International Rescue Committee, Lutheran Ministries of Georgia, Catholic Social Services, and World Relief work locally in Georgia to provide assistance resettling refugees. They work in conjunction with public entities, such as the Dekalb County Board of Health and the Dekalb County Board of Education. Together these groups provide refugees with important resources during resettlement.

There are many laws and services in place that assist refugees with initial resettlement and access to healthcare. However, not all programs are fully functional, nor do refugees always receive the help to which they are entitled. Resettlement organizations are underfunded, understaffed, and are not always able to provide the necessary attention that refugees require

during their resettlement transition. Furthermore, despite the many services developed on their behalf, refugees face many barriers in their attempts to seek healthcare. Figure 6 shows a flowchart of the process of resettling to the United States.

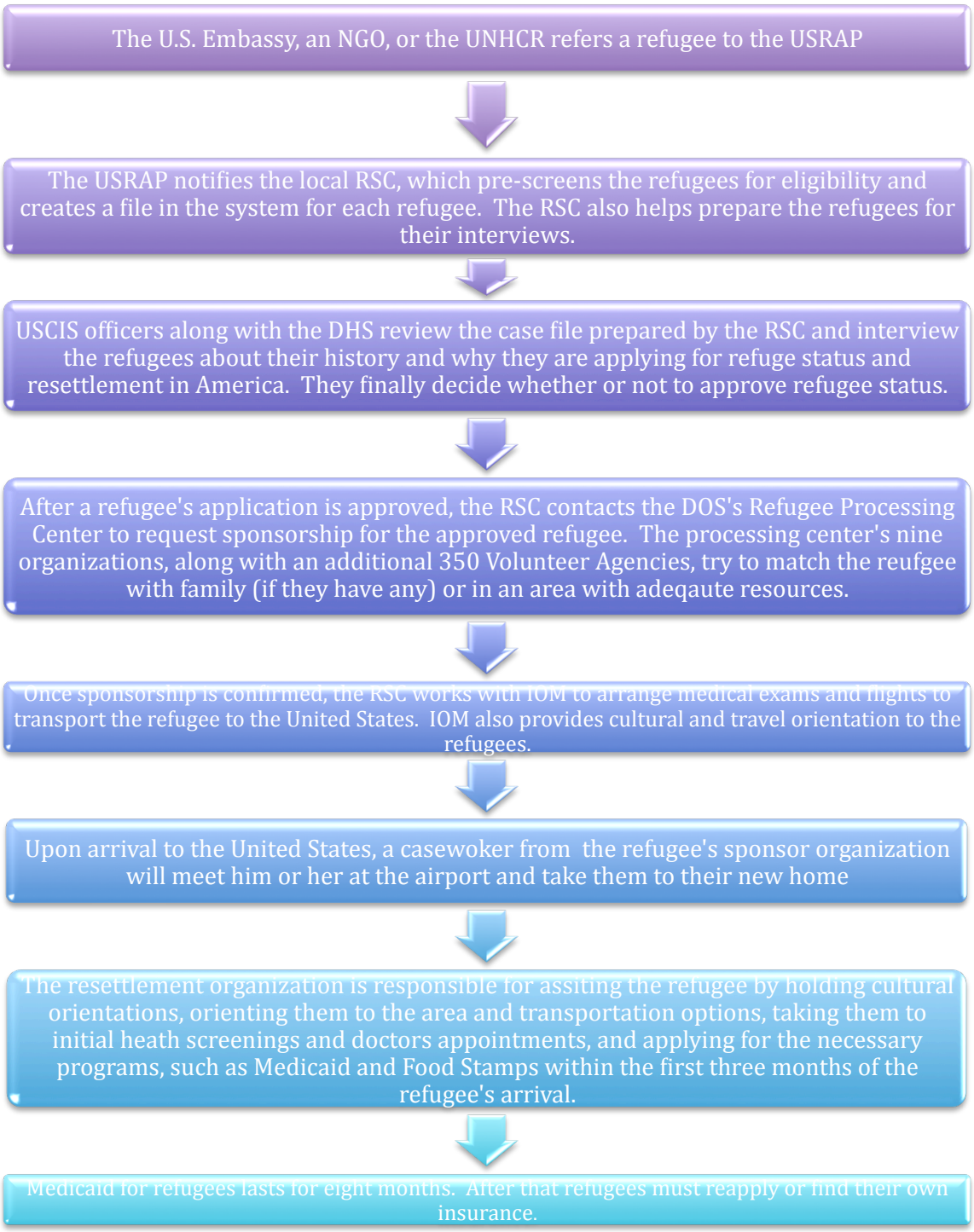


Figure 6: The Process of Refugee Resettlement in the United States

CHAPTER 6: BARRIERS TO HEALTHCARE FOR REFUGEES

Refugees face many challenges upon resettlement in America. Barriers to healthcare services are a significant challenge because refugees are unaware of how to navigate the American healthcare system. They face differences in the healthcare systems from their country of origin, language barriers, transportation difficulties, and other challenges to receiving healthcare. These obstacles hinder refugees' ability to get necessary medical care.

Refugees frequently work long hours and are unable to take time off to visit the doctor when they are ill. They are also unaware of what is actually available to them, such as free clinics and open hours from certain providers. Additionally, healthcare providers do not always inform refugees of these resources (Morris et al. 2009; Asgary and Segar 2011). Many refugees do not understand the legal system in place to help and protect them. This can lead to improper care for refugees who are entitled to certain benefits.

Understanding health insurance policies and how to get them is another issue that refugees face. In many cases, refugees do not purchase insurance and are forced to pay fees out of pocket. In addition, providing documents to insurance companies, as well as practitioners, is difficult for refugees and they are often unaware of what they need to bring with them to visits. Understanding the process of making appointments to see a practitioner is difficult for refugees to learn, and once they do, many are unable to communicate in English over the telephone (Asgary and Segar 2011; Swe and Ross 2010; Szajna and Ward 2014). Seeking specialist services can be similarly problematic. All of these challenges hinder access to medical care for refugees.

Finding reliable transportation poses hardships for refugees. Most refugees do not own cars and cannot easily travel to medical appointments. They must rely on friends or family with

vehicles or take public transportation. This is very inconvenient, takes more time, and is another unfamiliar system that refugees must learn. These "numerous issues pertaining to the access of health care, including lack of transportation or insurance, long wait times, appointment availability, and financial hardships in general" lead to frustration with the American healthcare system and can lead to refugees rejecting health services (White 2012: 146).

Language differences are a significant challenge between refugees and the American healthcare system and are a concern when providing refugees with medical care. Since the refugees and healthcare practitioners speak different languages, it is difficult to communicate during patient-physician interactions. Limited English proficiency is likely to affect the quality of care refugees receive. Refugees report "lower satisfaction with care and lower understanding of their medical situation" based on the language differences (Derose, Escarce, and Lurie 2007: 1261). Lower levels of English also affect patient safety. There is an increased probability of adverse medication reactions as a result of misunderstanding instructions. This applies to refugees' ability to fill prescriptions and properly take medicine (Asgary and Segar 2011). Even if written instructions are provided in the refugee's native language, this can still be problematic because many refugees have limited literacy in their native language as well.

Miscommunications can go both ways in interactions with healthcare personnel. Providers mention "the impact misinterpretation has on the quality of care they are able to provide, noting how difficult it [is] to properly diagnose patients when communication [is] broken and physician time is limited" (Morris et al. 2009: 534). Refugees also mention their frustration in the inability to describe their illness and symptoms properly because of their limited knowledge of English.

Difficulties based on linguistic difference lead to challenges with interpreter services for refugees. Due to the large variety of refugee populations it can be difficult to find and provide trained interpreters for all patients. When patients do not have a translator to work with they often rely on "ad hoc" interpreters, such as family members, janitorial staff, and other patients (Derose, Escarce, and Lurie 2007: 1261). This can be problematic because the patient may not want to share confidential information in front of them. Additionally, an untrained translator may "embellish or minimize symptoms to the physician in an effort to be helpful, or unnecessarily frighten patients when conveying a diagnosis, prognosis, or treatment plan" (Uba 1992: 546). When untrained interpreters provide translation between parties, some of the medical terminology may also be lost.

An issue with providing professional translators, however, is that some interpreters may come from opposite sides of a political situation in the refugee's home country. This creates conflicts of interest and leads to uncomfortable and unreliable translations. However, due to a lack of proper interpreters, it is often not possible to arrange for a replacement. Derose, Escarce, and Lurie explain, "those who need an interpreter but do not receive one fare the worst" (Derose, Escarce, and Lurie 2007: 1261). The lack of available interpreters can also lead to longer waiting times for refugee patients while an interpreter is located. Many times, however, no translator can be found and refugees must choose to return at a later date or to see the practitioner without translation services.

Interpreters are just one example of the lack of resources in healthcare for refugees. Providers are often overwhelmed by an influx of refugees seeking care. Providing same-sex providers to make refugee patients more comfortable is also not always feasible due to constraints on the system (Portes, Fernandez-Kelly, and Light 2011). Additionally, programs

that deal primarily with asylum seekers and refugees lack consistent funding. Depending on the locations where refugees are resettled, rural versus urban areas provide different levels of care and availability of services. Refugees are often resettled to more socioeconomically disadvantaged areas where there are greater provider shortages. For example, "healthcare providers also reported that due to high patient volume and practitioner shortages, many were no longer accepting new patients" (Szajna and Ward 2014: 4). Refugee health services lack funding and are frequently unable to provide their patients with important resources.

One great challenge that refugees face when interacting within the American healthcare system is that health care personnel lack understanding of the cultural history and background of a refugee's country, often called cultural competency. This is the concept of understanding that one person's worldview may be different than another's. A lack of cultural competency by a healthcare provider can have effects on the care offered to refugees due to lack of understanding of his or her cultural tendencies and beliefs. This can be problematic when a patient does not understand a concept or cannot adequately relay feelings and concerns to the physician through their interpreter (Hoang and Erickson 1982).

Many refugees feel that providers do not listen to their concerns and treat them as well as American patients (Asgary and Segar 2011). They think that health facilities often lack knowledgeable and sensitive providers who do not understand the differences in how refugees may perceive causes of illness and disease. Healthcare personnel must be aware of cultural differences between themselves and their refugee patients.

Refugees do not feel that healthcare workers are the only ones lacking in understanding; many still felt that they did not know about "fundamental cultural differences between the [health system] and that of their countries of origin" (Henderson and Kendall 2011: 12).

Practitioners sometimes forget to pay attention to the refugee's point of view when discussing treatment options. Since they are unaware of medical practices in the other cultures, often times personal beliefs are ignored and a treatment plan is forced on the patient. In these cases, providers do recognize their lack of knowledge, but do not know how to remedy it; "the opposing views of these two populations can result in disconnect between provider and receiver, which can ultimately affect access to care patterns of refugees" (Szajna and Ward 2014: 3).

Many refugees continue to use traditional medical practices from their country of origin. This can sometimes be harmful because there may be unknown negative interactions between any treatment prescribed by an American practitioner and other treatments used by the patient (Chung and Lin 1994). This can also be an issue as markings on a patient's body may be mistaken for abuse by a Western practitioner. For example, some Burmese refugees practice coining, the technique of rubbing a coin or a smooth metallic object on the skin, which leaves bruising marks on the skin (Uba 1992: 547). This is done in the belief that it removes unhealthy toxins from the body and stimulates blood flow and healing. The lack of understanding about the uses of traditional medicines further demonstrates how lack of cultural competency can harm the refugee patient experience.

Due to the language barriers that exist between refugees and their health care providers as well as the frequent lack of cultural competency between the two parties, refugees sometimes feel that they are discriminated against (Asgary and Segar 2011; Derose, Escarce, and Lurie 2007; Szczepura 2004). Refugees mention that doctors try to finish with them quickly without really listening to problems. They think that American citizens get much better treatment and more benefits from visiting health centers, explaining that doctors tend to spend more time with them and are more motivated to treat other Americans (Henderson and Kendall 2011; Muecke

1983). When refugees believe that they are discriminated against, they are then reluctant to seek care, which can lead to decreased use of health services.

A significant barrier that refugees face when seeking healthcare in America is the innate differences between their own illness beliefs and the Western medical model in the United States (Muecke 1983; Chung and Lin 1994; Nilchaikovit, Hill, and Holland 1993; Uba 1992). Many refugees are unfamiliar with Western medical health concepts. These differences are difficult for refugees to understand. Basic questions, such as age, disease history, and symptom presentation timelines can be challenging to calculate, as many refugees do not conform to the same time-telling style as in America (Szajna and Ward 2014).

A group of refugees may believe in the humor theory of the body and want to treat themselves with hot or cold foods, while a physician in the United States would want to prescribe an antibiotic therapy. These differences can lead to miscommunication between provider and patient and ultimately harm the patient. Differences also appear in interactions with healthcare providers. Refugees, particularly from Southeast Asia, act very passively towards their practitioners (Swe and Ross 2010; Muecke 1983; Nilchaikovit, Hill, and Holland 1993). In their culture, doctors are revered and highly respected; "according to many Southeast Asian cultural traditions, authority figures should not be questions or opposed…" (Muecke 1983: 435). Acting unquestioningly and passively to the doctor, a figure of authority, is the way they showed respect and interacted with physicians in the past. However, their unresponsiveness can lead to frustration for the provider and the inability to properly diagnose and treat an ailment. The differences in healthcare approaches often make refugees uncomfortable and less motivated to seek treatment.

Because refugees do not understand the process of healthcare in America, they can be fearful of using it. Some refugees believe that monetary gain motivates medical practice in the United States (Portes et al. 2011; Szajna and Ward 2014). They feel that practitioners do not actually care about healing them but only want to make money. Refugees may also fear that their healthcare-related bills, lack of documentation, or inability to pay for medical services can lead to deportation (Asgary and Segar 2011).

Refugees frequently go to urgent care clinics or emergency rooms because they are unsure of where else to seek treatment (Swe and Ross 2010; Morris et al. 2009; Szajna and Ward 2014; Uba 1992). This can be a barrier to comprehensive, preventive treatment for refugees, as they only access care when they are seriously ill. Refugees may not know about other potential healthcare alternatives, such as sub-specialties, the importance of continuity of care, and preventive care, and instead go to the over-utilized urgent care sites. One reason for this may also be that "in the face of many resettlement challenges, [refugees] often do not prioritize healthcare" (Asgary and Segar 2011: 515). Because refugees may not understand how to go about seeking healthcare, they may delay care until the problem becomes unbearable, and only then seek emergent care. This also happens because there are limited resources for health promotion for refugees.

Other barriers that refugees face in an attempt to seek healthcare are the costs of health care services (Chung and Lin 1994; Portes, Fernandez-Kelly, and Light 2011). Refugees do not have many resources and become concerned with paying for treatment when they become ill. Because many refugees do not have health insurance, nor do they practice preventive medicine through primary care visits, many hospital visits are to emergent care facilities where prices are high. High costs are also another reason that refugees continue their traditional healing

practices; “the importance of the alternative healing system is also reflected by the fact that the ‘out of the pocket’ expenses for the purchase of [health care] services are quite substantial” (Chung and Lin 1994: 110).

Refugees face many barriers to receiving healthcare upon resettlement in America. The Burmese refugees in Atlanta encounter great difficulties in their attempts to seek healthcare. They come from a completely different culture with different healthcare practices which leads to a challenging transition to America

CHAPTER 7: BARRIERS FOR BURMESE REFUGEES IN ATLANTA, GEORIGA

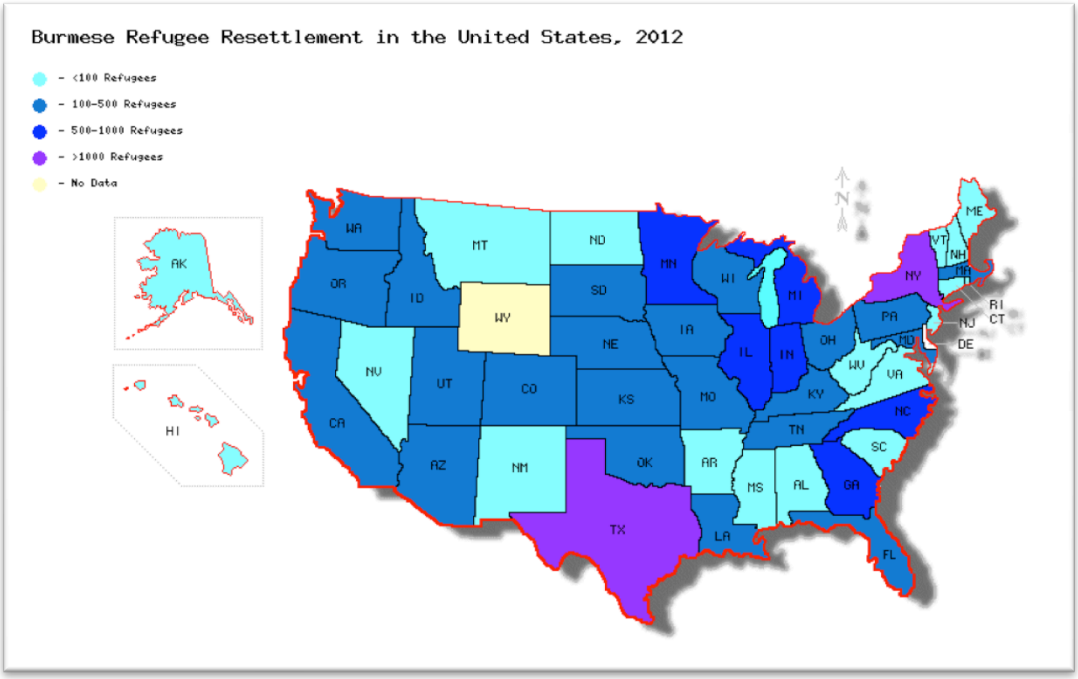


Figure 7: Map of Burmese Refugee Resettlement in the United States in 2012 (Refugee Arrival Data, USDHHS)

Over 100,000 Burmese refugees have resettled in America since 2001 (Refugee Arrival Data, USDDS). They have been placed in states all over the country and face many of the same hardships in each place. Figure 7 shows the populations of Burmese refugees living in various states. Burmese refugees interviewed about accessing healthcare in Atlanta mentioned many of the same barriers as mentioned in the previous chapter. Themes such as the cost of medical services, language difficulties, lack of transportation, trouble accessing specialists, a preference for self-medication, among others, were found throughout the interviews. Resettlement caseworkers were also interviewed on the subject and commented on additional barriers that they witness for Burmese refugees. Throughout the interviews with both the refugees and caseworkers additional challenges during resettlement emerged, such as a lack of resources at the resettlement agencies, feelings of isolation, and others.

Barriers to Healthcare According to Refugees

Language:

Every person interviewed spoke about how language was the most difficult barrier for him or her when trying to get medical care. It was difficult for refugees to understand how to make appointments, navigate hospitals, and communicate with providers. One refugee spoke of her experience when going to the hospital on her own for the first time:

> When we first came here, our caseworker took us to the hospital first and then he showed us how to take the bus so we can go by ourselves. Then after six months, then we have to go by ourselves. I don't like it. Because at that time my English is not that good, so I'm kind of nervous when I talk to the nurses. Because I don't know anything. (MN)

Some refugees mentioned that they found their treatment very good but communicating with the doctors and healthcare personnel proved difficult. One woman explained, "No, I couldn't understand them at that time. Only a little bit. Some people don't understand, they don't know doctors. The doctor treats them, I think good, but they don't understand that" (HN). Similarly, one man mentioned "They do trust the doctors, but the problem is, they are afraid of the language" (JW).

Another man thought the opposite, that refugees may actually receive subpar care because of the language barrier:

> One thing, if you don't know the language, it's going to be hard. Probably they might not really care you, as long as they get the Medicaid you give them, they check out the money, that's it. But if you do know the English, probably more care about you. But if you don't know, like we're treated differently… But it is one thing, it is not easy when the doctor speak to say what disease they have. They just say blah blah blah blah blah, and they're done. And if you don't understand, you don't know what kind of disease you have. (NK)

Refugees interviewed ultimately found that the language barrier led to serious difficulties with getting treatment from healthcare providers. Because they do not speak the language, they often require interpretation services, which are also difficult to obtain.

Interpretation:

While healthcare institutions should provide interpretation services for all patients who require them, not all refugees were able to get a translator. Often times refugees would bring a friend or family member with them to translate or use an untrained interpreter over the phone. This is a problem because they do not always understand the relevant medical terms. As one man explained,

> The problem is the language… And even I said, I have English, but sometimes, you know, with the medical terms, it makes it, it is vey difficult. And sometimes we get the interpreter through the phone. Sometimes those interpreters are very funny. The healthcare person asks for the organ donation, and then the interpreter will interpret that it is like a money donation or this stuff. (JW)

Another woman talked about how even though she was unsure of her English and wanted an interpreter, the medical staff prevented her from having one because she seemed to know enough English.

> They treat us very well, but I don't understand all of what they said. When I go I don't have a translator. But the doctor asked me if I need a translator or not. But they say you understand very well so you don't need a translator. (MN)

When refugees cannot have proper interpretation services for their visits to the doctor, they are unable to understand everything that is happening, which can lead to inferior treatment for their illnesses.

<u>Transportation:</u>

Finding transportation to get to medical appointments was another challenge for refugees. Most of them did not own cars. While resettlement organizations host orientations to public transportation, they still have difficulty using it. One women explained that the organizations "Taught us to use transportation in the beginning, but it is too tricky to remember it all and still have trouble. Want to go with someone else and rely on others to drive" (HN).

Refugees frequently asked friends or family with cars to take them to appointments. However, because of the busy schedule refugees have, this is not always possible. One woman said, "Because we live here, everyone is working, so some people are busy to go. If need help, to call someone, to take them to the hospital, they can't find anybody so they have to stay home" (MN). Finding reliable transportation was difficult for refugees. While some of them did use public transportation, it did not always go to their appointment locations. When they could not make it to an appointment, refugees got discouraged and decided not to try again. So many refugees are not getting the care they need.

Insurance and the Cost of Healthcare:

The barrier that came up most often was the prohibitive cost of healthcare in America. Medicaid covers refugees' healthcare costs for the first eight months that they are here based on their refugee status. Most refugees do not qualify for Medicaid after that period because of their income, and they must find their own insurance. But because of the high cost, few refugees will choose to enroll in an insurance policy. This leads to high out-of-pocket costs whenever they need healthcare services.

Many of the refugees discussed how the high costs of care keeps them from going to the hospital at all:

> Some people from my country, they say they don't… Some of them, they don't work, so they don't have [insurance]. So if they are sick, they don't want to go to hospital because they don't have money. That's the problem. (MN)

> When, every time when I'm sick I don't want to stay in a hospital. I don't totally like it. But if I have a major problem, I probably may. Me and my auntie and my uncle, they both don't work…Even when I'm sick, I just go to school. They are trying to take care of me a lot, but they cannot afford to go to the hospital. That part very expensive too. (NK)

> People don't go because it is expensive. Yes, you know, most refugees, just one family income. Insurance is very high for them. If go to the emergency room, later they come

> with the bills and they cry. And then sometimes they go to some agency to help them and to solve this kinds of problems. (JW)

> I feel comfortable now, but I still don't like to go. The problem is if I have, like, healthcare, Medicaid, yeah, if I'm sick I would go. But I don't have health insurance so I will not go to the hospital. My parents, before they quit the job, they still have the health insurance, so if they have so if they have appointment, they go. But now if they have appointment they don't go anymore because they don't have the health insurance. (MN)

Many refugees do not understand their options for healthcare when they do not have insurance. One refugee who works at a resettlement agency tries to emphasize to others in her community about the importance of health insurance:

> For some people who cannot be approved for Medicaid again or have no insurance, we want to set up payment for them. Somehow they have to learn. We insist to them that they need to get insurance… The first one or two years it is very difficult to understand the system. Two to three years later, people have learned and prepare something. (PV)

For others, it is a matter of learning about possible options when they do need care. One man exclaimed:

> Most refugee, they go to the DeKalb medical center, that is very expensive. Some people, they fall without Medicare or Medicaid. So they went there and after that they asking for the bill, very high price. But most refugees can go to the Grady hospital, but some people, they don't know how to get there, so they know only DeKalb medical center. That's the problem! (AT)

Ultimately, refugees suffer because they avoid seeking healthcare due to the cost. They do not know about all of their options, nor do they recognize the importance of health insurance. They instead only go to the hospital in serious situations. Refugees do recognize the importance of primary care visits, but these are just too expensive. Two refugees mentioned this:

> It is good to go to the doctor. If we don't have Medicaid and don't reapply for Medicaid, it's hard to go to doctor because we don't have money. Too much to pay, very expensive. (HN)

> Another part of the United States is healthcare plans. Very expensive. More than any other country. We understand that part. But when I went to the doctor, he just tap on my chest, just check my body with a stethoscope. And he told me $80. I said '$80 my

> goodness!' For just the regular check. Really expensive. Now we didn't have any Medicaid, so trying to take care of family and each other the best we can. (NK)

The high cost of treatment deters many refugees from going to the hospital at all. Many try to take care of themselves at home to avoid the expense. This leads to self-medication and avoidance of treatment for more serious health problems.

Self-Medicating:

Many refugees choose to treat themselves at home with over the counter medication instead of going to the hospital when they are sick. This is based on the high costs of hospital services as well as the challenges of communicating with providers. Three refugees explained:

> For me, when I'm sick, I don't go to the hospital first because I don't have health insurance. I take some medicine, at CVS I buy some. (MN)

> If I get sick a little bit, I go to pharmacy and get a little to get better. I have been to hospital. It was difficult at the hospital. (HN).

> It is very expensive, we couldn't afford to get money to get it, even though you want it when you're sick. Some family know how to do their own health. Want to help themselves as much as they can. They know it is very expensive to go to the hospital. (NK)

Refugees will try to avoid going to the hospital by taking care of themselves and their families. Some families have home remedies and use traditional Burmese medical practices instead.

The Use of Traditional Medicine and Learning a New Medical System:

Refugees choose to use traditional Burmese medicine for different reasons. Some refugees prefer the natural remedies to the Western biomedical practices used in America. A number of refugees mentioned this:

> Western and Burmese medicine is very different. In my country, the doctor treats people and gives medicine, like flu, cough. Give something to take, the sick stops. But now, sometimes they give us a medicine, a little bit. Like if cough, give medicine for cough. But my children still cough. Doesn't work as well here. The people who understand the

> medication, they give medication, but it is different what they give us. In Burma use mostly natural medicine. When come to America, don't like it as much… In my country, if have the flu, can take something, and the sick stops. From nature. In medication, natural. (HN).

> [In Burma] most Burmese people whenever they sick, they try to take the traditional medication like the natural thing. They try to get it from the jungle or they try to get it from the traditional medication pharmacist. Something like that type of person they are asking the, 'oh we got fever,' 'I got headache,' 'something happen.' So that person try to give the right medication to them. It is different here. Totally different (AT).

> What I understand is very different. In the camp, and the place that we live in the town, if you are sick, we know the environment to get the medicine. Even if we don't have money. People used to, when they are sick, they know how to get the medicine from the environment, kind of like tree or other. And here in America, you know, every time you sick, you have to go to the hospital… But, you know, like I said, it is very expensive. Extremely. (NK).

Refugees preferred that in Burma or the refugee camps they could get medications from nature and did not have to go to the hospital to treat sickness. Those cures could be found in the environment and did not cost the high price of hospital services in the United States.

Refugees are often uncomfortable seeking healthcare in America because it is a different process from what they were used to in Burma or the refugee camps in Thailand. They have trouble understanding how to make appointments for doctors visits. Primary care is also something new to them. A few refugees mentioned they would only go to the hospital if they were very sick:

> It is very different from in the refugee camp. There, there is no appointments, just go in and line up and you get the services. Here you have to schedule the appointments all the time. And most of refugees, they are not familiar with the appointment. So I heard from the community, they say: 'oh, if I die right now, what will happen to me, because I have to wait an appointment.' Because we go to hospital when we are sick. Never, we are not familiar with the regular check up, so the system was a little difficult. Appears you have to do all you regular check up and then you have follow with appointment and several services. But back home we are not familiar doing that and seeing separate doctors. (JW)

> Before my son I had a miscarriage. At that time we went to the emergency. It is difficult, the one thing, they took lots of blood. Different from Burma. Because in Burma when we got sick, they never took the blood. Here, every time we go to the

> doctor they take the blood…. The differences. First thing, when we got sick, we have to make appointment with the doctors. In Burma, we just go to see the doctor. Difficult to make appointments. (MV)

> Very different from the medicine in Burma. There, if you have a cold, you get a shot. You get medicine or you get a shot; one shot and go. Something like that. Sometimes in the pharmacies medicine is sold without a prescription, and you can get medicine. Usually people only go to the hospital when they are really sick or really in a bad situation. (PV)

The process of seeing a primary care practitioner with follow up care at a specialist is another difference in American medicine. Burmese refugees have trouble understanding that they need to see more than one doctor for different health problems. This can be especially challenging when they do not have access to transportation and do not speak English. As one man commented,

> The thing was, here is the one you have the healthcare provider, the family doctor. When have other issue, they have to schedule with other, different doctor, the specialist and also, they are far and not in the same place. So, the difficult thing is the transportation and that they don't know where. Especially, they cannot read. So the address that they got, is make them, difficult. Sometimes they even miss the appointment just searching around to get to the hospital or clinic. (JW)

These differences between the Burmese and American healthcare systems make it challenging to refugees from Burma to accept the new western biomedical model of medicine. Many refugees choose to not visit the hospital for these reasons and very infrequently seek preventive healthcare, which can lead to more serious health problems in the future.

Burmese refugees living in Atlanta encounter numerous barriers to healthcare services. They have trouble navigating the American healthcare system while they are at the same time adjusting to life in America. And these are not the only problems they have obtaining medical treatment; resettlement caseworkers cited additional barriers for Burmese refugees.

Barriers to Healthcare According to Caseworkers

The caseworkers interviewed found similar problems with language, interpretation services, and enrollment in insurance plans as the refugees. They additionally spoke about individuals taking advantage of refugees, the difficulties of finding willing doctors to adequately care for refugees, problems of refugees falling between the cracks for medical insurance, the docile nature of Burmese people, and problems with follow-up on refugee cases. These are barriers that refugees themselves may not have identified but still pose significant challenges to their ability to receive healthcare.

Finding Willing Doctors:

Resettlement caseworkers face a host of challenges in their position of providing healthcare services for refugees, for example finding healthcare providers who are willing to take the time to work with refugees on their specialized issues. Three different caseworkers explained how this is often the situation with their clients:

> If it was you or me with the doctor, it would take one hour tops. [With a refugee] we will spend three hours in a doctor's appointment because I will explain and then the doctor talks and we have to have someone interpret. And then its those culture things we have to also break down in order to get an understanding of what is really happening. So, you know, it takes awhile to get a doctor's appointment really accomplished and a lot of times people don't want to deal with that. They don't want to take the extra time to do the extra work that you have to do with the refugee. Because then there are step by step that have to go through. (TK)

> I have a spreadsheet and I have listed maybe two or three doctors for every illness that we have more frequently. And so those are generally the people that I work with the most. Because we often have people who have stomach pains or who have Hep B and so we use the same gastro person for all of them. We try to find someone who is refugee friendly, because then, in the refugee world everything is not perfect… You just need someone who has the patience to actually sit down and thoroughly explain because I've run into a lot of doctors who, this world is so different for them, that they are not trying to take part in it. And I can understand because it is definitely what I call an acquired taste. Some people can't deal with refugees. And some people spend all day doing it. (BB)

> We see different things. Since we are often at doctors' appointments with them we see different things. I've seen doctors who are very careful to speak slowly and know how to work with people from a different background and language and I can tell that they do

> just in the way that the interact and look for understanding. I've seen some doctors that basically don't talk to the person at all. They just go through the interpreter—ask him does he have this, ask him does he have that. And never seem to connect with the patient. I don't know that one is necessarily more effective or less effective in terms of the medical care. I know that people feel better when the person is speaking slowly and trying to help them understand and all. And that would make them more confident to go on their own. But it very much varies by the doctor. (DR)

Another challenge is finding doctors who will accept refugees based on their insurance, or lack thereof. One caseworker remarked, "So they do the healthcare screening and then send the referrals to us. And then they are able to go to anybody in, you know just like we were using insurance, anybody in their network. And that becomes hard in some sense that Medicaid isn't accepted everywhere" (BB).

Refugees also have certain preferences for providers that are easily accessible to them. They may care less about the quality of treatment and prefer ease of receiving care. As one caseworker noticed,

> Most people they want to just have the doctor that's right there in Clarkston near them. They don't care, they don't judge by who has best, what's the best doctor for my situation or my needs and who has the best medical credentials, or anything like that. It's all about access. 'Are they beside me?' 'Can I walk over to them?' So, most people are with a primary care physician right where they are in Clarkston. (DR)

Finding quality, willing providers to care for refugees is a challenge that caseworkers face in trying to provide healthcare to their refugee clients. This is important because if refugees are seeing subpar physicians and treated poorly, they are not receiving the care they deserve.

<u>Getting Taken Advantage of:</u>

Another difficulty caseworkers find with refugees is that they do not understand how the healthcare system works in America which leads to being taken advantage of. Some of this is due to the language barrier. There are opportunities for refugees to get health insurance or health

benefits, but they do not know how to access these resources. One caseworker explained the challenges in dealing with this:

> Frankly, there is no problem with people knowing that there are government resources out there. It's more a problem of, it's very, sometimes very difficult to access. DeKalb County, where most of our people live, the whole DFACS [Department of Family and Child Services] system, food stamps and Medicaid, is kind of a disaster right now. And not just for refugees but for everybody. And so they are caught in that. So since that system is so difficult to work with, you can get cut very easily if you don't do the review, and they'll send out letters that say you have to fill out this paperwork or go online and do this, or you have to be telephoned. [Refugees] don't know how to work the system well enough sometimes to deal with that. … So, the frustrating thing is, when it really comes down to these government offices making it really difficult and you have to just be somebody that goes in there and makes demands and knows their rights and is really pushing for that. They are not going to do that. They will just do without. Because it is a little too overwhelming, and sometimes its just not possible for them to manage that. I mean, they can't skip work to go, and they're not going to skip work to go, you know, try to get food stamps for their family. Which is to their credit… And in not doing that, they can lose out on benefits sometimes. So, yeah. The question is do they know? And yes, they know, but even knowing sometimes is just not enough. And it doesn't seem fair to them or us or anybody when, for example, they'll get a letter saying you will be called to do a review. If you don't do this you will be cut. They wait, nobody ever calls, or somebody calls but they, as soon as they realize they don't speak English, they hang up on them. And then they lose that opportunity. (DR)

Because refugees are new to having Medicaid and the American medical system, they are subject to scams by people who prey on the refugee's naïveté. One caseworker reported:

> A big problem that we've had… There have been like Medicaid scams going on… Apparently there have been instances of these scams continuing to go on where people just knock on refugees doors or call them and say 'I'm taking you to your medical appointment, we have to go.' So clients will get into their cars and will end up going to these like, unknown doctors or like clinics, provide them with their Medicaid information, their personal health information, and receive these services that they don't need, even like shots that they don't need, and you know, when you provide someone with your Medicaid number, it's, you know, basically the doctors are getting a cut of your money. So that's been a problem. I cover that in my workshop, don't go to the hospital with someone you don't know. So when we ask them, you know, where did you go? Who was this doctor? They don't know the name of the doctor, they don't know the phone number, and of course they can't really give you the location. There have also been instances where clients will get phone calls that say, 'I need your social security number,' you know, and 'you are eligible for this amount of money.' So I know that has happened to our clients. So they give away all this vital information, which is not good. (LK)

Refugees do not understand what information is acceptable to share with strangers, or when they should or should not do so. Resettlement organizations are intent on teaching refugees how to avoid such situations. Another issue is in the doctor's office. Refugees do not at first understand the process of waiting in the waiting room until they get called for their appointment. Instead, they wait for longer times and are overlooked. They do not speak up because they do not know to do this, nor do they feel comfortable doing so. As one caseworker explained,

> When I take them to the doctor's… I often, I think what if I was not here with them? Because I will see them, you know we will be waiting for 30-40 minutes. And I know we have an appointment. And I know that that's not super uncommon. But if every time I bring a refugee there, and they don't see that I'm present, but as soon as I mention something, right away we are taken to the back. Especially at the emergency room or something like that. If they notice that a refugee is just by themselves, they may be looked over. Seen in the medical field mainly. And I don't know, they are not seen as 'as important', or they don't want to be dealt with because it's difficult. (BB)

Refugees are viewed as less important than other patients. There are times when perhaps the doctor is accommodating, however, the office staff are less helpful when dealing with refugees. One caseworker elaborated:

> Sometimes dealing with the office staff is more a barrier than getting to the doctor. And if you can't get past dealing with the office staff you never get the medical care. So I have seen doctors where the doctor is great, but when people try to go on their own and talk to the secretary and she doesn't understand, they will try to send them away very easily. Or 'oh, you missed this,' 'you don't have this,' 'we are going to reschedule you,' and be very dismissive. So most, if they are by themselves without someone who is very confident or speaks English well or knows that 'hey, no, we know what we can do and we can work this out,' then they just kind of don't get seen and go back and try again. So yeah, all of that happens… (DR)

Refugees are uncertain about what to do in these situations and therefore cast to the 'back of the line' when waiting for an appointment. Some of this has to do with the disposition of Burmese refugees and their unwillingness to be assertive.

Docile Nature:

All of the caseworkers commented on the reserved nature of the Burmese people. Much of this is due to cultural norms of respect and deference to elders and those in positions of authority. They mentioned that while it made working with Burmese people generally easy, it also resulted in some difficulties when they went to medical appointments. The refugees would not speak up for themselves, even when they deserved better treatment. For example, in doctors' offices, the Burmese refugees would sit and wait for hours without saying anything. They may realize they can say something but will not. One caseworker noticed:

> If I do not push, then I feel like they are just laid back. Oh, they can wait. They are not going to complain, or something. And they won't. If we are there, we complain. So, you know, they always need a push and refugees, they don't do that. Especially Burmese. They are in general so calm and patient and they will not say anything. They will sit there. And they have learned that, I don't know, just by being in refugee camps and then being in America, sometimes we will, there are times that you have to wait. And they don't know the difference. It's up to us to know that we are not waiting because the doctor is just busy or an emergency happened. Like somebody who got here after us got called before us. That is not something that they are geared to look at or to think about. Or if we are in the emergency room and the doctor has passed us four times, like okay we've been here and you should probably check on them. I will say, especially Burmese, because of all the people we work with they are the most calm and gentle usually. They are scared to talk back. They are afraid that they will not get the treatment that they should if they talk back or just look at them wrong. Anything that is kind of rude, they don't want to do. But of course us, being here, we are the mamma bears. And say "look, she needs to be seen immediately. She has been here for three hours, what is taking so long? What is going on in the back?" and then they push around, okay you can come in immediately. And we always see that. (TK)

This can also be a problem with receiving treatment. The refugees may not understand what is happening during the appointment but do not ask questions. Similarly, due to cultural expectations about what going to the doctor means, Burmese refugees will go to a doctor once for their problem, and if it is not fixed, they assume that nothing else can be done. They do not question if they got the right treatment; they simply resign themselves to the care they got at that one interaction. One caseworker has found that:

> Some people will have an issue and they think doctors can just give them a pill and it's done. And so when they go to the doctor and they try one thing and it doesn't work, they just say oh well, I'll just live with this.' And some people will have an issue and the doctor recommends things… and they aren't going to be able to do that. So, yeah, language and confidence to address issues and knowledge to address issues are some of the biggest barriers for general things. (DR)

The docile nature of the Burmese refugees can lead to their not receiving the care they are entitled to.

Falling Through the Cracks:

When refugees first arrive in America they are entitled to eight months of Medicaid based on their refugee status. However, after this period ends, they must apply for their own insurance. Unfortunately, most refugees are not eligible for Medicaid when they reapply. They are above the income cut off, yet do not make enough to afford insurance on their own. They ultimately fall between the cracks and are left without health insurance coverage, which, as the refugees mentioned, prohibits them from going to the doctor for healthcare services. Two caseworkers commented on this frustration:

> The refugees can reapply, but they are not going to get it. Because here in Georgia, ... well now everything is so different because of the new healthcare laws. But since we didn't do healthcare expansion, they fall in between that gap where Medicaid ends and the Affordable Care Act begins. But if you make, if insurance is going to take up more than, I think its 10%, it might be a little higher than that, of your income per month, then you can be exempt from it. So that's where they fall. So we have relationships with sliding scale free clinics. Because after the eight months, it's like, that's almost their only option. But if they are lucky and by the fourth month they already have a job that has a full benefit… So what I usually tell the client is "wait until the eighth month, and then after that eighth month your Medicaid is gone, get insurance from your company. So that is what they get. They try to get the wife and husband covered after the eight month. And the kids, of course, the government, it's already paid. That's idealistic though. Because we do have many, many, many refugees that are just, that don't have healthcare after the eighth month. (BB)

> We're waiting [to hear about the Affordable Care Act]. I was kind of excited, like okay [refugees] will be able access some kind of insurance. And some people are working, they work through temp agencies that don't give insurance, and they should be able to afford something, so it seemed like a good idea. But it, from what I'm understanding

> right now, since Georgia didn't raise the Medicaid eligibility, our people are not going to qualify to get Medicaid anymore than they would have before, which is none. And yet they are not going to qualify for subsidies because the ACA is based on the assumption that people under a certain income have Medicaid. So they, most of our people, will fall in between. (DR)

This consequence leaves refugees without healthcare coverage and leads to fewer or no healthcare visits. This is can result in serious problems if a refugee seeks medical care and must pay fees out of pocket.

Insurance:

Most refugees do not have health insurance because they cannot afford it, or they choose not to enroll in it so they can earn more money at their jobs. Caseworkers try to encourage refugees to obtain insurance because they know of disastrous situations that refugees encounter without it. One woman explained:

> I try to really hone in, tell refugees you need to get all your vaccinations during the eight months because [Refugee Medical Assistance] is a federally funded program 100% so they don't have to pay anything during these first eight months. And a lot of time they won't get their vaccinations, and it affects their green card status, and you know they have to pay out of pocket for these immunizations because it's the case that a lot of clients don't have health insurance after the eight months is over. And then a lot of times, even if they are working and their employer provides health insurance, they don't choose to enroll in it because they don't want money going out of their monthly pay check. So, because, you know, who wants, that? Especially when you feel like you are in good health. But I mean, we have had clients where they choose not to because they are perfectly healthy and then they get into these major accidents. So that is one of the things I try to emphasize—if your employer offers health insurance, enroll in it. Trying to see health insurance as an investment. (LK)

Not having insurance also prevents refugees from seeking general healthcare. They do not want to pay out of pocket for health services, nor will doctors' offices accept people without health insurance. Additionally, there are fears that going to the hospital can lead to exorbitant fees, so many refugees avoid seeking healthcare at all. A caseworker found that:

> For larger issues, it really does come down to if you don't have insurance, nobody wants to see you, so there's just nowhere to go to access that once you've gotten past a certain

> point and you don't have any insurance. So that's a frustration for bigger problems or bigger issues where people really do need a surgery or really do need something. They don't have the money to spend on doing it themselves of course and they are very scared …. Everybody knows the horror stories of that person who went to the hospital and got the $10/20,000 bill. And so that makes everybody very hesitant to do anything if they don't have Medicaid basically. (DR)

Refugees do not like to go to the hospital at all when they do not have insurance. This leads to refugees having to pay huge fees when they do need emergency care. Caseworkers emphasize the importance of health insurance, but it is not always a priority for refugees.

Language and Interpretation Services:

Interpretation services are supposed to be offered in all healthcare institutions. However, because hiring interpreters or buying Lifeline (a phone interpretation service) can be expensive, many places lack this resource. This is detrimental to the care of refugees, as they do not always understand what is happening. One caseworker told a story of how this happened to one of her clients:

> I had a woman, she was a single mother, and she had a ten-pound baby so they had to use forceps. And she literally, she didn't know what was going on the whole time. And I was there with her and I think that that could have been comforting, but for me, if I am ever having a child, it's a lot happening! Doctors running in, people running out, and blood is here. How do you, if no one is talking to me, expressing to me what am I actually experiencing. That would be one of my biggest concerns as a refugee. You want to give me shots and not even telling me what that is in that shot. (TK)

Denying refugees proper interpretation is a serious problem. It denies them the basic right of understanding what is going on with their body. One caseworker mentioned her annoyance with the lack of interpretation services:

> My biggest pet peeve with the healthcare system, especially around here, because we are in Clarkston, is the lack of interpretation or the lack of knowledge that refugees exist. Like I go to doctor's offices and they just completely act like this is such a thing that is like not happening. Or they are like 'no, we don't offer interpretation services.' Or, 'no, you can't bring this person here even if you bring an interpreter.' And that is pretty much discriminating against them as a person because they speak a different language. You can't tell them that they can't be seen here at this doctor's office. And I run up against

> opposition for that often. And that is probably my biggest pet peeve, is that, I tell people often that I have learned the fine art of playing charades. Because I don't speak the Burmese language. And all day I am like, you know, playing charades with my clients, and we can make it. It's not going to be as laid out and as clean, but I can express to them enough. But I cannot explain to them why they need to have quadruple bypass heart surgery while doing charades. That is something that an interpreter needs to explain. They need to be able to ask questions. And they need to offer that at doctors' offices. Because if they are going to take your insurance, going to take that money, you should also be able to offer services that would help your patient. Because now they are your patient. And I don't see a lot of the, taking pride and taking ownership, like this is my patient. And I especially don't see it with refugees. … For us to not even, to look the other way when they try to get help, it's kind of hard to deal with. And I think that for the refugee is probably, I just often imagine being in a new country and someone just poking and prodding at my body. I don't know what is going on, but they told me this is what I need to do. Especially for women who have babies in this new country. At one of the most vulnerable times in life, they don't even know what is happening. (BB)

Some health professionals ignore the importance of interpretation services. They don't understand the difficulty refugees face by not understanding English. They are sometimes unhelpful, bordering on apathetic to the refugee's challenges. Another two caseworkers further commented:

> So I have a situation where a lady, her baby is very ill. The doctor tells her the fact that she needs to go see another doctor. The doctor just says, 'oh, you can just go to this hospital. You can just go in there and ask such and such.' And I'm like, okay, can you give us the suite? The door number? You can't just tell me, go to DeKalb Medical. DeKalb Medical has so many suites, so many floors, so many doors, I don't know which one to go to. So even when, me being there, I am just so confused, imagine for my lady, where she has, like a sick baby and she doesn't know what to do, she thinks it's her fault that the baby's ill, because of her. So there is so much confusion with her, and even me trying to help her. It's just so much confusion because the doctor himself doesn't know what is going on, he can't explain in details. Because he thinks, this lady, she can go. Even though she is a refugee, she can just ask someone else. Like, that's her job. So even me being there as an interpreter, I feel like they are not giving us enough information. And imagine if I am not there. How much she would have been lost. And I was lost even and I've been here for a long time that I know which place is what. And she has been here what, two to three days. It is just so much complication with the doctor's office, and I feel like that is their job to explain a patient. It doesn't matter if she is a refugee, asylee, it doesn't matter if she is American, it's your job to explain what is necessary so that you can help this patient. But yeah, that's the most complicated thing. (TK)

> There are some instances where interpretation is supposed to be provided, but even providing interpretation does not address the entire barrier because of cultural understanding and knowing what to do. And sometimes you have to, we always talk about that with medical appointments for example. Yes, they are required to provide medical interpretation for the doctor's services, but if the people can't even figure out how to get to the office or who to ask for when they get there, even understand anything about health and what questions to ask, then effectively they can't access the services. (DR)

Refugees must often bring a family or friend to translate for them. This helps them feel more comfortable in healthcare institutions. They must provide their own resources as none will be supplied for them. One caseworker elaborated on this:

> The biggest barrier is usually language. And the only way people really have to get around that is to be connected with a friend who speaks English who can come with them. Because even though there may be requirements by law, there is just no way that individual small doctors' offices are going to have every language that exists available. And for them to try to wait until that happens or to find doctors somewhere that would provide that delays their care such that sometimes they wouldn't get it. So I'm much more comfortable with them having doctors open to letting them have friends or family come with them to interpret. And as long as that will happen, people will usually, they may not understand what is going on and they will make mistakes as they go, in terms of they were given some medicine and they didn't understand it or they didn't go to the pharmacy and get it … But, eventually, that comes to light and then they learn and then they do it and then things can be okay. That's what I see happen quite a lot. (DR)

Refugees are also hesitant to go to the hospital on their own because they feel that their language skills are insufficient and lack the confidence to go on their own. One caseworker explained,

> They would be afraid to go [to the hospital] on their own, most people. That's where its really important that they are connected with others that have been there and gone through it before. So a lot of… I'll give the example of women and childbirth. In the beginning, you know, a lot of people were very fearful of going to the hospital, just because it was an unknown. Now it's, so many people have given birth here and gone through the process that everyone knows that pretty well. So I don't find that people are afraid of the hospital itself, again they are just more scared that "I can't go there and talk to them. Somebody needs to help me with that. Sometimes it's even, they can but they don't feel confident unless somebody is there with them that just makes them feel like okay I have a back up if I do stumble. If they ask me a question I don't know, I have someone who can support me. As long as somebody knows a little more English than they do, they will feel more confident to go together with them. (DR)

Refugees face significant barriers when going to healthcare facilities. This is made worse by not being provided with services they are eligible for. They must depend on others to help them or get lost in the confusion of the healthcare system.

Follow-Up Care:

Caseworkers acknowledge the challenges with following up with refugee patients. They are caught up in a system with so few resources that refugee patients are often overlooked. Because refugee resettlement organizations are only mandated to work with a refugee for the first three months, caseworkers cannot always follow up with a specific refugee's medical problems. One caseworker admitted, "So in terms of follow up from direct clients, I guess I don't really. I guess if they have something, like a really serious health problem, that is dealt with after the eight months with [another case manager]" (LK).

One interviewee works on a research project looking at the consistency of follow-up for patients coming from Thai refugee camps. They have found that many refugees do not return for appointments and they are not contacted again, despite having a significant medical problem. She explained,

> Right now we just want to make sure that the people are getting the care they need… We are in contact with the clinics. There's been several people that I've just heard of just through talking to clinics where … where you know, there was one for instance who, well when we looked at his results, we suspected he had an acute Hepatitis B infection. And we contacted the clinic to see if he got tested again to see if he got over it or if it turned out to be chronic. They told us that they had told him to come back, and he never did… But because we contacted them and asked them, they decided to give him another call. It was a year later, but. (AF)

This is a dangerous trend as it leaves many refugees without the care they need. Due to the lack of resources and overwhelmed caseworkers, refugees are often overlooked and their health problems never get addressed.

Caseworkers witness additional barriers to healthcare access that refugees may not recognize themselves. Refugees face further struggles seeking healthcare because they have recently arrived in America. They are transitioning to a new life and face the compounding challenges of resettlement.

Resettlement Barriers

There are many barriers that refugees face during their resettlement in America. A number of them relate to their opportunities for receiving healthcare, such as language barriers and difficulty finding transportation. Other obstacles that hinder Burmese refugees' adjustment to life in America include feeling isolated, struggling with living in a city, feeling overwhelmed by information, lack of resources at resettlement organizations, and others. These challenges affect daily life for refugees and make their resettlement difficult.

Language:

Most of the refugees came to America not speaking any English. This makes it more challenging for them to establish themselves because they cannot do many things, such as errands, without difficulty. One refugee told a story that when we first got here,

> We went to somewhere so we didn't have any car to drive and then we took one of the store carts and we bring it here. We didn't know we are not supposed to do that. We don't have any idea. So we just take everything. Every time we go we take the cart. We, another one is, we went to the store. First, we don't know the price. If they put like $1.99, we thought like $199.00. We thought 'oh my goodness!' And we are trying to get up front and ask so know what to buy. (NK)

Not being able to speak English also hindered the refugees from getting necessary services and understanding the process of how to do so. ESL classes are set up for newly arrived refugees, but it can take a long time to fully be able to communicate in English. A caseworker commented:

> I think the biggest barrier, we always tell our clients, is learning English. In order to get the services, food stamps, and the Medicaid, the government has set it up as such that clients have to go to English class. Because English… being able to survive in America without being able to speak for yourself, without being able to navigate. The ultimate key to helping to learn to how to do the healthcare system, to learn how to do the transportation system, to learn how to go to the grocery store, just various things, it totally, almost hinges on you being able to communicate with someone besides [the case worker]. Because she will be there with you for the first couple of months while we are paid by, you know, while we are able to help you, but then after a year if you still don't know English and you're in America, you can't even tap into certain systems that might work for your benefit because you don't even know about them or the people who might be able to help you can't communicate with you. (BB)

Not speaking English also keeps refugees from venturing outside their home and community. They rely on others to help them and have trouble becoming self sufficient in this way. A Burmese community leader noticed:

> [They have trouble knowing] like, how to live. Even though agency teaches them how to live, clean your house and apartment, they still don't understand. They stay, even though they want to go somewhere, they don't speak English so they are scared. They call to somebody who can speak a little bit English, but they calling all the time. Because they having problems to get somewhere. They call us all the time though. 'How to get there? How can I go there?' And if the children are sick or something, they try to call to us. They don't know where to contact. Even though they try to contact, they don't know. When people call the phone, their English, they just hang up. They never reply, no answer. That's a problem. Even they go through ESL. But some people, they still don't know. Because they never been to school. (AT)

Refugees struggle during their transition to life in America because language is such a barrier for them. They have trouble navigating the area where they live and only do so with help from others. They also have trouble getting around because they do not always have reliable transportation.

<u>Transportation:</u>

All of the resettlement agencies hold public transportation orientations on MARTA to help refugees learn how to get around Atlanta. However, few refugees feel comfortable with this

right away. Instead they do not feel like they have many options for getting around. Two refugees explained:

> The difficult part was the language and then the transportation. When we first came here we didn't have car or anything so we have to walk. It's kind of dangerous. We feel like, it's not safe. (MN)

> For three months, the resettlement organization helps. After three months they stop the help. When they stop, it is hard. That's too hard for me. The hardest was the car. Because at that time, we don't have drivers license and in the winter, it is too hard to travel because it is cold. (HN)

The refugees who are resettled in a city area, such as Clarkston, have more opportunities to travel using MARTA. However, those settled in more rural areas and places further from Atlanta have greater difficulties. One caseworker mentioned:

> Transportation is hard, but we have a person here that does MARTA training. And being in a city like Atlanta, or near a city like Atlanta, it's not as hard as I think, maybe resettling people in like Oklahoma might be. You know, somewhere where there's not as much, busses and trains. Somewhere where it wouldn't be as accessible. (BB)

Transportation difficulties are pervasive among refugees. They often do not know English, so it is significantly harder to learn how to navigate public transportation. Many refugees rely on family and friends who have lived in America longer and have cars to assist them with transportation. But when refugees do not have a community around them, this becomes a greater challenge.

<u>Isolation:</u>

Burmese refugees newly resettled in Atlanta or Clarkston today have an established community for which they can rely on. However, a number of refugees did not have the same community set up when they first came here. This is true with Burmese refugees resettled in areas with very few other Burmese people; they have more challenges to overcome when there is no one who can help them. Two refugees experienced this difficulty:

> The first time, to be honest, I don't like it at all. Because I never been in such a big country. I feel like, or if I had known that, I would not come here. Because first I don't know the language. That is the difficult part. And then my parents too, they don't know any English also. But when we first come here, we don't have any friends. Only our case worker. Brother too. Some of the other refugees from Ta Mae camp were here, but only three or four Karen families that live here when we first came here. (MN)

> It took four months to feel comfortable. During that time there is not a lot of refugees people… When I first came I didn't know anything. We had no idea. When I first came we didn't have nobody to drive and no one is going to help us. (NK)

This is a challenge that many refugees face. They feel isolated from other people like themselves and must deal with additional burdens when there is no community support.

Difficulty Living in a City:

Burmese refugees in particular face challenges when moving to America because it is so different from the conditions in which they lived in Burma and Thailand. Many have never lived in a city before, and the modern fixtures in their apartments are foreign to them. This is challenging because it is one more adjustment that the Burmese refugees must make. One refugee remarked:

> The living standards are different for Burmese people. Many people who are from Thai camps and lived their entire life in the jungle and refugee camp, they saw a car for the first time when they left the camp to go to the airport. They never used a flush toilet and never seen car or heaters or air conditioning or lived in American style homes or apartments. It is like heaven and earth. And I found that so many people struggled because of that. Many people cannot drive or don't know how to get to MARTA because they never used public transportation before. Getting on MARTA and slide the card is very simple, very easy, but for them it is a big challenge even though it is easy. Maybe other refugees from other countries have lived in other places and city. But Burmese refugees have so many more struggles because they are from the jungle. Atlanta is just another city for some people. But not the Burmese. (PV)

Learning American customs for keeping a home and adapting to this new lifestyle is very difficult for Burmese refugees. They often face hardships from their landlords who do not approve of the Burmese lifestyle. A caseworker noticed:

> The more rural a refugee is, the more difficult it is. So the most rural of the Burmese have the struggles of just maintaining a home, you know, being used to the standards of upkeep of a home that we have here. And, when they don't, having problems with the apartment manager and complaints and that. (DR)

Additionally, the American customs that may seem so simple and are ingrained in daily life are a challenge for Burmese refugees to learn. They are not accustomed to the American way of life and struggle to learn. As a community leader has found,

> One difficulty is [Burmese refugees] couldn't fit with the American society because our cultural and traditions are totally different. So they try to adapt, to follow the American society. But some people stay struggling with that. Our tradition is, sometime, even in Burma, we have different ethnic groups. And even the same ethnic groups have different languages too. So that's a problem. It is different. Like me, I lived in Rangoon, or like a big city. For me okay. But they live in the jungle. Most people are very hard to adjust to the American life. So, some stay struggling. (AT)

Burmese refugees face additional challenges when they move to America because the lifestyle is so different from what they were used to in Burma and refugee camps. They must learn all new ways of transportation, cultural norms, and modern technology in such a short time, which can be quite overwhelming.

Information Overload:

When refugees first come to America, they are met by caseworkers from resettlement agencies. The resettlement agencies host many orientations for the new arrivals and provide an abundance of information to refugees very soon after arrival. There are orientations on transportation, language, legal issues, education, healthcare, and more that refugees must sit through. All of this information is quite overwhelming to refugees and they struggle to retain it. Two refugees admitted:

> They help us with the initial appointment with the medical, yeah they will follow up with you and then for job also they will follow up with you. They do provide a MARTA orientation. And they do provide also a legal orientation about the welcome to America. It was kind of helpful because just arrive and learn all the things in the first couple days and couple weeks so, you know, you can imagine that those things are very difficult for

> the refugees to catch every single thing because it is a lot of information at one time. And it is overwhelming. We should take a little time to do this. (JW)

> World relief does help us, but we don't really pay attention. We don't know any English. Sometimes they try to come too, but I am not fluent to speak in that language and the interpreter is not the same language that we speak. So it is hard at many steps. I remember that the caseworker took me one time... But it's not really enough to know the details. And even if they are explaining when we go to the store, but we cannot understand. (NK)

One caseworker also added:

> And the cultural orientation process … And, I don't know, I think they do a really good job. I mean, I know the resettlement process is really overwhelming for… Sometime's we'll have a cultural orientation and someone who came on Monday, arrived late at night, and they will sit through an entire orientation on Tuesday. And then, it's like bam bam bam bam bam. Its one after another. Its like a waterfall of information, so I know its overwhelming, but I mean, personally, I think, I wouldn't really know any way around that. (LK)

Because the refugees are learning so much information before they have had a chance to use it in practice, they struggle to remember everything. Then later when some of the situations do come up they do not know how to handle it. This is a challenge for refugees and caseworkers, as organizations want to help the refugees understand as quickly as possible, but it is not always possible for refugees to understand immediately. One reason for this is the limited time organizations have for orientation due to a strain on resources.

<u>Lack of Resources:</u>

Refugee resettlement organizations are funded through federal programs. There is very little money to work with and an abundance of refugees that require services. Caseworkers are generally overloaded with refugee clients and cannot attend to everyone as well as they should. One refugee discovered:

> The resettlement agency caseworkers, they have to deal with a lot of people, so they cannot provide all the services the refugees need. But if possible, if they can go provide interpreter and transportation or things like that its good. But this will not happen I think. It is very difficult because it costs a lot of money and costs time. (JW)

Resettlement organizations are only required to work with their refugee clients for three months. After that, it is assumed that they are adjusted to life in America. However, while this is rarely the case, organizations do not have the resources to keep in contact with the refugees. One caseworker mentioned his wish to change this:

> As far as the resettlement process, all agencies are different … The requirements are very minimal. And if there are agencies that do the minimum requirements, they may be fine on paper, but I see it as a failure for the refugees because… The example I mentioned were these people were not very confident to tell us what was going on, I had to just see it for myself. And that required going often to their home. Really the requirement is we have to be there the first day, the day after they come, and one more beyond that. Other than that, I'm not required to ever set foot in their home. They have to come to me. That's how we could be set up. I don't, we don't do that. I don't like that and I think it basically serves to create a barrier for refugees that's unnecessary. So I would say its nothing to change by policy, but I would love it if everybody could treat the clients as if they were friends that they personally go visit and check on and establish relationships. But, that's, like I said, more of a practical thing. It not a policy thing that could ever be done. (DR)

There are so few funds given to support the refugees that it is difficult to fully cover their needs. Refugees are expected to be self-sufficient by the end of three months. This is very unrealistic, as many refugees still cannot speak English. This makes finding jobs very difficult, especially in such a short time frame. However there is not enough money to keep supporting the refugees past this point. One caseworker explained the difficulty of this:

> The funding sources, first of all, there's the refugee resettlement program that gives the agencies money for families to get them started initially. That amount is $925 per person in a family. So that's how much money we have to use. And we, it lasts as long as it lasts. So that's why the agency… we're the ones who kind of set the ideas of how its going to be spent or we have some minimum requirements and then we do things as cheaply as possible to make it last as long as possible. So that's the first set of money. So if it can stretch to three months, great. At the end of three months we have to have spent all the money. So we will hopefully have money left over that we can issue as a check for rent, for bills, beyond that. (DR)

Lack of resources in refugee resettlement makes it difficult to provide refugees with all that they need to get settled in America. They require additional help and assistance in those first months, but that is often impossible.

Other:

Some refugees who resettle in America come to live with previously established family members. This type of case does not have the same requirements as other refugees who come independently. Because family has agreed to sponsor the refugee and not a resettlement organization, the incoming refugee does not have access to many of the resettlement programs and orientations that help with transition to life in America. While this can be difficult, there may also be benefits to living with family members. Having more networking opportunities and an easier time adjusting are some examples. One refugee experienced this during her resettlement:

> The agency didn't do the cultural orientations for us, for our case because our cousin was there. But to other friends, their agency did it for them and taught them how to go to the grocery store and how to use MARTA. It was different for us. Our cousin, she and her husband helped us and taught us to drive and get our license shortly. They helped us to apply for jobs and look for jobs in places. So it is different. For some other friends it took them longer to learn driving and other things. But we had no transportation so we have to learn to drive. In three months, my sister and I can drive and get our license. So there are advantages and disadvantages to living with family. (PV)

While it may be helpful to be living with one's family, these refugees do miss out on many useful programs that help them learn American customs. Organizations should do more to include these refugees into their services.

Another difficulty is newly arrived refugees often fall victim to various scams and people trying to take advantage of them. Refugees are seen as easy targets because they do not yet understand very much about life in America and are easily tricked. Two caseworkers explained examples of this:

I guess when they go to grocery shopping, when they go to stores, sometimes they get cheated. Money in general, for any refugee, especially now it's tax season and a lot of them get cheated on their taxes. And they don't even know. Just, some of the basic norms that we take for granted as far as being able to use our money and how much to give back. And even, just on their food stamp cards, that's still their money and people will steal and take advantage. Especially because Burmese people tend to be… okay, because they have been in refugee camps so long and so persecuted, they literally ask when they first come here, 'is it okay for me to go outside?' 'Is it okay like if I need to leave city?' 'Do I need to carry, you know, these documents with me when I go somewhere?' 'Can my wife be outside after this time of day?' You know, various things that because they have been so persecuted, they don't know. They are not going to want to say anything. They want to make sure they are not going to do anything that is going go get themselves in trouble. And that leads over to them being taken advantage of in almost any situation, especially when it has to do with money. We have so many scammed people… We have so many people who learn that refugees in Clarkston don't understand certain things. Like I've had people that have taken Medicaid numbers from different refugees, or have taken food stamp cards, or sell food stamp cards. Say I have $500 cash. And this specific Burmese refugee has a $500 food stamps, or it could be more because they have like 10 kids in the family. And the person is like 'hey, I will give you my $500 cash for your food stamp card so you can spend it on whatever you want, clothes, or such and such, so that they are interested in the buying and selling.' And as soon as they are okay with it, just use $500 … So, food stamp scam is the top top main one. We have been warning every client that comes in, 'look, do not sell your food stamps.' Or they take the card and never give it back. Like, as Americans we will report it, but they are so afraid of getting in trouble, even if they are not the ones in the wrong. Even if someone just stole their card, and they don't know that. They are so afraid of getting in trouble that things they haven't even done wrong, they wouldn't tell. (BB)

I have seen, this is one of my clients as well. She has a relative that helps her out and she had no other relative … And he will take her shopping and what not. And when he does take her food shopping, he actually made her pay for his shopping, as well as her shopping. So, practically she is paying for two shopping lists. His and hers. And I asked her, why do you do that? And she says, well I feel like he is taking me to places and I feel like that's, you know, I have to pay it back. And I say, 'well, that's your money, you don't have to pay him. Even if you do pay for gas or transportation, just pay him $10-20.' And his grocery, she paid like $300 almost. So I feel like they have been cheated by their own family or friends sometimes as well. And that's what I see the most. And I feel so irritated when I see that… But I feel like that's not right. And I said, 'if you want to pay him, pay him separately. Say okay, I will pay you $20 or $10 for taking me for groceries.' And they do take advantage of it like, 'no, don't pay me, just pay for my groceries.' And its like, twice or more than that. Twenty times more than what he is supposed to be getting. So I feel like sometimes, just the close member of the family, cheats them the most. And you know with the taxes and the food stamp scams. And there are more strangers and they get robbed, and especially single mothers. Single mothers, if they are going to a bus station, and if they see you, just you and the kids and having to carry the kids, with the purse, they will rob you. and that's the difficulties that

> we are trying to face. Because we have like three clients before, they been robbed and they are trying to go to the health department or they are trying to go to school, or they are trying to do something better for themselves, an in the meanwhile, they got robbed, shoved, killed. You know, just anything is possible. (TK)

Refugees are vulnerable to scams but do not know enough about the situation to resist. Resettlement organizations attempt to teach them about such instances, but there are inevitably refugees who become victims to such tactics.

As mentioned previously, Burmese refugees are extremely respectful and reverent to others. This can lead to difficulties when caseworkers are trying to help them. Burmese people will often not tell anyone if something bad has happened, as they do not want to call attention to something they have done. One caseworker explained why this could make it challenging to work with Burmese refugees:

> I would say though that the biggest problem the Burmese populations in general have is that they, they are very hesitant to speak up for themselves and their needs. They will have a serious problem but not tell anybody. There's a concept called *onna* that is basically a respect of somebody who is above you who you shouldn't be bothering. Deference. And part of that is not bringing up negative things, especially not contradicting. And, so, people will often be shy to say what they need because they are kind of waiting for you to notice it and tell them, rather than bring it up themselves. Partially because to point out a problem is to say you didn't do a job you were supposed to. That's sometimes how they feel about it. Or just to, again, the whole 'they're busy, we don't want to, its bad to bother them.' Especially in the beginning there were a lot of times where I felt like I need to go to their home everyday or there will be something and they are not going to tell me. They, we took them shopping for groceries but they didn't buy enough and they've been out of food for two days but they didn't tell us that because, you know, they felt like they couldn't. Or they had a leak and they didn't know what to do but they didn't ask anybody. (DR)

This is challenging because it is harder to help Burmese refugees and know what they need if they do not tell the caseworkers. Their docile attitude can at times make it more difficult for resettlement organizations to properly assist them.

Finally, discrimination is one thing that refugees face. It happens in different situations and can affect how the group is viewed. As one caseworker has discovered,

> The one area about discrimination, I do feel like sometimes apartment managers will… Because they will have some people that don't keep their apartments as clean as the apartment manager expects they need to be or they do something like bring in animals that they kill to eat at the home. Sometimes they will treat families with a little bit of disdain because of that. And then they'll start kind of creating stories about how difficult it is to work with these families, when really it sometimes isn't even that true for any particular family, they just kind of will blanket say 'everybody's like this and everybody does this.' That can get a little bit frustrating sometimes if you feel like you have families that are… Managers are maybe ignoring their reports of problems in the apartment because 'oh, well they all break that all the time anyway. So if we fix it they will just break it again.' So, you know, that kind of thing. So when people are having problems like that, that can kind of delay them getting ahead. (DR)

Assumptions and stereotypes about refugees are often false and can cause problems for the Burmese community. In Clarkston, because there are so many refugees living in the area, there is less discrimination because many of the groups understand what it is like to be a refugee. However, there can be some trouble in areas where there are fewer refugees and they stand out.

Burmese refugees face many barriers, whether they are trying to seek healthcare or establish themselves in America. They are forced to face unique challenges and adjust to a new way of life. However, the Burmese people are very resilient and have established a strong community base on which they rely.

CHAPTER 8: A CASE STUDY OF BURMESE REFUGEES IN ATLANTA

Characteristics of Burmese Refugees

Through interviews a number of characteristics about Burmese refugees became clear. Based on testimony by both the refugees themselves and the caseworkers, the Burmese refugees settled in Atlanta are an extremely community based group. All of the refugees interviewed live in Clarkston, a small city in Georgia with a large refugee population. The Burmese refugees frequently lived in the same apartment complexes or within walking distance of one another. Families and friends gather together over meals, celebrations, or simply to relax together. Various churches are also located in the area, including the Clarkston International Bible Church where the Karen Christian Fellowships hold services on Sundays. The Burmese enjoy being around one another and find comfort in having companions who have been through a similar experience.

The interviews demonstrated the ways in which the Burmese refugees were constantly helping one another. Two of the refugees mentioned that as soon as they came to America they acted as translators and interpreters for other Burmese refugees, including those in America who had been there longer. One man explained:

> It take a long time to get comfortable here. But when I came, I had some English you know. So, I have a lot of problems as other of my friends and other of the refugees. At first I arrived, everything is new to me. But the first thing I have to deal with is to interpret for them…So, all the challenges that I have to overcome are done with them. Nothing new to me. Because since I arrive, I provide the interpretation services for them. (JW)

Another woman spoke of interpreting for family and friends already in America. She would help interpret for them over the phone because she had to work during the day:

> I have so many friends after I moved to the Clarkston area. Some of my friends, they called me and asked to schedule their doctor appointments for them and to interpret for them. I was working in the leasing office then so I couldn't get much time off. So I

> would mostly do phone translation for them…Some of my friends or clients, they call from other states also so I can check my calendar and set a time to provide interpretation for them. The first year we all were experiencing the same difficulty. (PV)

The refugees were willing to help others even without feeling completely comfortable in their new surroundings. Another man wanted to help new refugees because he did not receive help when he first arrived and understands the challenge:

> I do go with some people who are new here if they need help. They call me up and I am an interpreter for them. The part I try to do that, because some people who come in now, they got lucky…We already know how to speak English so we can help. When we came there was like nobody. We don't have agency, nobody speak the same language. The neighbors was, everyone was speaking English. It was not easy to try and get help. (NK)

In addition, the Burmese want to help and give back to their community. They not only provide assistance, but also encouragement to help others become self-sufficient. A community leader has found:

> If refugees need medical help, they are asking for me or some of my friends. Sometimes we try to encourage them—just go there and get the prescription and just give money or Medicare card or something. Try to encourage them. But every time, like 60% are okay, 40% are still having problems. (AT).

The Burmese continue to make an effort to give back to their community. This selflessness was also witnessed by a caseworker:

> So, for the Burmese specifically … there are a lot of different languages and ethnic groups amongst them. But overall everybody seems very well geared towards creating community, creating networks for each other and helping each other. Especially through churches and other organizations. So, I think by far more than any other group I've seen, they just have been so quick about getting organized amongst themselves. Which is a positive. And it has meant that the earlier groups, the earlier arrivals had more struggles with that, with adjustment than the new ones who are very quickly able to find people who drive and can take them places and show them things. (DR)

Newly arrived refugees learn to rely on previously established refugees for help. This is often the best and fastest way to get assistance. They feel comfortable reaching out because they know

that there will be other community members able to help them. A caseworker emphasized the truth in this:

> Really the way people get by is to get linked to community members who are going to help them get to the doctor. Especially amongst the Burmese, that really happens a lot. I see it all the time. And I would say, that's, if people don't speak English, don't have transportation or don't have an understanding of the medical system very well, that's the only way they are going to get by. Is to be connected with other community members who help them ongoing. (DR)

Burmese refugees want to develop their community so that everyone feels welcomed upon arrival to America. Many refugees work at resettlement organizations to have an official role helping newly arrived refugees. They feel that it is important to give back and make the transition easier for refugees that come after them. One woman works at Refugee Resettlement and Immigration Services of Atlanta and explains how rewarding her work is:

> I work at RRISA. I interpret for the Burmese people and new arrivals. I pick up clients at the airport. They are very happy when they see me, because they are scared to come to live here. They don't understand English very well so when go to the airport to pick them up, they are very happy and I am happy too. And some people, they don't understand English, they don't speak well. So I interpret for them and then they are very happy. This is my experience. And then, they need help. So I help. And I am so glad to help them… I very enjoy my job because I help. I can help people, from my same country…. I enjoy the job because help people from the same country. (MV)

Burmese refugees enjoy working with newly arrived refugees because they can offer ways to adjust they wish they had known upon arrival. They do not feel obligated to help but cherish being able to support their fellow refugees. They take pleasure in cultivating their community with new members and making connections between groups.

There are many different ethnicities of the Burmese refugees who resettle in America. The larger groups, such as the Karen and Karenni refugees, command a significant presence in the community. However, there is integration between the various ethnic groups. They have

many of the same customs, and although they may not all speak the same language, enough people are able to communicate among them.

The Burmese refugees also made claims in the interviews about wanting to work hard to get ahead. Two of the refugees interviewed are currently in college and highly value their education. One of them wants to become a computer engineer and the other a social worker so she can further provide assistance to refugees and immigrants. Many of the other refugees mentioned their desire to return to school.

The Burmese are also hard workers and determined to succeed. One caseworker mentioned that Burmese refugees are particularly dedicated to achieving their goals of a better life:

> …The people from Burma specifically, are very driven towards this idea of 'we can get established, we can get a future.' That they've never had the chance to before. But they have realistic expectations of doing that. And so, yeah, I think because of that they get ahead in the end. (DR).

This trait has allowed many Burmese refugees to become well established in America and achieve successful lives. This is also possible through the support system of the Burmese community and the networks that other Burmese refugees have to share with each other.

Foundations of these Characteristics

These characteristics of community building and dedication to success are founded in the journey that Burmese refugees go through, from fleeing their home country to resettling in America. Burmese refugees were forced to flee Burma due to civil unrest and political strife. All of the refugees interviewed in this study were from minority ethnic groups and were persecuted in Burma for this reason. Counterinsurgency groups destroyed their homes and villages. The refugees were left with no other options but to flee.

Some refugees lived as displaced persons in the jungle for many years before seeking sanctuary in a Thai refugee camp. Many of them entered alone or in small groups, but often without any family or friends. When they departed Burma, most refugees also left behind family and friends. In some instances the refugees were able to make contact with their family in the camps. However, large number of refugees never reunited with their loved ones. This was the case for two of the refugees interviewed who were young when they left Burma. They entered refugee camps alone and had no further contact with their families.

Burmese refugees live in Thai camps for many years before they are able to resettle in a third country. The refugees interviewed spent between seven and twenty years in the camps. They were not allowed to leave the camp or would face jail, fines, or get sent back to Burma by Thai officials. This extended period was filled with long, monotonous days with little to do and few resources on which to live. Three of the twelve refugees interviewed attended school in the camps. However, there is no official recognition of this education and they must start over once they come to America. In the refugee camps there is a pervasive sense of uselessness. Many refugees develop a strong desire to become fully educated and achieve success after resettlement so that they can go on to lead satisfying lives.

While living in the refugee camps, Burmese refugees are susceptible to a host of diseases and health issues. Infectious diseases, such as tuberculosis, malaria, and cholera spread rampantly through the camps. There is a constant risk of illness and often little the camp clinic can do to help. For this reason refugees must learn to care for themselves and use traditional remedies to treat one another.

Once in the camps Burmese individuals must apply for refugee status and resettlement in a third country. This is a long process with many steps that are confusing for the refugees. They

must go through numerous interviews, medical screenings, and reviews before possible acceptance to the United States. This demanding procedure is only a precursor to the uncertainty of what lies ahead upon resettlement in America.

After the trying ordeal of fleeing one's home country, living in refugees camps for years before final admittance for resettlement in a third country, the refugees encounter a whole new set of challenges during their adjustment to life in America. Most of the Burmese refugees come to the United States with little or no English skills; they are unable to communicate with even their caseworker without the help of an interpreter. This impedes the refugees' ability to be self-sufficient, as they must rely on others for constant help. This language barrier also contributes to the type of work refugees can get. Further challenges faced by Burmese refugees learning to live in America include adapting to American standards of living and maintaining an apartment, going to the grocery store, and accessing services such as public transportation and healthcare. These challenges perpetuate the long journey for refugees; resettlement in America is not always the end of a refugee's struggles as many may think.

These constant trials influence the way in which the Burmese refugees settle in Atlanta. They have constructed a tightly knit, supportive community where refugees feel comforted. The other community members understand one another because they have all gone through the same process and want to help each other, as well as newly arriving refugees. The Burmese refugees are also motivated to develop a community, particularly along different ethnic groups, because they were unable to do so in Burma. The opportunity to construct a support system for one another provides the refugees with something they did not have since they left Burma.

The Burmese refugees who live in Atlanta are also incredibly determined. They want to conquer the barriers they are faced with to prove that they can attain successful lives in America.

And they are willing to work hard for this. The refugees feel that they are deserving of the meaningful lives that were taken from them in Burma. This conviction allows for the Burmese refugees in Atlanta to get ahead.

By building a supportive community and staying motivated the Burmese refugees use America to live out the lives they would have had in Burma. Maintaining their cultural values is vital to their vision of this. In this way the Burmese refugees living in Atlanta reject assimilation in order to effectively maintain their Burmese culture.

Rejection of Assimilation to America

According to LaFromboise, Coleman, and Gerton assimilation is one model of understanding the process of transitions within, between, and among cultures (LaFromboise, Coleman, and Gerton 1993: 396). This occurs when a person living within two cultures "assumes an ongoing process of absorption into the culture that is perceived as dominant" (LaFromboise, Coleman, and Gerton 1993: 396). A member of one culture will lose his or her original cultural identity as he or she acquires a new identity in a second culture. They will suffer from a sense of alienation and isolation until he or she has been accepted and perceives that acceptance within the new culture (LaFromboise, Coleman, and Gerton 1993: 396). Burmese refugees must consider these patterns as they transition to their new lives in America.

Through interviews and interactions with them, the Burmese refugees demonstrate the ways in which they refrain from assimilation in America. The Burmese have surrounded themselves with others like them and continue their cultural traditions and practices through holiday celebrations, religious activities, and more. They want to do this in an effort to rewrite the history of their resettlement experience because they did not have the opportunity to do this

in Burma. Cultivating an understanding community allows the refugees to do this. The Burmese refugees reject assimilation in a number of ways.

Burmese refugees continue speaking their native language, and they are able to do this. There is a sufficiently large population of Burmese refugees in Clarkston to enable the use of ethnic languages. Gatherings with friends and families over traditional foods also remain a regular occurrence. Religious services continue among the various ethnicities. Within the community that refugees from Burma have built in Atlanta, they are able to sustain their customs together.

While the Burmese refugees may continue to uphold traditions, they do not completely reject American culture. It is important for the Burmese to learn American practices, such as how to maintain a household and norms for interacting with people. However, they simply incorporate these cultural patterns into their own. They understand the importance of adapting to their new home yet do not let go of their own customs.

This continued cultural practice and limited assimilation is possible due to connection the younger generation feels to the larger Burmese community. Young adults stay closely connected to their community and perpetuate it through continued participation in community events. The younger individuals are also often the ones who learn English and learn to navigate life in America sooner than their elders. They will then help others become adjusted and comfortable in America too. This means that the young people are constantly interacting with their elders and able to preserve traditions. The sustained contact that younger refugees have with the older Burmese generations bolsters the community and promotes cultural longevity.

Burmese refugees in Atlanta are also able to maintain their customs because of the location of their community. A large Burmese population resides in Clarkston, Georgia, a small

city with a majority of the population made up by ethnic minorities, immigrants, and refugees. Being surrounded by these other groups may enable the Burmese refugees to maintain traditions alongside different ethnicities who are also attempting to maintain theirs. Living in proximity to other groups of refugees and immigrants limits the amount of exposure the Burmese refugees have to American citizens. They are not an isolated group of Burmese in a wholly American neighborhood. Nor are they forced to engage exclusively in American cultural norms. The surrounding ethnic diversity instead allows for continued cultural practice with less expectation of assimilation.

There are a number of potential factors that affect why the Burmese refugees in Atlanta resist assimilation to American culture. Further studies would be useful in learning more about Burmese refugee populations around the country, such as: Does the unique population of Clarkston limit the assimilation to American culture for Burmese refugees? How does the continued dedication of the younger generation to the Burmese community influence the perpetuation of cultural traditions in America? As fewer Burmese refugees come to America, how does this impact the Burmese community? Will a decrease in new arrivals limit the strength of the current community? Examining these questions would lead to a further understanding of the Burmese refugee community.

The refugees from Burma living in Atlanta have constructed lives for themselves that allow them to maintain their traditional Burmese lifestyle. They engage in their community and aim to lead productive lives through each other's support. The Burmese refugees do this because they did not have the chance to do so in Burma; they were forced to flee and seek resettlement in America. Now they want to rekindle their connections to home and preserve their culture.

CHAPTER 9: CONCLUSION

Burmese refugees endure an extensive process from their journey of fleeing their home country through resettlement in Atlanta. First they are forced to leave home by a brutal military regime. In refugee camps the Burmese suffer health concerns and face challenges as they await resettlement in America. Once in America, refugees must learn to adapt to a new way of life. They face language barriers and difficulties seeking healthcare services. Yet these prolonged trials do not deter Burmese refugees, and they have built a strong community for themselves that supports them through their struggles.

Policy Recommendations

While refugees do receive assistance upon arrival in America, there are a number of areas that are lacking. This paper offers a number of possible changes that could be made to improve efficacy of the resettlement process in America to enhance refugees' experiences. The refugees and caseworkers provide some suggestions about how to better access healthcare. These are followed by suggestions about how the initial resettlement and healthcare process could be altered to assist refugees' experience.

The refugees and caseworkers interviewed had a few ideas about how health services could be improved to better treat refugees. One man suggested that all services should be offered in one location to avoid confusion with referral appointments and issues getting to unknown locations. He also recommended face-to-face interpretation services to better serve the refugees:

> Back home we don't have a lot of clinics like this. Here we have a clinic. If I could change, I would say if we have a general hospital and all the services that we can get in the same place. That would be good for the refugee because [it would help with] the transportation and the language. In the hospitals and everywhere they should have the interpretation services, this would be good for them. Because, sometimes, I think the face-to-face interpreter is better than the on call or online interpreter. Because

> sometimes, you know, some of the medical terms need to be explained, but on the phone they cannot see the patient's face that makes it confused or understands or not. So if you have the services like a face to face interpreter, the interpreter will see also the patient's face and they might read that 'I understand him/her, or not.' (JW)

A caseworker had ideas about changes that could be made to improve Medicaid programs for refugees:

> I definitely would like to see Medicaid expanded so that our people don't fall through this crack where they don't qualify for anything. And it'd be nicer if the time period that they give it to refugees for would go longer, because if they are trying to access it on their own, eight months is not enough. Sometimes they'll just be getting confident enough to deal with an issue, just figuring it out, and then it falls apart because they don't have Medicaid anymore. And yet insurance at jobs can be a little bit prohibitive for people, so that's not always a solution. Plus, too, the kinds of jobs they're in many times don't offer it. So that'd be nice if all that could change… (DR)

He also had ideas about ways that doctors could provide enhanced care to refugees:

> In terms of healthcare, if there were more providers who made themselves accessible to refugees by being a little bit more flexible about people coming in, walk-ins for example. The providers we work with are like this where the person comes in that doesn't speak English very well, but they will take time to try and understand what is going on…and figuring it out. The more that could do that the more access people would have to healthcare. They don't necessarily need an interpreter, they need somebody who is willing to work with the English level that they have. But sometimes that can be hard to come by. And if that's not there then people don't access the service. So again, its less of a policy you can evoke, more of just how do people work with people from different backgrounds…I am just more for, just be more open to working with low English and or letting community members be there to interpret for people. (DR)

These ideas would work to improve access to healthcare for refugees. They relate to the fundamental challenges faced by refugees. It is important to incorporate refugees' opinions in changes to improve barriers to resettlement for refugees.

One of the barriers that refugees felt impeded their transition to America was the way in which the resettlement organizations hosted orientations that taught them about life in America. They mentioned having difficulty remembering all of the information, having too much information thrown at them at one time, and not getting a chance to settle in before they were

expected to attend these classes. Based on the confusion that refugees faced in daily life, often on topics covered in the orientations, it seems that the initial information overload is not an effective method for teaching refugees relevant information. One solution would be to space out these training sessions to more properly coincide with the timeline of each refugee's arrival; instead of holding orientations on American culture, public transportation, laws, and money all on the same day, they could be offered on different days, when a refugee needs the information.

For example, a refugee's first visit to the organization could cover basic American cultural customs and norms and expectations for living in an apartment in America, such as how to use appliances, etc. A subsequent orientation could be taught "in the field" about grocery shopping and public transportation. Further information sessions could cover relevant information as it applies to a refugee's transition. These drawn out sessions would give refugees a chance to acclimate to their surroundings and understand how the information is applicable to them, as opposed to simply talking about arbitrary concepts and regulations. In addition, it could be helpful to hold these sessions with groups of the same ethnic background in order to address culturally specific topics. This would help to make the newly arrived refugees feel more comfortable and to allow for possible community building. With these changes the refugees may be able to retain more of the information they are taught and perhaps avoid the confusion they experience during their initial months in America.

A pervasive theme throughout both the literature and interviews was the difficulties refugees face learning English and communicating with others in America. The language barrier is a significant challenge for refugees as they settle in America and impedes their ability to become comfortable in their new environment. There are several programs in place to help refugees learn English; however the problem persists. It would be beneficial if more English as a

Second Language (ESL) courses were offered to refugees. Providing additional English language resources could help to improve language acquisition among Burmese, and other, refugees.

Measures should be taken to ensure that refugees are actively trying to learn English. Resettlement organizations could have their caseworkers follow up with clients on their attendance at ESL classes. There could be incentives, such as a free meal, when refugees attend the classes. A computer lab along with other technical resources could be acquired on-site to allow refugees different English practice methods and opportunities. There are usually a number of ESL courses offered each week; however, perhaps the times of these classes do not match well with refugees' work schedules. Scheduling different class times could increase attendance. Finally, for families with young children, daycare could be offered during classes so that parents can attend without worrying about their childcare responsibilities. These initiatives could significantly increase ESL class uptake and better the language skills for refugees. This would improve their self-sufficiency by being able to communicate with others and feeling more comfortable interacting outside of their community.

The language barrier also keeps refugees from seeking healthcare services. Refugees are hesitant to visit the doctor because they have trouble arranging their appointment, arriving at the hospital or clinic, filling out forms, and communicating with the physician. One solution to this is providing an interpreter from a refugee's home community to go with them to these appointments. This would be beneficial for a number of reasons. It would allow refugees the freedom to seek medical care when they need it, especially in the first eight months while they have insurance but may not know how to get care. The community-based refugees could have training to become an effective medical interpreter. They would be familiar with their clients

and have cultural understanding of the patient's medical beliefs. Many Burmese refugees already volunteer as interpreters for their friends and families, and this way they could earn contractor fees from resettlement offices. This would also allow caseworkers more time to deal with other issues instead of constantly attending medical appointments. Providing knowledgeable, familiar interpreters to accompany new refugees to healthcare visits would increase the number of refugees who seek care and ultimately ensure refugees are able to receive care when they need it.

Refugees who come to America are often not concerned with preventive care. They may not have had such options in their home country or simply do not hold it as a priority. However, preventive care is ultimately cost effective. This could be established through a clinic specifically for refugees. Many areas already have a refugee health clinic (such as the DeKalb County Refugee Health Clinic) that does initial screening and immunizations for newly arrived refugees. Adding primary care services would enable refugees to return to the same place for further care. It would be a community-run location in which refugees could feel comfortable seeking services. It would also allow for continuity of care. Such a place would help to prevent acute and emergency crises, which are much more expensive to treat.

Health insurance for refugees was another serious concern brought up throughout the interviews. Due to few Medicaid options after a refugee's first eight months, many refugees do not have insurance. While resettlement organizations and case workers try to emphasize the importance of health insurance to refugees, the efforts are frequently futile. The fear is that a refugee will have a serious accident and treatment will cost thousands of dollars out of pocket. One way to help refugees with this would be to start a small fund through refugee resettlement offices. Refugees could donate in an effort to assist community members in case anything

happens. Refugees could give as much as they wanted on a voluntary basis. This initiative could be used to help refugees and their families pay for medical bills in case of emergencies.

Many of these initiatives would be challenging to implement due to lack of funding resources in the refugee resettlement program. However, they also present preventative methods for dealing with future costly events. It is important for resettlement organizations to constantly question their strategies and not become complacent in their work. They should strive to improve offerings for refugees to make certain that they are receiving the assistance they need.

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APPENDIX:

Interview Questions with Burmese Refugees and Caseworkers

Questions for refugees:

- Where are you from?
- Why did you leave your home country?
- How did you come to the United States?
    - Did you stay in a refugee camp?
    - What was it like there?
    - How did you access services and healthcare there?
    - What were some of the struggles you faced in the camp?
- Did an organization help you come to the US?
    - How did they help you?
    - Did you come with anyone else?
- Tell me about your resettlement experience in the US
    - What was it like to enter the country?
    - How long did it take you to get settled?
    - What were some challenges?
- How did you access services here?
    - How did you learn about life and services in the US?
    - Did you feel like you understood how to get what you needed?
    - What did you do if you needed healthcare?
    - Did the resettlement organization help you with that?
- What were barriers for getting healthcare?
    - Would you see a doctor with an appointment or go to the ER?
    - Did you ever feel frustrated trying to get care?
    - How did you learn about your options for healthcare and health insurance?
    - Do you feel like you are comfortable now with the American healthcare system?
    - Do you think there are any differences between challenges Burmese face and other refugees?
- What are problems/concerns with the resettlement process that you would like to change?
- What do you do now in the US?
- Anything else you would like to share about your refugee experience and access to healthcare in the United States?

Questions for Resettlement Caseworkers:

- What is the basic trajectory of the refugee process, from country of origin to the US?
- How does your organization help refugees?
- What are problems that you can identify with the resettlement process?
    - For the refugee
    - For the resettlement organization
- What barriers to refugees face when they come to America?
- Do you think that there are differences in the barriers and difficulties that different refugees face?
- How do refugees go about getting healthcare services?
    - What do they do if they are really sick?
    - How do they learn about the healthcare system in America?
    - What are challenges they face in getting access to healthcare?
- What are problems in refugee healthcare services?
- Do you have ideas on how to better the resettlement process and help refugees gain access to healthcare?