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POST-RESETTLEMENT HEALTH REALITIES OF ROHINGYA REFUGEES: AN
ETHNOGRAPHIC STUDY IN THE CONTEXT OF U.S. HEALTH CARE SYSTEM IN THE
ATLANTA METROPOLITAN AREA

by

MD ASADUZZAMAN

Under the Direction of Cassandra White, PhD

ABSTRACT

Health is a significant part of human life. To keep good health, people seek the best option in the settings of their social, cultural, and economic circumstances. This study aims to examine to understand how Rohingya refugees consider their health perception and post-resettlement health realities in the Atlanta metropolitan area, USA. Through the theoretical lens of medical pluralism, practice theory, therapy management network, this study determines what factors facilitate them to seek health-care in the USA. In this study, data was gained by interview, key informant interview, observation, case study, and Autoethnography methods.

INDEX WORDS: Refugee, Health Settings, Healthcare Barriers, Medical Pluralism, Self-Medicating, Support Group.

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A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

2019

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Md Asaduzzaman
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May 2019

DEDICATION

To my mother, all of my family members, and Rohingya community people of Clarkston city.

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1 INTRODUCTION

At a refugee center where I was volunteering in the summer of 2018, I saw someone who looked South Asian. I welcomed him and asked: “How can I help you?” He just said, “I sick, go doctor.” I took his card and asked again: “Where your homeland?” He said nothing, just looking into my eyes with an anxious face. Again, I asked him with a word that means “country” in many South Asian languages: “*Desh?*” Then he replied to me, “Burmese.” I thought at that time, he is a Rohingya, and I asked again with his language, “*Tuhi ekkana Rohingya?*” (Are you Rohingya?) Then I saw him smile, and he replied to me very confidently, “*Humm, Aai ekkann Roingya.*” (Yes, I am a Rohingya). This is how I met Faruk in June 2018. He was the first Rohingya person I had a chance to meet in the United States.

During the summer of 2018, I volunteered at the WellRefugee Center in Clarkston, Georgia. When I got that opportunity through one of my professors, I was excited to do volunteer work with a WellRefugee Center because I was just passing time during summer vacation. In that time, I was doing some preliminary work for my thesis project. From the beginning of my graduate program, I planned to do my thesis on reproductive health issues. On the basis of that idea, I was preparing by working on a literature review and trying to make some contacts. But, when I started volunteer work in the WellRefugee Center and was introduced to Rohingya ethnic community people, I changed my decision and started thinking about working with this population.

I was familiar with the Rohingya refugee crisis in Bangladesh, and in 2017, I volunteered as a relief provider in a large Rohingya refugee camp. That was the largest humanitarian crisis in the world that I have ever seen. Most of the refugees were women and children. During this crisis, people lost their family members, left their homes all to save their lives from brutal

conflict. Some people were segregated from their family, children were roaming in the refugee camp and seeking their parents. I have observed their life crisis where Rohingya refugees were not concerned about their health issues. From those experiences, I thought pre-resettlement health realities of Rohingya refugees were different that post-resettlement.

During my volunteer time in the Wellrefugee Center as a health navigator, I met almost every day with Rohingya people. I noticed that Rohingya refugees were facing lots of problems in trying to deal with their health issues. After meeting Faruk, I saw language was one of the barriers for him to deal with his daily life in the U.S.

After meeting Rohingya refugees, I informally discussed many issues with them. For example, we discussed what the current situation of their ethnic conflict is, how many Rohingya people are living their home country, what their lifestyle was like in the refugee camp, and what the experience of going to the U.S. as refugees was like. In this way, I learned that they have a common place to hang out, the Rohingya Education and Community Centre (RECC). Each weekend, they meet each other. Faruk told me that he was informed about WellRefugee Center by other members of their community when he visited RECC. He appreciates that support from his Rohingya community people. It was a blessing for him, but some issues cause trouble and mental stress when he has faced the financial burden, language barriers, and complex health care system in his experience with U.S. healthcare. I decided to focus my research on some of the health challenges and health-seeking behaviors among the Rohingya community in Clarkston.

1.1 Objectives and Research Questions of the Study

This study is to see what the patterns and the factors of health perceptions and post-resettlement health realities among the Rohingya refugees of the Atlanta metropolitan area in the

USA. Through the ethnographic lens, this study aims to examine how Rohingya refugees are dealing with their health issues. Two specific research questions of this study are: First, how Rohingya refugees perceive their health by changes place and refugee status? Second, How different factors facilitate them in their post-resettlement health-seeking behavior? To carry out this research, data was assembled by qualitative research methods. I have taken 13 interviews in various places like WellRefugee Center, respondents' homes, and their social gathering place at the RECC. As a non-alien resident, regarding dealing with health issues in the USA, my own experiences are part of this research as well.

In this research, I have set a few specific objectives in order to address my research question:

- What is the cross engagement between Rohingya refugee's past health care system and the U.S. health care system?
- How do Rohingya refugees think about the U.S. health care system?
- How do the refugees' past experiences influence their health perceptions in the USA?
- How to categorize their illness based on their cultural knowledge?
- What is the nature of medical pluralism in the Rohingya refugee's living area?
- What factors are they facing during seeking health care?
- How do therapy management groups influence the refugees' choice of therapeutic care?

1.2 Historical Overview of Rohingya

All over the world, people have their own country, their own identity with the territory. This is the unfortunate realism for Rohingya ethnic community; they are persecuted from their homeland Rakhayan province of Myanmar and known as a stateless people to all over the world. From Myanmar, among the several ethnic communities, Rohingya people are one of the largest

and most vulnerable groups of people in the world who are being forced to leave their homeland. Somewhere they are known as a “stateless” nations, or “boat people”. According to UNHCR (2018), “68.5 million individuals were forcibly displaced,” over the previous year approximately .72 million Rohingya refugees have fled from Myanmar to Bangladesh for the targeted violence and brutal military regime. Now, almost 1.3 million Rohingya refugees are living in Cox’s Bazar, Bangladesh in several refugee camps, and worldwide 3.5 million Rohingya refugees were dispersed.

The Rohingya refugees are known as Muslim ethnic community, and they belong in Sunni Islam. The word Rohingya is derived from *Rohang*, the ancient name for Arakan. “In the Rohingya word and ‘ga’ or ‘gya’ means “from.” By identifying as Rohingya, the ethnic Muslim group states its ties to land that was once under the control of the Arakan Kingdom” (Human Rights Watch, 1996; Zarni & Cowley, 2014). Historically the Rohingya belong to a community “that developed from many stocks of people including Burmese, Arabs, Moors, Persians, Bengalis and others – all adhering to Islam” (Chaudhury and Samaddar 2018:06). Since 15th century Rohingya people were moved to Arakan successively. In the British colonial periods, Rakhine was also included with this colonial territory. During the 19th and early 20th century, most of the Rohingya people were migrated to this territory. After the independence from the British government and successively changed the role of this territory and since that time Rakhine included as a province of Myanmar.

1.3 Legal Status of Rohingya

The Rohingya refugee crisis started through an ethnic conflict where religious sentiment was a significant phenomenon. In Myanmar, there has been a relationship between the state and

religion for a long time; it can even be signified with their cultural norms and values which is happening through their ethnic sentiment as well. Since the pre-colonial period, religion has been a big part of their ethnic attitude. There are multiple ethnic communities or groups of people who fled from their country, and their religious beliefs and practices are different from the mainstream Buddhist religion which is known as a dominant state religion. In 1948, after independence, the state religion again became a dominant role. At that time, the crisis began based on religious sentiment in the Burmese societies. In the province of Rakhine, the Rohingya community is treated as noncitizen residents. As a Muslim minority ethnic group from the Arakan province of Myanmar, The Rohingya have been in such a state of flux that they have been in no position to negotiate with a particular nation-state to secure a home for themselves (Sengupta 2018; 22).

The government of Myanmar does not consider them as citizens of the state. In Myanmar, after 1948, during the independence period, there were several times when power was seized by the military. After 2007, there was a paradigm shift in a political regime in which democracy was introduced after a long time, but the dominance of the military in the political system of Myanmar was unchanged. In the Rohingya ethnic community, people are registered in their country as temporary residents. Before that, they were undocumented people and, for that reason, always treated as an illegal ethnic community of Myanmar so that, “[u]ntil recently, the Rohingya had been able to register as temporary residents with identification cards, known as white cards, that the junta began issuing to many Muslims, both Rohingya and non-Rohingya, in the 1990s. The white cards conferred limited rights but were not recognized as proof of citizenship” (Ullah: 2016).

1.4 The Study Population

In my study, I consider people of the Rohingya ethnic community who dispersed from their home country of Myanmar to different refugee camps in the Asian countries. Now, they are living in the different states of the USA. Particularly in my research, I am focused on the community of people who are living in the Atlanta metropolitan area with refugee status. Moreover, these people are connected to their community, home country, and past refugee camps. Refugees move from refugee camps or their home country to another place and keep social and cultural ties that cross the international border. According to Victor Turner (1987), the identity of refugees is defined as “liminal.” With the rites of passage concept, through diverse stages, people enter in a new group or positions. First, they disperse from their old positions and move forward to liminal stages where they learn new things for their future. After completing those stages, they enter society with the new status. However, all refugees do not become part of their new society with a new status. Sometimes, Rohingya refugees consider themselves members of U.S. society; on the contrary, other people in the community may not consider them like that.

The number of Rohingya refugees are increasing in the U.S. day by day. According to 2018 Refugee Processing data, the total number of Burmese Muslims is 20,219, including their second-generation. In the Atlanta metropolitan area, most of the refugees live in the small city of Clarkston, which “started to become a refugee destination in the 1980s, when people fleeing from Vietnam and other repressive Southeast Asian countries began arriving” (Stump 2018: online article). According to a Rohingya community representative, there are 150 families and over 450 individuals living in Clarkston, Georgia. In this city, housing/rent is affordable for the refugees. Also, there are many volunteer organizations for refugee people, as well as places of

worship, community gathering places, and a free health clinic for the refugees. The volunteer organizations provide many services like free English language classes, primary medical care facilities, mental health support for refugees, health insurance, health navigation service, and other services which are related to refugees, and “the new arrivals, who typically have already spent eight to 10 years in a refugee camp or dislocated from home, also usually have a skill that can help them find employment quickly” (Stump 2018: online article).

1.5 Historical Overview of Rohingya

There are currently 68.5 million forcibly displaced persons worldwide, 25.4 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 2018). There are an additional 40 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 2018).

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 generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border (The Definition of an Internally Displaced Person (IDP), IDMC 2108).

A stateless person is defined by UNHCR as:

...someone who is not a citizen of any country. Citizenship is the legal bond between a government and an individual, and allows for certain political, economic, social and

other rights of the individual, as well as the responsibilities of both government and citizen. A person can become stateless due to a variety of reasons, including sovereign, legal, technical or administrative decisions or oversights. The Universal Declaration of Human Rights underlines that “Everyone has the right to a nationality.” (The Definition of Stateless Person (SP) UNHCR 2018)

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: deportation home once circumstances allow or, if coming back is not possible, either mixing in the first country of asylum or immigrating to a third country (Refugees: Overview of Forced Displacement, UN 2013). Nevertheless, there are a few challenges that deter these actions.

At first, the 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 2013). All over the world, among the total number of refugees, less than half of refugees are supported by UNHCR directly and indirectly. The rest of the numbers are out of support and they faced the crisis for more than five years. There is an alternative way to mitigate that crisis, which has already started; developed countries can host the most vulnerable refugees’ resettlements (Refugees: Overview of Forced Displacement, UN 2013).

In the second stages of this 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 2013). Providing humanitarian help in environments of violence is not only difficult but extremely dangerous for aid workers. Humanitarians working in these locations, whose desire is to support the guiltless sufferers of brutality, are themselves more and more becoming targets.

Among all of the challenges, the third one is different than the other two; this 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 2013). Individuals have different motivations for moving. For example, migrants choose to move, whereas refugees are forced to flee. Many countries have accepted procedures intended to prevent those without proper papers from entering their region. Nevertheless, if applied too generally, these procedures can create problems for refugees and asylum-seekers who do not affect essential international safety. These challenges hinder the ability of refugees and IDPs to receive aid. One way in which refugees may suffer the consequences of these challenges is through a lack of access to healthcare.

Affording the world’s refugees with healthcare is hard. The UNHCR claims that “the aims and principles of refugee health...are simple, yet they 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 1995). The main objective for actors in refugee health is to prevent excess mortality and morbidity. The proper provision of effective refugee health care needs a multi-sectoral and anticipatory method. (Refugee Health, UNHCR 1995).

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 thesis will focus predominantly on the challenges that Burmese refugees encounter when seeking healthcare services in America, it also explores the background factors

contributing to these challenges. Anthropology, particularly medical anthropology, provides a useful approach 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" (Society for Medical Anthropology 2009). This paper attempts to provide an all-encompassing view of refugee health and the experience of Rohingya refugees in Atlanta, Georgia.

According to Hassan, "Migration is the horizontal mobility, movement from one place to another-specifically from place of origin to other places, of people in an expectation of vertical mobility (betterment of life)." This betterment of life is not merely about economic or social mobility, but, in some cases, is about survival or the improvement of living conditions. In the contemporary period, people are not only to moving from one place to another place to seek a better life, but they have also been forced by many reasons to be displaced from their country of origin. There are many reasons behind displacement: ethnic conflict, economic cause, war, oppression, and natural disaster (Willis 2008, 212). This pattern is undoubtedly applicable for migrated Rohingya refugees as well.

In the social science field, diaspora is a key theoretical concept and it has been discussed for a long time. Mainly, the concept of diaspora implies a national or religious group of people forcefully dispersed to another country who are sustaining with their culture without integrating

into the new circumstances (Faist 2010). That group of people wants to go back to their home country, but, most of the time, that could/would not be possible due to ethnic, religious, political, and other circumstances (Safran 1991). The Rohingya ethnic community is a contemporary example of diaspora. They were forcefully dispersed from their home country of Myanmar due to political, ethnic, and religious unrest. However, in the 1970s, the diaspora had dramatic changes from the aspects of theoretical and conceptual experimentation (Faist 2010). After the 1970s, the discussion of diaspora considers all type of migration of people due to multiple and diverse reasons (Cohen 1997). In my research, I focused on notions of diaspora to examine how Rohingya refugees are mentally and culturally connected with the health care system of their home country.

Rohingya refugees migrated in different stages. First, they dispersed from their home country to refugee camps in different countries. After that, they migrated and resettled to other different countries. In this journey, they were passing through a diverse health experience. In that context of these refugees' experience, an association of 'migration and health' is a key concept of this study. Migration plays a vital role in some changes of migrated people in the host country and changes their position, which may be different from their prior social position of their home country. Through the migration journey, refugees incorporated and assimilated in various contexts. Thus, the health experience and orientation of the refugee is expected to be different in the host country from their country of origin or past living place.

However, contemporary progress in communication helps people to keep more connections with their kin and community around the world. Also, when refugees migrate to a new place, they carry their customs, belief, and other cultural aspects with them. In this way "the

perception of health, illness, sufferings, treatment procedure are may not be in accordance with the cultural reality of new places since they are shaped by cultural factors of a society” (Chavez 2003; 198-199 in Hassan 2016).

2 LITERATURE REVIEW

A literature review is an essential part of any kind of research in social sciences. As other research in social sciences, it is also an important part of my research. In this section, I have tried to explain the theoretical frame of my study. Also, in this section, I have described all of the key concepts of my study elaborately. I discussed health, refugee health, disease, illness and sickness, health-seeking behavior, medical pluralism, practice theory, and therapy management group.

2.1 Health

According to WHO (1948, 100), "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." That definition is incomplete for anthropologists from the aspects of multiple opportunities for problematization. It is really hard to define the well-being of social, mental, and physical conditions around the world because there are differing knowledge and belief systems from the context of cultural diversity and “[p]eople's perceptions of health and health-seeking behavior largely controlled by episteme surrounding the local health care system, knowledge, and belief” (Hassan 2016;18).

2.2 Disease, Illness, and Sickness

Disease can be defined as the western biomedical explanation of dysfunctions of body parts that claims universal determination. However, by disease as a concept, Winkelman provides the following statements: "diseases are basically biological and indicated in the departure from normal measures of biological functioning, the generic conception of diseases is

reflected in a universally valid system of classifications, the belief that each disease derives from a specific physical cause or etiology, the belief that medical practice as culture free and scientifically neutral and objective" (Winkelman 2009:38). These definitions are considered only biomedical notions, not considering the social, political, and cultural facts, which facilitate significant factors in the disease perception. The biomedical concept of disease will be employed in this study to explain the biological factors of health-seeking behavior, but in most of the discussion of my thesis, I will try to engage the western biomedical assumption on this study.

Illness is defined as 'the subjective experience of symptoms and suffering.' It is culturally constructed because it is about how we perceive, experience, and cope with a disease. Illness manifests effects from perceiving consequences of the condition and cultural beliefs shape the experience of illness (Winkelman 2009). All over the world, illness is differently perceived on the basis of cultural and social construction. Experiences, expressions, and narratives of illness are varied from place to place and culture to culture.

The idea of sickness manifests on social effects as a malady (Winkelman, 2009). As Winkelman states, "this includes the effects of resources allocation, stigmatization, and consequences of medical treatment on a patient's life experience" (Winkelman, 2009:38). In my study, I explored health-seeking behavior of refugee people from the experience of sickness because this related to the societal distribution of resources allocation, stigmatization of the sufferers as burden to their family (which sometimes is related to gender roles as well), and the consequences of medical treatment in this disease.

2.3 Health Seeking Behavior

Health-seeking behavior is a significant indicator of cultural, social, economic and political realities of a group of people. Today understanding health-seeking behavior has been an important part of medical anthropology, especially in how it relates multiple healthcare systems with migrant and diasporic societies. Health-seeking behavior reflects a community's worldview which allows us to gain a deeper understanding of aspects of particular culture and the realities of life. One of the popular definitions of health-care seeking behavior is found in various literature where it is defined as a "sequence of remedial actions that individuals undertake to rectify perceived ill health" (Ward, Mertens & Thomas, 1996; Ahmed et al, 2000; Bhuiya 2009:69-70). Health-seeking behavior is described as the time and distance between getting sick and seeking care, the practitioners whom patients sought help from, how consequential patients with the prescribed treatment, and the reasons for choosing or not choosing particular health-care.

From the political and the capitalist world system perspectives, we can see that Erik Wolf in his book "Europe and the People without History" (1982) showed the complex economy that has a cultural and political effect of colonialism. In the medical anthropological study, I have tried to show that health-seeking behavior is also a complex mechanism of people's health care system which is controlled by the community and state. Some political and economic aspects affect health care systems. Health-seeking behavior is also variable from society to society and country to country.

In a country, the health care system is directed by a particular mechanism. Every society or country has its own system, which is the known political economy, cultural system, and belief system. Health systems or health-seeking behaviors are also regulated by these systems which

are available in the community, society, and state. Every society consists of different types of health care options, such as biomedicine, indigenous, local, or traditional health care systems. Whatever it is, in a particular country or all over world, the health care system, perceptions of health, and health-seeking behavior is dominated by the political economy, cultural system, and belief system of these particular country or society. It also differs from place to place and society to society. For that consideration, factors of health care and health perceptions are different in the USA for Rohingya refugees.

Paul Farmer (2001) explains that inequality impacts structural violence results regarding health experiences of people. He stated that people's health experience is regulated by their socio-economic factors, and distribution and outcomes of disease are also controlled by the society's inequality. He also posits that economic limitations and many kinds of barriers are mainly responsible for curing disease of people in a marginal society. In a society where inequality exists, people are identified by their experience of health care and health perceptions. Mostly, in that kind of society, social and economic facilities are unequally distributed.

For the Rohingya refugees, the U.S. health care system is a new experience in large part because of their social and cultural difference and their economic status. At the same time, their position in society is different from what they used to have in refugee camps for several years and through the transition from their homes to camps. Through that transition, people learn new health concepts, face new barriers, and create new ways of health care which are distinct in many ways from that of native U.S. people while similar in terms of the challenges faced by many underinsured and uninsured Americans.

2.4 Medical Pluralism

The term medical pluralism itself describes the medical system and pluralism. What is pluralism? It difficult to define pluralism as it is widely used among various fields. Medical pluralism means the existence of multiple medical sectors functioning in a particular society for health-seeking. Medical plural systems make opportunities for individuals and/or groups of people to access more than one approach to sickness and healing. Baer states “medical pluralism in the modern world is characterized by a pattern in which biomedicine exerts dominance over alternative medical care systems, whether they were professionalized or not. The dominant status of biomedicine is legitimized by laws that grant a monopoly over certain medical practices, and limit or prohibit the practices of other types of healers” (Baer, 2001 cited in Ember and Ember et al., 2004), and “[m]edical pluralism refers to the array of different medical systems within a society; mostly stratified society” (Baer 2004; 109). Medical anthropologists understand how cultural models are an important part of individuals’ understanding of illness. “Explanatory models” of illness are formed within a wider culture and by individuals trying to make sense of their illness experience. The explanatory model aims: “to understand how *culture*, here defined as a system of symbolic meanings that shapes both social reality and personal experience, mediates between the ‘external’ and ‘internal’ parameters of medical systems, and thereby is a major determinant of their content, effects, and the changes they undergo” (Kleinman 1978). Explanatory models coincide with cultural models. These ideas have also been articulated in multiple disciplinary contexts while American medical and psychological anthropologists have stated these processes using terms such as biomedicine in “medical pluralism” (Black 2019).

Dunn (1976) denoted three types of medical systems in a society which include the local medical system, regional medical system, and cosmopolitan medical system. Chrisman and

Kleinman (1983) developed a widely used model that discussed three overlapping sectors of the medical system in a society which include the popular sector, the folk sector, and the professional sector. These types or sectors include a relatively wide array of medical systems such as folk medicine, Ayurveda, Unani, herbal medicine, homeopathy, biomedicine, etc. Each of them was included in a different type/sector by different anthropologists. For example, whereas Dunn included Ayurveda and Unani in the regional medical system because of their low acceptance globally and biomedicine in the cosmopolitan medical system, Chrisman and Kleinman included all of them in a professional sector based on their institutionalized and profit-making nature.

For my study, I consider the medical pluralism idea mainly for two reasons. First, this concept exists in South Asia and Southeast Asian countries, and its presence influences the health-seeking behavior of Rohingya refugees. Second, though the biomedical system dominates in the USA, everywhere in the world, the health care system is incorporated through migration and diasporic ways, and “Even in the United States, the medical system is composed of physicians, dentists, druggists, clinical psychologists, chiropractors, social workers, health food experts, masseurs, yoga teachers, spirit teachers, Chinese herbalists, and so on.” (Leslie 1976;9 cited in Hassan 2016). The concept of medical pluralism has been employed in this study to understand various medical care systems in the Rohingya ethnic community in the study area.

In my study, I also gave attention to the etiology of illness and explanatory models for an illness that influences people’s health-seeking behavior. The ideology that there is one specific reason for each and every disease is found in a few cultures. There are more possible ways to frame the relationship of illness to the actions of the afflicted or their kin, if their explanatory

models are larger. Pluralistic health-care arenas not only provide the afflicted different ways of treatment but also generate illness scenarios around which personal narratives may be developed. Nevertheless, medical pluralism flourishing also causes a dilemma in the people's decision-making during illness or disease. For the Rohingya refugee people in the new place, their social and cultural reality in certain medical systems and their pre-migration knowledge plays a significant role in the decision-making process.

In the Atlanta metropolitan area, Rohingya refugees are living in Clarkston where refugees of many other nationalities and ethnicities are also living. That is also a new cultural setting for them where they have chance to engage with different health care options which may not have been available in their country of origin or past refugee camps. Thus, these kinds of new engagements may also profoundly impact Rohingya refugees' health-seeking behavior.

2.5 Practice Theory

Practice theory is one of the most important theories given by Pierre Bourdieu (Dimaggio, 1979). Practice theory is the outgrowth of several dominant tendencies in the discipline. 'Habitus' (Bourdieu, 1971) is a process by which a human being embodies the cultural beliefs and practices of a society. In the context of health-seeking behavior and its views and conception, society and culture has produced a certain type of cultural practice, which is that a society practices and it became a habitual expression. It could be any types of value, beliefs, and practice, and even a family's practice (Dimaggio; 1979). Moreover, in a society, people are not dealing with their health issues in a common way when they have multiple healing systems available in society. As Bourdieu (1986) argued, people's social, economic, and symbolic capital influences their society positions. That kind of capital defines not only their position but also

their engagements and associations. Habitus refers to a “system of durable and transposable dispositions” which creates the principles of generation and structuring of individual and collective practices in society (Bourdieu 1977: 72). So, habitus may form refugees’ perceptions of health and health-seeking behavior with a distinct experience which is also forged by society as well. This idea of ‘habitus’ is closely linked with my research.

2.6 Therapy Management Group (Network)

The concept of the therapy management group was also employed in the present discussion. It is an essential part of kin-based and network-based society in the case of health-seeking. Janzen is the first anthropologist who coined the concept in anthropology. Therapy management involves the action of diagnosis of disease as primary level, selecting health seeking, evaluating the treatment, and supporting the sufferers and therapy management group, which includes a set of a group of individuals and people who perform the above activities in case of health-seeking and disease-managing (Janzen, 1978). Janzen explained therapy management as “contextually sensitive analysis of the relationships among cultural assumption and values, behavioral processes, and social and economic structure that influence the therapy process” (Janzen 1978: 01). I employed this concept in my study to explore the role of patients’ kin groups and other social members to diagnosis.

In a society, community members also engage with the health care system by contributing their part in different stages. People are participating in that system differently. The first group of people contribute to assessing the problem, such as determining what type of disease or illness individuals are carrying and what type of health care is needed for that. After that, the second group of people plays a role to take all required steps and back the patient in the whole process

before and after the therapy. Notably, in a society, there is no specific number of people in the “therapy management group.” It may vary from community to community and society to society. Also, there are no obligations for community people to do work for other people.

To understand the therapy management group, health care procedure is essentially matter which is influenced by cultural values, economic positions, and behavioral processes of that society (Janzen 1987). In a community, interaction and influences on decision-making are determined by cultural norms and values. In some societies, people tend to be more supportive and cooperative. Also, people are involved with customary activities like reciprocity among the member of the community. Thus, the therapy management group is formed based on a group of people’s support and assistance. Another important aspect of these groups is that patients are often less responsible or have no responsibility for decisions about their health.

In my study, to understand the health realities of Rohingya refugees in the context of their post-resettlement position I first need to clarify how refugees perceived their health issues in a new setting. For that concern, it would be explained with practice theory where habitus is a key concept which is more relevant in the contexts of refugees pre-experience in their home country, refugee camp and finally resettlement as a refugee in a host country. Besides, a concept of medical pluralism which is articulated by different types of the medical system, with this theoretical lens it also would be useful to understand the liminality of refugees. Finally, the therapy management group concept is articulated within the study because in a broader community, a small group of people is connected with their members' health decisions.

3 METHODS

This chapter of my thesis deals with the research methodology of this study, including the approaches of this research, tools and techniques of data collection, recording and analysis, discussion about the sources of data, discussion about the selection of the study area, discussion of the sample population whom I have taken as respondents and informants for conducting data, and information for conducting this study.

3.1 Approaches to Research

The present study, *“Health Seeking Behavior of Refugee People: An Ethnographic Study on the Rohingya Ethnic Community in the Atlanta Metropolitan Area,”* is a medical anthropological study; this study has been conducted on the basis of the anthropological research approaches. In my study, I have applied the following research methods of anthropology.

3.1.1 *Holistic approach*

I have applied this approach to the research. Through the application of this approach in my research, I gathered a comprehensive and complete picture of the studied people. As this study is about health-seeking behavior, I need to collect data on how this health-seeking behavior is related to their historical, socioeconomic, and political factors that might influence peoples' decision-making processes and belief systems. During my days in the field, I observed their health-seeking behavior as it relates to disease, illness, sickness, and other lived experiences of the Rohingya refugee people in Georgia.

3.1.2 *The emic approach of cultural particular approach*

Since this study is a cultural interpretative study on health-seeking behavior of refugee people, this study demanded interpretation based on an insider's point of view. For this reason, the ‘emic’ approach has been employed for collecting explicit data from Rohingya ethnic

community peoples' point of view who have experience as refugee people in the study area. Applying this approach, I tried to explore this health-seeking behavior from the Rohingya people's point of view, including how people define disease, illness, and sickness according to their beliefs and views, their assumptions, and their evaluations. Finally, for making an intrinsic analysis of this health-seeking behavior and its cultural interpretation, I will apply this approach.

3.1.3 Cultural relativist approach

Although a cultural relativist approach of a methodological perspective of anthropology has some postmodern debates, I have applied this methodological approach in the present study. I engaged this idea to understand respondents' behavior, perceptions, and knowledge concerning their cultural perspectives. I explored this approach to understand the context where their behavior is meaningful and effective. As this is a cultural interpretive study of health-seeking behavior, I will try to explore this from their cultural perspective.

3.2 Approaches to Research

Access to the Rohingya ethnic community in Clarkston was easier for me since I have linguistics skills and was a volunteer of "WellRefugee Center" last summer. The Rohingya people speak the "Rohingya" language, which is similar to the southeastern local language of Bangladesh. I met with Rohingya refugees when they came for health navigation service in this organization. I was in communication with several people. These people helped me to interact with other Rohingya community people and instruct me. In that time, I have visited the "Rohingya Education and Community Center (RECC)" in Clarkston, Georgia. I usually go to South Asian gathering places like restaurants, mosques, and grocery stores where people meet with each other. Usually, I visited 'Maszidul Muminin,' one of the Islamic centers and mosques

in Clarkston on Friday for prayer. In that time, I reached many Rohingya people and interacted and spent time with them, which supported my network.

However, as a researcher, I hope I have had a different experience. Though Rohingya people are usually living here with refugee status, they are passing hectic days on weekdays and the weekend. Sometimes, they work on weekends as well, or they have plans with friends and family to hangout. Generally, I visited Clarkston every weekend to meet with them at their gathering places, as well as contacted them over the cell phone. Also, when they felt any type of complexity regarding their health issues, they even reached me by phone or asked me when I visited RECC. With that process, I had made good relationships with them. Then, when I proposed to interview them, most of the people agreed to help me, and a few people refused due to their daily busyness.

3.3 Recruitment and Sampling

Multi-ethnic community people are living in the USA; this is the real beauty of this country. People from many parts of the world have migrated here. However, people from the same origin of state or common ethnic community live closer to a particular area.

First, Rohingya refugees in the USA came from different Asian refugee camps. They are living in the different states of the USA, clustered with their community people. In the Atlanta metropolitan area, though they are living in the city of Clarkston, they are not accommodated in a single apartment like a refugee camp or country of origin. Generally, I met with them in their common gathering places. First, I made some contact with people who are familiar with me from my voluntary work period. Among them, I have selected two key informants for my study purpose. Both persons helped to reach other informants.

Methodologically, I used applied referral method as well as snowball sampling to find out my targeted respondent. When the study population is small and scattered in a large area, these methods are effective and useful (Bernard 2006; 192). From all of my contact persons, I have chosen them as my possible respondents on the basis of their living age in the USA. Finally, I interviewed 13 informants who have lived in Clarkston between 3 months and 7 years. Among all of my respondents, there was 9 men and 4 women. With the purposive sampling method, I selected them and categorized them into the three groups. Among all of my participants, five have been living here for four to seven years, four for two to three years, and the remaining four residents for three months to less than two years. Based on that categorization, I found different time stages experienced from the Rohingya refugee.

3.4 Research Method

3.4.1 Source of data

To conduct this research, I will collect data from two important sources.

Primary source of data

Ethnographic fieldwork is considered the primary source of data for considering the household and the individual as basic units of analysis.

Secondary sources

Published literature on refugee health, health seeking behavior, journals, web writings, newspapers, statistical data published by both government and non-government institutions.

3.4.2 Tools and techniques of Data Collections

Traditionally, participant observation is the oldest technique of data collection in anthropology, introduced by early anthropologists such as Margaret Mead and Bronislaw Malinowski. They lived with the people they were studying and gathered data from the native

point of view that were then interpreted through an etic lens (in this case, that of these Western anthropologists). For my formal research, I will not do participant observation, but my volunteer work at WellRefugee and time spent with Rohingya families constitutes participant observation that has informed my research questions for this project. The methods which I will employ to collect first-hand data from the field are:

- Interview
- Case Study
- Key informant interview
- Observation
- Autoethnography

Interview

I carried out my research through the interview method. At first, I took a structured interview of the people. But soon I realized that I am not satisfied with what I am getting as people tended only to answer the questions I asked, and not anymore. This posed a significant problem for me.

But then I started to take an unstructured or open-ended interview of the people. In this case, I took a checklist so that I could capture as much as possible. While taking the interview, I wrote all the information on my notebook. In some cases, I used a recorder so as to not miss any important information. After collecting data, I analyzed all the information I got that particular day, which helped me to understand what I missed and what I must collect from the next interview session.

I took 13 interviews, of which there were 9 men and 4 women. For my interviews, I considered adults who have past experience and whose age range was 27 to 58 years old, where I tried to include views of various age group and people with different living experiences. I have

collected various kinds of data from these open-ended interviews, which include where they go treating illness, why they go to that particular medical system, how people categorize illness, how they mobilize therapy management group, and what they think about the traditional and biomedical healing system. In order to get these interviews, I had to take second time interviews, as some interviews resembled others. I had collected data, such as where they go for treating illness, what kinds of illnesses and diseases they go to that particular healing system for. Also, I have tried to interview them about what they think are the reasons that cause the particular illnesses, what they think about free clinic services, hospital services, and the U.S. health care policy or system, etc. I conducted most of my interviews I took between December 2018 and February 2019 time. My key informants, now friends of mine who live in Clarkston, helped me to gain entry to the field and managed some respondents for me. I crosschecked one's given information to that of others, which gave me a comparable understanding of some particular issues.

Case Study

I applied the case study method to collect more subjective data because, from an interview, it is not possible to collect detailed data from an individual respondent. In this sense, a case study can be summarized as the process in describing, understanding and explaining any phenomena. It provided me with various data and information on post-resettlement health realities of Rohingya refugees.

As this study was done based on the refugee people's cultural interpretations on health-seeking behavior in the refugee status perspective, it has detailed information on this research topic. Thus, I had followed this technique in the field to collect various types of data. In my

research, I profiled multiple case studies, which are the summarized description, understanding, and explanation on the present research topic.

Key Informant Interview

I was a volunteer at ‘WellRefugee Center,’ but as a researcher I was a stranger to them. It was quite difficult to interact with them in order to collect data; this is especially true for female informants. I had taken a 30 to 45-year-old key informant, and they helped me to collect data from the female respondent and also helped to interpret.

3.4.3 Tools of data recording

This research was done primarily on the basis of the data and information of the interviewees; in this regard, field notes may be an important source of data recording. As I also applied the in-depth interview and informal interview techniques for the data collection on knowledge, beliefs, and interpretations of health seeking behavior of refugee people in the study area, I used a tape recorder for recording from the interview. So, the major tools of data recordings were

- ✓ Field notes
- ✓ Tape recording

3.5 Selection of Study Area

An anthropological study is a holistic approach to a micro area of investigation. It also was done based on a specific community and more focusing on a specific research topic. However, to conduct this study, I had selected the refugee-accepting city of Clarkston, a small city to the east of Atlanta, Georgia that is part of the greater Atlanta metropolitan area. There were some good reasons for this choice. Various literature about refugee health shows that most of the urban refugee people are suffering from multiple diseases. Evidence also shows that refugee people are

suffering from varying diseases. The number of refugee patients is increasing, and most of the Rohingya refugees are not aware of these diseases. Rohingya people sometimes come directly to the U.S. after years of living in refugee camps characterized by a lack of resources, limited opportunities to income, education, knowledge on health and hygiene and knowledge of their rights. I had conducted this study in the selected area to find out the answer of the following questions including: how the Rohingya refugee people explain their transnational and diasporic interpretations on health-seeking behavior, what socio-economic contexts underlay, what socio-cultural context can explain, and how refugee people interpret their psychological and physical health. That is why I have selected this study area.

3.6 Ethical Concerns

There are ethical concerns in all research involving humans. Cultural anthropological research is prominent due to its particular research methods working with living people. I followed ethical principles outlined by the IRB and by the American Anthropological Association. Although refugees are not listed as a “vulnerable population” according to IRB, they are vulnerable in many ways. Health issues can also involve ethical issues, particularly working with transnational and diasporic cultures. The common ethics which I followed in my study are:

1. Discussion on health-seeking behavior is very much a sensitive issue among the refugee people. Generally, people do not show interest in dealing with this issue publicly. I assured them about the secrecy of their information.
2. I assured their confidentiality by using pseudonyms and not revealing other aspects of their identity in this thesis.

3. I treated them as my teachers, and I was their student.
4. I did not force them to share their experience. They had the freedom to choose to answer questions or stop being in the study at any time.
5. I gave importance to their time because I was aware of their busyness and physical health conditions.
6. I did not discuss with them what was contradictory with their belief system in this study.

3.7 Limitations of the Study

Every research has some limitations. The limitation may stem from the researcher's perspectives to collect data and analyze data while applying theories, concepts, and methodologies. As a researcher, this study is not beyond limitations. During collecting and analyzing data, I felt some complications which made me nervous. As this is a very sensitive issue in refugee locale, respondents may show little interest to share their experience. They were very much worried about keeping their information confidential. Besides this, I did not get enough time to collect more in-depth qualitative data. Undoubtedly, the area of this study is vast. As I am a researcher, it was challenging for me to accomplish my research within such a short period. Therefore, the limitations that can affect my research output are shown below:

- a) The study topic is broad, but it would not be possible for me to collect all information, as I am a student and there was a limitation of time due to my academic purpose.
- b) As there was no funding for the research, there was also some limitations in terms of what I could do in the time I have.
- d) It is a new research topic, so this study demands an elaborate explanation, but with such a short period of time it was very difficult for me.

Despite the limitations with this study, I was able to provide the perspectives of a small group of Rohingya refugees in the Atlanta metropolitan area. The findings may be useful for future researchers who are looking at health perceptions and health-seeking behavior among refugees in other contexts around the world.

4 HEALTH PERCEPTION OF ROHINGYA REFUGEES

Health perceptions depend in part on people's cultural backgrounds. For people who are refugees it also depends on other contexts, including the circumstances of resettlement and the adaptations to a different lifestyle, a new environment, and different perspectives. Change comes about through the introduction of these new perspectives. Rohingya refugees' health perceptions in the U.S. tend to be different from those they held pre-resettlement in the refugee camp or home country since the health care system, religious beliefs and knowledge, and facilities were quite different. In this chapter, I investigated their pattern of perception of health in the U.S. and what variables accounts for this change.

4.1 Access to Health Care System

Recalling the day I visited WellRefugee Center in Clarkston, I had a chance to meet with one of my key informants, Yousuf (a pseudonym), 43, married with two children; has been in the U.S. for 4 years after living in a refugee camp in Thailand; worked at a construction company; and was affected by accident. He went there for doctor's appointment assistance at Grady Hospital in Atlanta. As a volunteer attendant of WellRefugee, I took his initial information for the data entry sheet. That time I assumed that he was Rohingya, on the based on his appearance and language accent (I was familiar with Rohingya people from 2017 when I was a volunteer at Rohingya refugee camp in Cox's Bazar, Bangladesh). To gather more detailed information, I asked his ethnic identity, and he confirmed that he was Rohingya from Burma (now known as

Myanmar, but most refugees from Myanmar in the U.S. introduced themselves as “Burmese”). During his waiting time in the reception of WellRefugee, I introduced myself as Bangladeshi, and we discussed the Rohingya refugee camp of Bangladesh. He stated that before age 13, he was in Bangladesh, and he can speak and understand the mainstream Bengali language. I am also able to understand the Rohingya language because this language is very similar to the local language of the south-eastern region of Bangladesh. Yousuf has been living Clarkston for nearly 3 years, but still he faced problems in accessing a doctor’s appointment. WellRefugee Center helps refugee people who face challenges in accessing healthcare, including enrolling in insurance, making doctor’s appointments, and accessing food stamps. They provide mental health facilities and other counseling facilities for refugees as well. My key informant also stated, in my formal interview with him, that he can rely on WellRefugee center for insurance enrollments, making doctor’s appointments, and getting any kind health-related information.

Yousuf first arrived in Chicago from a refugee camp in Thailand. He stayed for two months in Chicago, but he and his family members faced problems associated with the cold winters in Chicago. Yousuf contacted someone he knew who was living in Clarkston, Georgia and got information regarding the environment and cost of living. Chicago was much colder than Georgia. They were not used to cold weather, for that reason they moved to Clarkston, Georgia. Also, one of the reasons was that they moved in Clarkston because they knew that almost two hundred Rohingya people were living in Clarkston. They wanted to live somewhere with an established community of Rohingya like this.

Yousuf first visited WellRefugee Center in the first week of his arrival date of Clarkston. One of the community members guided him and let him know that if he needed free health facilities and information about insurance, he can visit there. When he first came here, he knew

that how refugee people can get more facilities from the hospital. He was not fluent in the English language, and he had a hard time understanding spoken English. He knew that from that non-profit center authorities can provide a translator for them in the hospital and office. Also, WellRefugee Center provided translator facilities. According to the suggestion of WellRefugee's health navigator, Yousuf applied for a Grady card which is reduced his co-pay up to eighty percent after the insurance paid the amount to bill.

Another one of my research participants, Tofael (pseudonym), 50, married with 4 children; has been in the U.S. for 2 years 6 months after living in a refugee camp in Thailand; worked at a superstore; and is affected by several diseases. He told me his entire story of being in the U.S. regarding his health care access and how he is doing now. He invited me to his apartment when I asked him to do the interview. I was surprised that he arranged different types of food for me. We had a nearly 3 hour-long discussion regarding health issues. Before coming to the U.S., he spent almost four years in the Thailand refugee camp. There was a different medical care system there than in the USA. Most of the time they had access to free, volunteer medical services provided by NGO and volunteer organizations. Also, they had free access to get medication from the pharmacy. In the U.S., they came here with refugee status. Tofael stated one thing that is very remarkable that he had no idea how to contact the hospital and did not know how he could get medical care. In that time, Tofael deals with his and his families minor medical problems by the guideline of Rohingya community people. First, he bought some medicine without prescriptions from Walmart pharmacy by consulting Walmart pharmacists. Usually, they can decide to take over-the-counter medicine for some common and familiar disease and illness. Headache, fever, allergy, such kind of medical problem they deal with common medicine. In the U.S., the names of common medicines are different but pharmacists can help

with non-prescription medications. Tofael mentioned that he took “Advil PM” here for headache, which is known in Thailand as a “Tiffy” tablet, one of Thailand’s paracetamol products. Now, he is very knowledgeable about the names for basic over-the-counter medicine for primary care of common disease and illness.

All of the participants mentioned in their conversation and discussion; they were not more health concern before came in the USA. More specifically, in their home country or previous refugee camp in Thailand, Bangladesh or Malaysia, health knowledge was not a concern for them. They knew that time if they fall any sickness, they were able to take traditional medicine or health services from voluntary organizations, which was a completely different experience from current living experience in the USA. Because in most cases the health care system was easy to deal with and they were not able to understand the significance of health information.

4.2 Health Consciousness Regarding Food and Daily Life

Health consciousness for refugee people depends on the food they take for their survival and under what environmental, social, and relationship conditions they live. During my days in the field, I have learned from my informants that is taking of pure and dietary (*pushtikor*) foods are essential for maintaining sound health.

The food system here is the mixture of subsistence sources of food, natural sources of food and finally, the market-oriented sources of foods. Natural sources of foods are such types of food which have no restrictions to gather such as vegetables from the gardening; those are owned privately. Before arriving in the U.S., many Rohingya had other natural sources of foods they could gather, such as parts of and leaves of plants and other non-cultivable vegetables. Rohingya people are generally used to their traditional food. Their main foods are rice, vegetable, fish and meat. In their home country, they met up their food demand by agricultural

mode of production. When they moved to a different country as a refugee and living in the refugee camp, their food source depends on nongovernmental organization's aid or their income. But, in the refugee camp, they were used to in the same types of food.

Hamiz (pseudonym), one of my key informants, 46, married with three children; has been in the U.S. for 4 years after living in a refugee camp in Thailand; works at a ride share company; and is affected by primary diseases. Earlier, he was living in Bangladesh as a refugee for ten years and lived in Thailand for four years. Almost, 14 years he lived as a refugee in two different countries. He noted that his family and other Rohingya people were not too health-conscious regarding food. In Bangladesh and Thailand and their home country Myanmar, they were used to the same food habits. For breakfast, for example, this would be *ruti* (or roti, similar to tortilla), a fried egg, and vegetables. At the same time they did not think about the nutritional content of their meals. They just knew that egg is very good for health and if anybody consumes an egg in their daily meal, they it would lead to very good health. But most of the time, it was very hard to include one egg in. Also, they didn't know what types of nutrition fact contain meat and milk, but they knew that this type of food is very good for health. Now, in the U.S., Hamiz is very aware of his health regarding food and food habits. He said to me in his interview that he believes more protein is very harmful in terms of causing heart disease, and sugar and carbohydrate food can increase risk for diabetic disease. Specifically, he had learned that red meat is a high risk for heart disease.

The distribution of foods is also found in the intra-household level in where gender, age are highly considered as the major way of dimension. Nutritional value is directly related to the consuming food system what the peoples take. Food processing procedures before cooking the foods depends on their cultural beliefs. They usually take a meal three times daily as their

complete meals. But this does not mean that they do not eat other food. They take different types of additional snacks such as seasonal fruits and cakes, rice (*Cira, Muri, Khoi*), etc.

When I visited Yousuf's apartment for his interview, his wife served me tea, and before that asked me that if I need sugar with tea. She also served tea for Yusuf, and I noticed that he did not include sugar with his tea. I asked him why he denies sugar. He informed me that his sugar level was above the normal range, and now he is trying to avoid all types of carbohydrates and foods with sugar. Also, he changed his daily food habits for his diabetic problem; rice is very high in carbohydrates, for example. For that reason, Yousuf changed his diet system to reducing daily rice consumption for his better health. Also, he always tries to avoid other carbohydrate food like bread, bun, and donuts. In every week when they met their social gathering place in Rohingya Education and Community Center (RECC), they discuss their food and grocery item habits regarding their health conditions. Tofael was not able to maintain his daily physical activities after his accident, and for that reason, he is conscious about his food and cholesterol levels. He mentioned that if he is getting too much cholesterol and sugar, it would be a threat to his health. When he got in an accident, his community instructed him what type of food he can consume during his time. Also, which kinds of food can fit him in regular life, he learned from both doctors and the Rohingya community in the U.S.. Tofael mentioned to me some vegetables' nutrition and medicinal facts. Bitter melon and bitter gourd, which is locally known to them as 'karela,' have very potential health benefits; it helps in maintaining blood sugar levels, helps in lowering the bad cholesterol levels in the body, helps for glowing skin and lustrous hair, it also strengthens immunity and prevents allergies and indigestion. Tofael also mentioned broccoli which has significant health benefits; it decreases the risk of heart disease, obesity, and overall mortality.

In social gathering and parties, they serve different types of food, but Rohingya people preferred their local and traditional food like beef curry, chicken masala, and roasted, scented rice with spice as the main dish. After that, they preferred any kind of sweet food for an appetizer. *Rosgolla* (sweet dumplings in syrup) is one of the familiar appetizers which contain high-level sugar. Ahmed (pseudonym), 37, married with two children; has been in the U.S. for 2 years after living in a refugee camp in Malaysia; works at a store; and is affected by diabetes. Ahmed expressed to me that when he found out from the hospital that he is a diabetic, after that he did not get any kind of *Rosgolla* as an appetizer. Ahmed is also concerned about his sickness in the U.S.; he thought that any kind of sickness is a big burden for him and his family members. If anybody got any sickness, it's very hard to deal with doctor's appointments, going to the hospital, paying for medications, and paying co-payments. For that reason, Ahmed thinks that everyday food habit can be one way to prevent illness. Ahmed never wants to get any sick that he could prevent with food habits and daily activities.

4.3 Community Support Group

I had visited a few Rohingya refugees' homes as an invited person. On most occasions, I have visited their apartments or attend a weekly meeting at Rohingya Education and Community Center (RECC) where their community people gather. According to my respondents' preferences, I conducted a discussion sessions for interview purpose in their apartments where they feel no confusion and able to maintain their privacy. I gave them a choice of whatever place they felt relaxed. I thought about why those people had preferred their homes for the interview. I asked them and most of my informants acknowledged, they prefer to spend their free time with family members. However, in Atlanta, Rohingya refugees also maintain their social connections with people in their community, sometimes making a relationship with another group of people.

They consider their community people as a family member because in crisis moment only they are seeking help to them and friends help them. In here, Rohingya people are always conscious of their friends and family members. Ahmed explains:

We are living with our family and children; in a sense, it is a big support group abroad. At the beginning of U.S. life, I was helpless when I moved here and faced many complexities regarding seeking health care. I didn't know where a hospital is, how to go to the hospital, and not only that, but also I didn't know how to make a doctor's appointment. Now, my family members are eligible to do that kind of task, which is big support for my family. Before, in my home country, my relatives were living very near to us, and they helped my family regarding any health complexities. Sometimes, I am missing that here. I did not feel any pressure for that complexities. But that in the USA, I am much too conscious of my health and my children's health because I know here I have no strong support like my kin.

Also, other informants stated their experiences where they mentioned that they feel anxiety in here regarding dealing with health care. They always depend on their community people which is remarks their inability to maintaining with the system. That circumstance makes a sphere of anxiety which also pushed them to learned new things in that existing system on the contrary deter them to avoid the existing system. "The void created due to moving from an extended to small nuclear (in most cases) family creates a constant awareness of their family member and their health. This void is created because of the new social settings that shape their life" (Hassan 2016; 49).

Kabir (pseudonym), 56, married with two children; has been in the U.S. for 7 years after living in a refugee camp in Malaysia; works at a store; and is affected by diabetes. He explained his experience to me that when he came to Clarkston from Chicago, in every step of his resettlement process, people from the community helped and suggested to him what he needs to do regarding getting food stamps, a driver's license, an apartment lease, and hospital visits. Particularly, community members help to decide on the critical moments. When they come here,

many among the Rohingya have a very limited idea what type of job they can do, how they can manage the cost and expenses, where they can go for visiting doctors, and who can help to take family health insurance. Kabir mentioned that without suggestion and help of people in the Rohingya refugee community, it was impossible to survive in an unfamiliar city in the U.S. Due to a lack of language skill and proper information, Rohingya refugee people cannot explore appropriate facilities for them in the U.S. In that situation, the support group plays a primary role to rescue from the initial obstacle.

4.4 Complications Related to Language Differences

Rohingya people speak Rohingya as their first language; it is very similar to the south-eastern local Bengali language. I am also from the south-eastern part of Bangladesh. I am Bengali speaker and can easily communicate with them well. All of the Rohingya refugee people came here from the refugee camp of Thailand and Malaysia. Prior, they have the experience of living in Bangladesh, Pakistan, and Saudi Arabia. For that reason, some people can speak multiple languages. In the Rohingya refugee community of Clarkston, some adult men and school going child can speak and understand the English language. When anybody wants to go to the hospital or seeing doctors, they need interpreter or translator. Almost all of newcomer Rohingya people are facing this problem of not understanding the English language. Kabir mentioned that when he came to Clarkston, after seven days, his wife was suddenly sick. Neighbors suggested him to the hospital's emergency room, the first time they visited the emergency room of Grady Hospital, from the very beginning they did not understand the instructions of staff and doctors. Also, after the visit, they did not understand the instructions given to them by the emergency room doctors. Some Rohingya refugees who do not have strong

skills in the English language try to avoid doctor's appointments or hospital visiting altogether except in cases of severe illness.

4.5 Financial Burden

Ahmed stated lack of easy access to health care facilities and doctor's appointments as one of the significant differences between the Myanmar, refugee camp and the U.S. health care system. In the refugee camp Bangladesh and Thailand, access to a doctor's appointment and getting medicine was not complicated; there were multiple options people had. In Myanmar, at their local place, they were used to a pluralistic medical system. For common medical problems, people visited a local healer (indigenous healer) or a village doctor (who would have biomedical and homeopathic training), and there was low cost for visiting and medicine. In the refugee camps of Thailand, Malaysia, and Bangladesh, they had access free of cost access to visiting doctors; most of the time they got free medicine from government and volunteer organizations. On the other hand, consulting doctor, getting medicine from a dispensary without a prescription is not easy to in the USA. Ahmed said, "It's a very crucial situation we would face if my child gets sick suddenly and I have no options to consult with doctors immediately if I am going hospital's emergency center, that is great fear for me due to the financial burden."

Regarding the U.S. health care system and insurance policy, refugees face many obstacles to deal with that. It's also pushed them to get the awareness of the U.S. health care system. Among all of my informants, nobody has a clear idea about health insurance; they have insurance, but they do not want to see doctors due to the cost. It is very difficult to calculate the treatment cost beforehand, whereas in both Myanmar and in refugee camp settings, patients had a very clear idea. Generally, hospitals, clinics, and doctor's offices in other countries provide clear information. It's helped them to incorporate easily with that system without any

complexities and they were able to take their decision based on their economic capability. Now, in the U.S.A, the insurance system and other correlated complications remarkably affected decision making about health care. People are not clear all rules and regulations of the insurance policy. Almost all of my informants have no idea which hospitals permit low-cost treatment with their insurance or which insurance is better for their regular treatment.

Moreover, not all insurance policies allow access to all health care providers. In the same insurance policy, hospital to hospital, bills and benefits can differ, and state to state, the rules are not the same. As Yousuf stated his insurance does not fully cover doctor visits, medication cost, and diagnostic tests, and at every step, he needs to pay a copayment, which is a financial burden for him.

According to my informant Tofael, the U.S. health care system is very complex and unaffordable for low-income people. Especially for refugees and immigrants, health insurance is a complex system that makes it challenging to get medical care. Tofael expresses his opinion about co-payments that after getting insurance policy why people need to pay for treatment. He feels co-payment is a big burden for refugee people who have not enough of an earning source. For that reason, people are more aware of their health, and they do not want to get any kind of sickness to avoid co-payments.

I can vividly recall that when he expresses the complexities of his health problems, before and after a car accident, his facial expression illustrates about his mental pain regarding dealing with medical care access, co-payments burden, continuous medication cost. He was a full-time worker in a company. His insurance was provided by the employer, but when he visited a doctor or hospital there was a mandatory co-payment. He also mentioned that the co-payment system generally seems very low payment, but that is a big challenge for him.

Refugees' health perception not only depends on their cultural background, but it is also shaped by their health realities during migration periods to refugee camps, resettlement process, socio-economic situations of host country, and health policy of host country. In the USA, Rohingya refugees' health perceptions are shaped by their cultural context, as well as dominated by social, cultural, economic, and health policies of the USA.

5 POST-RESETTLEMENT HEALTH REALITIES

For the understanding of refugees' post-resettlement of health realities, health-seeking behavior is an important indicator. Health-seeking behavior reflects the cultural, social, economic and political realities of a group of people. Today, understanding health-seeking behavior has been an important part of medical anthropology, especially in terms of how it relates biomedicine in different societies. In this study, with the lens of health seeking behavior to understand post-resettlement health realities reflects a Rohingya community's worldview, which allows us to gain a deeper understanding of aspects of their particular culture and the realities of life. This chapter is the key part of this thesis as I focus on the main research questions of how refugee status influences Rohingya communities' post-resettlement health realities. In this part of the study, I study their approach to health settings in a resettlement context as well as perceptions of disease, illness, and sickness, health care barriers as refugees.

5.1 Resettlement of Rohingya Refugees and Health Settings

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 the 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. Rohingya Refugees face many challenges upon resettlement in Clarkston, Georgia. Barriers to healthcare services are a significant challenge because Rohingya refugees are unaware of how to navigate the U.S. healthcare system.

5.2 Perception of Disease, illness, and Sickness

In this section, I will discuss people's knowledge, beliefs and their interpretations on health, including how people define their health including disease, sickness, and illness. With the help of knowledge of medical anthropology under the discipline of anthropology, I have tried to interpret Rohingya refugee's perspective on how they define their body according to their social, economic, political, and geophysical context. To explain this, I have employed the concept of "explanatory models" of illnesses by Arthur Kleinman. Explanatory Models (EM's) are the ways a person or group understands and interprets different aspects of illness (including cause, symptoms, and cure).

Health obviously has a biological component, but it is shaped by cultural and social factors as well. It is related to our human behavior and action with the relation to ecology, economy, politics and other social relationships; relationships with family members, kin members, community and other social networks. Whereas the dominant view of western biomedical science focuses primarily on biological determinants of health and well-being, medical anthropology takes a more holistic approach. The explanation of medical anthropology is that health is shaped both by biology and by the relationship with socio-cultural, economic, and ecological conditions as well as adaptation strategies they maintain for surviving in the face of

social and natural constraints. The limitation of the biomedical perspective is that “disease is basically physiological, and the mental and psychological issues are irrelevant” (Engle, 1972, 1980, cited from Winkelman, 2009). This above discussion tells us how health is culturally manipulated and constrained. Health is connected with our belief system that is our ideological level of culture.

People in different cultures have their own explanations and interpretations and perspectives of their body. All people around the world do not define their body according to western knowledge; rather it depends on cultural beliefs and practices. People define and redefine their health on the basis of a variety factors, from material conditions and what resources they control, along with the process of adaptation with ecology and environment and some other ideological aspects such as concepts of food, diet, ideal body communication, education, migration, industrialization, policy regarding medical licensing and product regulation, and availability.

Anthropologists have referred to the other factors that have a direct bearing on pluralistic health care include how and when people utilize alternative therapeutic systems, patterns of treatment of sickness, explanatory models of sickness, performative aspects of health-care provision, expectations of therapy, and evaluations of therapeutic efficacy (Nichter and Quintero, 2004).

It is very crucial in making decisions when people need to see a doctor or not. For Rohingya refugees, this is not easy, especially for those who do not have insurance. In that time, they are very strategic while making decisions. Here I will discuss their decision-making processes and priorities in making healthcare decisions.

For Rohingya refugees, the environment and healthcare structure of the U.S. is very different from what they experienced before coming here. Illness is culturally structured. Rohingya refugees in Clarkston have moved here from different refugee camps. So, this is a new society for them and in a new society pattern of illness, treating illness can be different and challenging. In both the home country of Rohingya refugees and in refugee camps, the healthcare landscape is different, and some illness like fever, dysentery, flu, coldness are very common and minor health issues. Cancer, cardiovascular diseases, diabetes are serious health issues. For minor issues, they are less concerned; they do not go to the doctor and know what exactly they need to do. They can deal that types of minor problem with their previous experience. In every family of Rohingya refugees I met, they have experience in dealing with minor health problems. Most of the time they are trying to avoid biomedicine and depend on the home remedy. However, in the U.S., they are facing frequent common minor health problems, including flu, fever, and colds, especially in the winter months. Hamiz explains the comparisons between home country, refugee camps and the USA:

I never heard before that the flu is a serious issue in my home country, Burma, and the refugee camps of Thailand. But, in the USA, they spread awareness through media, posters, flyers, and billboards that people need to take the flu shot. Here they are showing importance which is completely different. However, in my home country and refugee camps, I have seen circulations for child's essentials medicinal drops and shots through TV media, a billboard, newspapers.

However, there are differences term of disease and illness in between the two places. According to Tofael:

There are many differences according to the name of the disease. According to biomedicine, there is a difference between dysentery and diarrhea, but in our country of origin all are known by "Fedoth Kammuir (stomach problem)." Also, our community people are not familiar with other illnesses and diseases name here. For example, I was not familiar with 'arthritis,' here; now, I know different types of arthritis names:

rheumatoid arthritis, osteoarthritis, psoriatic arthritis. But, before [I] came here, that type of disease was familiar only by the name of ‘Baat.’ Also, I noticed here that ‘mental health’ issues are much more emphasized and circulated in the hospitals, NGO, and public places. These are also new things for me.

It is clear that culture and social circumstances shape the perceptions of illness. People categorize illness into three types- illness of natural force, human-induced illness, and illness of supernatural force. Though this categorization varies according to people’s class and level of education, but in general, illness is primarily two types for them. People seek differently for those two types of illness. In their home country, while Rohingya refugee to treat illness of natural force go to a biomedical practitioner, homeopath, and *kabiraj*(folk healer); to treat illness of supernatural force, people go to folk healers. Most of the time in the USA, they have no options to go folk healers rather than home remedy or biomedical options.

5.3 Health Care Barriers of Rohingya Refugees

In the USA, Rohingya refugees face many obstacles regarding health care system compare to with their home country. They face many barriers to deal with their health care issues. Among the several barriers, language illiteracy, transportation access, and health insurance complexities are mainly responsible for deterring them from getting necessary medical care.

5.3.1 Language

Language is one of the primary challenges between Rohingya refugees and the U.S. healthcare system and is a concern when providing refugees with medical care. Regarding the refugees and healthcare providers speaking different languages, it is hard for refugees to understand everything that takes place in patient-physician interactions, even when a translator is present. Lack of English language skills is likely to affect the quality of health-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). Sometimes doctor's written instructions are not understandable to refugees; this can also be problematic in understanding medications and other instructions.

All of my informants I have interviewed mentioned how language was the most difficult for them when trying to get medical care. It was difficult for Rohingya refugees to understand how to make appointments, search for hospitals, and confirm an appointment with doctors. One of my informants Malek (pseudonym), 47, married with 3 children; has been in the U.S. for 4 years after living in a refugee camp in Malaysia; works at a superstore; and is affected by common diseases. He shared his experience when going to the hospital on his own for the first time:

When we came to Clarkston, one volunteer introduced the hospital first, and then he showed us how we go by ourselves. After three months, then we had to go by ourselves. It was a bad experience for me because at this time my English skills were not good. I was nervous and confused when I talked to the health provider.

Miscommunications can go both ways in interactions with healthcare personnel. Providers mention "the impact misinterpretation has on the quality of care they can provide, noting how difficult it [is] to properly diagnose patients when communication [is] broken and physician time is limited" (Morris et al. 2009: 534). Rohingya 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 also emerge 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). Hazera (pseudonym), 35, married with 4 children; has been in the U.S. for 1 year after living in a refugee camp in Thailand; domestic caretaker at home; and is affected by common diseases. She mentioned that she found treatment very good but communicating with the doctors was too difficult. She explained:

I couldn't understand the doctor and nurse's language at that time. I could assume what they wanted to say a little bit. They were well mannered and tried to understand very consciously what my problem was. I was happy with their service and cordial behavior, but I was afraid of the language.

Hamiz thought the opposite; according to him refugees do not receive full care because of the language barrier:

When I was first visiting the hospital, my experience was hard, I thought they didn't understand what I tried to say about my problem. They checked my pressure, weight, pulse and tried to manage a translation, but unfortunately, in that time in the hospital, there were not any Rohingya translators. After that, they said many things I couldn't understand and they prescribed medication. That time, I thought, if I knew English probably, they could care more about me. After completing my visiting session, I did not know what kind of disease I have.

When untrained interpreters provide translation between parties, some of the medical terminologies may also be lost. 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. Sometimes, interpreters’ lack of basic medical knowledge creates an ambiguous situation for refugee patients. Ruhul (pseudonym), 39, married with 3 children; has been in the U.S. for 6 months after living in a refugee camp in Malaysia; works at a company; and is affected by cardiovascular disease. He explained his experience when he visited hospitals with over phone interpreters. He explained:

When I visited the hospital, the healthcare provider talked to me through a translator from an over-the-phone service. I explained my problem to the translator, then he explained to the nurse. When I got feedback from the translator, I was much too confused and thought that maybe the translator was not able to interpret properly to the nurse. I noticed that when a nurse was talking about some medical term to the translator, he said many times, ‘I don’t understand.’ Also, I noticed that they had taken a long time and repeated their conversations. From that time, I thought that the translator was not a good solution for that purpose.

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 73 1983).

A significant barrier that refugees face when seeking healthcare in the USA 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).

5.3.2 Transportation

Getting to medical facilities or to pharmacies to buy medication is another challenge for Rohingya refugees. Most of the Rohingya refugees do not own cars, specifically those who came within one to two years. 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 US healthcare system and can lead to rejecting health services (White 2012: 146). For most of the Rohingya refugees who came within the last two years, their monthly salaries are not enough to afford a personal car, car insurance, and the cost of gas. When they came in Clarkston, resettlement organizations host orientations to public transportation; still they feel difficulties in using public transport in Atlanta. Ruhul mentioned that:

In our living area, public transport is not available. If we want to go to Grady Hospital, first we need to take a bus, then train. Most of the time, we need to wait much more time for bus and train. Specifically, on weekend days, public transport is not as frequent as a regular day. Moreover, my family cannot afford a private rideshare service like Uber and Lyft. Otherwise, if we want to go, we have to go with community people who have their cars and rely on others to drive. In that case, I feel very uncomfortable.

Rohingya refugees frequently asked friends or family with cars to take them to hospitals or appointments. However, because of the everyone’s busy schedules, this is not always possible to help when exactly someone has a need. Yosuf explained his experience:

For the first 18 months, I was not able to afford to maintain a car. When I need help to go to the hospital, usually I call someone. But everyone is working with their busy schedule, so that they couldn't help me. It happened several times that I couldn't find anybody, so I had to stay at my home and miss my appointment.

5.3.3 Insurance and the cost of health care

Understanding health insurance and how to get it is a complex issue for Rohingya refugees. For many reasons, Rohingya refugees do not get insurance, and they are bound to pay extra fees out of pocket. Furthermore, the way of purchasing insurance policies, providing documents to hospitals, health provider is difficult for them and often they unaware of what they need to bring 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). Also, how to seek specialist services, how they need to confirm followup visits—all of these challenges are facing Rohingya refugees.

The barrier in the health care system of the USA is the exorbitant cost could pay by refugees. Refugees' medication costs cover for the first eight months based on their refugee status. According to community leader, most of the Rohingya refugees in Clarkston do not qualify for Medicaid after that period because of their income. For that reason, they must find their own insurance. In that situation, few Rohingya refugees enroll in an insurance policy. For that reason, whenever they need health services, they often wind up paying out of pocket. Hamiz explained his experience why he did not go hospital:

When I lost my job, I didn't have insurance. If I was getting sick, I needed to go to the hospital. During my unemployment, I was afraid when I would get the sick. For that reason, I didn't want to go to the hospital because I didn't have money, and that was the big problem for me.

If people are sick, they are trying to avoid going to the hospital because of money. In the Rohingya refugee community, most of the family consist of 4 to 6 members, and in the family, they have only one income source. Only job holder member has free insurance; other members need to buy insurance out of pocket. Moreover, the insurance price is high for them. For that reason, most of the family members have no insurance, and they know that without insurance if they go to the hospital for health care facilities, it would be high cost form them. Jamila (pseudonym), 33, married with two children; has been in the U.S. for 1 year 3 months after living in a refugee camp in Thailand; domestic caretaker at home; and is affected by diabetes. She explains that:

When I am sick, if I do not feel that it's much too serious, I don't express it to my husband. Sometimes, my husband can understand that I am sick and offers to take me to the hospital. I refused that, and I said, I don't want to go to the hospital. If I feel a major problem, I go, but my husband cannot afford to go to the hospital. That is very expensive for us.

Refugees are always seeking treatment that costs less; when they lived their origin of country, the refugee camp of another country, most of the time they could get free treatment and medication. When they lived in Thailand and Malaysia refugee camps, they were facilitated by non-governmental organizations, government aid for their health checkup, doctors' appointment, free of cost medicine. When I interviewed Jamila, also with my other informants, I noticed that their desire to receive all of the health care free of cost in the U.S. All most everyone mentioned that 'The USA is a first world country and they should provide all of health care facilities free of cost for all of the refugee people.' Before coming to the U.S., they thought they would get all kinds of health facilities without any burden. But when they came here and had gone for health care feel that this is created a complex situation and mental pressure for them. Yousuf stated that:

I feel okay now. If I got sick first, I would like to go to ‘Grace Village Clinic (Free clinic in Clarkston).’ They will provide me free treatment. But, sometimes they refer to Dekalb Hospital or Grady Hospital because they can only provide some preliminary forms of healthcare. Once they referred me to Dekalb Hospital, and later, I did not go there. I did not have health insurance. That time, I thought that if I went to the hospital, I needed money, and I needed an interpreter for everything in this situation. I would not feel better. That’s why I did not go.

In the Clarkston, there are many non-governmental organizations for refugee people. I was a volunteer at "WellRefugee Center." This organization is providing many kinds of facilities for refugee people. Especially, they are providing health navigation facilities, insurance enrollment support, doctors’ appointment confirmation, mental health support, etc. Also, there are some free clinics, ‘Grace Village’ is one of the renowned to refugees. Grace Village provides free of cost doctors’ visits, mental health facilities, some basic medication. In my observation, most of the Rohingya refugee know that kind of organizations provides support for them, but also feel they hesitate and don’t know well how they can receive these supports. Some organizations also work for who cannot be approved for Medicaid again or have no insurance; they set up payment for them. Health navigators and care providers of these organizations are also mentioned as things that refugee people have to learn, they insist to them that they need to get insurance for better treatment and get all kinds of facilities. According to health navigators or providers, the first one or two years after a refugee arrives, it’s very difficult to understand the system. After three to four years later, they have learned and get access more facilities than they did in the past.

In Clarkston, Rohingya refugees have an organization called RECC (Rohingya Education and Community Center). Each week, on Sundays, they meet and discuss their community welfare. They are doing some welfare activities for their community children. Once a week they arranged religious education session for their children. Also, they meet each other and share their

experience, helping each other regarding any types of problem. I am met all of my respondents every week in that place. A community leader motivates the Rohingya community's people to go to the RECC. He believes that if they can share their experience every week regarding their job recruitment, dealing with health problems, and getting benefits as a refugee, it would be very helpful for them. Regarding health issues, this Rohingya community leader told me:

Most of the Rohingya refugees in Clarkston usually they go to Dekalb Medical Center because that place is very near to Clarkston, but that is very expensive. Some people have no insurance and fall without Medicare or Medicaid. When they visit that hospital, after that they ask for the bill, and that is a very high price. I think, if someone tries to avoid seeking the treatment that's a problem, they have another very good option, and they can go to Grady Hospital. Some Rohingya people, they don't know that information about how to get benefits from Grady Hospital. They know only Dekalb Medical Center, that makes the big problem for them. If my community people actively participate in our RECC activities every week, everyone would get better information for dealing with any kind of problems.

Moreover, Rohingya refugees physically and mentally suffer because they are always trying to avoid seeking healthcare due to the expense. Due to lack of information, they do not know all other better options. Also, culturally they are not able to recognize the importance of health insurance. If they are getting serious sickness, only in that situation they go to the hospital. Who have no insurance, they are going for primary care visits, but these are too expensive. Arif stated that:

I know, it is good to visit the doctor. But, if I have no Medicaid and don't reapply for that, it is difficult to go to the doctor because I don't have sufficient money to pay too much. It's very expensive.

Tofael is a fifty year old man right now who is going to school for GED. He analyzed the USA health care system from his own experience:

I think the US healthcare plans are much more expensive than any other countries. I can understand that part. In Europe, everyone can get free access to healthcare facilities.

From my experience, I can compare how it is much more expensive than Thailand. Here, when I visited the doctor, he just checked my body with a stethoscope and tapped on my chest. After that, he told me the cost was \$70. I said, 'oh my god!' It's really expensive for just a regular checkup. When my family and I did not have any Medicaid, trying to take care of our family was our concern.

The high expenses of US healthcare deter refugees from going to the hospital. In that case, they are trying to take care of themselves at home to avoid the cost. Also, in the more serious health problems, this leads to self-medication and avoidance.

5.4 Self-Medicating

Many Rohingya refugees treat themselves at home with indigenous healing and other practices instead of going to the hospital when they are sick. Regarding the high costs of hospital services as well as the challenges of languages, and longtime practice of their healing system, Rohingya refugees choose home remedy options. As the people of Rohingya try to find out the cause behind the disease, they try to find out a remedy also. They try to cure themselves through their healing process. I have noticed in Clarkston that they have a treatment process for every common disease. And they respect their healing process. As a result, they take measures according to their own treatment processes along with allopathy, homeopathy, Unani, and Ayurvedic healing system.

Rohingya refugees will try to avoid going to the hospital by taking care of themselves and their families. Many of my informants stated their opinion. Yousuf, Ruhul, and Hamiz express their opinion:

When I am sick, I don't want to go to the hospital first. I know when somebody doesn't have insurance it's much more expensive. In that case, I am going directly to CVS, or Walmart Pharmacy to buy medicine. (Yousuf)

I am always concern about my health conditions. If I feel little bit of sickness, I go to the nearest pharmacy and buy some common medicine for common symptoms. After that, if I am feeling very bad, I go to the hospital. But, it was always a difficult experience for me. (Ruhul)

Hospital is always expensive. Usually, I couldn't afford to get health care. Even though I don't want to go when I am sick. Some family knows how to do a home remedy for their sickness. People help themselves as much as they can. Everyone knows, the hospital is expensive. (Hamiz)

Some families have home remedies and use traditional medical practices instead. Causes of different diseases and indigenous healing practices of Rohingya refugees have been discussed below.

➤ Name of Disease- Boils

- Rohingya Name- *Houra*

Boils (skin infections) are a very common condition. According to inhabitants of Rohingya refugees, boil may appear in any part of the body. Refugees think, boil appear in leg, thigh, and buttock. Boil can be small or big. As big the boil is, the pain is severe. As the time passes boil matures, later pus is pushed out. A person suffers from the boils and can suffer from boils again and again. Lack of cleanliness creates boils, according to one explanatory model of the Rohingya, although some think there is no simple etiology. A common joke among the Rohingya is: "A boil is a sign of wealth; if anybody suffers from the boil, this is the symptom that s/he will become rich shortly."

- Home remedy of boils

To treat boils, people put Chun (lime) on it so that it “ripens.” Rohingya refugees think lime ripens boil quickly. As the boil ripens, pus is pushed out. Later, bean paste (smash of bean) is used on the injured spot. They think bean is very effective for recovering from the boil.

➤ Name of Disease- Toothache

- Rohingya Name- *Daatoth Betha*

Toothache, which can have multiple causes, is a common disease of Rohingya refugees. I have noticed a significant number of respondents suffer from toothache. This disease creates swelling of gum, bleeding from gum. Sometimes, toothache becomes a severe one.

- Home remedy of toothache

Usually, there are two types of local healing the Rohingya people follow. One is boiling water with guava leaf and rinsing with that water. Another one is boiling water with lajabotij pata (a type of leaf) and rinsing with that water. Moreover, villagers put salt in the root of the tooth which aches, for a while it brings relief to them.

➤ Name of disease- Fever

- Rohingya Name- *Hor*

Fever is a common symptom among Rohingya refugees. Accordingly, fever can originate due to different causes. They believe that overworking, injury, staying in the water for a longer period, working in a hot environment may lead to fever. A fever patient feels the heat in his body, suffers from headache.

- Home remedy of fever

The local healing measures that Rohingya refugees take for fever patient are given below:

- The patient is told to rest.
- The patient is given water on his head so that temperature comes down.
- Warm clothes or blanket is given to the patient.
- The body of the patient is massaged.
- pineapple, orange, apple, banana are arranged for the patient. But they think, especially, pineapple is very effective for fever. So, they can arrange any other fruit or not; they try best to arrange pineapple for their ailing loved one.

➤ Name of the disease- Hypertension

- Rohingya name- *Fressure*

Nowadays, hypertension has become a common disease of Rohingya Refugees. There is a common belief among them; tension creates hypertension. Somebody thinks that overwork is the reason behind hypertension. Usually, they think, people who are overweight mostly suffer from hypertension. They describe the symptoms as:

- Dizziness
- Neck pain

- Chest pain
- Weakness
 - Local treatment of hypertension

I have noticed, if a family member suffers from hypertension, other members ask him not to be tense. They think, being tension free is the panacea to be free from hypertension. Everybody takes care of the hypertension patient.

Refugees think the sour type of food is effective for hypertension. So, they feed the patient tamarind juice and mango bar juice. Moreover, hypertension patient willingly avoids beef, mutton, fast food.

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

Rohingya refugees use their traditional medicine for different reasons. Some people prefer natural remedies instead of western biomedical medicine in the USA. Rohingya's traditional medicine is very different than western medicine. In the origin of the country, Rohingya refugees mostly used natural medicine whenever they are sick. When they came to the USA, do not like to use it as much. Hamiz explained:

When we were in Burma, most of the time we try to get the traditional medication. We tried to get it from the jungle or from the traditional healer who was known by 'Kabiraz' or 'Ozha'. This person found out the disease through traditional ways and prescribed and provided traditional medicine. That person tries to give the right medication to people. In the USA, it is different. There are very few ways to practice traditional healing.

Tofael compares his two stages of life between when he lived in Thailand and now in the U.S.

His analysis is:

I think this is very different. When I was in camp, if we were sick, we know we can collect the medicine from the environment even if we don't have money. When people are sick, they know how to get the medicine from nature, like a tree, herbs or other. But, in the USA, when you get sick, every time you need to go to the hospital, and you know, this is very expensive for us.

Rohingya refugees preferred traditional medicine in their home country Burma or the refugee camps. Usually, they did not have to go to the hospital to treat sickness. Now, if they can manage traditional medicine in here, they do not cost the high price for hospital services.

Rohingya refugees are often feeling uncomfortable seeking healthcare in the United States because it is a different process from what they were used to in their home country or the refugee camps in Malaysia and Thailand. In the U.S., people experience difficulties in making appointments for doctors' visits. This is something new to them. Nuru (pseudonym), 37, married with 3 children; has been in the U.S. for 2 years after living in a refugee camp in Thailand; works at a company; affected by common disease. mentioned they would only go to the hospital if they were very sick:

My experience is very different from when I lived in a refugee camp in Thailand. There were no appointments, just go to the line and get the doctor's visits. But, in the USA you have to schedule the appointments all the time. Most of the Rohingya people are not familiar with the appointment. In our community, people say: 'if I get severely sick right now, what will happen to me, I don't know when I will get an appointment.' When we are sick, only then do we go to the hospital. In here, it is difficult to make an appointment instantly time. Also, we are not familiar with the regular check-up, so this system is difficult for us. In our home country and refugee camp, we were not familiar with doing that.

Jamila explained her own experience with a comparison between two healthcare systems:

I had a miscarriage, and that time we went to the emergency room. One thing was unusual; they took lots of blood. It's different from my home country. In my home country, when we got sick, healthcare providers never took the blood. But, in the USA, every time they took the blood. Also, when we got sick, we have to make an appointment. In my home country, we just go to see the doctor. It's really difficult to

make appointments. Also, medicine is different in here, for my cold sickness. I got a shot. In Burma, there was no need of a shot for cold.

The process of seeing a primary care practitioner with follow up care at a specialist is another difference in the US healthcare system. Rohingya refugees have trouble understanding that they need to go to more than one doctor for different health problems. This creates another challenge when they do not have available access to transportation and lack of language.

Rohingya refugees living in Clarkston, Georgia encounter numerous barriers to healthcare services. These types of differences between the home country, refugee camps of Rohingya and US health care systems make it challenge to them accept the new western biomedical system. Many Rohingya refugees do not visit the hospital for these reasons, which can be lead to more serious health problems. They have trouble navigating the US healthcare system while they are at the same time adjusting to life in the United States of America.

6 CONCLUSIONS

Rohingya refugees fled from Myanmar to different refugee camps, like Malaysia, Thailand, and Bangladesh. Many of them maintain connections with members of their community both in the host society and in the refugee camps. They are often existing in a liminal state in the different places in terms of the social, political, and cultural environment. They have trouble fully adjusting to the U.S.' larger society and culture and do not maintain strict boundaries with other communities. In the research, I tried to explore their perception of health and post-resettlement health realities in the United States which would be different from that of Rohingya people who are living in their place of origin and refugee camps.

In the resettlement process of Rohingya refugees in the U.S., they have started learning new things from their experience. Also, they entered an acculturation process from the perspective of larger U.S. society and culture. During the whole process, they face many things which are related to their way of life and contrast with their past habits and practices. There is triangle cross engagement with the U.S. healthcare system, refugee status, and cultural origin. This engagement shaped Rohingya refugees' health perceptions and health-seeking behaviors in Clarkston and in the wider Atlanta metropolitan area.

The health perceptions and health-seeking behaviors of Rohingya refugees that significantly shaped their interactions were significantly shaped by the U.S. healthcare system, which is in some ways diametrically opposed to their past health practices. Access to the U.S. health care system is a complicated journey to them from the aspects of insurance policy, complicated steps and rules, the hidden cost of treatment (co-pay), non-available alternative and traditional medicine, and purchase way of medicine. According to all of my informants, now their food habits and preferences have changed after coming to the USA as a refugee. Also, many participated in a community support group intended for all of Rohingya refugees to be more conscious about their diet and food choices. For that reason, refugees are more aware of the nutritional value of food. It also differs from person to person among them. Some people, who have institutional education and can speak English, know the exact nutritional value of food, such as which food contains protein, which food contains high carbohydrate, calories. They can understand all types of dietary benefits from the food's label. Other refugees who are not able to read English, they might not know which is better for health, which is not good. Particularly they might not understand the relationship of diet and health/illness.

Regarding food and consumption, Rohingya refugees adopted new practices after coming to the U.S. Now they are trying to get health literacy for more awareness of health and illness. At the beginning of the resettlement time, organizations taught them multiple tasks within a brief time, which is challenging to learn everything appropriately. For that reason, they could not adopt and feel afraid from this time. Informants have said that they thought the difficulty comes from remembering all of the information from the bunch of multiple orientation sessions. For that reason, they were overloaded, and it created anxiety about all issues including health care issues. In that context, this study would recommend that resettlement authority could design intensive workshops or orientation programs related to refugee health. For that task, they need to take a long-term program that takes into consideration refugees' health perspectives.

Also, the language barrier creates difficulty in seeking U.S. healthcare. Rohingya refugees are feeling hesitant about going to a clinic or hospital, visiting a doctor, arranging an appointment, communicating with the nurses and doctors, and filling out forms. In those situations, resettlement authority could focus on community-based translator training, and after the successful completion of this training, they could apply for translator jobs in the hospital and refugee-related offices. Without a potential of paid employment, refugee people may not have any interest on that work. In addition, transportation barriers restrict their physical mobility for seeking health care due to limited public transport services. In that context, therapy management groups or networks play important roles to overcome many barriers. Most of the time, newly arrived refugees' decision-making motivated shaped by therapy management group.

In the post-resettlement health realities, the U.S. health insurance is another big barrier for Rohingya refugees to seeking health services from the hospital. After the first eight months, most of the Rohingya refugees do not enroll any health insurance plan. From their perspective,

getting health insurance puts a huge financial burden on them. All of the informants stated that the process of enrolling, obscure insurance policies, co-pay systems, and the cost of a huge amount of money deter them from getting health insurance. The fear is that if they go to the emergency room due to serious health problems, they will feel mental pressure about the bill. Regarding the U.S. health insurance and healthcare dealing with Rohingya refugees, the entire experiences shaped their perceptions of health, changed their practices, and shaped Rohingya refugees' health-seeking behavior. Based on my findings in this study, eight months is not nearly sufficient for free health insurance coverage, unless refugee resettlement organizations can ensure that people are registered for an affordable plan or for Medicaid by the end of that time. Otherwise, people need coverage for at least five years, which, based on the community I worked with, is my estimate of how long it takes for refugee families to adapt to life and work in the United States.

It is important to point out that many of the challenges faced by the Rohingya point to a larger crisis in American healthcare that affects by native-born and foreign-born people. Nearly 33 million people (about 10% of the U.S. population) were uninsured in the United States in 2015 (U.S. Census Bureau 2016), and many Americans take similar approaches to the participants in my study in terms of health-seeking, including using home remedies and over-the-counter remedies, going to the ER for non-life-threatening health problems, and sometimes neglecting certain health problems because they cannot access medical services.

Rohingya refugees prefer self-medicating to deal with the common diseases through seeking biomedicine, traditional medicine, and alternative medicine. Moreover, their decision depends on the level of seriousness of their disease and illness. In this study, findings have shown that Rohingya refugees are practicing medical pluralism, but, in the USA, the context of

practicing or seeking multiple healthcare options is different than pre-resettlement positions. For avoiding multiple barriers, refugees are seeking alternative healthcare in the USA, but those alternative healthcare options are connected with their habits and practices which are culturally integrated and may have been carried from generation to generation.

This research contributes to understanding the Rohingya refugees' unexplored complications in terms of getting health services in the United States as a refugee people. Nevertheless, the significance of this study is not exclusive to only the Rohingya ethnic community, but also this insight can provide an understanding about other refugee people, particularly other Burmese refugees who are living in the Atlanta metropolitan area and to those who have lived in refugee camps for several years before resettling in a host society. In a broader sense, the difficulties in accessing healthcare reflect a broader healthcare crisis in the United States that disproportionately affects low-income people.

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APPENDIX

One-on-one interview questions

Background information

- Can you tell me your age?
- How do you identify in terms of ethnicity, race, and/or family background?
- Where did you grow up?
- When did you move to Atlanta?
- What's your educational background?
- Do you work currently? If so, what position?
- Are you currently married?
- How many family members do you have? What are their ages?

Questions about health seeking behavior

- Can you give me an example of what you do when you or another family member is sick or needs medical care?
- What are some things that are difficult or easy about getting this care for different people in the family (adults, children)?
- Do you have home remedies that you use for health?
- Do you have access to obtaining these main ingredients of home remedies?
- Do you or other members of your family have health insurance?
- Are there health clinics/doctors that are close to your house?
- How do you get to a doctor's appointment (walk, take MARTA, drive)?
- What are some hard or easy things about getting medical care in Atlanta?
- What are your biggest concerns about healthcare in the US?
- Do you think US health care system is appropriate for refugee people?
- Do you think your refugee status make any limitations to get health care in US?
- If it is not appropriate, what type of clause or rules makes limitations?
- Are you practicing any indigenous healing system in U.S?
- Do you think you have limitations to practicing indigenous healing?
- Your indigenous knowledge is working in US as a healing practice?
- Are you practicing any religious healing in U.S?
- If you are practicing religious healing, can you explain it?
- Do you think US health care system makes any cultural or religious violations with you?
- Do you take any help to go hospital?
- Do you take any suggestion from your neighbor?
- Do you feel any trouble to make appointment with doctors?
- Do you feel any language barrier to talk doctors or hospital staff?
- If you are not able to speak with doctor's language, how do you understand the instruction?
- Do you bring any interpreter to doctor's chamber?
- Do you have any individual experience in hospital/ with doctors? Can you explain it?

