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From Sydney to Syracuse a Transcontinental Exploration of Women's Health in Karen Refugee Communities

A Capstone Project Submitted in Partial Fulfillment of the
Requirements of the Renée Crown University Honors Program at
Syracuse University

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and Renée Crown University Honors
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Honors Capstone Project in Anthropology

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Abstract

From Sydney to Syracuse a Transcontinental Exploration of Women's Health in Karen Refugee Communities. There are many impediments to refugee women's access to health care and sexual and reproductive services in their countries of resettlement, including language difference, transportation, and absence of culturally appropriate support. Through focus groups and participatory observation this paper identifies some major challenges that Karen (an ethnic group from Burma) women face accessing health care in their respective cities of resettlement (Syracuse, New York or Sydney, Australia). It is through such documentation and analysis that policies and services can be improved and any harm they inadvertently produced can be alleviated.

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Executive Summary

The ongoing armed conflict in Burma¹, known as the longest civil war in the world, has resulted in 73,000 Burmese refugees resettling in the United States and about 23,300 in Australia (UNHCR 2014). A majority of these refugees are Karen, which is one of the hundred ethno-linguistic groups that make up the Burmese population. About 1,800 Karen have been resettled in Syracuse New, York and roughly 1,000 Karen are living in Sydney, Australia to date. Refugees, people who have been forced to flee their country because of persecution, war, or violence, are among many cultural and linguistically diverse communities who often face challenges accessing health care in countries of their resettlement due to challenges concerning language differences, transportation access and knowledge of and access to available humanitarian services.

Prior to resettlement the Karen refugees were exposed to violence, rape and forced labor. Most of the Karen have been living in refugee camps for ten to twenty years. Because of past experiences, the Karen living in the United States and Australia are more vulnerable to diseases, disorders and illnesses than the general population. The aforementioned vulnerabilities include psychological disorders such as anxiety, depression and Post Traumatic Stress Disorder (PTSD) as well as physical consequences caused by malnutrition, torture and armed conflict. Karen women in particular are at significant risk for sexual and reproductive health disparities because of sexual and gender-based violence that existed within the camps (NSW Refugee Health Service 2011). It is imperative that Karen communities have access to effective health care in the locations of their resettlement. One way to ensure that services are being utilized and are

¹ Although Burma is now called Myanmar, I will refer to it as Burma out of respect for the Karen.

effective is to ask.

In my project I facilitated discussions with Karen women currently living in Sydney and Syracuse in order to understand the challenges they face accessing health care. Originally, this project was intended to be a comparative study that examined how the Australian health care system impacted the livelihood of refugees in comparison the United States health care system. However, after engaging with these two Karen communities it became clear that this task was impossible because of how complex and diverse the two Karen communities were or rather had become. Therefore, the focus of my project shifted and it became more important to fully understand these communities and its individual members, in order to be able to identify the challenges they face accessing health care. The discussions focused on personal experiences that the Karen women had accessing health care in their communities. In addition to these discussions, I attended many community events and religious services in both Syracuse and Sydney to better understand the social, and political organization and practices that exist within the Karen communities.

In order to gain a deeper understanding of the Karen culture in regard to health and health care, I also traveled to Thailand, where thousands of displaced Karen also reside. There, I lived in a Karen village where I observed Karen refugees and their experience with health care. Finally, because most of the Karen women had been living in refugee camps before they came to Sydney or Syracuse, I also visited the Tham Hin refugee camp in order to observe what health care access looks like before resettlement.

By engaging with all four Karen refugee communities, I was able to contextualize the challenges that were identified in the group discussions with the Karen women and also identify that these challenges are not homogenous among all Karen refugee populations. The discussion

must include the needs of individual people as well as individual communities when beginning to think about implementing policies to improve health care services for refugee populations.

Acknowledgements

First and foremost I want to thank the many Karen I met throughout my journey. I will be forever grateful for the warm welcome I encountered in every location. I especially want to thank the Karen community members in South-West Sydney, the Karen community members in Syracuse, New York and the Karen in Palau, Thailand. I would personally like to thank Daniel Zu, Eh Soe Gay, and Lulu Naw who acted as interpreters and guides throughout the whole project. Finally, I would like to thank my reader Professor Sandra Lane, my Australian advisor Professor Anthony Zwi and my capstone advisor Professor Rubinstein, for his guidance, support and dedication.

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Preface

As a child I was sick quite frequently with high fevers, ear infections and the flu. I spent a considerable amount of time in waiting rooms, getting my blood drawn in the occasional hospital bed. For me, there was nothing more frightening than not knowing what was wrong, and it was not until the doctor looked me in the eye and said, "everything is going to be okay," that I would begin to feel better. This project stemmed from my experiences tutoring in the Syracuse City School District, specifically working with Karen students, and learning that there are many people who get sick and are unable to access the care that they need. Not only have Karen refugees experienced years of struggle in their homeland and living in refugee camps, they are still facing challenges accessing health care in the countries of their resettlement. Through this project, it was my intent to identify some of the key challenges the Karen face accessing health care in Syracuse, New York and Sydney, Australia which can then be used when we begin thinking about how to eliminate these challenges, so everyone can have the equal opportunity to "be okay."

Introduction

Off the main road, past fields of pineapple and sugarcane a woman wearing only of black and gold tells the story of the elephants. Her hands dance with the melodic Karen language. “Last rainy season a herd of seventy elephants came through our village.” Her hands grew wide. “All I could see was a tall gray shadow and then I was up in the air, flying above the pineapple plants.”

I had seen one of these wild elephants my first day in Thailand. We were packed in the bed of a pick-up truck, the uneven roads flinging our bodies every which way, as we headed west towards the Thailand-Burma border. Eh Soe Gay and the others protected their faces with their sleeves. I made a mask with my fingers and peered out. The truck jerked right around a great blur emerging from the surrounding trees. My dust covered hands dropped at the sight of the ivory tusks, the cracked skin of the trunk and the two fierce black eyes.

The loud gear shifted through the sound of rubber tires on dirt and we were chugging up the hill, leaving the grand figure dancing behind us. “You can’t shoot elephants here you know, you will go to jail.” Eh Soe Gay yelled through the wind, collecting bits of dirt in her eyelashes. It was not until she spoke the word elephant that I was even able to recognize the massive object in front of me. Elephants were in zoos or metaphors in George Orwell’s short stories, not on roadsides. She cupped her hands around her mouth and moved in close. “Some of them come from Burma...maybe because there is not enough food or maybe...” The truck turns and dirt spits out from the rubber tires. “...or maybe because in Burma, they kill the elephants. Here they are seen like gods.” She grabs a sweater from her bag to cover her face while I scour the passing trees for elephants or anything unfamiliar hiding in the jungle.

Chapter 1.

Background: The Karen People

Like the elephants, the Karen were forced to flee their homeland and seek refuge in the jungles of Thailand, refugee camps on the Thailand-Burma border and in cities across the globe. The Karen are one of the hundred ethno-linguistic groups that make up the Burmese population. However, within this ethnic group are diverse sub-groups. The majority of Karen are Buddhist, about twenty percent Christian and the rest Animist and Muslim. There are roughly twelve Karen language dialects that are spoken amongst the Karen based on geographical locations. The two major languages are Sgaw and Pwo. Sgaw is spoken among mostly Christian Karen communities in the hill areas of the Karen state, while Pwo is most commonly spoken by Buddhist Karen in the lowland areas of Burma (South 2011).

After gaining independence from Great Britain in 1947, Burma entered what is known as the world's longest civil war. The country has since experienced conflict between the central government and a range of armed ethnic and political groups. The article titled, *Burma's Longest War: Anatomy of the Karen Conflict*, argues “ conflict in Burma is orientated along two main axes: a predominantly urban-based movement struggling to achieve greater accountability and democracy in a state dominated by a military government since the 1950s; and an overlapping set of conflicts between a centralized state and representatives of ethnic minority communities, which make up approximately 30% of the population (South 2011).”

One of the armed ethnic groups is the Karen National Union (KNU), which was formed once Burma became an independent nation. The KNU claimed territorial and political concessions from the central government that were promised when Great Britain had control

over the country. When these claims were not met the KNU revolted and for the next half century the KNU controlled territory across the Karen State. In 1994 the Democratic Karen Buddhist Army was established in resistance to the KNU and, with the help of the central Burmese government the Karen National Union, was overran (South 2011).

During this time the Burmese government began targeting civilian populations in an effort to eliminate conflict and establish control. By the mid 1990s, as a result of decades of armed conflict, tens of thousands of mostly ethnic Karen fled, some living in the nine refugee camps spread out along the Thailand-Burma border, a larger number were displaced in Burma and two million Burmese migrants (many of them Karen) were living in Thailand with a very uncertain legal status (South 2011).

Since 2005, it became possible to apply for resettlement in a country outside the region. As of 2012, the United States has welcomed about 73,000 Burmese refugees. In addition to the United States, roughly 19,000 Burmese refugees in Thailand have gone to other resettlement countries, including Australia, Canada, Finland and Japan (UNHCR 2014).

Chapter 2.

Intent/ Methodology

Prior to secondary resettlement refugees must pass a medical examination in their first country of refuge. The medical examination consists of a physical examination, a skin test, chest x-ray examination for tuberculosis and blood test for syphilis. Because of these regulations refugees arrive to the country of their resettlement in fairly good health. However, based on previous experiences in their home countries or in refugee camps, refugees are vulnerable to

disease, disorders and illness. These include psychological disorders such as anxiety, depression and Post Traumatic Stress Disorder as well as physical consequences, due to past experiences of malnutrition, torture and armed conflict (UNHCR 2014).

Because of these risks it is imperative that health care services be available, accessible and effective in areas of refugee resettlement. There have been numerous studies done that seek to understand how health care services are being used by refugee communities. These studies have identified that there are many challenges that refugees face accessing health care services in countries of resettlement like language difference, financial need, and transportation. Many of the findings from these studies have been used to implement new policies or practices in health care services.

I too wanted to investigate the challenges that refugees face accessing health care with the intent that my findings might be useful to implement new policies or practices that could improve provision of health care services. My familiarity with the Karen community in Syracuse and the political situation in Burma motivated me to focus on this particular ethnic group. In this project I engaged with two Karen communities, a Karen community in Syracuse and a Karen community in Sydney, Australia.

I used several methodologies in this study, including, participant observation, informal and formal interviews with Karen patients and service providers, focus groups with small groups of Karen women and one life history with a young Karen woman named Eh Soe Gay living in Sydney and an older Karen woman named Lulu Naw living in Syracuse, New York. I also traveled to Thailand with Eh Soe Gay and a Karen Christian Youth Group, there I was able to visit several Karen villages, areas with internally displaced Karen peoples and the Tham Hin refugee camp. The purpose of traveling to Thailand was to learn more about the Karen culture in

regards to health and health care, to understand where the Karen I had met had been living for ten to twenty years of their life, and to observe what health care was available in the refugee camps.

The field-work took place in three different countries over the course of a year and a half. From March 2012-July 2013, during my study abroad, I was working with a Karen community in Australia. Since August 2013, I have been working with the Karen community in Syracuse, New York. From December 25-January 17th I traveled with members of the Australian Karen community to Karen villages and the Tham Hin Refugee Camp in Southern Thailand.

Chapter 3.

Life History: Eh Soe Gay Zu

Eh Soe Gay Zu was eighteen year's old when I met her in Sydney, Australia. "Soon to be turning nineteen," she said with deep importance. She arrived in Sydney when she was thirteen years old on April 3rd, 2007. Over the past six years she attended middle school, high school and is now studying for her Bachelor's of Nursing.

Eh Soe's father, Daniel Zu, was born in 1964 in Syriam (Thanlyin). He was a member of the Karen National Union and in 1987 he learned he was being hunted by the Burmese military. On June 20th, 1987 Daniel left Rangoon, where he was studying, and fled to the Karen state. There, he became a high school teacher in English, social studies, history and geography, and also met his wife Beh beh, who was a teacher at the high school as well.

When I inquired about their marriage Eh Soe Gay explained "In Karen, Karen people if we would go about the Karen culture if...we would date by writing letters." As Eh Soe Gay told

me this, one of the Karen women named Lily Shaw went into the house then came back with a pile of letters. They were hand written in Karen from her husband Moser, asking if she would be his girlfriend.

Daniel Zu and Beh beh got married in 1991 and had two children, Ta Nay Thar Zu in 1992 and Eh Soe Gay Zu in 1994. Moser, the man that ran the bible school spoke up. "I was there when you were born." He proceeded to tell us the story of the night during the rainy season when all you could hear was the slapping of water against the bamboo roofs and screams from Beh beh. Moser was outside when Daniel came running towards him. Something was wrong and they needed to bring Beh beh to the clinic. Daniel and Moser moved Eh Soe Gay's mother from the bamboo house into the bed of the truck. Moser sped through the trees towards the clinic, while Daniel held onto Beh Beh's hand. But the rain had mixed with the dirt roads, creating a thick layer of mud around the tires. They attempted to push the truck, but it was no use, the tires spun, spitting the dirt from under them. Daniel ran back to the village for the other truck but it would not start. He ran back with a hammock and he and Moser carried Beh Beh back to the house. "You had a big head, you were almost born in horse shit," Moser laughed. I watched Eh Soe Gay's cheeks flare up as she interpreted this for me.

In 1995 there was an advance warning. Multi-nationalists, the Burmese army and the Thai government had joined forces in order to construct a gas pipeline from Burma to Thailand through the Karen State. In 1997 the Burmese army moved into the Karen state, forcing the Karen off the land with bombs, fire, and bullets. On February 23rd, Daniel, his family, and the last group of students fled to Thailand. When they finally reached the border the Thai authorities trucked them and about 2,000 people to the site that would eventually become the Tham Hin camp.

Despite the massive amount of available land, only sixteen acres were designated for the 7,500 Karen that would soon fill the Tham Hin Camp, because the Thai had intended for the camps to be temporary (Frelick 2012). When the Karen arrived, they had to build their own houses from bamboo and to set up toilet areas. Many people were dying of diarrhea, dysentery, and malaria. Daniel became a leader of the camp, acting as the liaison between the Karen and the international and Thai authorities.

Eh Soe Gay lived in the Tham Hin Camp for nine years, from age four to thirteen. She cannot remember fleeing Burma but she describes her days in the camp as pleasant. “The camps were all I knew, every day I would wake up, go to school, where I learned Karen and some English. Then, I would play and if there was no school I would play all day until I got scolded. On certain days, we would be called to go and get rice, soap and cooking oil for the entire month.”



Eh Soe Gay journaling in the Karen Village.

Daniel Zu sent his son, Ta Zu to live with a Thai family outside of the camps. Ta tells me

about his childhood in Thailand. "I was lucky because my uncle was one of the wealthier men in the village. I had a nice life. It was fun to be a kid man. I went to Thai school during the year and in the summers I went to Tham Hin Camp to be with my family."

When I asked Eh Soe what she did when she got sick in the camp she explained, "Just rest. Do hot water with traditional medication some herbal mix, it was the flu my mom made this leaf drink, It didn't smell very nice it's tasteless... You only go to the clinic if you are really sick if you have diarrhea or if you have a headache or if you have a fever if you did the clinic the medic do a check up and they give you the medication that is provided there. A lot of the time you have to wait like people line up like people go do check up like people go get medication or vaccination or sick so you kind of have to wait. It's very limited but if someone's really sick then they would send them to the closest Thai hospital outside of a camp.

In 2005 it became possible to resettle to countries like the United States and Australia. From 2006 to 2007 Daniel and his family went through interviews, medical checks, and cultural orientation and in 2006 they arrived in Sydney, Australia. "Before we get to come to Australia we had to have a medical check, in Thailand in when we were in refugee camp, we had to do a medical check we had to get vaccines."

When Eh Soe Gay arrived in Australia with her family at age thirteen, her case worker brought her and her family to a general practitioner that spoke Burmese. There, they were given a general health check up. When I asked here what her experiences have been over the past six years she said she has not really been very sick. "It's not like in the camps, you don't get sick a lot... but maybe if I do I go see the general practitioner."

When I left Australia I was sad to say goodbye to Eh Soe Gay. We had become close over the past six months. However, I knew I would see her again in Thailand. This would be the

first time she returned to Thailand since she was living in the refugee camps.

Chapter 4.

Thailand, Culture and Health Care

I woke up to the calls of an old rooster, the acrid smell of ground chili and the low whispers of Karen. It was nearly four a.m. and the sun had just started climbing the surrounding mountains. I could see Eh Soe Gay's shadow moving through the bamboo door. I grabbed my two Karen sarongs and followed her down to the river.

The previous day we drove the truck four hours from Palau to the Thai-Burma border. Three Karen National Union (KNU) soldiers met us on motorcycles, where the rubber plantations merged with the jungle. The men took my backpack and we followed the tire tracks on foot through the trees, rivers and up the mountains. Just before darkness we made it to the Karen village. The village consisted of one house and one church, both made from bamboo. Three families lived in this village. I placed my shoes in the pile beneath the house and sat on the floor beside the small dinner table. Two Karen women brought us a large bowl of rice each and then placed smaller bowls filled with chicken, taro and freshly made chili paste for all of us to share. There was no fruit and very little vegetables and meat. I watched Eh Soe Gay use her hands as utensils, breaking the rice and then mixing it with the chili paste and meat. Then she shoveled the concoction into her mouth. "I eat this way at home, I thought coming here would be a lot different, but it is not. We have kept our culture in Australia." After dinner, exhausted and in complete darkness the Karen women and I set up the mosquito nets in the bamboo house, while the men put together their tents outside.



Dinnertime in the Thai Jungle.

Bathing in the river was a process. Eh Soe Gay showed me how to wrap the sarong around my body and then carefully drift into the river. "If you go in too fast the water will make your sarong fall off," she warned. "I remember doing this in the camp" she said to me. We washed our bodies with soap and she laughed at me as the water flooded into my sarong. "Thankfully the men bathe upstream, separate from the women," she said. We changed into our clean, dry sarongs and washed our jungle-covered clothing from yesterday. Two of the young women had come down to the river to wash their clothes as well. I watched their hands dip the clothing in the river, then using only one hand, they rung out the soap and water. One of the women took my sarong and placed it into the water. She placed the wet sarong in my hand and guided it firmly as I tried to squeeze out the soap. I was too slow for her. She finished and hung the sarongs in the trees, out of sight from the men.



The Karen women and I bathing in the River.

I walked back to the village to find about fifty or sixty Karen men, women and children now cooking over an open fire pit and playing soccer in the dirt. I squatted next to Eh Soe Gay who was helping two other women pick off leaves from small vines and put them into a large pot of warm water. One woman held a child on her back as she did this. "Darcy you have to learn to squat," Eh Soe Gay pointed at my legs which were shaking as I tried to center my weight. I laughed, thinking about my struggles with the hole in the ground toilet.

After breakfast I went back to the bamboo hut to find the Karen girls braiding the hair of two older women in preparation for the Christmas celebration. The women's teeth were stained red and the corner of their lips looked as though they were bleeding. Eh Soe Gay explained to me that chewing beetle nut is a common tradition among the Karen people. Even in Syracuse, the women chewed beetle nut during our focus groups. Once the women were dressed in their celebratory sarongs, the music started and their sons led them into the church.



Preparation for the Celebration.



Entering the Church.

The church services were long, but gave me time to write, and observe. The other families that arrived in the village this morning lived in the surrounding jungle. “These people are IDP’s, [internally displaced persons] they came to celebrate Christmas with us,” explained Eh Soe Gay. Many of these men were members of the KNU and spent their days patrolling the border, while their families lived in temporary homes made from branches and leaves. I looked out at the six hours of thick jungle that separated us from the Burma border.

We spent three days in this area and I was able to inquire about the health care or lack there of. A young woman told a story about the German doctor that came to the village last year and diagnosed her with mouth cancer. “But nobody has been back since,” she says worriedly as she grips her mouth. The common illnesses in this area are malnutrition, malaria, parasites, mouth cancer and urinary track infections. There was very little indication of preventative care. The Karen eat extremely spicy food, which in my opinion was a cultural feature. However, according to Karen ethnomedical beliefs the chili is used to fight off parasites. This community also practiced boiling the water that the women collected from the river in the morning. It was an odd sensation drinking scolding water in ninety-degree weather.

Once or twice a year the Karen group from Palau visit this village and try transport those in need to the Thai government Hospital in Hua Hin, which is about six hours away from the village. However, because these people are internally displaced, they must obtain permission from the Thai authorities in order to travel further into Thailand. While I was there, two Thai soldiers strolled through the village to insure everything was in order.

One Karen man had lost his leg in a land mine and had been waiting two years to be granted permission to go to the Thai hospital. When I met him he was using tree branch to prop himself up as he walked. Eh Soe Gay informed me that he would be coming back with us. “The

Thai say he finally is allowed to go.”

When we arrived at the hospital in Hua Hin I immediately noticed the level of cleanliness. There were mangy stray dogs walking in the hallways and flies buzzing around the nurses stations. However, after two years of waiting, the doctors were able to get the man what he needed.



Nurses Station in Hua Hin Government Hospital.

I observed similar situations in the other Karen villages that I visited. Although these people were not IDP's, they were Karen and therefore they had very limited access to health care. “In Thailand the Karen are seen as less than human,” a Karen woman explains to me. “Sometimes we go to the clinic and they will see us and just make us sit there, without even helping. They don't know how long or expensive it was for us to get there.” In another Karen village, about two hours from Palau, an older woman dumped out a bag of packaged medications onto the bamboo floor. “Will you help me see what to do with these?” she asked me. Apparently

the European doctor, who comes once a year to the village, brought this for the Karen but did not explain what they are used for. The labels were printed in Thai so the best I could do was read the expiration dates.

Chapter 5.

Resettled Karen Communities

The Karen community in Sydney, Australia

There are about 900-1,000 Karen living in Sydney, Australia. Most of the Karen are Christian and there is a small group that are Buddhist and Animist. The Karen community that I spent six months getting to know, is only one of the four Karen Christian communities in New South Wales. This community is a tightly knit group of Karen that reside in South-West Sydney. Most of the Karen live in the suburbs Carramar, Yennora, and Lidcombe. These suburbs are safe and close to one another. The main mode of transportation is the train line, which stops at all of these suburbs and goes into the city. Therefore, it is fairly easy to use the train to travel to a health care facility. There are also two health care services right in Carramar. S.T.A.R.T.T.S (The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors) and FLYHT (A health care center for youth), which are both used by this Karen community quite frequently. Several members of this Karen community work at both of these places and act as liaisons, connecting the services with the Karen community.

The main meeting place for this Karen community is at the Lidcombe-Berela Church. The meetings for various groups including the Karen Women's Group and the Karen Youth Group meet on Sundays and Fridays after church services. "Because the community is so small

we all know each other,” Daniel Zu tells me. The majority of the Karen are young adults and children who are all either in school or working. “Many of the Karen girls are studying at University to be nurses. This way they can go back to Burma to help their people.”

I found the Karen community in Australia by a series of odd coincidences. Lost in the heart of Sydney, I asked a woman where to find the closest bus stop. As we walked, she started telling me about her co-worker who had just come back from the Thai-Burma border, where he spent one month training Karen medics about drug and alcohol prevention. It was this man, Dr. Ken Curry, who put me in touch with Daniel Zu. “Hello? Daniel Zu” “Yes. Who is this?” “My name is Darcy Cherlin, I am a student from the United States, I would like to learn more about the Karen in Australia.” “Okay. Right now I am busy. I will call back in an hour.” He called back. “Darcy? Hello? Yes you will come to the youth group next week? You have my email? Email me and I will send you the address.”

I arrived at the location, late and sweaty, after getting off at the wrong train stop and having to walk several extra miles. There was Daniel Zu along with about twenty young Karen men and women. Mr. Daniel Zu is a leader in the Karen community and Project Officer at S.T.A.R.T.T.S. Over the next five months Daniel became my key informant and good friend, introducing and welcoming me into the community, interpreting when necessary, and providing me with useful contacts and information.

After the youth session Daniel invited me over his house to meet his wife and family. “We try to make it feel like home,” he said to me as he pointed at the bamboo rugs on the floor and KNU flags hanging from the ceiling. He introduced me to his wife Beh beh, his two sons and daughter Eh Soe Gay.

Upon my departing I was invited to a Sunday church service which was a four

long hours of prayers and hymns all in the Karen language. There were about two hundred Karen, both men and women standing on opposite sides of the church. Many of the women were holding infants. The Karen were wearing traditional Karen clothing which consists of handmade sarongs, shirts, and bags. The men's shirts are blue, white and red. If a woman is married or widowed she usually wears black and if she is not she wears white. In between the prayers the Christian Youth Group sang songs and hymns using, electric guitars, and a drum set, which produced this interesting Christian Pop sound. At the end of the service I was invited to join the Karen leaders for dinner. I sat at the table, as the guest and only female, surrounded by the Karen leaders, while the women served us food.



The Karen Christian Youth Group in Australia.

The Karen Community in Syracuse, New York

My experience meeting the Karen community in Syracuse was quite different than in

Australia. I met one Karen woman named Lulu Naw while volunteering at the refugee resettlement center at the Northside CYO in Syracuse. The refugee resettlement center provides services for the refugee population in Syracuse including, applying for jobs and registering for English language classes, locating translators, finding housing, and securing medical care. Special academic programs prepare refugee children to attend school.

Lulu Naw is a leader in the community and before she was diagnosed with cancer she worked as a medical interpreter. It was Lulu who introduced me to the Karen Buddhist community in Syracuse.

In Syracuse there are about 1,800 Karen. Within this population there are about 60 Buddhist families. Most of the Karen live on the North Side of the city. The Buddhist monastery is a large house located on the north side, which was purchased and turned into a monastery by the community members.

I was invited to the monastery to attend the annual “Karen festival of water.” Unlike in Australia, work and other activities took precedence to religious practice and community gatherings. One young woman explained, “Many of the males work in factories while the women stay at home and watch the children who are not old enough to attend school, so we don’t meet very often, it is so nice to have everyone together today.”

When I arrived at the monastery, I was welcomed by a man named Coco , a medical interpreter at St. Joseph's Westside Health Center, Syracuse Community Health Center and the University Health Care Center. The inside of house was decorated with balloons and small Democratic Karen Buddhist national flags. This was an interesting contrast to the KNU flags that had been in Daniel Zu’s house and I wondered how the two communities would have gotten along. The kitchen was filled with Karen women preparing many different traditional Karen

dishes that I had eaten in both Thailand and Australia.

The larger room had a golden Buddha in the center. Both men and women were bowing in front of and bathing the Buddha. As they did this their children held onto their clothing to symbolize how their parents support them. There were three monks sitting at the front of the room, being served food by the Karen women. I noticed the older Karen and small children were dressed in traditional clothing, Karen shirts and sarongs, however the teenagers and young adults were wearing Americanized clothing. Coco introduced me to a young woman who was thirteen when she came to Syracuse with her mother and father. She now goes to school at OCC and is studying to be a counselor for her people. "I want to help them find jobs because they do not know English and life here is very hard for them," she says. She told me that all of the children are learning English in school but a lot of the adults do not know English. "Even though there is a school where they can learn, they are very busy working or taking care of the children, they cannot go."



A Karen woman participating in the Buddhist ceremony in Syracuse, New York.

Chapter. 6

Tham Hin Refugee Camp

Dear Darcy,

I only got to visit Tham Hin for a day because I didn't have much time but I got to meet my cousin and her children which was good. Tham Hin seems to have change quiet a bit, It's a lot more crowded then it used to be and I didn't really know anyone a part from family, there was new faces everywhere. I visited the school for a bit and I talked to one of the teacher at junior college and found out that one of my old classmate is now a high school teachers which I think is quiet exciting and interesting. A lot have change with the school, I think it's great that they have access to learning and using computer now because we didn't have computers back in the days but it's also quiet sad to hear that they're short of teachers now which isn't a good thing for the students. Over all I think it was good to go back there and see what the current situation is like in the camp, I enjoyed it. How was Tham Hin? What was it like for you?

Kindly,

Eh Soe Gay

“When I tell you, you need to lean back okay?” Joanna explained to me from the front seat. Eh Soe Gay and the group continued up north while I traveled further south to visit the Tham Hin Refugee Camp. I stayed with a Karen family and a woman named Joanna, a minister from Minnesota and friend of the Karen in Palau. Joanna taught English in the Tham Hin Camp and agreed to take me in with her. It was not until we were on our way to the camp that she

informed me that I had not been granted permission to enter.

Along the way we picked up two Karen men, one who interpreted for her and the other who was going into the camp to give his cousins some money. "Hin means stone," Joanna said as she drove over the rock filled dirt road. We drove for about an hour, on a dirt road, surrounded by beautiful mountains and rivers, until we finally reached the entrance to the camp. "Okay, now I need you to lean back." The car stopped and I pressed my body hard into the seat. Joanna opened the car door and walked up to the Thai guard hold a book in one hand and a gun in his side pocket. I held my breath. I noticed her hands shaking as signed her name in the book. I wondered what would happen if we were caught. The guard waved her on. "We did it," she exhaled, as we drove past.

Still fearful of being caught I walked closely to Joanna as we walked through the camp. "It's okay, the guards rarely come in here." The camp was small and compact. The bamboo house were stacked next to each other other and you see the heat coming off of the black tarps roofs.

The school that Joanna taught at was a large cement building. Her class had about fifty students. Before she started, the students stood up and in unison they greeted her in English. "Good morning teacher." While class was in session two students took turns walking to the windows, coughing every few minutes and spitting up something from their lungs. Joanna taught a lesson on descriptive words and then asked the students to split up into pairs and use the words they had just learned to describe their partners. Luckily there was an odd number and I got to participate.

"My partner has a heart shaped face with freckles that cover her cheeks and nose. She has light

brown eyes that compliment her dark brown hair that she wears tied back. When she laughs she has a big beautiful smile.”



Students in the Tham Hin Camp.

At the end of the class I stood in front of the students and asked them to tell me what life is like in the camp. One young woman raised her hand and in English said, "in the morning we go down to the river to get the water and bring it back up. Then we eat breakfast, go to school. Then we have a break, go back to school and play football, eat, read and then go to sleep." Then I asked what people get sick from here and where do you go when you are sick? They explained that most people get sick from respiratory infections, malaria, urinary track infections, stomach cancer and hepatitis.

After class Joanna took me to see the health clinic, which was a one-room building. There were patients lying on the ground in different areas of the room. I tried to enter the room where the medication was kept but a man appeared told us that we had to leave the clinic.

During my discussions with the Karen women in Syracuse and Australia I asked them to share their experiences with the clinics and health care in the refugee camps:

"I never go to the clinic because every time I go I want to vomit or something... it's not clean"

"If we get sick we go to the clinic, to the medic. There was one doctor from France that trained the medics for 14 months. The clinic is only open from nine to two. There are only four or five medics and two hundred patients a day. You have to wait a very long time."

"They check you for malaria and then give you medicine and in a few days you stop taking it because you feel better."

"When I was sick in the refugee camp I had a fever. I went to the opt (out patient department) and nurse take my blood pressure, medic come, give medication and in two days it was better."

"The houses are very close together, so infections spread and disease. Also we only have maybe three clothing, not enough changing, not enough soap and the water is not sanitary."

"Also because of the men or culture underwear had to be kept hidden so they could not dry, they need wind and sun".

"And when you pee in the camp, you are very close to the ground. I said you have to try to stand or the dirt gets in everything".

Chapter 7.
Results and Discussion of Focus Groups

Table 1. Challenges faced by Karen women in Australia and Syracuse

<u>Challenges</u>	<u>Focus Group in Australia</u> (Karen women ages 18-21)	<u>Focus Group In Syracuse</u> (Karen women ages 31-61)
Knowledge of Available Services	-Only aware of services connected to the Karen community	- Only aware of services affiliated with the refugee resettlement center
Culture	- It is “not normal” to discuss sexual and reproductive health topics in the Karen culture, therefore the women are resistant to seek out certain services	-Lack of preventative care - Tend to not ask questions out of respect for doctors

Table 1. Continued.

<u>Challenges</u>	<u>Focus Group in Australia</u> (Karen women ages 18-21)	<u>Focus Group In Syracuse</u> (Karen women ages 31-61)
Gender/ Nationality of Service Providers	<ul style="list-style-type: none"> -Participants expressed that they felt more comfortable seeing a general practitioner or service provider that was female -Participants preferred an English or American health care professional over the Burmese general practitioner 	
Interpreter		<ul style="list-style-type: none"> -Interpreters speak different forms of Karen - Interpreters are not familiar with the United States health care system -Interpreters are not familiar with medical terms
Language	<ul style="list-style-type: none"> - There are medical terms in the English language that cannot be translated into Karen 	<ul style="list-style-type: none"> -There are medical terms in the English language that cannot be translated into Karen -Making appointments -Filling out initial paperwork -Communicating with health care professionals
Transportation		<ul style="list-style-type: none"> - Many participants did not drive and therefore had to rely on friends or foot, which made accessing services difficult especially in the winter

Focus Group with Karen women in Syracuse, New York

In both Syracuse, New York and Sydney, Australia I conducted focus groups with two groups of Karen women. In these discussions we discussed: How do you access healthcare? What do you do when you are sick? Where do you go when you are sick? Who do you call?² The two focus groups were recorded, transcribed and then analyzed to identify the major challenges that these women face accessing health care. In both communities, I met with a large group of Karen women. During these initial meetings I explained the intent of the project, any possible risks and asked for volunteers. All participants were asked to sign an informed consent form.

Two focus groups were conducted in Syracuse, New York. The discussions were held at the refugee resettlement center at the northside CYO in Syracuse. Overall there were nineteen participants. The first focus group consisted of nineteen Karen women and the second group had six women. The women's ages ranged from 34 to 65 years old. All of the women had come from the refugee camps in Thailand and had lived there for 10-20 years of their life. The women have been living in the United States for five to eight years. These women requested to have Lulu Naw interpret during the discussions. The discussions went as follows: I would ask a question, Lulu would translate the question in Karen and the women would discuss the question among themselves. Lulu would repeat the discussion back to me in English and I would ask for clarification or ask the women to elaborate based on their responses. Two women only spoke Burmese so Lulu had to interpret in both Karen and Burmese. All of the women were married or widows with children and they all lived on the North side, near CYO. Most of the participants practice Buddhism or Animism.

² The full discussion questions can be found in the appendix

A number of challenges were identified during the focus groups that influence how the Karen women access health care in Syracuse. These included knowledge of available services, language/communication, transportation and culture.

Language

The major challenge identified in the focus groups was language, which acts as a barrier at many different levels in the health care system, including making appointments, completing paperwork, communicating with health care professionals and understanding treatment/medication prescriptions.

When initially making an appointment the women explained that calling on the phone is extremely complicated and therefore it is easier to make appointments in person. One woman shared her experience calling to make an appointment over the phone:

"Want to make an appointment call on the phone but it is very confusing push 1, 2, 3... so I just go in person or don't go."

The participants explained that even when they do make appointments in person it is often unclear when those appointments are they end up missing the appointment.

The participants also expressed their challenges initially checking-in at various health facilities prior to meeting with a doctor. First, they are handed paper work that they are unable to

read or fill out. Then a nurse comes and asks them questions in English, which they are unable to answer. One participant described her interactions with the nurse when she arrived at the hospital:

“Nurse comes and asks questions, what medicine did you take? How long have you been feeling sick? What happened? Family history, fill out this paper. I don't know how to say or write any of this so I just sign my name.”

Finally language became an issue when receiving instructions from pharmacists regarding prescriptions and re-filling prescriptions. The women explained that there is no interpreter at the pharmacist so they are unable to understand the instructions explained when they pick up their medication. Most of them said they ask their friends or children to read the instructions for them.

The participants explained that the difficulties with language often resulted in miscommunication which led to missed appointments, mis-diagnosis and in some cases discouragement to seek further help.

Interpreters

Another challenge is using interpreters when communicating with health care professionals. The women identified three major problems with the interpreters. 1) the interpreter is not familiar with medical terms 2) the patient and interpreter speak different Karen

dialects 3) the interpreters are not familiar with the health care system in the United States.

Although the interpreters speak Karen, they are not necessarily familiar with the medical terms in English and are also unaware how to translate them into Karen. This often leads to a tense situation where the interpreter will get frustrated with the patient. The participants explained that they will not go to certain health facilities because they do not like the interpreter that works there. One woman shared her experience with the interpreter:

"Sometimes the interpreter not fair to the patient, the doctor asked about insurances and the interpreter explained but I didn't understand so I asked her to repeat but the interpreter got angry."

Another problem is the patient and the interpreters speak different forms of the Karen language. The Karen language has two major dialects Pwo and Sgaw and there are many differences in those dialects based on geographical locations. Also, those that lived near the cities in Burma speak differently than those that lived in rural areas.

The third issue that the women expressed, the interpreters are foreigners themselves and therefore are not familiar with the health care systems in the United States. This makes it difficult when the women ask questions about health insurance, seeing specialists and payments.

Issues with the interpreters lead to miscommunication, having to travel farther distances to seek out services with different interpreters or not utilizing services at all because of the interpreters.

I had the opportunity to interview a Karen interpreter. He also shared that the many Karen dialects makes it difficult for the patient and interpreter to understand one another. He also explained that there are certain medical terms in the English language that the Karen language does not have words for. Because of this, it takes him a lot longer to explain what the doctor is saying in a way the patient can understand. Finally, he shared that because the Karen are a minority group in Burma, many of them did not receive any institutional education. This also adds to the difficulties trying to explain the doctor's diagnosis and instructions to the patients.

Culture

Another challenge that was identified in the focus group was culture. There seemed to be little practice of preventative care among the Karen such as annual check-ups. A common theme among the women's stories was that they only sought care when conditions were severe, often calling 911 or checking themselves into the emergency room.

"When I was sick I call 911 and then someone came. Most of the time I walk to the emergency."

Culture also comes into play when the participants are communicating with health care professionals. The participants explained that they do not feel comfortable asking the doctor questions or describing symptoms because they do not want to be disrespectful. This meant that even if the women did not understand the doctor's instructions they would shake their heads and show that they understood rather than ask for clarification.

Lulu Naw brought a Karen patient who was feeling very dizzy, nauseous and feverish to the doctor. When the doctor asked the patient what was wrong the patient replied "Nothing."

When I asked Coco if he ever experienced this he said all of the time. "Before the doctor comes in, we are talking just us and the patient tells me everything, my head hurts, my back aches my knees. But then the doctor comes in and asks what wrong and the patient only says my head."

Transportation

Another challenge that the participants expressed was transportation. The first year that they arrive Bob's School, an organization through the Syracuse City School District, provides them with transportation. After one year, they have to find transportation on their own. Most of the women do not drive and therefore have to ask their friends for rides or walk. Walking becomes at night or anytime during Syracuse's harsh winters. Because of this challenge, participants may not be able to make or attend their appointments.

Awareness of Services

The final challenge identified in the focus group was awareness of services. The participants only seemed to know the services that were available to them through Catholic Charities. The women were all aware of the clinics and hospitals that they could attend in Syracuse. However,

this became an issue when we started discussing sexual and reproductive health care services, specifically family planning. The participants started talking very quietly and explained that they are aware that there are those services but they do not know what or where they are because Catholic Charities does not allow them to speak about it.

Limitations of Focus Group

The first focus group had nineteen participants and was too large. This made it impossible to get through all of the questions and not every participant was able to speak about each topic or question if they wanted. Also, using an interpreter made it difficult to facilitate the discussion and I was unsure what the women were talking about sometimes because there was some things discussed that Lulu did translate back to English. Next time it would be useful to have smaller focus groups as well as go over facilitation methods with the interpreter prior to the discussion. Finally, there is a need to organize more focus groups, in smaller groups in order to be able to discuss all of the topics and for everyone to have the opportunity to share their responses.

Focus Group with Karen women in South-West Sydney Australia

One focus group was conducted in South-West Sydney Australia. There were three participants between the ages of 18-21. The focus groups took place at one of the participant's house in Carramar All three participants were Karen and came from the Tham Hin Refugee Camp where they lived for 8-10 years. The women have been living in Australia for 4- 6 years. Two of the participants are studying nursing and one of them is studying business. The women

were all Christian and belonged to the Lidcombe-Berela Baptist Church. The focus group was conducted in English. In this focus group we were able to discuss challenges women face accessing health care as well as challenges they face accessing sexual and reproductive health care.

A number of themes resulted from the discussions in respect to access to health care and sexual and reproductive health care. These included language/communication, interpreters, awareness of services, gender/nationality of health care professionals and culture.

Language

Language was a challenge when communicating about sexual and reproductive health care issues with doctors. The participants all expressed that it is challenging to talk about sexual and reproductive health topics in Karen because there are many English terms that cannot be translated in Karen. Therefore, the participants expressed that they prefer to speak in English about these issues.

"There's not a lot of words for in Karen that can describe all you know you can talk about sexual health. Because if you talk about sexual health in the Karen language there's not much of professional words that you can use, I prefer talking in English about it. "

However, these women were fairly proficient in English. This raised the question, how do those who are not comfortable speaking English seek out sexual and reproductive health services? The women explained that they are often asked to go with their family members or

parents friends to act as interpreters. This sometimes can be very uncomfortable for both the interpreter and the patient, especially when talking about SRH.

Culture

Another challenge identified in this focus group was culture. The participants explained that in the Karen culture it is not common to discuss sex or topics regarding sexual and reproductive health care. Therefore, the participants said they do not feel comfortable speaking to family members or a service providers about these issues related to SRH. The women discussed how it would be uncomfortable talking about sexual and reproductive health topics with their parents and members of their community except for their close friends. When asked who they would talk to if they had a problem related to SRH, they said that sometimes you can't even trust your close friends. All three of the women said they have learned about some things in school and the rest of their questions they look up on the internet.

Awareness of Services

The only services that the women were aware of were those that had Karen people working at them. When asked how they find out about the services available the women mentioned that members from the Karen community work in both S.T.A.R.T.T.S and Auburn Diversity Services. They notify the Karen community about certain events and talks that are going on. The Karen community in Sydney is a tightly knit community that is centered and affiliated with the Lidcombe-Berala Baptist Church. Being involved with the church and

community seems to be crucial in terms of accessing information and services. This limits the services that the Karen are aware of and creates problems for Karen people that have to move away from the church or community or Karen that are not Christian.

Nationality/ Ethnicity/ Gender of Physicians

The women discussed how nationality/ ethnicity of the general practitioner greatly affects whether they feel comfortable seeking SRH information or services from doctors. They said they would trust an English doctor more than a Burmese doctor. Even though the Burmese doctors are supposed to keep information confidential the Karen women feel that you cannot trust any Karen/Burmese people to keep information private. One women explains:

"...if I want to ask about that stuff I think it's better for me personally like I would just go see an English doctor because they would be confidential. I think English people are more confidential. They keep some privacy. I trust them more if they are English I am not sure with Burmese because of their culture I'm like I'm not sure if he will go and tell someone or something I don't know."

Also, it is not normal to discuss sex or issues concerned with sexual and reproductive health care in the Karen culture so the participants would be more comfortable speaking with a non- Burmese doctor. The participants also felt non-Burmese doctors were more professional and that makes them feel more comfortable and secure. Finally, the participants explained that they would prefer a female doctor when discussing these issues. One women spoke:

"when it comes to health and sharing our problems tend to like to talk to female more so it's more like understanding if we talk to a female doctor it's more safer that way. When it comes to privacy stuff we like to talk to females."

Limitations

Because there was only one focus group, the information collected can only be used as an initial starting point. Ideally, more focus groups should be conducted with a larger and more diverse group of participants. Two of the women were sisters and all three of the women had known each other for most of their lives. Therefore, they might not feel comfortable sharing certain information, especially when discussing sexual and reproductive health topics. Finally, although the women requested to have the focus group in English, one of the women was not as comfortable speaking English as the other two and therefore did not respond as frequently.

Chapter 8.

Closing Remarks: Limitations, Future Research Questions and Continued Works

By engaging with the Karen refugee communities in Syracuse, Sydney and Thailand, I was able to contextualize the challenges that were identified in the group discussions with the Karen women and also identify that these challenges are not homogenous among all Karen refugee populations.

In Syracuse, difficulties with language often resulted in miscommunication which led to missed appointments, mis-diagnosis and in some cases discouragement to seek further help.

Language was also an issue in Australia and often led to the women preferring to speak English if that was an option. Because there are some medical terms that cannot be translated into Karen, even speaking English led to miscommunication and misunderstanding.

Issues with the interpreters also led to miscommunication, Karen women having to travel farther distances to seek out services with different interpreters or not utilizing services at all.

Aspects of the Karen culture in the Syracuse community prevented the women from asking doctors questions or practicing preventative health care. In Australia the women identified that it was not part of the Karen culture to talk about sexual and reproductive topics. This discouraged the women from seeking out sexual and reproductive services, instead the women used the internet for answers to their questions and concerns.

When I asked the women in Australia if they were uncomfortable talking to interpreters and doctors about sexual and reproductive topics they all laughed. One woman said:

"The women in Australia must be very old..."

I found this humorous because the women in Australia were a lot younger. Although there are too many variables to identify why there are these differences in cultural views, based on what I know about both communities I think this difference is probably influenced by the difference in age, the closely-knit community and influence of the Christian dogma. The younger women may not feel comfortable discussing topics around sexual health because they have not had a lot of experiences with these issues, whereas the older women in Syracuse have all been sexually active and have given birth. Also, the community in Australia is very closely knit, most of the members go to see the same Burmese doctor. The women voiced that they were worried about their privacy. The importance of privacy is crucial when discussing these topics because in

this community pre-marital sex is not allowed. If you have sex before marriage you are considered married in the Karen culture. Therefore, the women seemed hesitant to even discuss these topics because of how strict this rule was.

Transportation was a challenge in Syracuse for the women accessing health care. Most of the women do not drive, normally the women would have no problem walking, because walking was their mode of exercise in Burma, however in the winter it is very difficult. Also, in Burma because all the Karen lived near each other, it was easy to drop the kids off at a neighbor's house and ask a friend to drive you to a clinic. Now, everyone is separated and busy with work. Therefore participants are often unable to make or attend their appointments.

Awareness of services was also identified as a challenge when accessing health care. In both communities the participants only knew of services that were connected to the Karen or refugee community in some way. This limits the care that the participants have access to. This also becomes a problem for Karen that are not as closely connected with community.

Finally, nationality and gender of the health care providers caused hesitation among the women in Australia to seek out services. The women preferred to have an English female doctor when discussing sexual and reproductive health care issues. Because the participants all went to the Burmese doctor they were reluctant to ask for information regarding family planning, or sex.

Because of the variety of challenges found among the two refugee communities, it is crucial that the discussion include the needs of individual people as well as individual communities when beginning to think about implementing policies to improve health care services for refugee populations.

Limitations and Future Research:

Due to time constraints only two focus groups were conducted in Syracuse with nineteen participants in Syracuse and one focus group with three participants in Sydney. There is a need to conduct more focus groups with more Karen woman in order to begin thinking about how to reduce these challenges.

It was also intended to conduct interviews with health care providers to see what challenges they observe the Karen experiencing, as well as what challenges they face themselves, providing care to Karen populations. Unfortunately, due to time constraints, this portion of the project was unable to be completed. Therefore, future research should include investigating the challenges health care providers face providing care to Karen refugee communities.

Finally, I noticed a considerable difference between livelihood of the Karen living in Australia and the Karen living in Syracuse. It would be interesting to compare the Australian and United States health care systems by asking questions like: what kind of health care services does each country provide for refugees? Answers to these questions, combined with the personal experiences of individuals on a local level, would be very useful for policy makers trying to improve health care services for refugees on a national level.

Other Identified Needs:

During one of the focus groups in Syracuse one women suggested that it would be useful to have doctors and health care providers come into the refugee center and talk about preventative care, where to access certain services, and how to fill out medical paperwork. The

women also made a list of topics they wanted to learn more about. This included Kidney disease, Hepatitis, stomach ulcers and depression.

So far I have organized two sessions where doctors and counselors have come to the refugee center to discuss kidney function and depression. However, there is a real need for more health education based programming.

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Appendix

Focus Group Discussion questions / prompts

1. Introductions:

- Name
- Age
- What you do/ hope to do?

2. When did you arrive in the United States/ Australia? When did you come to Syracuse/ Sydney?

3. What do you normally do when you are feeling sick?

- Who do you talk to about it / seek advice from?
- Do you ever see a doctor/ general practitioner?
- How did you find your doctor/health provider?
 - What have your experiences been like?
 - Were you satisfied with the way you were treated and the diagnosis you were provided with?
 - Who else do you talk to about health problems?

4. What do you think it means to be healthy? What is most important to you, as a young woman in terms of your health?

This project is focused on talking with young women and understanding their experiences. For all of us, sexual and reproductive health issues, as we grow up, are important and at times challenging. We'd like to focus some attention on these issues now. Is that OK?

5. What do you consider to be part of sexual and reproductive health?

- *Puberty / body changes*
- *Menstruation*
- *Dating*
- *Vaginal Infections*
- *Pregnancy*
- *Contraception*

6. How have you found out about issues related to SRH in the past? (like relationships, sex and contraception)

- Have your parents discussed these issues with you?
- Do you receive information at school? What issues/topics?
- Did you discuss these topics in school?

- Was there anything that stuck out to you? -Practices/ topics that seemed strange or unfamiliar?
- Do you discuss some of these topics at church? In what way/context?
- Do you discuss these issues with your friends (and which kinds of friends), boyfriends?
- Has the media played any role (TV, radio, internet, magazines)?
- **Has your experience with these topics been different since coming to the United States?**
 - Was it easier to discuss/ learn about them back home or in the refugee camps? Has the person you go to changed?

7. Do you find it easy speaking to people about these issues (parents, friends, relatives, service providers)?

8. Is sexual and reproductive health something that is discussed in your community / are people comfortable talking about it?

- **Does religion (or other issues) impact this (and how)?**

9. Do you feel reasonably well informed about sexual and reproductive health? Are there gaps / things you'd like to know more about?

10. Who would you speak to / where would you go if you had questions concerning issues like family planning (contraception, pregnancy), or avoiding sexual infections and HIV, or other related issues?

Or if you see your general practitioner:

- Are you comfortable going to them for issues like this?
- Can you share with us some of your feelings and experiences?

11. Do you currently know of, and/or have access to, any services that you could go to when you have questions or problems with your sexual and reproductive health?

12. How have you found out about these services?

- Can you share with us some of your feelings and experiences around finding and accessing services? Are there any difficulties or challenges?
- Would you be comfortable going to a service like this? Or are you more comfortable going to a general practitioner?
- Have you had any personal experiences with any of these types of [SRH] services?
- Were there things that were good or done well (examples)?
- Have you had experiences that were less positive (examples)?
- What are your general impressions of services – accessible? Suitable for young people? Appropriate?

- What do you expect from SRH services? What are the most important aspects of a SRH service for young people? How could they be improved? How could they be better promoted/advertised?

Some prompts:

- Where would you go if you found out you were accidentally pregnant?
- What would you do if you thought you were losing your baby/having a miscarriage?
- If you were going to visit a doctor/ service, who would you take with you?

13. Do you feel services are sensitive to your experiences as a migrant, and in many cases, as a refugee from Burma?

If not, what else could be done to make these services more appropriate and sensitive – can you name some things you’d like to see improved?

Respectful of culture, aware of cultural differences, language differences, gender, cost of service, confidentiality, trust, location of service, access to service (close by/ near public transport/ parking available), understanding of diagnosis.

14. How are the services different here than those you experienced back home?

- What were some of the challenges then and how do the services available now differ from those [in your country of origin or refugee camps?]

15. Do you have any additional comments, concerns, feedback or suggestions? Anything you think we should explore in more detail?