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Marielena White
Butler University

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Undergraduate Student Paper

Cultural Definitions of Health Care: A Case Study of Burmese Refugees in Indianapolis

MARIELENA WHITE
Butler University

ABSTRACT

As a result of ongoing civil war and civil unrest in the Southeast Asian country of Myanmar, every year, the United States accepts increasing numbers of refugees from Burma, of which there is a population of significance within the greater Indianapolis area. When considering options for health care, Burmese refugees may opt for self care instead of care from a health care professional as a result of clashing cultural factors or fears of the unknown.

This study aims to uncover how members of the Chin ethnic group have been challenged or confronted by the social, cultural, and political institutions surrounding the United States health care system. What meanings and values have these groups assigned to their traditional health care practices? How have these practices been modified as a result of influence by the US health care model or through sociocultural experiences while living within the United States? What meanings have these refugees attached to their cultural beliefs about health care in contrast with the expectations found through the utilization of the US model of health care?

It is important to understand the meanings and values that Chin refugees place on home remedies and traditional practices of medicines and how these meanings and values have come into contact with the American system. Uncovering the qualitative values of experiences had by members of this population will produce a basis for future study and an impetus for improved health care services.

KEY WORDS Burmese Refugees; Cross-Cultural Healthcare

In 1980, the United States government passed the Refugee Act, which created the Federal Refugee Resettlement Program. The Office of Refugee Resettlement states that this program serves to aid in the “effective resettlement of refugees and to assist them to

achieve economic self-sufficiency as quickly as possible after arrival in the United States.” Within the parameters of this policy, states receiving refugees for resettlement are required to use allocated funding to provide refugees with initial medical screening and medical treatment, which is an important element in determining which refugees have “medical conditions requiring, or medical histories indicating a need for, treatment or observation and such monitoring of such treatment and observation as may be necessary” (U.S. Department of Health and Human Services 1999:1). Under the policy guidelines, refugees are supposed to become economically self-sufficient as swiftly as possible so as to not place strains on welfare costs or on the communities in which they are placed. For this goal to be achieved, the health of refugees and the general knowledge and understanding of the US health care system by refugees is imperative.

Refugees are of increasing importance and value to communities, cities, and the United States as a whole. As discussed by Haines and Rosenblum (2010:392), “Refugees have been in a unique position to discredit authoritarian regimes, to glorify core American political values (e.g. freedom) and economic practices (capitalism), and to demonstrate American decency in humanitarian relief.” They are, if nothing else, symbolic of the ideologies which the United States is founded upon and help to reinforce those values by their very presence. As Haines and Rosenblum further postulate in their study, refugees must be given particular attention, as they are “not only survivors of some of the most wrenching events of the modern world, but when resettled in America, are also at the locus of American structures and reconsiderations of race, ethnicity, class, immigration, economics, politics, religion, and society” (p. 392).

The current resettled refugee population of Southeast Asians from Laos, Cambodia, Burma, and Vietnam continues to grow each year within various cities of the United States. These populations of people come as unskilled laborers and receive aid from the federal government paid by US taxpayers. To reduce dependency on federal and state funding, it is important these refugees and asylum seekers receive health care that will allow them to prevent illnesses, stay healthy, and stay in work. Unfortunately, as Marjorie Muecke (1983) explains, hospitals and other venues of health care are “one of the few culturally sanctioned sources of institutional support for [refugees]. . . . Many adult refugees can be expected to seek care and attention on a long-term basis from health providers” (p. 437). When refugees do seek medical care but receive less than sufficient care due to barriers in language and/or cultural competence, the health care system is ultimately marginalizing a portion of its patient base. If the health care providers are not prepared or educated on how best to provide services to these persons, health concerns can go ignored, misunderstood, and untreated. This does not aid in assuring refugees that the host country is a place where they can feel welcome or at home. Rather than entering the United States and gaining a sense of security, refugees can be left feeling even more nervous, confused, or stressed.

It has been in the best interest of the US health care system and the population as a whole to consider that refugees are more likely to carry diseases that are not common in the United States, such as tuberculosis, malaria, smallpox, and leprosy (Muecke 1983). Refugee populations, in general, suffer higher levels of morbidity, or illness that can be

related to “infectious diseases and physical and emotional trauma resulting from torture, poor nutrition, and histories of limited health care” (Meyers et al. 1989). As a result, the Department of Health and Human Services now requires refugees to receive an initial health screening during their resettlement period to prevent these illnesses from spreading.

The prevalence of illness is only further aggravated by the refugees’ lack of financial security, by language barriers, and by their legal status as refugees. Refugees see themselves as the “other,” or as outsiders to an alien society, leading them to avoid utilizing the host country’s or host society’s major institutions. “Cambodian refugees have a far greater mental health burden compared with other US-born and immigrant Asian Americans” (Marshall et al. 2006:1835), but seeking some form of care is rarely practiced because of distrust, lack of resources, or merely a fear of stigmatization related to being sick. When considering options for health care, Southeast Asian refugees may opt for self-care instead of care from a health care professional as a result of clashing cultural factors: their attitudes toward suffering, their conceptions of illness, a distrust of Western medicine, unfamiliarity of medical methods, cultural ignorance on the part of providers, lack of bilingual staff, inaccessibility of services, and a limited means of finances (Smith 2003; Uba 1992).

This study aims to uncover how members of the Chin ethnic group have been challenged or confronted by the social, cultural, and political institutions surrounding the US health care system. It also aims to answer several questions: What meanings and values have these groups assigned to their traditional health care practices? How have these practices been modified or altered as a result of influence by the US health care model or through sociocultural experiences while living within the United States? What meanings have this group of refugees attached to their previous beliefs about health care in contrast with the expectations encountered through the utilization of the US model of health care?

Refugees are not voluntary migrants, and as such, they do not come to the United States under circumstances of the past (for better opportunities). They come as a result of political abuses and terror and ultimately have become victims of treatment that would warrant their countries of origin as unlivable and dangerous. For that purpose, they may not be as eager as other immigrant groups to accept, participate, or integrate into mainstream culture but rather may hold on more tightly to the only parts of home they have left—their cultures and traditions.

When it is believed that cultural traditions and beliefs of other groups of Southeast Asians, such as the Vietnamese, pose a barrier to Western-style medicine (Jenkins et al. 1996:1050), it is important to understand the ideographic underpinnings of a group of similar geographic origin who have also come to occupy US cities: the Chin ethnic group of Burma/Myanmar. Traditional health care can be practiced not merely out of habit but also out of comfort and a belief in the effectiveness of the practices. Often, US hospitals are underequipped to handle patients struggling with “a layer of premigration stresses such as loss of country, home, family, friends, and a way of life and

severe forms of physical and emotional trauma” (Dhooper 2003:65). It is important to understand the meanings and values that Chin refugees place on home remedies or traditional practices of medicine and health care in general, as these meanings and values have come into contact with the American system, which seems to be devoid of culture but resplendent with prescriptions, expensive surgeries, and precious few moments spent with actual doctors.

LITERATURE REVIEW

Within the city of Indianapolis, there is a growing population of refugees from the Southeast Asian country of Myanmar, which is recognized by its inhabitants as Burma. Despite this influx of refugees not only in Indianapolis but in the United States in general, “they remain one of the most under-studied groups, with relatively few studies of their health status and service use compared to other minority groups” (Ngo-Metzger, Legadza, and Phillips 2010:111). The World Health Organization (WHO) in its ranking of health statuses for individual countries lists Burma/Myanmar as second to last, 190th of 191 countries—not surprising, considering the birthrate of 20/1000 and the relatively low number of biomedical physicians in the country (*Encyclopedia of Medical Anthropology*). This suggests that the population entering the United States has relatively low experience or interaction with the style of health care used in the United States, which depends on biomedical physicians, specialists, prescriptions, immunizations, and the like.

Without exposure to this particular system of health care, refugees from Burma entering the United States are with little faculty to maneuver themselves through their host country’s health care system. This places a significant strain on the communities in which they live, especially considering that employment relates directly to one’s ability to work. When “refugees are also a metaphorical connection to the essence of the immigrant experience in America” (Haines and Rosenblum 2010:400), their relative success through the attainment of self-sufficiency is of significant importance. Coming to a comprehensive understanding of the refugee experience can be a useful tool in accelerating the process of self-sufficiency, especially when “the multiple positionalities and identities of refugee communities often place them in opposition with the sociocultural context of their adopted country” (Hickey 2005:25). Leaving one’s country with a vastly different culture from the host country can lead to what any traveler can be expected to experience upon visiting or living in a new place: culture shock.

The populations of refugees from Burma, though, are not solely ethnically Burmese; rather, they represent distinct ethnic minorities from Myanmar. This study focuses on the experiences and perceptions of ethnically Chin people from the Chin State of Western Burma. The members of this group have been victims of what has been called Burmanization under the Four Cuts policy of the current regime in power (Falise 2010:57). This policy, aimed at creating one race, culture, and religion within Burma, has been ongoing since 1962 and has led to large-scale religious and cultural discrimination, human rights abuses, and ethnic cleansing. It includes but is not limited to militarization,

forced labor camps, prohibition of Chin languages (of which there are several) or literature to be taught in schools, violation of religious freedoms, and more (Sangtinuk 2006). These groups have been victim to a barring of basic rights, to which the international community has been giving increasing attention.

Historically, the geographical region of Myanmar/Burma has been a location of British colonialism. Hegemonic imperialism ultimately led Chin groups to be marginalized and brutally punished by the Burmese elite who came to power after the British left the colony post-World War II (Rajah 2002). This group had not been previously loyalists to the crown but had allowed British Christian missionaries to evangelize them to the point that today, more than 90 percent are Christian (Kung 2009:83). After World War II, the British proposed the introduction of Frontier Areas as a means of unifying the one-third of the inhabitants of Burma who were not ethnically Burmese (Kung 2009:86). Although the Chin people, as well as other minority groups, supported this policy, the Burmese elite and government leaders were vehemently against said policy and used it as part of the justification for the Four Cuts policy, which continues today. Because of the half century of political and social disarray and upheaval, Chin ethnic groups are said to be part of “the largest community of internally displaced people in Asia” (Cheesman 2002:208).

This flood of refugees has left surrounding countries to provide camps, basic health care, employment opportunities, food, and the like to a population which cannot support itself under current conditions. This incredible influx of refugees has led countries such as Thailand and Malaysia to threaten to close their borders to further asylum seekers (Fuentes 2010:23). As a result, various developed nations, including the United States, have accepted small percentages of displaced populations. With this admission of refugees or asylum seekers, the United States is expected to meet the needs of victims with varying degrees of mental and/or health care concerns and stressors, but also with varying degrees of differences with regards to their cultural behaviors and/or traditions.

A review of available literature shows very few studies on the health care-seeking behaviors or the health culture of Burmese refugees in the United States. This begs the question: How has the experience of Chin refugees been shaped by *their* cultural health care practices, contrary to the culture of Western-style health care practices? Have they felt that their needs have been met within the context of what is socially and culturally acceptable within their ethnic groups? “With the growing diversity of the US population, members of minority ‘racial’/ethnic groups have sought to eliminate the adverse effects of racism in the delivery of health care services” (Chin 2000:25). Unfortunately, health care providers may continue to offer inadequate services to refugees because of a lack of cultural understanding and a failure to look outside the context of Western-style medicine. Has this been the case for the focus group in this study? Have their experiences been defined by confusion, miscommunication, stress, or fear? Or, rather, have they been met with medical staff and practitioners with cultural aptitude and interpreters with the ability to communicate with them during appointments?

In a study by Lynn R. August and Barbara A. Gianola (1987), the authors found that war-induced refugees often suffer from post-traumatic stress disorder (PTSD), which can ultimately lead to complex health issues. One example explained:

A 32 year-old male was trained as a soldier and worked for the CIA during the Vietnam conflict. . . . After the first six months of his resettlement in the [US] . . . he began to suffer from sudden uncontrollable shaking of his limbs and from stinging pain in his muscles. . . . The authors are not aware of any services provided to this patient. (p. 824)

The influx of refugees introduces the possibility not only of unseen or untreated diseases but also of the entry of unstable refugees who suffer from mental health issues as a result of the high levels of trauma experienced within their countries of origin and refugee camps.

Often, those who work most closely with these refugees are English teachers, volunteers, or aid workers with little or no health or clinical experience, which creates a gap between health care providers and regular resettlement-assistance providers (August and Gianola 1987). If these refugees were met with health care providers and facilities with language and cultural competence, they would be more likely to trust their facilities and seek help if needed.

Health practices and concerns are important to understand for the population of Chin refugees occupying the city of Indianapolis. This is especially true when migrant populations are found to be less healthy than the rest of the population (Feldmann et al. 2006:29). Past research has found that Southeast Asian refugees, specifically from Vietnam, have been found to have frequent cases of parasitic infections, tuberculosis, malaria, hepatitis B, and diphtheria, among others (Morris et al. 2009:529; Young et al. 1987:761). With health care issues such as these, it is imperative that practitioners and other health care providers be prepared to communicate with refugees on language and cultural bases. This study poses the question: What have been the emerging health concerns of Chin groups, and how have these conditions been handled or treated by the refugees themselves or by health care providers?

It is important to understand how Chin refugees perceive health, medicine, and care in terms of their own culture but also to learn how that has clashed or coincided with the existing health care system. Another Southeast Asian refugee group, Hmong living in Kansas City, have been found to have modified their health care beliefs and practices from solely traditional Hmong culture and Chinese medicine to include a mixture of Christian-based and Western-style biomedicine. They have developed a mixture of seeking care from massage practitioners and herbalists, as was traditionally taught and acceptable, and using the services of biomedical physicians (Capps 1994). Over time, they have slowly developed a plurality of medical and health care-seeking behaviors that could also be prevalent in Chin groups.

The aforementioned study failed to look at the reasons *why* refugee groups create hybridizations of health care culture. This study will be asking that very question: What aspects of the US health care system are attractive or have led Chin refugees to adapt new cultural practices or beliefs? Other immigrant or refugee groups from similar geographic locations have been found to combine cultural beliefs with their health care-seeking behaviors. For example, in a study by Young et al. (1987), it was discovered that 39 percent of Vietnamese female refugees reported home deliveries and less than 14 percent sought assistance from a physician with child care issues (p. 771).

Because little is known about the help-seeking behaviors of this population of refugees, it would be important to take a closer look at understanding how they maintain their health and how they utilize the US health care system. In one recent study by Hlaing Min Swe and Michael W Ross (2010), exploratory research was conducted to understand refugees from Burma/Myanmar living in Houston, Texas. Researchers sought to understand the major issues or concerns faced by this particular ethnic group with respect to health-seeking behaviors and obstacles in receiving care. They found that refugees found it difficult to figure out where to go. One refugee explained, “We don’t know how to go . . . to the place [the clinic] we went to initially. It’s very far and I don’t know how to get there” (p. 20). Aside from this, refugees also faced difficulties finding clinics that provided bilingual services. Because this group comprises various ethnic factions all speaking distinct languages, often, only one of the two popular languages was offered where both were necessary. Although this study does explore the health care experience of Burmese refugees, it does not focus on how their cultural values or misunderstandings have defined these experiences.

Whether Burmese refugees in Indianapolis utilize the American health care system is not academically known, but previous “findings typically support a hypothesis that Asian Americans with mental health problems are less likely than their non-Asian counterparts to contact health service providers for assistance” (Marshall et al. 2006:1830). It would be interesting, then, to understand what cultural methods or practices are used to aid in coping with illnesses that can be attributed to mental strains, stressors, depression, or the like. In other words, how do aspects of culture affect the health care beliefs, practices, or experiences of Burmese refugees or asylum seekers? By understanding this, health care providers could optimize the services they provide patients. Generally speaking, health care providers, as participants in a for-profit industry, have come to recognize the economic value of catering services to varying ethnic populations (Chin 2000:26), and refugee groups should be included in this demographic.

Without proper care or integration, refugees can be left feeling they are outside or separate from the community in which they live. Isolation has been targeted as one of the leading causes for an increase in illnesses from psychological to biological standpoints (Burnett and Gebremikael 2005). Essentially, not feeling integrated within the dominant society can lead to a rejection of its institutions (e.g., health care system). This is only perpetuated by 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 (Morris et al. 2009). Even if refugees came to accept completely the

culture and system of US health care, they would still face marginalization due to their inability to gain access to care. What have been the specific obstacles when attempting to obtain care for those Chin refugees who seek it? What has been done by health care providers, refugee resettlement agencies, and Indianapolis policies as a whole to help these groups access care?

It is important to recognize to what extremes and over what length of time Chin refugees have modified or accepted new forms or methods of health care practices. What cultural or traditional Chin practices have been maintained? Practicing traditional or cultural medicinal methods directly correlates with what generational level a person is for mixed-ancestry Asian Americans. Those of first-generation mixed ancestry were much more likely to use Western-style biomedicine as a *secondary* option after use of their traditional cultural methods (Tashiro 2006). Thus, although it is important to understand the meanings that refugees attach to their traditional and cultural health care practices as well as the ways in which they have come to understand the US health care system through various experiences, it is also important to understand why they are statistically a group who are more likely to use methods of self-care over a doctor.

METHODOLOGY

For the intents and purposes of obtaining a comprehensive study of Chin health care definitions, experiences, behaviors, and challenges, interviewing was used to best understand the shared experiences or reasons for seeking or avoiding health care among study participants. Semi-structured, but in-depth, open-ended interview questions were used (see Appendix). Conducted interviews lasted from 35 to 50 minutes and covered several predetermined topics concerning traditional health practices, comparative experiences, access of care, cultural clashes or parallelism, and levels of trust within the American system.

This study included the participation of ten Chin refugees between the ages of 19 and 66 who lived on the Chin community on the south side of Indianapolis at the time of their interview and had been living in the United States from four months to nine years. This was to ensure that the group of interviewees would represent a variety of experiences from the vantage points of relative newcomers to seasoned residents. The interviewees were invited to participate in a research study on Chin health culture and perceptions of US health culture. Through use of snowball sampling, a Chin community member and church leader helped to make calls within the church directory to assemble a list of 10 potential interviewees. Interviews took place in the homes of the participants to ensure both privacy and a relaxed environment.

A series of three interpreters who speak Hakha Chin as a native tongue was utilized during each interview as a means of communicating with interviewees to translate questions and answers. Although many of the participants spoke some levels of English, the use of interpreters was to ensure that nothing was lost in translation and to ensure the comfort of the participants. All three of the interpreters had been living in the

United States for more than 10 years and had already or were currently pursuing university degrees in the city of Indianapolis.

Examples of the interview questions include “When people are sick or they do not feel good in Chin State, what do they do?” “What are some reasons why people get sick in Chin State?” “When they have to go to the doctors, how do they get there?” and “If he was not feeling well, how would he make an appointment with the doctor?” Although there are general topics to be discussed in this study, the research design has been reflexive in order to ensure authenticity of the social contexts being studied in the sample of Chin refugees. Allowing the participants to lead the questions in the directions they wished to discuss and share provided an inclusive and more wide-ranging understanding of exactly the concerns and themes they find most important or worth noting.

To be sure no information was lost during the interview process, interviews were recorded using a digital voice recorder and were afterward transcribed verbatim into a document for further study. All of the recordings, transcriptions, and documents were held confidential so as to protect the anonymity of the participants. Certain responses were coded as they related to the questions being asked. To best code the responses, and as can be seen from the previously stated example questions, the nature of the interview questions implies some of the coding categories. Other coding has been based on previous studies of refugee experiences, specifically the experiences that relate to Southeast Asian refugees, as very few directly discuss or focus on Burmese and none specifically relate to Chin refugees.

The results of this study are not able to be generalized to the experiences or perceptions of all refugees, Burmese refugees, or even Chin refugees living in Indianapolis. This study focuses on the particular individuals, their experiences within their country of origin and within the US health care system, and what events or issues have arisen that have deterred or prompted them to avoid or utilize the health care system in the United States. Through in-depth understanding of the sentiments and meanings that this group attaches to its health care experiences, practices, and behaviors, there can be a strong internal or causal validity to explain their behaviors both past and present.

It is important to also note that this is in no way a measure of the collective beliefs, traditions, and cultural experiences of all Southeast Asian refugees; nor will it speak on the collective experiences had with the US health care model of even the population of Burmese refugees. It merely attempts to understand the feelings of Chin refugees and the meanings they associate with health and how those meanings have clashed or coincided with their experiences with Western-style medicine. Anonymity of participants has been preserved and was ensured to them through use of translated consent forms prior to the interview process. It was imperative that their responses come out of trust and comfort. It was also ethically necessary to allow what they said in confidence to the interviewer to be kept anonymous as a means of aiding them in feeling protected from any possible negative consequences their responses could possibly have had with their respective resettlement agencies, status as refugees, or health care providers.

FINDINGS

The study focused on the health care perceptions, experiences, and habits of the refugees as they moved from their state of origin through their country of asylum (in all cases, Malaysia) and to their host country (the United States). Analysis of interviews with Chin refugees uncovered several patterns in the experiences of the participants. These include hybridization or plurality of their health care culture, trust in doctors and biomedicine, the desire to appear appreciative and accepting of the host country's health care culture (social desirability as a goal), prevalence of community-based support systems, and the desire to be viewed as healthy. These do not, however, reflect a generalization of the population of Chin refugees living in Indianapolis and should not be understood as such.

Hybridization to Adoption of Health Practices from Chin State to Malaysia

The results of this study have shown that several of the participants, while they make use of traditional forms of medicine in rural areas of Chin State, have also added biomedicine as part of the diversity of health care in their state and their culture. Their discussion strongly exemplifies the effect that a biomedicine-based health care system—or as one participant called it, “Western medicine”—has had in even what was described by participants as rural or undeveloped Chin State. This effect has resulted in the development of a hybridization of practices based on generations of tradition and practices introduced by Western-based biomedicine.

Throughout the interview process, a few different forms of traditional medicine or medicinal practices were uncovered. One participant spoke of *lung thi*, which is medicine collected from rock secretions found in mountain forests and used for its healing qualities. He described its purpose: “[We] get cut and stuff; [we] put that [*lung thi*] on, and they say it heals . . . when [we] get sick. [We] drink that and it actually—and [we] feel better.” The interpreter explained that *lung thi* contains some measure of iron in it, which makes it a medicine more widely used by women during pregnancy. He also explained that a Chin doctor living on the south side of Indianapolis distributes *lung thi* to pregnant women in the community. Another respondent spoke of the use of different honeys from caves and bees' nests which serve to help chest congestion. Both of these practices have been used based on perceived effectiveness and family or cultural traditions.

Several participants spoke of a process of finger binding and bloodletting, which were also common practices in areas of Europe and the United States as late as the eighteenth century. One man described the process:

When [we] get really high fever, there's a tradition where [we] wrap [our] hands really tight so all the bloods goes to the tip of fingers and they punch it with little needles to take out the bloods. . . . They wrap it around my fingers and then . . . all the blood goes to the tip of the fingers and then,

with the needle they just pop it and basically let all the blood drain out. They are basically draining all of the bad blood that is causing the illness to go away.

Another participant explained that the practice is used on adults, children, and infants and that many people are taught the practice by other relatives. One man explained that his wife had taught him the practice, while another woman explained that she had had the procedure performed on her within the past two years.

These practices, although traditional and valued, coexist with Western-style biomedical practices and medicine within Chin State. Respondents specified between the difference of Western biomedicine and the traditional health care practices taught to them by their family members. One woman explained that the probability of someone practicing one style of medicine over the other is dependent on one's region of origin:

In Chin State, we don't have those kinds of traditional medicines, but in rural areas like . . . in states other than Chin State, you would have a lot of traditional medicine like ginseng. They have a lot of medicine—traditional medicine, so some people would only depend on traditional medicine . . . and some people only depend on Western medicine.

When asked about the normative practices of sick persons in Chin State, most respondents stated they would buy medicine in a “pharmacy” or “drug shop” but that a prescription was not required. These medicines included cough medicine, headache medicine, and, as one woman specified, paracetamol, which is a Western medicine used for general aches and pains. These are similar to over-the-counter drugs bought by Americans in pharmacies in the United States.

Before entry into the United States, all of the participants in the study first sought refuge in Malaysia. The health care procedures were different in Malaysia based on their entry as refugees rather than citizens. Many of them explained they felt they had to abide by special regulations due to this status. One woman in the study compared a birthing experience had in Burma to one had in Malaysia:

So in Burma they can pick if they want to have their babies in their house if they want to and call a nurses, but in Malaysia . . . [I] was not allowed to do that. [We] had basically to have the babies in the hospital. That's just the regulations they have. The clinics that [we went] to are part of the refugee status. So they make [me] stay in the hospital. [I] wanted to stay in the hospital since there were doctors. [I] wanted to stay there.

While they were in Malaysia, one respondent explained, nongovernmental organizations (NGOs) covered most of the cost of medical care, and one usually had to pay only five

Malaysian ringgits, which, the respondent explained, is worth much less than five US dollars, making the visits and costs affordable to their families.

There seemed to be a consensus among participants that in Malaysia, people went to the hospital or to an NGO clinic when they were sick rather than taking care of themselves in their homes. This was to follow procedure or policy, but a few admitted it coincided with their personal preferences.

Social Desirability as a Goal

Although refugees shared opinions that were favorable toward Western or biomedicine when discussing their health care practices before entry into the United States, the participants were especially complimentary of the system within the United States. The refugees' use of compliments and positive descriptions of the doctors and health care system was placed directly prior to or immediately after they explained any difficulty had or confusion felt. One man explained, "The first thing is, we need to make appointment to see the doctor. It's difficult, but after that, it goes smoother and then the doctor or nurses—the people is kind." While they expressed that making appointments or getting to the doctor's was difficult in the United States, they complemented their arguments with appreciation of the services and treatment given them by their doctors and nurses.

One 43-year-old woman had particular difficulty expressing her frustration over public transportation. She explained that walking the distance to the doctor was too far but asked the interpreter to explain she did not want to complain. She explained that she felt sad when she had to miss an appointment because she could not find transportation. She then asked if sharing good or bad feelings about how she got to the doctor was preferred. The interpreter explained that the purpose was just to be honest. The participant blushed deeply and said, "If there was more transportation [in Indianapolis], it would be better." Her hesitancy to make a critical statement demonstrated her dislike for appearing ungrateful or generally negative.

Regarding their narratives from home, participants were more willing to share information about their use of pharmacies, clinics, nurses, and the like, as these aspects can also be found in the model utilized in the United States. One man, aged 66, who had been living in the United States for nine years expressed:

Since there are few medical doctors in Burma, most of the time we buy ourselves medicine that a medical doctor used to prescribe [to us]. . . . We stock them at home. Whenever we are sick we use those medicines. But in some area we just use any medicine that is available. It's Western medicine. You can go to any pharmacy and buy any medicine. . . . Traditional medicine? No, in Chin State, we depend mostly on the Western medicines.

The use of biomedicines, or “Western medicines,” introduces the idea of advancement or perhaps merely suggests that Burma is not underdeveloped or primitive. The existence of modern biomedicine was equated with development, wealth, or Burmese control of a particular region. The irony expressed was that, even with the presence of biomedicine and a formal hospital system in Burma, some respondents still did not feel it was serving its purpose to help the people in need. A 35-year-old woman expressed, “With all the poverty, it takes maybe three days to get to the doctor. Because [we] don’t have any money, [we] sometimes don’t go to hospitals.”

Participants were, however, reluctant or hesitant about sharing information about traditional medicine, home remedies, or styles of self-care. One respondent told a story of a traditional practice but rejected it as being part of his community:

Some really small villages, they do this kind of witchcraft thing. . . . It’s very small, in very small villages. Not everywhere. They call it *Rai Thuai*. That’s just a practice, a very old practice that people use when people are very sick, and they believe they are possessed by a *Hnem* [witch]. So that’s a very old thing that people used to do. [I’m] actually not familiar with it, heard about it; I haven’t witnessed it. I haven’t done it. So [I] don’t know. It’s very rare now.

When respondents did share information about traditional remedies or practices, it was something they had “heard of,” or something from “a very rural area,” or something only “very few people practiced,” rather than something they themselves had been taught or had performed.

Prevalence of Community-Based Support Systems from Burma to the United States

General knowledge about health care practices, traditions, facilities, or medicines generated from the level of communication and the strength of the support systems whether participants were in Chin State, Malaysia, or the United States. What they understood came from what they “heard,” or what was told to them by friends or relatives. In Burma, utilization of doctors was dependent on three things: presence of a doctor in the region, ability to pay for a doctor, and existence of transportation. Transportation in the case of Burma, one man explained, came in the form of walking, riding a horse if the family could afford one, or, if one was too sick to walk or ride a horse, “they ride piggy back, or on the backs of relatives to the doctor.” If one could not afford the doctor’s visit, the participant went on to say, “We just ask people in the village what to do.” All forms of traditional medicine are passed down through family members and spread through the particular villages or towns.

Malaria, or *raifan*, was brought up by each of the respondents, and each expressed the ways in which community members served to help the fight against the disease. One woman reassured me, “If they’re close by the doctor or hospital, they go themselves, but if the malaria is very serious, they ask for help from people in the neighborhood.” When

asked how they knew what medicines to take, another participant explained, “People who’ve been to the doctor tell you what medicines to buy at the pharmacy.” The community was a source of information and services provided by friends, neighbors, and family members.

Many of the participants of the study came to the United States with friends and relatives already living in Indianapolis. Dependency was placed on advice they had received from the connections they had in Indianapolis, which were based on past learning experiences or presence of English abilities. One man explained how the community started its support system before the institutions provided needed services:

Before I have my own car, friends and relatives would take me to the doctor. Before there were interpreters, we asked our family members who spoke English, and we asked them to help to make appointments for us. . . . We look for people who speak both languages in the community, and we go to them.

Even after Indianapolis became more equipped with interpretive services, several participants explained they depended on word-of-mouth information for help with health care services. One woman explained how she knew to take her sick daughter to the area clinic: “[We] already knew there was a translator there. People talk, people told us.” This was similarly expressed by another woman, who explained that friends told her about pharmacies, particularly CVS, over-the-counter medications, and which ones to use for various symptoms.

Participants felt more comfortable in the system when they came knowing other friends or relatives were already resettled in the area. One woman explained finding transportation to get to doctor’s appointments with her five children did not worry her: “Sometimes, some other people take us to the clinic . . . and we fit [in the car]. Sometimes for me, my friends take me to the place [doctor’s office].” The community served to explain how and why respondents were able to maneuver through the system and muddle through any misunderstandings or confusions.

Trust in Doctors and Biomedicine

Although many of the respondents discussed traditional medicine or practices, they were quick to admit they would prefer to visit a hospital and see a doctor. This was no different on resettlement in the United States. Participants articulated their thoughts and perceptions of the US health care system, and one respondent expressed her preconceived notions about the United States. This 35-year-old woman explained, “At home, the people say that the United States is next in line to heaven. That’s what people [say]; the place is so good, so when [we] see clinics like that, [we] think, ‘Wow, okay, this must be it.’ You know, that’s why it’s very nice.” Although she described the US health care facilities as celestial bodies, others faced issues with the new regulations and protocols that met them in those facilities. One man, who had lived in the United States

for six years at the time of the study, explained that “the first thing is we need to make appointment to see the doctor. It’s difficult, but after that it goes smoother and then the doctor or nurses, the people, are kind.”

When participants told stories of the tradition in Burma of giving birth in the home, several women explained they would now rather see a doctor and have a baby in a hospital setting. Each of the women provided different motivations for the switch as might affect them personally. One woman justified the adoption of hospital births:

The reason we have babies at home in Burma is that there is no medical facilities. So that is why we have so many difficulties delivering babies in Burma because. . . it’s very painful, but in the United States you have better facilities and hospitals, and having a baby is much easier here, so most women prefer to go to hospitals.

The hospital was expressed as an entity that could ensure lower rates of infant mortality. Another woman found that the doctors had a “sweet talk,” and she said the medical staff “treated them better than in Burma,” where the participants explained the Chin people were not recipients of quality care because of discrimination related to their inability to speak well in Burmese or because of their difference in traditional forms of dress.

There seemed to be an attitude of “doctor can do no wrong” among participants. One man gave the account of a time he suffered a stroke within the United States. He explained that he waited in the waiting room for two hours before he saw an ER doctor. When asked what he thought of this, he replied, “I believed it was the procedure of the hospital,” which seems to enforce the idea that these refugee participants had an unquestioning trust in a system they were all but strangers to upon placement and resettlement.

Healthfulness as a Desired Quality

A lack of knowledge about health care systems in Malaysia or Chin State was excused by participants due to their never having been sick. Many of the participants expressed they had no knowledge or experience of actually seeing a doctor because, as one woman put it, “I have been healthy all my life.” Visiting a doctor was a practice only done if one was already sick, respondents explained; therefore, one’s knowledge of doctors was based on the stories from other people or from personal experience of having a higher propensity toward illness.

Healthfulness was also associated with less strain on the family’s expenses. One woman expressed the fear she used to have of having to visit a doctor or to use medical services:

In Burma, there’s not much Medicaid or any health care system like that [in US health care]. So I just feel different

when I get sick; you know, I guess I worried much more [in Burma], but here, there is Medicaid and stuff like that, so I feel more at ease about becoming sick. Because I know that I can get help. There's no support system like that [in Burma], so you basically have to . . . when you get sick, you need to have money to treat yourself to be better.

Concern was expressed by several of the participants because of the initial health screenings required upon their entry into the United States.

What had previously been stigmatized as a sign of weakness or instability was now introduced as a requirement and a normative practice. The doctor's visit once associated with sickness or illness was now associated with regulations and protocol. One man explained his perceptions of this phenomenon:

Here, *before* people get sick, they go to the doctors and they get checked first. You know, everything with the blood pressure. What you have; what you actually have [is checked] . . . but in Burma, you can just go to a place and get a medicine, and they don't really check you.

Participants needed to adjust to visiting a doctor as an act of maintaining healthfulness rather than as a means of overcoming an illness. One woman explained she had never seen a doctor in Burma or Malaysia but now she goes regularly "to get checked for breast cancer and other problems." The idea of "getting checked" was expressed as a responsibility toward one's health. To be perceived as healthy in the United States, respondents noted, people go to the doctor, whereas in Burma, to be perceived as healthy, people do not go to the doctor.

DISCUSSION

The results of this study based on responses from participants illustrate that the Chin refugees have a resiliency to culture shock and an adaptability to US health care protocol which exceeds that of Hmong, Vietnamese, or Cambodian refugees of previous studies. This can be attributed to the existing hybridization of traditional and Western medicines in Burma, the availability of language services through interpreters and a call-in interpretive service, and the presence of a large population of ethnically similar refugees located within the same geographic community.

Although this study demonstrates there is an obvious hybridization of health care culture among the participants, Morris et al. (2009) contend, "While maintaining the culture of one's homeland often provides comfort to newly arrived refugees entering a foreign place, it can at times make accessing and navigating their new country's health care system more challenging," (p. 535). In the instance of the Chin refugees, previous exposure to biomedicine or Western medicines has helped in the process of accepting and understanding the US health care model.

Four main aspects can be attributed to the acculturation of the Chin ethnic group with respect to their health care beliefs and practices. Considering the responses of the participants in this study, the theoretical framework of *cultural change* as discussed by Gail Hickey (2005) can be established to help understand and explain these points. She postulates:

Use of a psychological perspective to explore instances and issues of cultural change . . . should result in greater understanding of how individuals approach and grapple with differences between the cultural beliefs and traditions represented by the birth culture and those encountered in the host society. (p. 27)

Judging from the narratives of participants of this study, the greatest aid to their resettlement and adjustment was the preexistence of Chin people in Indianapolis. In many cases, these participants moved from their primary city of entry to Indianapolis as a means of being part of a community. Chin refugees living in Southport provided newcomers with a support system whereby they could get information and learn about the resources available to them. Several of the participants started their US experience in other cities but, motivated by the incentives of relatives already living in Indianapolis, moved to the city as secondary migrants. The strength of the community, especially as a window to health care access, directly relates to the pull factors or migration chains that attract new migrants.

Other aids in this process of acculturation have been the help and support of the Chin Community Church, located on the south side of Indianapolis. Many community members attend weekly prayer services or go to the church leader for advice or counseling. A third type of participant in the support system is refugee resettlement agencies. All participants mentioned the aid of caseworkers, or Exodus Refugee Immigration, Inc., in providing services that aided in their health care needs.

The last aspect is the high concentration of interpreters in southside health care facilities. Any confusion or misunderstandings, the participants explained, were communicated to them through not only an interpreter but also a member of the community. This group of participants found many of their medical issues easily solved with the presence of interpreters or translators. Whereas many studies, such as Marjorie Muecke's 1983 study on Asian refugee patients in the United States, suggest that hospitals and health facilities are often ill equipped to serve refugee populations, this study exemplified how the Southport community of Chin refugees in Indianapolis might be an exception. Many of the participants explained that their local clinic and hospital did not have just one but several ethnically different Chin interpreters on staff. Where interpreters were not provided, respondents explained that they were provided with interpretive services through a telephone service called the Language Line.

Limitations

Limitation to this study can be attributed to the possibility for interviewer error. The difference in ethnicity and culture between the interviewer and the participants may have caused the participants to answer in ways they perceived would not offend or discredit the interviewer's cultural heritage, specifically the health care system. It was important to express that honesty is to be rewarded and regarded as valuable and respected. The best measure of authenticity comes from the honesty of the participants and a complete understanding of their opinions, experiences, and feelings. This was best born through trust and through the interviewer's expression of general interest in the narratives of the participants.

Another limitation to this study is the researcher's involvement with the Chin community, both teaching English classes and working with a refugee-resettlement agency. Although her previous exposure could be viewed as an advantage to the study and an understanding of her participants, it might also have influenced her perceptions or opinions about the ethnic group as a whole. Researchers may have a tendency of "going local," as can sometimes be the temptation during ethnographic or qualitative studies such that the one asking the questions already has assumptions. Regardless, many of the researcher's assumptions were proven inaccurate based on participant responses, leaving the researcher to reevaluate her understanding of Chin health care culture. Lastly, the responses from this study were translated. Although they were translated by native Chin speakers, translation cannot account for the many expressions or phrases that are culturally unique in either English or in Hakha Chin. This diminishes a level of the authenticity of the responses used and takes away from the rich value of one's native language.

Suggestions for Further Research

To follow up with participants based on their coded responses, secondary interviews would have helped to clarify or work out the deeper meanings or motivations behind particular responses. This would build a greater level of trust with the refugees involved as a means of ensuring the honesty and clarity of the responses.

It would be of significant value to have the interview questions translated by a translator prior to the interviews. These translated questions could then be given to the interpreter to ask of the participants. Although the interpreters could all speak very proficiently in English, mastery of all concepts of a language can be difficult; this step in the process would provide more foundation to the interview process.

CONCLUSION

The findings of this study suggest that refugees were able to make sense of their health care experiences, practices, and beliefs in Burma through the support of family

traditions, societal norms, and perceived benefits or outcomes. Their desire to be viewed in a positive light led many of them to follow procedure and not ask questions even when questions were due. Doctors, nurses, and health care professionals were viewed as bearers of standard procedure but also as the best option for any health care concern. The provision of Medicaid to this group has left them trusting their costs will be covered, and the facilities have them believing any health concern can be solved within those hallowed halls.

This study demonstrated that Chin refugees depend on one another and provide fellow Chin people with advice and support to help in the integration process. It has been shown in previous studies and has been reinforced here that when refugees are resettled in areas with dense populations of people both ethnically and culturally similar, they have an easier time learning to adjust to a new system. The Chin refugees who participated in this study demonstrated an acclimation and level of acculturation in terms of accepting Western medical models that this researcher was surprised to discover. The responses demonstrated an openness and willingness to understand and appreciate the resources given them. At the same time, participants were eager to share aspects of their culture and to teach an understanding of their country's traditional treatment of health and illness.

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APPENDIX

BURMA

1. What do you do if you do not feel well in Burma or at home?
2. Tell me what people do when they get sick in Burma or at home.
3. Why do people get sick?

4. Where does it (sickness) come from?
5. What are different kinds or types of sicknesses or illnesses?
6. What do people do if they are very (a lot, much) sick?
7. What do people do if they are a little sick?
8. What kind of help to people get when they are sick?
9. Do people ever see other people if they are sick or do not feel good in Burma? Do they see other people?
10. Who are the others?
11. Do they seek or look for help, advice, or medicine?

THAILAND/REFUGEE CAMPS

12. What do people do if they get sick in Malaysia or India?

UNITED STATES

13. What do you do in the United States if you are sick?
14. What do people do if they get sick in the United States?
15. Why do people in the United States think people get sick?
16. Is it important to follow the doctor's advice?
17. Is the treatment different in the United States?
18. How is the treatment different?

Health Care Access in the US (for patients who have seen a doctor)

19. Have you been sick and seen a doctor?

20. How do you get to the doctor?
21. How do you make an appointment to see the doctor?
22. Do you live close to a clinic or doctor's office in Indianapolis?
23. Did you understand or know all of what the doctor said to you?
 - a. If no, what did you not understand?
24. Do you think, feel, or believe the doctor understood you?
 - a. If no, what did the doctor not understand?

CONSENT BY SUBJECT TO PARTICIPATE IN RESEARCH STUDY

Research Project: Cultural Definitions of Health Care: A Case Study of Burmese Refugees in Indianapolis

I, _____, give consent to take part as a participant in the study, under the direction of Lena White from Butler University. I give permission without being forced to do so and after the information has been explained to me.

The Purpose and Length of Study:

This study works to understand how Chin refugees think and feel about health care in their country: Burma, in refugee camps: Malaysia or India, and in their new home: the United States. It also aims to discover traditional ways refugees take care of themselves in Burma, in Malaysia, in India, and in the United States. By participating or being part of this study you will be asked a set of questions or interviewed for 45 minutes to one hour.

Possible Risks or Benefits:

You will not be hurt in this study. If any questions make you uncomfortable, please say this and you will not have to answer the question. You will not gain anything or be given anything from this study, but it may help doctors, hospitals, and clinics to understand Chin people better, as well as find out or discover how Chin people see or think about being sick.

You do not have to participate in this study. It is not required of you. If you do not want to participate, you will not be punished in any way. You can decide to stop being part of the study. If you do so, everything with your information on it will be destroyed. If you do participate, information about you will be kept secret. What you say will not harm you in any way, but it will be recorded. This study may be presented to other people, but your name will be kept a secret.

Participants:

I know that I can choose to participate or not participate. My name and other information will be protected so no one but Lena White and the interpreter know the answers. I was given a copy of this paper. I know I can call the person asking questions whenever I have a question.

Signature of Subject

Date

HLATHLAI CAWNNAK AH I TELTUM DING IN HNATLAKNAK TUAHNAK CA

Hlathlainak Project: Nunphung mit in Ngandamnak khinhhramh kong Fianternak:
Indianapolis i Burma mi ralzam pawl an kong hlathlainak

Butler University in Lena White nih a chim ning tein hi cawnnak i i teltum ding in keimah _____ nih hnatlaknak ka tuah. Hi hnaltaknak hi ho hmanh nih hramhram in tuah an ka fial ruang ah ka tuah mi a si lo i tuah ding mi kong an ka fianh hnu ah ka tuahmi a si.

Hi Cawnnak Nih Aa Tinhmi le Caan Rauh Ding Kong:

Hi cawnnak nih hin Chin ralzam hna nih an ram Burma ah siseh, Malaysia silole India ah ralzam dirhmun in an khuasaknak ah siseh, an ram thar a simi US ah siseh, an ngandamnak ca i an i khinhhramhning kongkau ah an hmuhning le an ruahning hngalh aa timh mi a si. Burma, Malaysia, India, le America ah ralzam pawl nih an mipfun tuah tawnmi phung ning in an i khinhhramh ning kong zong hngalh chih a duh fawn. Hi cawnnak i naa tel ruang ah hin minit 45 in suimilam pakhat chung hrawng bia zeimaw zat hal na si lai.

Sungkhawh mi le Hlawk khawh mi:

Hi cawnnak kong ah hin na caah a poi ding a um lo. Bia halmi chaukhat leh ding i na sia a rem lo ahcun cu cu chim ko law, cu biahalnak cu na leh a hau lai lo. Hi cawnnak ruang ah hin ze hmanh na hmu in ze hmanh pek na si lai lo, nain hi cawnnak catial hi siibawi te le, sizung, siikhan pawl nih Chin mipfun kong an theih deuhnak ding bawmtu a si lai leng ah Chin mipfun nih zawtfah timi hi zeitin dah an hmuh an ruah ning a si, ti an hmuhchuah khawh lai.

Hi cawnnak ah hin naa tel hrimhrim a hau tinak a si lo. Na tuah a hau, tinak a si lo. Naa tel duh lo zong ah ze dantatnak ding a um lo. Naa tel hnu zong i ngol than khawh a si ko. Cuti naa ngol ahcun na rak chimcia bia vialte cu hlohhrwah dih a si ko lai. Naa tel a si le na kong cu ho theih lo awk in chiah a si lai. Na chimmi bia nih zeitin hmanh in hnahnawhnak aan pe lai lo, nain catial in chiah a si lai. Hi cawnnak hi midang sin ah pek a si lai, nain na min cu chimphuan a si lai lo.

Aa telmi:

Tel ding le tel lo ding cu keimah duhthimnak in a si, ti ka hngalh. Ka min le ka kong cu Lena White le holhlettu dah tilo midang ho hmanh theihter an si lai lo. Hi ca i a khawpi hi pek ka si. Biahal awk ka ngeih tik paoh ah bia a ka haltu hi ka auh khawh peng lai, ti ka hngalh.