MYANMAR
formerly known as BURMA

CULTURAL COMPETENCY AND TUBERCULOSIS CONTROL

A Practical Guide for Health Professionals Working with Foreign-born Clients
GEOGRAPHIC LOCATION

- Myanmar (formerly known as Burma) is located in Southeastern Asia.¹
- The capital is Rangoon (Yangon).¹
- The country is bordered to the north by China; and to the south by the Bay of Bengal and Andaman Sea. To the east the country is bordered by China, Laos, and Thailand; and to the west, India and Bangladesh.¹

Note: The information provided within is an introduction only and does not characterize all individuals from this country.
OFFICIAL LANGUAGE(S):
- **Official language**: Burmese¹ (spoken by ethnic Burmans as well as some ethnic minorities)³³
- **Other languages**: Minority ethnic groups have their own distinct languages, and various dialects are spoken within each group.¹³⁶,³⁷

*Note: These languages may be called different names by different ethnic groups.*³⁶

- **Refugee camps**: Most of the persons in refugee camps speak, as their native language, one of three main dialects of Karen. Approximately 68% speak S’gaw Karen, 9% speak East Pwo Karen, and 4% speak Western Pwo Karen. About 15% of the refugee population speaks one of the dialects of Karenni. Other common languages spoken among refugees include Shan, Mon, and Chin.³⁵,⁴⁶

Approximately 20% of the refugee population can speak Burmese, depending on their level of education. Less than 2% can speak English.³⁵,⁴⁶

ETHNIC GROUPS:
- **Majority**: 68% Burman¹
- **Minority**: 9% Shan, 7% Karen (multiple subgroups³⁵,³⁶), 4% Rakhine/Arakanese, 3% Chinese, 2% Indian, 2% Mon, 5% other¹

*Note: The government in Myanmar recognizes as many as 105 ethnic subgroups in the country. Members of any of these ethnic groups may be considered “Burmese” because their home country is Burma/Myanmar. “Burman” refers only to the majority ethnic group.*³³

- **Refugee camps**: The ethnicity of the population within the refugee camps is approximately 80% Karen, 15% Karenni, and 2% Burman. Smaller numbers of Shan, Mon, Chin, Rakhine/Arakanese, and Rohingya comprise the remainder of the population.³⁵

*Note: Among the Karen and Karenni, there are a number of distinct ethnic and linguistic subgroups.*³⁵

DOMINANT RELIGION(S) WITHIN THIS COUNTRY:
- 89% Buddhist¹
- 4% Christian (3% Baptist, 1% Roman Catholic), 4% Muslim, 1% Animist, 2% other¹
- **Refugee camps**: Approximately 52% of the persons residing in refugee camps are Christian, 30% Buddhist, 11% Muslim, and 7% Animist*. Less than 1% of the refugees practice other religions.³⁵,⁴⁶

*Animists may believe that objects in nature (e.g., trees, mountains, the sky) possess a soul or consciousness; some may believe that people have spirits that do or can exist separately from their bodies.*²⁶
**LITERACY OF CITIZENS:** Defined as persons ages 15 years and older that can read and write.

- Total population: 89.9% (2006 estimate)\(^1\)
  - Male: 93.9%
  - Female: 86.4%

*Note: Although education is highly valued, most refugees have had little access to formal education unless they lived in urban areas of Myanmar. Approximately 55% of refugees have had only primary education, and 32% have had no schooling.\(^{34,46}\) Therefore, literacy rates among refugees will be much lower than the figures above; also keep in mind that the language refugees can read and write may be an ethnic language, not Burmese.*

**MEDICAL SYSTEM:**
- The medical system in Myanmar is a mix of public and private sectors; both sectors offer traditional medicine for the care and treatment of health problems.\(^{17}\)
- Within the **public sector**, biomedical and traditional health care services are provided by dispensaries and hospitals for free, although a referral from a dispensary is necessary for admission to a biomedical hospital.\(^{17}\)
  - The public health sector in Myanmar is challenged with shortages of equipment, drugs, and healthcare professionals.\(^{2,43}\)
- In the **private sector**, patients can make an appointment directly with a specialist at private clinics and hospitals. Private services are not covered by the social health insurance program and must be paid for out-of-pocket.\(^{17}\)
- Many refugees from ethnic minority states had little access to the formal medical system in Myanmar; rather, they have relied on traditional medicine provided by members of their own communities. In the refugee camps, these groups have had increased access to medical clinics and biomedical treatments.\(^{46}\)
- Infection control within hospitals is limited and blood collected for transfusion purposes is generally not screened for blood borne infections prior to use in smaller hospitals.\(^{38}\)
  - In Myanmar, some blood donors do not self defer because the act of donating blood is commonly believed to be a way to earn significant religious merit.\(^{38}\)

**MAJOR INFECTIOUS DISEASES WITHIN THE BIRTH COUNTRY:**
- **Vector borne:** dengue fever and malaria (Plasmodium falciparum, Plasmodium vivax)\(^{1,39}\)
  *Note: Malaria is reported to be a leading cause of morbidity and mortality in Myanmar.\(^{39}\)*
- **Food or water borne:** hepatitis A, typhoid fever\(^1\)

**FERTILITY RATE OF WOMEN RESIDING WITHIN THE BIRTH COUNTRY:**
- 1.89 children born/woman (2009 estimate)\(^1\)

**RELEVANT HISTORY:**
- Myanmar is one of the least developed countries in Asia.\(^{36,45}\)
The country has experienced civil war for over 50 years, and many persons from Myanmar (especially minority groups) have become refugees in neighboring countries. Some forced migrants of Myanmar live in other countries as “illegal immigrants.”

The country’s current government is a military dictatorship.

The country’s name was changed from Burma to Myanmar during the late 1980s by the Burmese military government following a democratic revolution among the people.

Note: Currently, military authorities promote “Myanmar” as the official country name; however, political activists and others who oppose the current government often continue to refer to the country as “Burma.” The US government has also not adopted the change and continues to refer to the country by its former name; however, the country is referred to as Myanmar throughout this guide.

THE ESTIMATED NUMBER OF INDIVIDUALS FROM THIS COUNTRY EMIGRATING ANNUALLY TO THE UNITED STATES:

- 3,403 persons from Myanmar obtained legal permanent resident status within the US during fiscal year 2008.
- The average number of persons from Myanmar who obtained legal permanent resident status annually (1999-2008): 2,089.
- The United States officially accepts refugees from this country.
  - Beginning in 2006, significant numbers of refugees (primarily Myanmar’s ethnic Karen people) began to relocate to the United States. During fiscal year 2007, 13,896 refugees were resettled in the US and 18,139 arrived in fiscal year 2008.
  - The US government proposes to resettle an additional 17,000 refugees from Myanmar in fiscal year 2009.
  - As of 2000 (prior to the influx of refugees), the majority of persons from Myanmar living in the United States were of Burman ethnicity, and many were educated professionals.
  - The communities established by these immigrants may be bypassed by current refugees: the majority of whom are not Burman, originate from rural villages of Myanmar, and have had little or no formal education.
- Over the next 5 to 10 years (as of 2008), Burmese refugees will be resettled in the United States, Canada, Australia, and the Scandinavian countries of Norway, Sweden, Denmark, and Finland.
  - This next wave of expected refugees is religiously, ethnically, and linguistically diverse; they are predominantly members of ethnic subgroups and not of the Burman ethnic majority.

*Legal permanent residents are foreign nationals who have been granted the right to reside permanently in the United States. Often referred to simply as “immigrants,” they are also known as “permanent resident aliens” and “green card holders.”

**Refugees are legal immigrants and are eligible to apply for legal permanent residence after one year in the US."
According to 2007 Immigration and Naturalization and US Homeland Security Data, individuals who became naturalized citizens from this country indicated the following top 10 states as their intended state of residence.

The percentage of the total number of legal permanent residents by state:\textsuperscript{6}
1. California – 43.3%
2. New York – 13.6%
3. Indiana – 5.3%
4. Florida – 3.1%
5. Minnesota – 3.0%
6. Texas – 2.7%
7. Maryland – 2.6%
8. Virginia – 2.3%
9. Washington – 2.3%
10. Illinois – 2.2%

THE ESTIMATED NUMBER OF INDIVIDUALS FROM THIS COUNTRY EMIGRATING ANNUALLY TO CANADA:
Note: Detailed data regarding persons from Myanmar who are granted permanent resident status or who become legal permanent residents each year in Canada are not available through Citizenship and Immigration Canada.
• Since 2006 and continuing through 2009, approximately 3,900 Karen Burmese refugees from camps in Thailand are expected to be resettled in Canada. Approximately 300 Rohingya Burmese refugees from Bangladesh were to be resettled in 2006-2008.\textsuperscript{50}

THE ESTIMATED NUMBER OF INDIVIDUALS FROM THIS COUNTRY EMIGRATING TO COUNTRIES WITHIN THE EUROPEAN UNION:
• Statistics available through Eurostat (2006) indicate that the majority of immigrants from Myanmar to the European Union have migrated to Norway, Germany, and Sweden.\textsuperscript{8}

• Within the European Union, the majority of refugees from Myanmar are being resettled to the Scandinavian countries i.e., Norway, Sweden, Finland, Denmark.\textsuperscript{32,46}
**Estimated Burden of Tuberculosis (2007):**

- **Incidence:** 171/100,000\textsuperscript{12}
- **Prevalence:** 162/100,000\textsuperscript{12}

*Note: The 2009 WHO Global TB report cautioned that the TB burden in Myanmar is likely underestimated and that current estimates need to be reviewed.*\textsuperscript{12}

**Reported Cases of TB (2007):**

129,081\textsuperscript{9}

**Estimated Burden of HIV Infection (2007):**

- **Estimated prevalence:** 0.7\%\textsuperscript{10}
- **Low estimate (adults):** 0.4\%\textsuperscript{10}
- **High estimate (adults):** 1.1\%\textsuperscript{10}

*The WHO estimates 160,000-370,000 persons in Myanmar are living with HIV.*\textsuperscript{10,40}

**TB/HIV Co-Infection* (2007):**

- **Estimated co-infection:** 10.9\%\textsuperscript{9}
- **Adults ages 15-49 yrs:**
  - **Incidence:** 19/100,000\textsuperscript{9}
  - **Prevalence:** 9/100,000\textsuperscript{9}

**Level of Multidrug-Resistant TB* (2007):**

*Multidrug resistance is defined as resistance to at least isoniazid and rifampicin.*

- 4\% of new TB cases are multidrug-resistant.\textsuperscript{12}
- 16\% of previously treated TB cases are multidrug-resistant.\textsuperscript{12}

**Standard TB Drug Treatment/TB Medications Readily Available for the Treatment of TB in This Country:**

<table>
<thead>
<tr>
<th>R or RMP or RIF = Rifampicin or Rifampin</th>
<th>S or STM or SM = Streptomycin</th>
</tr>
</thead>
<tbody>
<tr>
<td>H or INH = Isoniazid</td>
<td>Et = Ethionamide</td>
</tr>
<tr>
<td>Z or PZA = Pyrazinamide</td>
<td>CIP = Ciprofloxacin</td>
</tr>
<tr>
<td>E or EMB = Ethambutol</td>
<td>P or PAS = p-aminosalicylic acid</td>
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- Under DOTS, **new cases** are treated with 2HREZ/4HR.\textsuperscript{12}
  *Note: This regimen is prescribed without drug susceptibility testing.*\textsuperscript{14}
- **Previously treated** patients are usually prescribed 2HREZS/5HRZ until drug susceptibility test results are available.\textsuperscript{14}
• **In refugee camps**, the World Health Organization’s standard four-drug therapy with B6 is used.\(^7\)

*Note: Susceptibility results are usually not available until after the initial 2 months of treatment have been completed.*\(^14\)

Between 1967-1994, a treatment regimen containing streptomycin and isoniazid was used in Myanmar. Between 1993-1996, the country experienced significant shortages of streptomycin.\(^15\)

In 2006, Myanmar’s reported treatment success rate for new smear-positive cases was 84%. Re-treatment success of smear-positive cases was reported to be 70%.\(^12\)

### TB CONTROL/DOTS COVERAGE:

• According to the World Health Organization, 95% of the country’s citizens are covered by DOTS (2007 estimate).\(^12\)

• DOTS implementation began in 1997; however, expansion of the program was gradual due to drug shortages. By the end of 2003, a TB program report indicated treatment default among new sputum smear-positive patients was estimated to be 10%.\(^15\)

### TB MEDICATION AVAILABLE AT NO COST THROUGH TB PROGRAM:

- Yes\(^12\)
- No
- Information Not Found/Unknown

**Comments:** Without additional assistance from international aid organizations, the country is expected to experience interruptions in the TB drug supply in 2010. This interruption may come about because the agreement to obtain medications from the Global Drug Facility (GDF) is set to expire at the end of 2009, and funding that has been secured from the Global Fund to Fight AIDS, TB & Malaria is not scheduled to be released until 2011.\(^19\)

*Note: The GDF has granted free TB medications to Myanmar since 2002.\(^16\) The GDF usually allows countries to obtain free medications for a maximum of two terms of three year grants (total of 6 years). The GDF has already extended this support until the end of 2009.*\(^19\)

### TB MEDICATIONS AVAILABLE ONLY THROUGH NATIONAL TB PROGRAM:

- Yes
- No\(^15\)
- Information Not Found/Unknown

### TB MEDICATIONS AVAILABLE THROUGH PRIVATE PHARMACIES WITH A PRESCRIPTION:

- Yes\(^15\)
- No
- Information Not Found/Unknown

**Comments:** TB drugs are available over the counter in Myanmar.\(^15\)
USE OF BCG VACCINE:

- Yes  □ No

- BCG is given to infants at 6, 10 or 14 weeks of age.17,44

Approximate percentage of the population that is covered by the BCG vaccine:

- 85% coverage (2007 estimate, WHO/UNICEF)11

Note: Persons from refugee camps may not have received the BCG vaccine, depending on when they entered the refugee camps (some individuals entered the camps 15–20 years ago), or if they were born in the camps – as the camps may or may not have had vaccination services available.46

NICKNAMES/COMMON NAMES FOR TB:

Note: No nicknames or common names for TB were found in the literature.

COMMON ATTITUDES, BELIEFS AND PRACTICES RELATED TO TUBERCULOSIS

GENERAL COMMENTS:

- Despite free treatment from the National TB Program (NTP), many TB patients in Myanmar tend to first seek care from the private sector. It is important to note that the private sector does not always follow recommended treatment guidelines or provide case notification to the NTP.16,42

  Note: The failure of private sector physicians to provide case notification stems from concerns related to the referral hospital’s ability to treat persons who do not respond to TB medications.36

  – The poor may choose the private sector over the NTP because of easier access and flexible hours.42 The costs these patients may incur include the cost of drugs not provided by the NTP, lost wages, and cost of transportation.16,17

- In Myanmar, a limited level of social welfare is available through initiatives for poor patients who cannot afford medication, transportation to hospitals, or rehabilitation.17 Some social welfare initiatives target those poor patients who first seek care from private providers.16

- For many patients, social welfare is not available. Family members will often accompany patients to the hospital to help provide care. In some instances, family members will go elsewhere to buy medications and other necessities that are unavailable at the hospital.2,36

- The Mae La Camp in Thailand houses about 45,000 Burmese refugees. Those with TB are sent to the “TB Village” in order to decrease transmission and facilitate DOT. Patients and their family members live in the TB Village, acting as caregivers for their sick family members.7

  Persons within the camp are separated according to whether they are smear-positive, smear-negative, or have MDR-TB. MDR-TB patients sleep in separate quarters from their family members. Persons with MDR-TB are likely to remain in the TB Village for two years.7
– Refugees who test positive for TB must complete TB treatment under strict DOT management before being allowed to travel to the US.
– Treatment occurs in the TB Village during the first 2 months; afterwards, refugees choose to complete DOT either in the TB Village or a treatment site in the general refugee camp.

Note: Refugees whose smears and cultures are negative for AFB, or who have extra-pulmonary TB, usually decide to delay treatment until after immigration.7

COMMON MISPERCEPTIONS RELATED TO TB ETIOLOGY/CAUSE:
Note: No information concerning common misperceptions specific to the etiology/cause of TB was found in the literature.
• Persons from Myanmar regard health as the harmony between the physical body, spiritual elements, and the natural world. Illness, in general, may be thought to be caused by a lack of harmony between these factors.4

COMMON MISPERCEPTIONS RELATED TO DISEASE TRANSMISSION:
Note: No information concerning common misperceptions specific to the transmission of TB was found in the literature.

MISPERCEPTIONS RELATED TO DIAGNOSTIC PROCEDURES:
• Private practitioners in Myanmar primarily use radiography (X-ray) to diagnose TB.42 Clients of private practitioners may question other procedures (i.e., sputum smear and culture, blood tests) used to diagnose TB.

Note: Public providers often do not have access to radiography and instead utilize clinical exam and sputum microscopy to diagnose patients.36

CURES/TREATMENTS THAT MAY BE USED:
• In Myanmar, traditional medicine is often used to treat minor illnesses while biomedical treatment is preferred for severe illnesses.17
  – Traditional medicine is especially important among ethnic minorities in Myanmar.18
  – Urban dwellers tend to prefer biomedical treatment.17
• Traditional medicine includes remedies made from plants, massages, and acupuncture.17
  – Traditional medicine to treat sore throats and coughs may include a mixture of pepper, dried catkins (flowers from trees), dried ginger, liquorice and medicinal salt. As the medicine is made, prayers may be repeated to ensure its potency.22
  – Yesah is a herbal powder believed to be a common cure-all.2,20
  – To diagnose an illness, traditional Karen medicine practitioners will check arterial pulses in the wrist and examine a patient’s face and eyes.21,33
• The Burmese concept of illness follows a hot/cold dichotomy whereby imbalances may cause disease. The physiological imbalance may begin at the physical or spiritual level.4,20,21
The imbalance of “hot” and “cold” elements may be remedied by taking medication or food of the opposing temperature. For example, “cold” foods must be eaten during a “hot” illness in order to restore health.

- Traditional Karen medicine also follows the hot/cold dichotomy. Most illnesses are thought to arise from eating the wrong foods for one’s body type. Treatment for these illnesses entails releasing the excess heat or cold from the body; which may be accomplished using leaves, branches, roots, or oils from a variety of plants and trees.\(^{21,33}\)

- In Myanmar there are extensive formularies of traditional treatments. If persons from Myanmar are unable to find the natural herbs, leaves, etc. that they are familiar with, they may experiment with substitutes.\(^{36}\)

Note: Herbs and other plants have the potential to interact with prescribed medications. Additional study of the pharmacological properties of herbs/plants used in traditional medicine practices is needed; however, this is beyond the scope of this guide.

- Children from Myanmar may wear amulets with religious significance around their neck. Amulets may also be worn as good luck charms that help maintain health, or as symbols of friendship and close personal affiliation.\(^{22,36}\)

- Persons from Myanmar may believe in \textit{nats} and ghosts, which are considered spirit entities that have an effect on health and illness.\(^{2,4}\)
  - \textit{Nats} are spirits who are benevolent - if an individual treats the \textit{nats} with respect. Some believe that \textit{nats} may induce fever or stomach problems or can tamper with a person’s mind if a person is not respectful of the \textit{nats}. There are 37 \textit{nats} represented in Burmese spiritualism, all of whom are thought to have been human at one time. To appease these spirits and restore health, a person may make donations to \textit{nat} shrines.\(^{4}\)
  - Ghosts are believed to be the souls of the departed whom no one prayed for at the time of their death. Ghosts are thought to prey upon the sick by drawing the sick person’s energy or even possessing them. To restore health and drive away a ghost, patients will seek care from traditional healers.\(^{4}\)

Note: These beliefs may only apply to Buddhist refugees. Animist and Christian refugees may believe in different supernatural beings or may not attribute illness to supernatural causes.\(^{2,46}\)

MISPERCEPTIONS RELATED TO TREATMENT/MEDICATIONS:
- Persons from Myanmar may believe that traditional medicines require a long time to take effect but achieve a longer lasting cure as compared to Western care.\(^{4}\)

USE OF TRADITIONAL HEALERS:
- In the Burmese language, the word \textit{saya} may be used to describe a traditional healer or teacher/master.\(^{20}\)

Note: Persons from the Hill Tribes in Myanmar are much more likely to use traditional healers due to a lack of access to biomedical resources.\(^{41}\)

- A variety of religious practitioners may be called upon for health problems. These practitioners are generally male and provide services appropriate to animist beliefs of most Buddhists.
As indicated previously, animists may believe that objects in nature (e.g., trees, mountains, the sky) possess a soul or consciousness; some may believe that people have spirits that do or can exist separately from their bodies. Religious practitioners may include:

- Spirit dancers: who become possessed by spirits then perform healings and tell fortunes
- Tattooists: who have knowledge of the occult
- Healers
- Magicians
- Astrologers

• Astrologers have been described as “external healers” who must first read a patient’s numbers; the astrologer will then give the patient certain advice (e.g., where to go, what to eat) and warnings to follow. Traditional medicine doctors have been described as “internal healers” with the ability to immediately sense an illness.

• The Burmese astrological system is based upon the Hindu system. Astrologers predict the future based on astrological computations; these computations are used to guide patients’ life decisions.

• In addition to spiritual healers, “witches” are also considered human agents/mediators for the spiritual world.

• Witches are thought to have a power to harm that cannot be restrained. Persons from Myanmar who believe they have been affected by a witch may believe they can be saved from a witch’s damaging power if they consult a spiritual doctor.

• Large sections of the refugee population believe witches pose a threat which can only be neutralized through the power of spiritual healers and Buddhist monks.

STIGMA AND STIGMATIZING PRACTICES SURROUNDING TB IN THIS COUNTRY:

• Because TB has long been one of the leading causes of death in Myanmar, a diagnosis of TB can be stigmatizing for the entire family.

• In Myanmar, loss of employment following a TB diagnosis is common.

IMPORTANT TUBERCULOSIS EDUCATION POINTS:

• Assess clients’ knowledge of TB; prepare to provide basic/general information.

  – Keep in mind that deeply held spiritual beliefs affect some refugees’ notions of disease, which in turn can affect treatment outcomes. These beliefs often have gender, ethnic and religious features.

• When providing patient education, take time to explain the rationale behind what you are asking the client to do.

  – When discussing medication regimens and dosing of medication, explain why the prescribed medication regimen was chosen to treat the patient and the rationale for the length of treatment regimen.
• Emphasize the need for, and reasons why, TB medications must be taken even when symptoms resolve.
  – For persons diagnosed with LTBI, emphasize the rationale for preventive therapy, despite the absence of symptoms.
• Encourage your patients to ask questions and use teach-back techniques to ensure sufficient explanation has been given.
  – Non-physicians might begin an education session by asking, “Was there anything the doctor said that you would like me to explain in more detail?” or “What questions do you have now that the doctor has talked with you?”
  – Because it is considered impolite to be forward or to question someone in authority, encouraging a person from Myanmar to ask for further clarification or additional information may not elicit a response. If possible, provide general information in a format that a client can take away and review.36

COMMON ATTITUDES, BELIEFS AND PRACTICES RELATED TO HIV/AIDS

GENERAL COMMENTS:
• Myanmar has a generalized HIV epidemic. Sexual transmission accounts for the majority (67%) of HIV infections, followed by injection drug use (30%). Mother-to-child transmission, contaminated blood and blood products, and unsafe injection practices account for the remaining 3% of infections. Thus, commercial sex workers and injecting drug users are among the country’s most-at-risk populations.29
  – Burmese women seeking refuge in neighboring countries may become vulnerable to HIV through trafficking and coercion into the commercial sex industry. The highest infection rates of HIV among persons from Myanmar have been found among those crossing the Myanmar border into Thailand, especially among the Shan group. Estimates of HIV prevalence among the Shan range from 3% for women to 9% for men.23,24
  – As indicated previously, blood collected for transfusion purposes is generally not screened for blood borne infections prior to use in smaller hospitals. Therefore, transfusion-associated HIV infections are much more common than in settings where prescreening of donors is routine.38
  – Condom use among young people in the general population is relatively high. However, use of Voluntary and Confidential Counseling and Testing (VCCT) is low due to limited availability of HIV testing.27,36
  – Surveys among Burmese migrant workers living in Thailand indicate low knowledge of: HIV transmission, risk factors, prevention strategies, and low condom use (<12%).25
• Antiretroviral therapy (ART) began in 2003 and was expanded into the public sector in 2005. However, access to ART is limited. According to UNAIDS, ART and services designed to prevent mother-to-child transmission do not reach more than 15 percent of those in need.

**COMMON Misperceptions RELATED TO HIV/AIDS ETIOLOGY/CAUSE:**

Note: No information concerning common misperceptions specific to the etiology/cause of HIV/AIDS was found in the literature.

**COMMON Misperceptions RELATED TO DISEASE TRANSMISSION:**

• Kissing
• Sharing a toilet

**Misperceptions RELATED TO DIAGNOSTIC PROCEDURES:**

Note: No information concerning misperceptions specific to the procedures used to diagnose HIV/AIDS was found in the literature.

**Cures/Treatments THAT MAY BE used:**

Note: No information concerning cures/treatments that may be used for HIV/AIDS was found in the literature.

**Stigma and Stigmatizing Practices Surrounding HIV/AIDS IN THIS Country:**

• HIV-positive persons in Myanmar may be fired from their jobs if their diagnosis is known.

• When a Burmese woman has HIV, she may not be welcome in her home village. Also, she may not want to return to her village, in order to keep from overburdening her family.

**Important HIV Education Points:**

• Assess clients’ knowledge of HIV/AIDS; prepare to provide basic/general information.
• Discuss stigma and concerns related to discrimination.
• Provide patient education regarding methods of HIV transmission, disease risk, and prevention.
• Discuss the benefits associated with condom use (for both men and women); offer instruction in the proper use of condoms.

Note: Sex is generally not discussed among friends and family or in educational settings because premarital sex is prohibited in Burmese culture.
Most of the information provided within this guide is drawn from sources describing the ethnic majority Burman population. It is important to keep in mind that a remarkable level of ethnic and cultural diversity exists within Myanmar.

Because of differences in culture, language, access to health care, geographical area of origin, and level of education among the ethnic groups from Myanmar who are being resettled as refugees, the courtesies and characteristics provided below may or may not be applicable to the clients with whom you will interact.

**CULTURAL COURTESIES TO OBSERVE:**

- Shaking hands while maintaining direct eye contact is an acceptable form of greeting when meeting a person of the same sex.\(^{17,30}\)
  
  - This greeting is more often used among immigrants from urban areas of Myanmar or among those with more education.\(^{46}\)

- A more traditional greeting involves placing your hands together as if in prayer (fingers pointing upward) and bowing slightly.\(^{17,30}\)
  
  - This greeting is more likely to be familiar to persons who come from rural backgrounds.\(^{46}\)

**What to Say (Karen)**

- *Oh-sooh-ob-clay* (Hello)\(^{52}\)
- *Oh-moo-ab* (How are you?)\(^{52}\)
- *Le-bah-theyi* (Goodbye)\(^{52}\)

**What to Say (Burmese)**

- *Mingala ba* (Hello)\(^{2}\)
- *Ne kaun bad hala?* (How are you?)\(^{52}\)
- *Thwa ba oun me* (Goodbye)\(^{2}\)

- To address a man in the Burmese language, *U* followed by his name may be used.\(^{2,20}\)
  
  - *U* literally translates as “Uncle”

  *Note: Some interpret U as a respectful title synonymous with “Mr.” but others report that U is an honor that must be earned.*\(^{36}\)

- To address a woman in the Burmese language, *Daw* followed by the woman’s name may be used.\(^{2,20}\)
  
  - *Daw* literally translates as “Aunt”; it can also mean “Ms”\(^{2,20}\)
  
  - To address a woman in the Karen language, use *Naw* rather than *Daw.*\(^{52}\)
Other Forms of Address in Karen

- *Dee-dee* (uncle)\(^{52}\)
- *Ma* (sister or young girl)\(^{52}\)
- *Tha-caw* (“my friend”)\(^{52}\)

Other Forms of Address in Burmese

- *Ko* (elder brother or friend)\(^{2,20}\)
- *Maung* (boy or young man)\(^{2,20}\)
- *Ma* (sister or young girl)\(^{2,20}\)

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**Is there a need to match client and provider by gender?**

- Yes\(^2\)
- No \(\Box\)
- Information Not Found/Unknown

**Comments:** It is considered indecent for a Burmese woman to expose her body, so she should be covered with a thin sheet of cloth during a medical examination. Male doctors should be accompanied by a female staff member during any type of examination.\(^{17}\)

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**FAMILY:**

- The Burmese culture is family-oriented. According to Buddhist beliefs, parents are one of the “five objects of worship”; therefore, it is sinful to disobey one’s parents.\(^{20}\)
- Traditionally, extended family members have lived together in Myanmar, but nuclear families are more common among refugees and immigrants.\(^{20}\)

**NAMES:**

- The Burmese do not use nicknames.\(^2\)
- Women do not change their family name upon marriage; children take the family name of the father.\(^{17}\)

**CULTURAL VALUES:**

- An important cultural value in Myanmar is *a-nah-dab* which is the art of courtesy and persuasion or “solicitousness for other people’s feelings or convenience”.\(^{20}\) For example, according to *a-nah-dab*, rather than telling someone “no” outright, a person should try to convince the other individual that what is wanted is not worth having.\(^{2,20}\)
- Burmese refugees’ tendencies towards modesty and politeness may create misunderstandings by health providers because patients from Myanmar may only tell the health provider “what they want to hear” and not their true feelings or thoughts.\(^{34}\)
- When a request is made of a person from Myanmar, they may be reluctant to say no, even if the task is too difficult for them to complete.\(^{17}\)
- Punctuality is not strictly observed. It is generally acceptable to be late unless a situation is critical.\(^{17}\) Healthcare providers may want to discuss time schedules at the start of treatment/therapy.
• Dress is modest.\textsuperscript{50}

• \textit{Thanaka}, a pale yellow paste from the \textit{thanaka} plant may be applied to the cheeks, forehead, and arms for sun protection or cosmetic purposes and is used more frequently by females. This paste may be worn at home or in public.\textsuperscript{2,20}

**COMMUNICATION PATTERNS (VERBAL AND NONVERBAL):**

• The Burmese tend to be friendly and outgoing.\textsuperscript{18}

• It is improper for a Burmese person to lose his or her temper or show too much emotion in public.\textsuperscript{18}

• Direct eye contact is considered polite during greetings and helps to assure confidentiality between healthcare personnel and patients.\textsuperscript{17}

• In Burmese culture, it is acceptable to touch children and it is acceptable for a physician to touch a patient as a way to comfort or assure a patient. However, touching is not acceptable among adults, especially among persons of the opposite sex.\textsuperscript{17}

The following gestures may also be considered inappropriate or offensive to a patient from this country:

• Public displays of affection are unacceptable.\textsuperscript{17,30}

• The head is considered a sacred part of the body and is not touched.\textsuperscript{20,30}

\textit{Note: Patting or touching children on the head is believed to be dangerous to their health.}\textsuperscript{18}

• It is polite to remove your shoes when entering a Burmese home; avoid pointing your feet at anyone or exposing the bottom of your feet to another person.\textsuperscript{18,20,30}

• To a person from Myanmar:
  – It is rude to point a finger or hand at another person.\textsuperscript{20}
  – It is insulting to beckon someone with an upraised index finger.\textsuperscript{20}
  – It is impolite to take a seat that is higher or at the same level as an older or more respected person.\textsuperscript{20}

**DIET AND NUTRITION:**

• Food is thought to be medicinal as well as nutritious and is categorized into “hot” or “cold”.\textsuperscript{17}

• There are six Burmese tastes (sweet, sour, hot, cold, salty, and bitter); a diet of either more or less of these six tastes is recommended to treat various illnesses.\textsuperscript{20}

• Typical Burmese dishes include: rice, beans, fish, green tea, soup, chicken, curry, salad, fruits.\textsuperscript{17}

• The Burmese usually eat a meal in the morning and one in the evening; persons from Myanmar may use their fingers or utensils to eat.\textsuperscript{18}
TRANSLATED EDUCATIONAL MATERIALS AVAILABLE THROUGH THE WORLD WIDE WEB

TUBERCULOSIS SPECIFIC MATERIALS (TITLES PROVIDED IN ENGLISH)

BROCHURES AND FACT SHEETS

General disease information

• What is Tuberculosis? (Burmese):
  http://www.refugees.org/uploadedfiles/Participate/National_Programs/Healthy_Refugees/Brochures/Burmese-TB.pdf

• What is Tuberculosis? (Karen):
  http://refugees.org/uploadedfiles/Participate/National_Programs/Healthy_Refugees/Brochures/Karen-TB.pdf

• Health Messenger – Special Issue on Tuberculosis (Burmese):
  http://burmalibrary.org/docs3/PdF%20FINAL%20ISSUES/ISSUE%207.pdf

• Active TB Disease (Karen):

Diagnostics

• Instructions for Collecting Sputum for TB (Karen):

• The TB Skin Test (Karen):

Explanation of Contact Investigations

• TB Contact Investigations (Karen):

Treatment

• Medication Information (Burmese):

• Active TB Treatment Plan (Burmese):

• How to Break the Chain of Transmission – Tuberculosis (English, Burmese):

• Treatment for Latent TB Infection (Burmese):
  http://www.findtbrsources.org/scandocs/AD32907.pdf
• Treatment for Latent TB Infection (Karen):

HIV/AIDS SPECIFIC MATERIALS (TITLES PROVIDED IN ENGLISH)

BROCHURES AND FACT SHEETS

• What is HIV? (Burmese):
  http://www.refugees.org/uploadedfiles/Participate/National_Programs/Healthy_Refugees/Brochures/Burmese-HIV.pdf

• What is HIV? (Karen):
  http://www.refugees.org/uploadedfiles/Participate/National_Programs/Healthy_Refugees/Brochures/Karen-HIV.pdf

• Basic Facts about HIV/AIDS (Burmese, English):

• Health Messenger – Special Issue on HIV/AIDS (Burmese):
  http://burmalibrary.org/docs3/PdF%20FINAL%20ISSUES/ISSUE%2025.pdf

• Health Messenger: Special Issue on STDs and HIV (Burmese):

• Questions and Answers on HIV/AIDS (Burmese):
  http://www.unicef.org/myanmar/mm_pub_AIDS100_QA_MM.pdf

INFORMATION ABOUT REFUGEES FROM MYANMAR

BROCHURES AND FACT SHEETS

• Welcome to the United States: A Guidebook for Refugees (Karen):

• Burmese Refugee Camps in Thailand’s Tak Province:
  http://www.churchworldservice.org/PDFs/refugees/TakProvinceCamps.pdf

• Burmese Muslims:
  http://www.churchworldservice.org/PDFs/refugees/BurmeseMuslims.pdf

• Who Are the Muslim Karen?:
  http://karenkonnection.org/Docs/012008_Who%20are%20the%20Muslim%20Karen.pdf

• Karen Refugees from Burma in Tham Hin Camp: A profile:
  http://www.churchworldservice.org/PDFs/refugees/Burmesefs.pdf
• Karen Refugees from Burma: A Background:
  http://www.churchworldservice.org/PDFs/refugees/Karenrefugees.pdf

*Please note that this resource list is not exhaustive and does not represent all the resources available for this subject. Additional TB educational resources may also be found at www.findtbrresources.org

REFERENCES


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46. Stephanie Spencer, MA, Program Liaison. TB Control Branch, California Department of Public Health. (Personal Communication December 26, 2008).


Staff–to–Staff Tips and Insights

Do you have experience working with clients who were born in this country?

Share your insights with your colleagues.