

TB & CULTURAL COMPETENCY

Notes from the Field

Northeastern Regional Training and Medical Consultation Consortium

Issue #7 Spring 2008

REACHING OUT TO BURMESE REFUGEES

Introduction

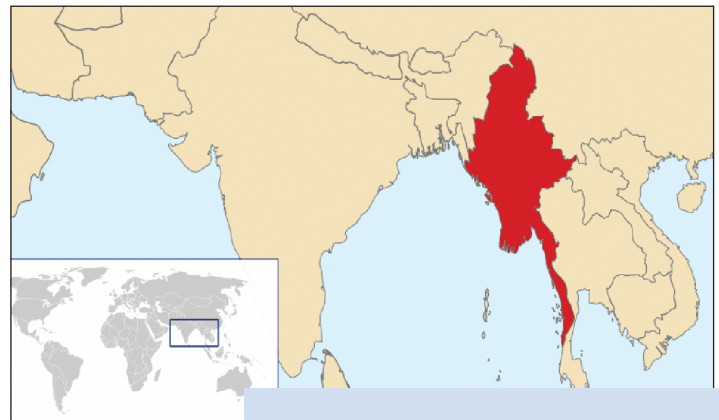
Increasingly, TB control in the United States involves working with populations of people from different countries and cultures, who have come to the United States for a variety of reasons. Each year approximately 400,000 *immigrants* and *refugees* enter the United States. An *immigrant* is someone who leaves his or her country of origin to take up permanent residence in another country. This may be someone who comes to the United States for employment, or to join family already here. A *refugee* is someone who has been officially granted permission to settle in another country after being forced to leave his/her home because of war, poverty, political turmoil, natural disasters or persecution based on race, religion or gender. These kinds of problems also create *internally displaced persons*, who are forced to flee their homes, but remain within their country's borders. As noted in issue #2 of this newsletter (December 2004, <http://www.umdnj.edu/globaltb/downloads/products/Newsletter-2.pdf>), there may be particular health needs and concerns in working with refugees.

This issue of *TB and Cultural Competency* is focused on refugees from Burma (Myanmar), since over the last several years there has been an increase in this population entering the United States. Over the next 5-10 years, approximately 140,000 Burmese refugees will be re-settled in the United States.

As will be described more fully below, since Burma is one of 22 countries with a high-burden of tuberculosis identified by the World Health Organization, this will have implications for TB Control Programs in the United States. Some programs have already begun to feel the impact of this resettlement. This newsletter will include a brief cultural profile of Burma as well as some highlights from a TB outbreak contributed by two public health nurses in a low-incidence state in the upper Midwest.

Background

Burma has a complex history including multiple different ethnic groups and a number of dynasties and kingdoms



Burma, also called Myanmar since 1989, is located in Southeast Asia. It is slightly smaller than the state of Texas.

with evolving power and borders. The land was first unified as a multi-ethnic kingdom as early

as 1044 AD. This was followed by centuries of shifting power and interethnic struggles. In the 19th century several serious conflicts with Great Britain culminated in the total annexation of Burma in 1885. While the economy of Burma was transformed from subsistence farming to large-scale exports of the country's rich natural resources under British rule, power and wealth remained in the hands of foreigners and as a whole, the Burmese people did not benefit from the prospering economy.

In 1948 the Burmese achieved independence from Britain and a parliamentary democracy followed, though ethnic conflicts continued as minority groups demanded autonomy from the government. In a 1962 military coup, the Burma Socialist Programme Party seized power and held it for the next 26 years. There were no free elections, and human rights abuses were common. The government violently repressed demonstrations by students, monks, and the general population, including mass national protests in 1988. The military fired into the crowds killing thousands.

Continued on page 2

Continued from page 1

In September 1988 the armed forces staged a coup to restore order but also violently repressed protesters.

The results of 1990 parliamentary elections, won by the opposition, have been ignored and the military group who took power in 1988 still rules the country. Due to the extreme political and economic crisis over the last five decades, there has been increasing isolation from the international community, and a lack of adequate infrastructure and access to resources. This affects millions of people in the country, who live in conditions of extreme poverty with little access to health and education services.

In September 2007, the army again cracked down on pro-democracy demonstrators led by Buddhist monks. Many were killed, thousands jailed, and more refugees streamed from the country. In spite of stronger sanctions, the government continues to resist international pressure to open the political process and improve the human rights situation.

(Sources: US Department of State, Bureau of East Asian and Pacific Affairs 2007, The Burma Campaign 2007, and United Nations Office on Drugs and Crime, December 2005)

Burmese Refugees

Many Burmese flee conflict and violence between the military and insurgent groups, state oppression and/or political and religious persecution. An estimated 500,000 people, mostly ethnic minorities, are internally displaced within Burma. Many may also escape to neighboring countries, such as Thailand, Malaysia, India, and Bangladesh where some settle in refugee camps. Refugee camps are intended to be temporary settlements, though many residents may live there for several years. Living conditions in these camps can be very difficult. There are a number of refugee camps in Thailand along the Thai-Burmese border, and an estimated 150,000

Burmese refugees, largely from the Karen ethnic group, have lived in camps in Thailand, often for more than a decade. Prior to arriving in Thailand, the refugees and asylum seekers may have experienced torture, rape, forcible conscription of their children in the military, and forced labor. Many may have lived as internally displaced persons within Burma for extended periods.

In 2005 the Thai government approved the resettlement of Burmese refugees from these camps. Significant numbers of Burmese refugees from Thailand began to be resettled in the US starting in 2006.

(Source: Thailand: Burmese Resettlement Offering New Opportunities and Creating Complications, Refugees International 2007)

Burmese in the United States

The predicted influx of Burmese refugees from Thailand is expected to change the makeup of the Burmese community in the United States over the next several years. As of 2000, most of the estimated 20-30,000 Burmese living in the US were immigrants. The largest numbers were living in California, New York, Pennsylvania, Texas, Maryland, Massachusetts, and Illinois. Most of these were ethnic Burman immigrants and included many educated professionals. The new group of expected refugees is religiously, ethnically, and linguistically diverse. Many new refugees do not follow the migration

patterns of earlier Burmese immigrants, and often are originally from rural villages in Burma. These new refugees may bypass established Burmese communities in the United States. In the past two years groups of Burmese refugees have settled in Syracuse, Phoenix, Minneapolis, Fort Wayne, and Dallas. (UNHCR, 7/27/07). Additionally, as refugees, the needs of these new communities may be different than those of communities of more established Burmese immigrants.

Refugees undergo a medical assessment overseas before being cleared for travel to the US. In 2007 the Centers for Disease Control and Prevention (CDC) revised the *Technical Instructions for Tuberculosis Screening and Treatment (TB TI)*. These new TB TI are in the process of being implemented and have been already been piloted at the Mae La Camp, a Burmese refugee camp housing mostly ethnic Karen refugees in Thailand.

AN OUTBREAK AMONG BURMESE REFUGEES

Introduction

Last year two very serious cases of TB were reported among students in one high school in a low incidence state in the upper Midwest. Both students were recently-arrived Burmese refugees. One patient was diagnosed with pulmonary disease with a multi-drug resistant strain, and the other with

Continued on page 4

REPORTING REQUIREMENTS

In October 2007 the CDC Division of Global Migration and Quarantine issued a letter reminding state and local health departments of the reporting mechanisms for Burmese refugees evaluated for tuberculosis after arrival to the United States. Since the Burmese refugees from the Mae La camp are the first population to be screened according to the 2007 TB TI, the results of domestic evaluations are very important for assessment and oversight. It is also important that the CDC learn in a timely manner about any Burmese refugees diagnosed with TB disease after arrival to the US. Full information, including the letter, instructions, and reporting procedures can be found at <http://www.cdc.gov/ncidod/dq/refugee/burmese/index.htm>

BURMA (UNION OF MYANMAR)

- **Population:** The population of Burma is estimated to be between 47 and 55 million. One third are younger than 15 years of age; only 8% are older than 60.
- **Name:** In 1989, the ruling military junta officially changed the name of the country from Burma to Myanmar. The two words have the same meaning. However, the word Burma was traditionally used informally, especially in spoken language. Myanmar is the literary form of the word, traditionally used in publications and in ceremonial and official settings. Opposition groups within the country tend to still use Burma, as a rejection of what they consider to be an illegal government, or the government's attempt to impose the more literary language.
- **Ethnicity and religion:** The government recognizes as many as 105 separate ethnic sub-groups in the country. Members of any of these ethnic groups may be considered "Burmese" because their home country is Burma. However, not all people from Burma are "Burman". Burmans are the majority ethnic group, making up about 2/3 of the population. Other major ethnic groups are Shan 9%, Karen 7%, Rakhine 4%, Chinese 3%, Indian 2%, Mon 2%, and others 5%.
Buddhists comprise 89% of the population, with Christians 4% (Baptist 3%, Roman Catholic 1%), Muslims 4%, animists 1%, and others 2% in the minority. The Muslim and Christian populations face religious persecution. There are more than 540,000 internally displaced persons, mostly ethnic Karen, Shan, Mon, and other groups. Many have kin in nearby countries and there are nearly 300,000 refugees in camps located in border areas of Bangladesh, India, and Thailand, as well as several thousand more in Malaysia.
- **Education and literacy:** Overall, the Burmese population is highly literate, with about 90% of those over 15 years of age able to read and write in their native language. Ethnic Burmans speak Burmese, as do many others, but minority ethnic groups also speak their own languages. The US Department of State, estimates that functional literacy is much lower. Educational services in Burma have been limited and interrupted in many areas in recent years, with minority populations at a disadvantage.
- **Occupations:** Most Burmese work in agriculture (70%), with services (23%) and industry (7%) being less prominent.
- **Health indicators:** Life expectancy is 57 years for men and 63 years for women. In 2003, the infant mortality was estimated at about 50 per 1000 live births, and the maternal mortality ratio at 380 per 100,000 live births. Infectious diseases still predominate as the cause of hospital deaths. Burma has one of the most serious HIV epidemics in Southeast Asia: HIV prevalence among pregnant women was estimated at 1.8% in 2004, prevalence among sex workers and IV drug users is much higher. The epidemic may now be self-sustaining in the general population.
- **Health system:** Nationally, there is a shortage of primary health care workers (nurses, midwives, basic health personnel). In many areas, access to care and qualified doctors may be difficult. There is a large private medical sector; private health expenditures account for over 80% of total national health expenditure. In the public sector medications may be in short supply; however, antibiotics, including anti-tuberculosis medications, are available in pharmacies and markets. Traditional medicine is recognized as an integral part of the health care delivery system.
- **Tuberculosis:** Burma is among the 22 high-burden countries as reported by the WHO; however, the national TB program is showing steady improvement. The 2005 TB incidence was estimated at 171 cases/100,000 population per year. In 2004, 4.4% of new TB cases were MDR, as were 16% of previously treated cases. Global targets for TB control have been reached in Burma despite serious constraints in resources – both financial and human. The greatest challenge facing Burma is to sustain their successes in the context of limited resources, an increasing number of persons co-infected with TB and HIV, and increasing rates of drug-resistant TB. There are strong initiatives to engage the growing number of private general practitioners diagnosing and treating TB throughout the country. However, services are needed for populations especially vulnerable to TB in Burma, including the Thai-Burma cross-border populations and persons residing in remote locations.

Sources:

Central Intelligence Agency, *The World Factbook*: <https://www.cia.gov/library/publications/the-world-factbook/geos/bm.html>

U.S. Department of State, Bureau of East Asian and Pacific Affairs: <http://www.state.gov/r/pa/ei/bgn/35910.htm>

World Health Organization, <http://who.int/countries/mmr/en>; <http://who.int/whosis/database/core>;

http://www.searo.who.int/EN/Section313/Section1522_10916.htm; http://www.searo.who.int/LinkFiles/Country_Health_System_Profile_7-myanmar.pdf

WHO Country Office for Myanmar: <http://www.whomyanmar.org/EN/>

UNAIDS (Joint United Nations Programme on HIV/AIDS): http://unaids.org/en/Regions_Countries/Countries/myanmar.asp

YOUANDAIDS, the HIV/AIDS Portal for Asia Pacific: <http://www.youandaids.org/Asia%20Pacific%20at%20a%20Glance/Myanmar/index.asp>

Continued from page 3

pulmonary and extra-pulmonary disease with severe complications.

Fortunately, there was no documented transmission in the high school, but secondary cases and contacts with latent TB infection were found in churches and places of employment. In the end, a total of five active cases and many infected contacts were identified and treated until completion. Over the course of their interaction with this refugee community, the TB program staff faced many challenges related to the impact of pervasive TB-related stigma, the use of interpreters, and cross-cultural communication.

Because of cultural issues specific to refugees, including a history of persecution and related distrust of government, this was a challenging population to work with. In this newsletter, we are presenting a vignette from one of the cases and highlighting some of the challenges encountered. We will explore some of the cultural factors that may have potentially contributed to the challenges, as well as some possible approaches and lessons learned in retrospect. However, it is important to note that there are no “right answers” and the vignette simply presents issues to think about in this particular instance and some approaches that might be used when encountering similar situations.

Pervasive Stigma & Working with Interpreters

On the first visit to one patient's home, the public health nurse communicated directly with the teenage patient, who understood English very well and was receptive to information she offered. The public health nurse contacted the Burmese interpreters who worked with the department of health for assistance with the contact investigation and ongoing DOT. However, the interpreters were hesitant to get involved for fear that they would be associated with TB disease and rejected by other Burmese community members. This may have

been a reflection of the level of stigma around TB in Burma.

The nurse made her second home visit without an interpreter and met with the patient's family. They had fled religious persecution in Burma, arriving in the US several months before the patient was diagnosed with TB. The family was very involved in the activities of a local church group that had sponsored their settlement in the US. The adult family members spoke limited English, but the school age children were fluent. Therefore, the patient and the patient's siblings acted as interpreters for the parents and other adult members of the extended family. This was only a temporary solution, and it created tensions in the family as it put the young people in the role of ‘gate-keepers’ in interactions with the health department.

The contact investigation expanded to local churches in which the family members were active. The interpreters remained hesitant to participate in group education and testing, stating “If I go into a building with TB, others will think I have it and will not come to me for help anymore.” Deacons and young people volunteered as interpreters during the TB education and testing sessions at the churches.

The health department staff undertook the challenge of educating the interpreters about the cause and transmission of TB, and its treatment, emphasizing how TB is *not* spread and how soon someone on appropriate treatment is no longer infectious. While the interpreters may have understood this, they remained concerned that others in the community would not understand and would shy away from them. They were, however, willing to work over the phone, since it avoided face-to-face contact.

Health department staff recognized that there would be no easy solution to addressing the stigma-related issues presented by the interpreters, and decided to work around the issues

instead of trying to change the situation. Luckily, a Burmese international medical graduate working in the area joined the interpreter team, providing a ‘cultural bridge’ between the interpreters and the health department. Staff felt confident about the accuracy of TB information that she provided, and she acted as a role model for the interpreters. The interpreters never became comfortable with the idea of going into patients' homes, but as time went on, they became more confident in communicating TB information and began helping in other ways: providing clients with transportation to clinic or to apply for social services and helping out in public events. Because of the role the interpreters served in the community, in time, they began to serve as liaisons who could assist with providing access to the community and provide information about the importance of the health department efforts.

Another unexpected challenge in working with the interpreters had to do with ‘territory’. Sometimes interpreters from one ethnic group preferred to interpret only for patients from their group. They respected the ‘territory’ of another group's interpreter, saying that each interpreter should stick to the patients with whom they had already started working. In this case it was important for the health department to realize that it was not simply an issue of language, and that the complex social structure of religious and ethnic groups that make up the Burmese population must be respected. Both community members and interpreters seemed more comfortable following the intuitive roles and relationships established within their cultural group. By demonstrating respect for this approach the health department staff was able to work with interpreters to effectively meet their public health goals in a way in which the interpreters felt comfortable.

Another challenge around the use of

interpreters is highlighted in this case: it is clear that the interpreters were an important part of the community. Because of this and their relationships within the community, they may not have been able to serve as objective medical interpreters, and may have presented some of the same concerns as using family members to interpret. For more about working with interpreters, see *Making the Connection: An Introduction to Interpretation Skills for TB Control*, a video and viewer's guide produced by the Francis J. Curry National Tuberculosis Center.

The health department staff also noticed that patients themselves seemed to express more concern about the effect of their disease on their place in the community than about their own health. The patients, and those interviewed as part of the contact investigation were very concerned about being isolated or shunned by their peers and others in their community. Health department staff had to understand these points of view to be able to address their clients' concerns and gain their cooperation. Due to stigma, association with the disease could lead to isolation from their community. In this context, a positive TB test result was threatening primarily because of what it might imply about an individual's integration into the community, and was only secondarily concerning as a health issue. An approach that might be useful in this situation may be to ask the patient what their most important priorities and concerns are, which would help provide insight into how to meet their needs, so that the patient could then focus on treatment. If in fact, their biggest priority is to maintain an active role in the community, one approach might be to emphasize getting well as the first step to re-entering the community as well as to reinforce the idea that TB itself does not discriminate and anyone can be infected.

This emphasis on TB threatening patients' integration into the commu-

nity, rather than their personal health, may also speak to the community and family structure among Burmese and the more typically non-Western focus on the larger community, rather than individuals. In many cultures the individual is valued most for the role he or she plays in family and community. Another potential contributor to this seeming disregard for personal health may be a perception of health and illness as something that is given to a person and that cannot be controlled. It may be seen as the will of God, or the universe, and the final outcome of what will happen is already determined, so the individual must accept what happens. This is different than the mainstream Western perspective that views personal health as strongly influenced by the individual and the actions he or she takes.

People who have been recently displaced may place a very high value on preserving harmony and participating in the greater community.

Similarly, even people who are relatively comfortable in a new culture may seek guidance and solace from their culture of origin in difficult situations, such as life-threatening illness. Again, an understanding of these concerns, values, and perceptions of illness may assist the health worker in addressing the concerns and fears of the patient in order to gain commitment and adherence to treatment, as well as cooperation in the contact investigation.

Communication Issues

Health department staff were surprised to learn that some individuals who should have been identified as contacts early in the investigation were not identified until much later. This surprised the health department for two reasons:

- Although trust was initially a challenge in working with this community, health department staff felt community members now understood the risks of spreading TB, communicated openly, and cooperated freely. This was a significant accomplishment given the fact that many community members had little experience dealing with organized healthcare systems and many had reasons to distrust or fear such systems based on previous experiences with an autocratic government.
- Health department staff felt they had clearly defined for community members exactly who should be considered a "contact."

Who is a contact?

Health department staff defined a "contact" as someone who had been in the same space as the original case. To the health department staff, this explanation seemed an obvious description of who should be included as a reportable contact. In hindsight, it is clear that some community members did not consider people who frequently come and go to fit this category. For instance, health workers learned later into the contact investigation that one patient's family held 24-hour prayer services in their home upon learning of the patient's TB diagnosis, with various members of the community stopping by. It became increasingly clear that many of the social groups were inter-related, mostly through their churches. If one family member got a specialty food product, they would all gather to have a potluck meal. However, this type of event was also typically not mentioned to TB control staff. To the community members this was considered a normal occurrence of everyday life, not a "visit" or a "reportable event."

Neighbors and friends continued to visit the family's home. However, the patient reported having no visitors,

Continued on page 6

Continued from page 5

since those visiting the home had actually come to see the patient's siblings. Over time, the patient and a sibling (a secondary case) grew to understand that they were under home isolation, but the family did not understand that this meant the whole house was under isolation. As a result of these misunderstandings, the health department continued to identify new contacts while patients were still infectious.

Cultural Communication Styles

Looking back, one might conclude that this miscommunication around who is defined as a contact occurred due to differing cultural communication styles rather than differing agendas or issues of mistrust. The predominant American communication style values unique individual expression and clear, direct verbal clues. This style facilitates exchange of specific information, facts, or opinions and information is often

presented using a very direct approach. Burmese culture may be described as more collectively-oriented, favoring indirect, nuance-filled communication over the literal meaning of the spoken word. Self-expression within this communication style reinforces collective values and identities, and can function to prevent disagreement and preserve harmony. The way community members viewed visitors to the home may be one example of this. In the events described here, the interpreters

TRADITIONAL MEDICINE

The World Health Organization reports that up to 80% of the world's poor and rural populations rely on traditional medicine for primary care. Traditional health practitioners tend to be more accessible than conventional healthcare services in many rural areas. Health workers in refugee camps in Thailand find that many Burmese prefer traditional medicine for common health conditions – and that belief may be found in Burmese in the US. However, it is important to remember that in many cultures traditional and Western medicine co-exist and healthcare workers should not assume that members of a specific cultural group will use traditional medical practices. It is also important to avoid provoking a direct confrontation between the two. Rather, healthcare practitioners should ask patients about their use of traditional medicine so that they can coordinate and avoid any potentially dangerous interactions.

Though traditional medical practices vary by ethnic and religious group, the following are examples of some Burmese ethnic traditional health practice. However, the healthcare workers involved felt that these did not play a role in the case study described.

“Burmese traditional medicine is based in Ayurveda, the classical healthcare system of India, as well as in indigenous health traditions. Health is believed to be related to interactions between the physical body, spiritual elements and the natural world, referred to as the ‘dat system’, which includes Wind, Fire, Water, Earth and Ether elements. Burmese medicine also follows concepts of hot and cold, common in many indigenous health systems, which are believed to cause fevers and coldness in the body, and can be influenced by diet, seasons and spiritual elements (MacDonald, 1979). Illness within this system is believed to be caused by a physiological imbalance, which may begin on both physical and spiritual levels. Illness is classified as an imbalance and, therefore, treatable, until the very final stages, at which point it is classified as a disease.”

“Burmese spiritualism is based on a complex system of spirit worship, not directly related to Buddhism, but which has become part of the spiritual practice of Burmese Buddhists. Within this system, belief in spiritual entities and agents is linked with beliefs about the causation, progression and treatment of illness. A panoply of spiritual entities and their agents has been identified (Spiro 1967). These include witches, demons, ghosts and nats – Burmese spirit beings. Spirit influence is believed to include possession and illness. Accordingly, treatment methods incorporate spiritual healing and exorcism.”

Muslim Burmese may use amulets around their children's necks. These are made by a Burmese traditional ‘doctor’ who uses Muslim numerology and Burmese astrology, corresponding a lucky number to a verse in the Koran. “Once the specific verse is identified, it must be written on high-quality white paper, wrapped tightly and neatly in plastic, tied up with a thread and worn around a specific part of the body.”

Karen practitioners diagnose illnesses by checking wrist pulses and examining the face and eyes. Most illnesses are thought to be caused by heat in the body, often related to eating the wrong foods for one's body type. An astrologer is consulted for problems of external health and well-being, while a doctor would be sought for internal health issues.

Sources: Bodeke G, Neumann C, Lall P, and Oo ZM. *Traditional Medicine Use and Health Worker Training in a Refugee Setting at the Thai-Burma Border*; Journal of Refugee Studies, Vol. 18, No. 1, Oxford University Press; 2005. Neumann C. *Amulets and Tears* (photoessay); *The Journal of Alternative and Complementary Medicine*, Vol. 9, No.1, pp 21-33, 2003. Neumann, C. *Vanishing into the Hills of Burma: Traditional Karen Medicine* (photoessay); *The Journal of Alternative and Complementary Medicine*, Vol. 9, No.4, pp 461-465, 2003.

working with the health department were members of the affected community and may have felt intrusive or disrespectful directly translating queries about visits to the home by any person for any purpose or directly asking who had been in the home. If that were the case, the interpreters might have shaded the definition to be more compatible with the traditional communication style.

Faced with such a challenge, health care providers can try to bridge differences in communication styles by specifying the different types of visitors who may come to house, such as other family members, friends of others in the house, people who came over for meals, and state that this type of person, even though they were not particularly there to see the patient, is also someone who might have been at risk. In this case, since a contact investigation was conducted at the high school, other students or teachers who were in the same classrooms or common areas could be used as an example to demonstrate the concept of sharing space.

Another approach in this situation might be to discuss communication styles in advance with the interpreter and describe the type of information that will be presented and gathered from the patient, and ask the interpreter if they think that there are any cultural or communication style issues that may hinder effective communication around these concepts.

Conclusion

In working with refugees or immigrants from other cultures, health department staff will encounter issues of establishing trust, communicating health information, overcoming language barriers, explaining our health system, and clarifying who will do what to ensure that diagnoses and treatments reach a successful conclusion. This vignette presents only some of the issues that may arise when working with recent refugees from Burma, or other settings. When working with recent immigrants and

Social Services for Refugees

A range of social services may be useful for assisting refugees who are resettling in our country. These include pre-school, academic assistance for elementary school children, and for adults: English language classes, computer training, companionship, cultural orientation, case management, interpretation, translation, assistance with immigration, navigating the health system, and food bank support. The following sources have information on these services:

- U.S. Department of Health and Human Services, Administration for Children and Families, Office of Refugee Resettlement lists contractors receiving matching grants in many of cities and states where Burmese refugees are settling www.acf.hhs.gov/programs/orr/programs/mgpss.html
- Human Rights Watch – Refugee Project www.hrw.org
- UNHCR (United Nations High Commission on Refugees) – The UN Refugee Agency www.unhcr.org
- Episcopal Migration Ministries www.episcopalchurch.org/emm
- Church World Service – Refugees www.churchworldservice.org
- State and local health departments also often have an office in charge of refugee services.

TB Educational Materials

As noted earlier, there are a number of different languages spoken in Burma. The following websites provide TB education materials in various languages, including some languages spoken by Burmese refugees:

- The Minnesota Department of Health (Karen) <http://www.health.state.mn.us/divs/idepc/diseases/tb/brochures.html>
- US Committee for Immigrants and Refugees (Burmese, Karen) <http://refugees.org/article.aspx?id=2045&rid=2086&subm=178&area=Participate>
- The Michigan Department of Community Health <http://www.michigantb.org/hcp/documents/EnglishandBurmesePatientEd.pdf>

Additional information on Burmese refugees and resources is available at: <http://www.umdj.edu/globaltb/products/newsletter7.htm>.

refugees, it is important to consider how the many cultural nuances impact not only patients and their families, but also the social service providers and interpreters who may be part of the community and share the same values and beliefs. We hope that this issue of Notes from the Field offers a range of perspectives that will be useful to TB control staff facing these challenges.

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Thanks to Greg Harrington, MD for his contribution to enriching this case study. We would also like to acknowledge Carolyn Wagner, RN and Kitty Katz, RN and other members of the TB control team who worked so effectively on this outbreak in the Burmese community.

Mae La Camp

The following information was drawn from trip reports and presentations regarding a May 2007 Advisory Council for the Elimination of Tuberculosis (ACET) and CDC site visit to the Mae La refugee camp. The purpose of the visit was to assess the implementation of new TB Technical Instructions. Thanks to Wanda Walton, Branch Chief, Communications, Education, Behavioral Studies Branch, Division of Tuberculosis Elimination at CDC for providing information and photos from the trip.

With 573 acres, the Mae La Refugee camp is the largest camp on the Thai-Myanmar border. **As of September 2007, about 15,000 refugees from**

Continued on page 8

Continued from page 7

this particular camp were expected to resettle in the US.

The population in the camp is about 46,000 with 97% identified as Karen. There are 26 schools with 16,460 students and 675 teachers.

Resettlement efforts have improved TB case finding in the camp. The International Office for Migration (IOM) is now conducting medical evaluations and identifying TB cases.

IOM also conducts life skills training for refugees scheduled for relocation. These sessions cover TB transmission and pathogenesis. Education, training, and coaching on sputum collection are provided for refugees who must produce a sputum specimen. TB nurses provide individual education for those diagnosed or suspected to have TB disease.

Once diagnosed with pulmonary treatment of TB, patients are isolated in the "TB village" located at the far end of the camp up a steep hill. In May of 2007, about 200 people were being housed in the TB village.

All TB patients in the camp receive DOT with treatment regimens following ATS/CDC/IDSA standards. Patients within the TB village are treated by a physician from the aid organization Doctors Without Borders.



Above: Administering DOT.

Left: Information boards, like this one depicting photos and stories from relocated refugees are very popular at the camp.

If you would like to provide feedback on this newsletter please visit our website at <http://www.umdnj.edu/globaltb/contactus.htm>



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