Original Publication

Working With Burmese Patients: Understanding Historical and Cultural Contexts to Improve Health Care Access and Health Status

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Abstract

Introduction: Burmese patients resettled in the United States as refugees constitute one of the country’s largest refugee populations. As health inequities within the wider Asian and Asian American population have garnered more attention, medical professionals have worked to better understand how to provide care to Burmese and Burmese American patients. This workshop addresses the pressing need to provide culturally responsive care to this growing population. Methods: Our interactive 60-minute workshop was developed to increase the knowledge and confidence of health care providers and trainees regarding the specific needs of Burmese communities in the United States. It was implemented once in person and twice virtually. The workshop included a PowerPoint presentation and case studies. Pre-and postworkshop evaluation forms assessed the effectiveness of the module. Results: The workshop’s 70 attendees included an interdisciplinary group of medical students, academic faculty, graduate students, and health care staff. Following module completion, all learning objectives were met. Paired-samples t tests revealed significant increases in average number of correct responses for all learning objectives. Discussion: This module is part of a larger initiative to provide current and future health care providers with information to empower them to supply culturally responsive care to Burmese and Burmese American patients and their families. We offer recommendations for improving care for this patient population on individual, provider, and systemic levels. We hope that this module will inspire opportunities to advocate for change in policy and health care/research funding for Burmese and Burmese American patients.

Keywords
Asian Americans, Refugees, Cultural Competence, Social Determinants of Health, Diversity, Equity, Inclusion

Educational Objectives

By the end of this workshop, participants will be able to:

1. Describe the history of the Burmese within Burma and the United States.
2. Describe health issues and inequities experienced by Burmese living in refugee camps and in the United States.
3. Identify at least two health care access issues faced by Burmese living in the United States.
4. Identify at least one barrier to conducting research aimed at improving the health condition of Burmese patients in the United States.

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Introduction

Burmese—an inclusive term we use to refer to both Burmese refugees and Burmese natives—began migrating to the United States in large numbers in 2008 to escape from religious, political, and economic oppression.1-3 Between 2000 and 2019, refugees with Burmese origins were the largest refugee group to resettle in the US, particularly in areas such as New York, Texas, and Indiana.2 Burma is a culturally diverse country made up of more than 100 different ethnic groups. A Providing culturally responsive care to this growing patient population in the US requires a deep understanding of Burma’s multicultural identity and the historical context of Burmese refugees’ displacement.1 Information on Burmese health is limited to postmigration health screening, which identifies hepatitis B, parasitic infections, and mental health issues as the most pressing issues.2 An analysis from 2010 to 2014 demonstrated high rates of lead poisoning in young Burmese refugees.5 This may result from unsafe housing conditions offered in the US and the use of traditional Burmese medicines, such as a digestive aid Daw Tway, found to have...
high levels of lead. Burmese-specific health outcomes following resettlement are poorly understood, exacerbated by the historical aggregation of Asian/Asian American subgroups as a monolith in national epidemiological studies and survey data. Health inequities in refugees compared to the general population have been documented for many years, including increased rates of chronic pain and lower rates of cancer screening. Refugee populations are diverse, and this heterogeneity is reflected in their health outcomes. For example, West African women experience higher rates of stillbirths than their fellow refugees in North and Middle/East Africa. Data from another study show that in comparison with South Asian immigrants, refugee women from Afghanistan and Bhutan are more likely to have postterm births. An Australian study found that Burmese refugee women are significantly more likely to need an interpreter, have poorer maternal health, and are more likely to have induced labor compared with Southeast Asian immigrant women. Refugees, including Burmese, are also significantly more likely to have mood disorders compared to the general population and are less likely to have access to mental health services. Significant ethnocultural variation exists across refugee groups in the emotional expression of the effects of trauma. This can limit a provider’s ability to effectively detect and treat mental health issues.

Despite demonstrated health needs, Burmese patients as group possess low levels of health care literacy and suffer from a lack of health-related resources. Thirty percent of Burmese in the US live in poverty, twice the national rate of poverty in the United States. Burmese students in the US have the highest high school dropout rate of all Asian major ethnic groups at 44% and have lower rates of English proficiency compared to their Asian/Asian American counterparts. These barriers impair the ability of Burmese patients to navigate the complex medical system and result in low rates of satisfaction with their primary care doctors and clinic experiences. Recognizing and responding to the unique health challenges of the Burmese community while integrating strong cultural assets should be a priority for health care providers wishing to address health inequities and improve clinical outcomes.

Published curricula on the needs of Burmese patients are sparse. McHenry and colleagues published a study evaluating the effectiveness of a brief intervention on caring for Burmese patients directed at resident physicians. A review of MedEdPORTAL revealed several publications specific to refugee health, among them resources providing direction on both pediatric and adult refugee health. To date, no current curriculum focuses on the specific needs of Burmese refugees. We used a social determinants of health framework developed by the World Health Organization’s Committee on Social Determinants of Health to provide a starting point for addressing persistent health inequities for Burmese, as well as those from other refugee populations. Our workshop serves to teach current and future providers about the specific needs of Burmese refugees, supplementing the broader refugee education provided by other resources. Our workshop is designed to be used as a stand-alone teaching tool to focus learners’ attention on the Burmese population in their community. It can also be presented in conjunction with broader refugee education initiatives.

The aim of our 60-minute workshop is to provide health care professionals, trainees, and prehealth students with an overview of Burmese history, health care status, barriers to health care in the US, and limitations in research regarding the Burmese population. We have included ways to facilitate research on the health care needs of Burmese and Burmese American patients to continue the development of evidence-based strategies to improve patient care. We provide participants with recommendations that can be readily applied to their practice to improve care. Our long-term goal is that this curriculum will contribute positively to improving health equity and care provided to Burmese and other refugee populations living in the US.

**Methods**

This workshop was developed and initiated by a medical student in conjunction with a Burmese-born premedical student with deep community health worker experience within the Burmese refugee community. Curriculum development was guided by an assistant professor with a background in health professions education. Our senior author was an assistant dean for student support and inclusion and an associate professor of community medicine with a background in health education. We developed and revised the workshop based on a literature review and feedback from an interdisciplinary team of experts. The team included a Burmese-born physician and founder of a Burma-based health care nonprofit organization practicing in the US, a physician with extensive experience caring for Burmese patients in the midwestern US and creator of an educational module on Burmese refugees for medical residents, and a community leader of Burmese Karen refugees in the Albany, New York, area.

The workshop was designed using Kern’s six-step approach to curriculum development, a systematic method of designing, implementing, and continually improving medical curricula that
has been applied in a variety of traditional and online settings. In step 1, problem identification and a general needs assessment were conducted and completed. A PubMed and Google Scholar search identified multiple articles that informed the content of the workshop curriculum. In step 2, a targeted needs assessment was conducted using open discussion technique with community members and health care providers who had experience working with Burmese and refugee populations. Gaps in care and medical training were identified, which guided the creation of our goals and objectives for the workshop, completing step 3. In step 4, we decided that our educational strategies would include an interactive PowerPoint Presentation and case studies. For step 5, we implemented our workshop three times, through both in-person and virtual platforms. In the final step, evaluation and feedback were obtained by surveying participants to determine the efficacy the workshop. The curriculum was approved by the Albany Medical College Institutional Review Board (IRB).

Three 60-minute interactive workshops were conducted once in person and twice virtually between March and April 2021. The first workshop was an in-person presentation. We recruited potential participants broadly from within our institution and from the membership of refugee health-related student organizations and student organizations representing the identities and interests of students historically underrepresented in medicine. Due to COVID-19-related restrictions barring in-person events, we held the next two workshops virtually. The virtual workshops expanded our audience to include medical students from other institutions, health care workers, prehealth students, and members of the Burmese community. Medical students copresented each session with the same Burmese community member who created the module.

The goal of this workshop was to increase health care trainees’ understanding and confidence in understanding health inequities in the Burmese population, barriers to accessing care, and how to identify negative influences on health status of Burmese in the US. Furthermore, we intended that at the end of each workshop, attendees would be able to identify research gaps and opportunities for advocacy in Burmese and other refugee populations in their specific locales. Our program’s target audience was health care trainees and any health care sector worker or student who might encounter Burmese patients.

We pursued the workshop educational objectives using the following approaches: a PowerPoint presentation with a corresponding facilitation guide (Appendices A and B), interactive case study discussion (Appendix C), and pre- and postworkshop surveys for evaluating workshop efficacy and areas for improvement (Appendix D).

- Appendix A: Working With Burmese Patients—This 60-minute, 46-slide PowerPoint presentation provided an overview of the major conflicts that resulted in the displacement of Burmese citizens to refugee camps, a timeline of migration to the US, and characteristics of the population in the US. We included a discussion of health care issues of Burmese patients in the refugee camps versus the US, barriers to accessing health care in the US, proposed ways to address the barriers, and the status of research on this population. The presentation concluded with two interactive case studies and recommendations for serving the Burmese community. Participants in the virtual workshops could participate by entering text responses.
- Appendix B: Facilitator Guide—The facilitation guide included discussion points for the case studies and speaker notes to allow facilitators unfamiliar with Burmese history and Burmese health care status to conduct the presentation. The facilitation guide was iteratively updated based on feedback from workshop attendees and facilitators.
- Appendix C: Case Studies—The two clinical case studies following the presentation highlighted health care barriers and common health concerns (as mentioned in the workshop’s PowerPoint slides). These case studies cases were developed to further elaborate on common health issues of and barriers to accessing quality care by Burmese and Burmese American patients, as displayed on slides 37 and 40 (Appendix A).
- Appendix D: Pre- and Postworkshop Evaluation Forms—We asked participants to complete pre- and postworkshop evaluation surveys. These were administered using Qualtrics XM software and quantitatively determined whether there was an increase in knowledge of the four learning objectives from before to after attending the workshop. The preworkshop survey included demographic information, and the postworkshop survey included additional feedback questions. We allotted 2-3 minutes during the workshop to complete the surveys.

Review of the facilitator guide, PowerPoint, and case presentations took approximately 1 hour. Materials needed for the in-person workshop included writing utensils, audiovisual equipment to display the PowerPoint presentation, and printed copies of case presentations. Materials needed for the virtual workshops included a computer with video and audio capabilities and an online meeting platform.
We analyzed the IRB-approved survey data using descriptive statistics for demographic information and a one-tailed paired-samples t test to compare pre- and postworkshop responses. We used Wilcoxon signed rank tests to determine if there was a statistically significant difference between mean survey responses before and after the workshop. We conducted all statistical analyses using STATA version 16.1 (StataCorp).

**Results**

A total of 70 participants attended the in-person and virtual workshop sessions. Out of the 70 preworkshop surveys completed, 60 participants entered a unique identifier, which allowed for pairing of the preworkshop survey with the corresponding postworkshop survey. One paired postworkshop survey was not complete and was excluded from analyses.

The final study sample of 59 participants (response rate: 84%) consisted of 50 medical students (85%), one academic faculty member (2%), and eight individuals (14%) who identified their role as "other." Forty-four of the respondents (75%) self-identified as female. Of the individuals who reported race and ethnicity, 23 (39%) identified as only Asian, four (7%) identified as only Black/African American, four (7%) identified as only Latinx/Hispanic, 22 (37%) identified as only White, and five (8%) identified as multiracial (Table 1).

Results of the paired-samples t tests revealed a statistically significant increase in average number of correct responses for all four learning objectives (all ps < .05) in postworkshop surveys compared to preworkshop surveys (Table 2). Reports of self-confidence demonstrated a statistically significant increase (all ps < .01) for all learning objectives after completion of the workshop through a Wilcoxon signed rank test (Table 3). A subanalysis of the workshop based on in-person versus virtual attendance demonstrated similar increases in postsurvey responses but showed statistical improvement in two out of the four questions (Table 4). Changes in confidence levels did not vary across in-person versus virtual sessions.

**Examples of feedback from attendees included the following:**

- “I completed a clerkship at a family practice office which cares for several refugee populations. While there, I encountered several Burmese patients and their families and observed significant barriers to care for this population. One in particular was the lack of appropriate translation services in doctor’s offices as well as by medical office/support staff. This presentation helped me understand my patients’ experiences and challenges with the medical system in the context of their culture and history and helped me better understand the need for translation services across all points of patient contact with the health care system in order to achieve equitable care.”

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**Table 1. Characteristics of Workshop Participants (N = 59)**

| Characteristic                  | No. of Participants | %  |
|--------------------------------|---------------------|----|
| Role                           |                     |    |
| Medical student                | 50                  | 85 |
| Academic faculty               | 1                   | 2  |
| Other                          | 8                   | 14 |
| Sex                            |                     |    |
| Female                         | 44                  | 75 |
| Male                           | 13                  | 22 |
| Transgender or gender nonconforming | 2                | 3  |
| Race/ethnicity                 |                     |    |
| Only Asian                     | 23                  | 39 |
| Only Black/African American    | 4                   | 7  |
| Only Latinx/Hispanic           | 4                   | 7  |
| Only White                     | 22                  | 37 |
| More than 1 race/ethnicity     | 5                   | 8  |
| Other                          | 1                   | 2  |
| Sexual orientation             |                     |    |
| Bisexual                       | 5                   | 8  |
| Gay                            | 3                   | 5  |
| Pansexual                      | 1                   | 2  |
| Queer                          | 6                   | 10 |
| Straight                       | 43                  | 73 |
| Something else                 | 1                   | 2  |
| First-generation college graduate |                 |    |
| No                             | 45                  | 76 |
| Yes                            | 14                  | 24 |
| Session number and type        |                     |    |
| 1: in-person                   | 23                  | 39 |
| 2: virtual                     | 17                  | 29 |
| 3: virtual                     | 19                  | 32 |

*Percentages may not add up to 100% due to rounding.

**Table 2. Mean Percent Correct Response Rates for Pre-/Postworkshop Objective Assessment Knowledge Questions (N = 59)**

| Objective Assessment                                                                 | % Correct | Preworkshop | Postworkshop | M Difference (95% CI) | p  |
|---------------------------------------------------------------------------------------|-----------|-------------|--------------|-----------------------|----|
| 1. Identify the major ethnic group in Burma.                                           | 32        | 86          | 54 (40-68)   | <.001                 |    |
| 2. Identify a common health concern or inequity to Burmese refugees living in refugee camps and in the United States. | 10        | 64          | 54 (39-70)   | <.001                 |    |
| 3. Identify barriers in seeking health care for Burmese refugees.                      | 52        | 76          | 24 (10-38)   | <.001                 |    |
| 4. Identify a way to reduce power inequities in refugee research.                      | 44        | 64          | 20 (3-38)    | .01                   |    |

*Reported p values are for one-tailed paired-samples t tests.
### Table 3. Mean Responses to Pre- and Postworkshop Confidence Questions (N = 59)

| Objective                                                                 | Mean Confidence<sup>a</sup> | No. of Participants With: | Increased Confidence | Decreased Confidence | Same Confidence | p<sup>b</sup> |
|--------------------------------------------------------------------------|-------------------------------|--------------------------|----------------------|--------------------|----------------|------------|
| 1. The history of the Burmese within Myanmar and the United States.     | 0.6 (2.6)                    | 54                       | 0                    | 5                  |                | <.001      |
| 2. Health issues or inequities of Burmese refugees living in refugee camps and the United States. | 0.6 (2.9)                    | 55                       | 0                    | 4                  |                | <.001      |
| 3. Identifying at least two health care access problems faced by Burmese refugees in the United States. | 0.8 (3.4)                    | 54                       | 0                    | 5                  |                | <.001      |
| 4. Identifying at least one barrier to research on Burmese refugees in the United States. | 0.7 (3.2)                    | 53                       | 1                    | 5                  |                | <.001      |

<sup>a</sup>Rated on a 5-point Likert scale (0 = no confidence, 4 = complete confidence).

<sup>b</sup>Reported p values are for Wilcoxon signed rank tests.

- “I had been working in a surgery clinic, screening preoperative patients when I heard one of the members of the health care team making fun of a Burmese patient to the other members of the health care team, commenting on how he had a ‘stupid name,’ that was ‘difficult to pronounce,’ ‘not English at all,’ rolling her eyes and asking if he ‘even speaks English.’ At the time, I did not know how to react, or how to help. This presentation helped me to recognize the significant adversity the Burmese population has faced and learn how to be a better advocate to encourage more empathetic and caring treatment for patients. I will encourage my health care team members to consider how important the patient’s social situation was in terms of considering costs of the surgery and post-op. This presentation helped me become a better provider to ALL my patients.”

Attendee feedback provided valuable suggestions for workshop improvement. Some individuals wanted more information on historical context, more information on what could be done in their locale to better serve this patient population, and more opportunity for interaction and case discussions.

### Table 4. Mean Percent Correct Response Rates for Pre-/Postworkshop Objective Assessment Knowledge Questions by Attendance Type (N = 59)

| Objective Assessment                                                                 | % Correct       | p<sup>a</sup> |
|--------------------------------------------------------------------------------------|-----------------|---------------|
| **In-person attendance (n = 23)**                                                   |                 |               |
| 1. Identify the major ethnic group in Burma.                                         | 35 (100)        | 65 (44–86)    | <.001          |
| 2. Identify a common health concern or inequity to Burmese refugees living in refugee camps and the United States. | 17 (48)         | 30 (0–61)     | <.05           |
| 3. Identify barriers in seeking health care for Burmese refugees.                   | 52 (65)         | 13 (0–37)     | .13            |
| 4. Identify a way to reduce power inequities in refugee research.                   | 39 (56)         | 17 (0–48)     | .13            |
| **Virtual attendance (n = 36)**                                                     |                 |               |
| 1. Identify the major ethnic group in Burma.                                         | 31 (78)         | 47 (28–66)    | <.001          |
| 2. Identify a common health concern or inequity to Burmese refugees living in refugee camps and the United States. | 6 (75)          | 69 (54–85)    | <.001          |
| 3. Identify barriers in seeking health care for Burmese refugees.                   | 53 (83)         | 31 (13–48)    | <.001          |
| 4. Identify a way to reduce power inequities in refugee research.                   | 47 (69)         | 22 (0–44)     | <.05           |

<sup>a</sup>Reported p values are for one-tailed paired-samples t tests.

### Discussion

The goal of this workshop was to educate medical trainees on the historical perspectives and health care status of the growing Burmese community. The paucity of research on how to care for this diverse patient population, along with the historical, cultural, religious, and linguistic diversity of each Burmese ethnic subgroup, reinforces the need to evaluate sociocultural factors that contribute to individuals’ health care statuses. Using Kern’s model of curriculum development, we created an effective, well-received workshop.

A strength of this workshop was the collaboration between medical students, faculty and local community health workers, and members of the Burmese community in the workshop’s development, ensuring that it included a perspective on Burmese health care issues not often found in the literature. Opportunities to reflect on the strengths of the workshop were elicited through the postsurvey feedback. Participants enjoyed the comprehensive overview of the historical background, health, and socioeconomic/demographic factors of the population, as well as the emphasis on the strengths of the Burmese community. Others complimented the interactive case studies that provided...
opportunities to collaboratively synthesize and apply information learned in real-world scenarios. One participant shared that the workshop discussed “a lot of important concepts that aren’t always emphasized throughout the medical education, especially during the pre-clinical years.”

Iterative improvements were made to the workshop based on participant feedback from the postworkshop survey. Participants requested more information on how to better engage with Burmese patients and access interpretation services, as well as asking for more locale-specific information to help support the Burmese community. We therefore suggest that future presenters tailor the PowerPoint by adding such information.

There are several limitations that should be taken into consideration in both the implementation of the workshop and the conclusions from the data. Seventy-five percent of workshop learners were female, reflecting the membership of diversity and inclusion-related student organizations and refugee-focused service-learning organizations at Albany Medical College. Although this could have introduced sampling bias, we believe that implementing the workshop three times in multiple settings enhanced the effectiveness of the module.

Our participant group comprised mainly undergraduate medical learners. Future research should explore the value of the module to clinicians, academic faculty, and staff. The in-person workshop, our first session, showed improvement in survey responses but statistically significant improvement in only two out of the four questions (Table 4). In response to postsurvey feedback, we strengthened PowerPoint content and continued to make iterative changes in the curriculum after each subsequent presentation of the workshop. Changes in confidence levels did not vary by session, and we believe the statistically significant results for all four learning objectives during all subsequent workshop presentations. Although our learning objectives are lower-order objectives based on Bloom’s taxonomy, they are in line with our goal to provide strong information tailored to the needs of people who care for Burmese patients but have little baseline knowledge or understanding of their cultural and social context. Open-ended feedback from participants indicated that they achieved higher levels of understanding of issues and topics presented than our initial workshop objectives sought. Participants who attended the workshop during their clinical rotations or were otherwise caring for Burmese patients shared that they were readily able to identify areas to improve the quality of their care and opportunities to advocate in their local health care teams.

The workshop’s focus on both the social and structural determinants of health and the methods for targeted health advocacy can also assist medical schools and residency programs to achieve accreditation requirements. This module’s content aligns with the Liaison Committee on Medical Education’s requirement for medical school curricula to include content regarding "the basic principles of culturally responsive health care, the impact of disparities in health care on all populations and potential methods to eliminate health care disparities.”

This module can help residencies fulfill Accreditation Council for Graduate Medical Education guidelines that require residents to demonstrate competence in communicating effectively with patients across a broad range of socioeconomic and cultural backgrounds. The workshop has been preemptively adapted for both in-person and virtual sessions, and therefore, it can be tailored to their academic needs and environment.

Conclusion
This workshop is designed to be implemented as a stand-alone module or as part of any curriculum on the topics of structural and social determinants of health, health equity, health inequities, and/or refugee health. The module may be particularly useful for learners who are training in or intend to practice in locations with large Burmese populations.

Providing culturally responsive health care for members of refugee communities of Burmese or any origin remains a multifaceted, complex, yet rewarding endeavor. Our workshop represents an opportunity for participants to promote health equity by delving deeper into the health inequities and cultural nuances that exist within local refugee populations in general and the Burmese population in the US specifically. We advocate using this workshop as part of health care provider training in refugee health, regardless of geographic location. Modules such as this one enhance learners’ ability to grow as culturally responsive caregivers and anticipate the needs of their patients, no matter what their background. In addition, this workshop reinforces key insights needed to work with patients with limited English proficiency: Providers can assess health literacy by asking for the patient’s perspective on medical conditions or medications, ensuring that translation services are provided in the patient’s dialect, and providing written medical and drug information in the patient’s language.

This work represents the outcome of a partnership between community-based organizations, community members, medical students, and faculty in the design, implementation, and evaluation of an educational tool aimed at enhancing culturally responsive care provided to patients. The supplemental readings
and suggestions for advocacy enable participants to gain a greater understanding of and foundation in advocating for change in policy, increased research funding, and provision of more culturally responsive care to patients and their families.

### Appendices

- A. Working With Burmese Patients.pptx
- B. Facilitator Guide.docx
- C. Case Studies.docx
- D. Pre- and Postworkshop Evaluation Forms.docx

All appendices are peer reviewed as integral parts of the Original Publication.

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### Prior Presentations

Stella A, Wang T, Zay H, Sama J, Eggan B, Mason HRC. Historical and cultural contexts in care: improving healthcare access and health status for Burmese patients. Presented virtually at: New York State Academy of Family Physicians Winter Weekend Conference; January 15, 2022.

### Ethical Approval

The Albany Medical College Institutional Review Board approved this project.

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