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Revitalization and Development of Karen Traditional Medicine for Sustainable Refugee Health Services at the Thai–Burma Border

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The Burmese regime’s protracted violent conflict with its ethnic minorities has resulted in 2 million migrants and refugees settling across the border in Thailand. In addition there are an estimated 600,000 internally displaced people in border regions within Burma. For many, conventional health services are limited or unavailable. This article reports on the use, preservation, and practice of traditional Karen medicine among refugees and migrants along the Thai–Burma border. Traditional health practitioners are adapting their practices to meet refugee and migrants’ changing needs, creating options for sustainable community-based health services.

KEYWORDS traditional medicine, Karen, refugee health services, Thai–Burma border, Burma, sustainable healthcare, medical revivalism, revitalization

BACKGROUND

Burmese Conflict

Since establishing independence from Japanese and British powers in 1948, Burma has been crippled by protracted civil conflict under oppressive military rule. Burma’s ruling military junta, the State Peace and Development
Council (SPDC), has continuously and brutally suppressed any form of dissent, in particular among ethnic minorities. Since the student uprising of 1988, the military has greatly intensified its violent campaigns. The Saffron Uprising of August/September 2007, where Buddhist monks led tens of thousands of civilian protestors in daily marches calling for democratic change in Burma, resulted in a savage crackdown. The army and police shot at unarmed protestors, arresting more than 6,000 people including as many as 1,400 monks. When in May 2008 Cyclone Nargis tore through the Irrawaddy Delta and Yangon, the government response was one of indifference and denial, resulting in a situation 18 months later where there was “still an overall gap of 178,000 households that required urgent shelter assistance and that had been waiting for support from the humanitarian community for over a year” (Human Rights Council, 2010, p. 26, clause 107).

The United Nations Special Rapporteur on the situation of human rights in Myanmar, Tomás Ojea Quintana, reported in March 2010, “there is a pattern of gross and systematic violation of human rights which has been in place for many years and still continues” (Human Rights Council, 2010). The human rights that are part of this pattern are broad ranging and include the rights to life, to liberty, to personal integrity, to freedom of expression, assembly and religion, to judicial remedy and due process of law, to nationality, to protection of civilians and internally displaced communities, and to prohibition against discrimination, among others. The Special Rapporteur noted that ethnic minorities and civilians along the country’s border areas are subject to discrimination and grave human rights abuses “due to the prevailing culture of impunity” within the Burmese government and military (Human Rights Council, 2010, p. 2).

As a result of this situation, the Human Rights Council estimates that in addition to 184,00 refugees, there are over 2 million migrants from Myanmar in Thailand, many of whom would meet the criteria for official refugee status, but for legal reasons cannot be classified as such. A report from The Karen Human Rights Group published in February 2010 argues that many of these migrant workers come to Thailand “not out of an apolitical desire for economic opportunity, but as a protection strategy initiated in response to the exploitative and violent abuse that drives poverty in their home areas” (Human Rights Council, 2010, p. 2).

Although the release of Daw Aung San Suu Kyi shortly before national elections in November 2010, after 20 years under house arrest, brought wide international praise, this move has yet to indicate any change in government policy or military strategy. Burma’s November 7, 2010, national elections were declared fraudulent by the United Nations and many Western countries. Indeed, Aung San Suu Kyi, in drawing parallels between the 2011 democracy protests in the Middle East and the prodemocracy movement in Burma, noted that unwillingness by armies in Tunisia and Egypt to open fire on their own people was a key difference (Hunt, 2011).
The Karen of Burma

Burma is one of the most biologically, ethnically, and linguistically diverse regions in Southeast Asia, and indeed, in the world (United Nations Educational, Scientific and Cultural Organization, 2005; Conservation International, 2007). Nestled between Thailand, China, Tibet, Bangladesh, and India, an estimated 30%–50% of the country’s 47 million people belong to over 100 ethnic groups (PBS Frontline, 2006; Burma Project, 2006; Matthews, 2001). The Karen people of eastern Burma are one of the country’s largest ethnic minority groups, comprising an estimated 10% of the total population and numbering between 6 and 7 million people (Burma Project, 2006).

Many of Burma’s ethnic minorities stem from China’s Yunnan Province, but the origin of the Karen people remains unclear (Marshall, 1922; Kunstadter, 1967; Anderson, 1993). It is speculated by some that the Karen originated in southern Tibet (Lewis & Lewis, 1984). Indeed, the Karen languages, which include the Sgaw, Pwo, and Pa’o branches, belong to the Tibeto–Burman group of the Sino–Tibetan language family. The Karen are documented as entering Burma during the thirteenth century (Rashid & Walker, 1975), and today they inhabit Karen state, as well as parts of Karenni and Shan states in eastern Burma, the Irawaddy Division. Over the past few centuries the Karen have also settled into northwestern Thailand.

The Karen live predominantly in village structures throughout low foothill elevations, and are mainly agrarian, using terraced farmland to cultivate rice and maize. Animism has historically been the dominant spiritual practice among the Karen. These practices continue today, although the majority of Karen have converted to Buddhism or Christianity. These religions, among the Karen and throughout Burma, coexist with indigenous deities and spirits such as Nats and ghosts (detailed later), as well as with traditional medical beliefs and practices. Traditional health practices among the Karen are based in animism, Buddhist and Ayurvedic medicine of India, and local indigenous and family traditions (Spiro, 1967; MacDonald, 1879; Neumann, 2003a; Tun & Kyaw, 2003).

This article focuses on the impacts of ongoing conflict in Burma on the traditional and spiritual health systems of Burma’s persecuted ethnic minorities, in particular the Karen and Karenni, and how these populations are adapting their indigenous health systems to meet refugee, IDP and migrant needs along the Thai–Burma border. The article begins with a narrative on the origins of traditional medicine in Burma, including an introduction to Burmese and Karen medical theory, and reviews the current practitioner training systems run by national government and minority authorities. Once this historical and theoretical context is set, the authors introduce select field data to illustrate key points about the refugee and migrant health experience. This includes ways in which Burmese and Karen health beliefs and treatment systems are affecting health seeking and self-treatment behaviors.
Traditional medicine and the Karen of Burma

among these populations. This article aims to present the most up-to-date review of traditional Karen medicine available, and to describe how conflict has shaped, and in some cases led to the revival of traditional medical theory, practice, and practitioner training and service delivery networks. Data presented is derived from ethnographic case study research conducted between 2001 and 2008, including in-depth, ongoing interviews with key informants; participatory research during group interviews; second-hand ethnography; archival and document review; and observation.

TRADITIONAL KAREN MEDICINE

Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being. Countries in Africa, Asia and Latin America use traditional medicine (TRM) to help meet some of their primary health care needs. (World Health Organization [WHO], 2002, p. 7, box 1)

Traditional Burmese medicine is derived from the principles of Ayurvedic medicine, India’s ancient and classical medical system. Ayurveda was introduced to Burma in approximately 700 AD (WHO, 2001). Burmese medicine is also heavily influenced by indigenous practices and beliefs of local regions, religions and ethnic groups, including Buddhist, animist and family traditions, spiritualism, and astrology. Traditional Karen medicine shares many of the same theories and principles, but is also based to a considerable extent in local beliefs, practices and family traditions. These various forms of knowledge and practice have been incorporated to form Burma’s current “formal” traditional medical system, which is recognized and regulated by Burma’s Ministry of Health.
Traditional medicine training is available at many levels throughout Burma, ranging from informal and local, to standardized and nationally recognized. In 1976, Burma established the Institute of Indigenous Medicine (WHO, 2001, p. 195), which became a University of Traditional Medicine (Mandalay) in 2002 and currently offers 3- and 4-year formal training programs which are regulated and recognized by the national Ministry of Health (WHO, 2005; Pi Pi, 2009). According to WHO, in 2001 there were over 8,000 traditional practitioners trained and/or registered by the Burmese government, and the World Intellectual Property Organization (WIPO) estimates that and by the mid-2000s, there were approximately 16,000 traditional medicine practitioners—both government and informally trained—practicing in Burma (WHO, 2001; WIPO, 2010). In the ethnic minority regions, training tends to be locally developed and regulated by indigenous and community authorities.

The four main branches of both Burmese and Karen traditional medicine include: Desana naya, Bethi tea naya, Netkhata veda naya, and Vissadara naya:

1. Desana naya: Desana has been described as consisting of “all the words or teachings delivered by the Buddha Himself during His lifetime” (Sayadaw U Panna Dipa, 1998). More concretely, in Burmese and Karen medicine, Desana relates to concepts of hot and cold seen in many indigenous medical systems, and draws on Buddhist philosophy for wider conceptualization of health and disease. Theories of hot and cold relate to internal as well as external factors such as weather, diet, seasonal changes and blood circulation cycles. According to these theories, diet and weather can exacerbate and create illness. Blood circulation is thought to run in two consecutive 6-week cycles of ascending and descending, which must be considered during diagnosis and treatment (MacDonald, 1879). Medicines are given for various conditions on the appropriate day, which is determined by the blood cycle.

2. Bethi tea naya refers to Ayurvedic medical theory and practice, including diagnostic methods using universal elements, pulse diagnosis of mind—body constitutions—*doshas* (literally “impurities” or governing metabolic principles), or *dats*, from the Ayurvedic *dbatus* or basic tissues, which maintain and nourish the body. Extensive use is made of herbal and mineral compounds used in treatment. Ayurvedic theories, as adapted into Karen traditional medicine, are referred to as the “dat system,” which refers to the four elements of the body including wind, fire, water and earth, all which are held in motion by the heaven element. These elements, as referenced by MacDonald (1879) and the WHO (1985, 2001, p. 310), and as delineated in our research by master traditional medicine practitioners who are also Buddhist monks in the Mae Sot district at the Thai—Burma border, include the properties shown in Tables 1 and 2. Within this system, diseases result from three
TABLE 1 Panchamahabhutas (Universal Elements and Associated Properties)

<table>
<thead>
<tr>
<th>No.</th>
<th>Pali</th>
<th>English</th>
<th>Colour</th>
<th>Taste</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pa-hta-we</td>
<td>Earth</td>
<td>Dark black</td>
<td>Rich taste</td>
</tr>
<tr>
<td>2</td>
<td>Ar-paw</td>
<td>Water</td>
<td>Red and pink</td>
<td>Sweet, salty</td>
</tr>
<tr>
<td>3</td>
<td>Tae-zaw</td>
<td>Fire</td>
<td>White</td>
<td>Sour and spicy</td>
</tr>
<tr>
<td>4</td>
<td>Wa-yaw</td>
<td>Air</td>
<td>Yellow</td>
<td>Bitter</td>
</tr>
</tbody>
</table>

Note. Panchamahabhutas refers to Ayurveda’s five elements, which includes these four elements plus space (akasha, in Sanskrit). Burmese theory uses only four but also relies heavily on spiritual elements, a form of the space element.

Table: Table 1

sources: the destruction of entire constitutions; suppression of any one element; or the “disorganization” of the earth element. According to MacDonald, earth is said to be the chief of all elements and must be in balance for the maintenance of good health.

3. Netkhata veda naya, or Burmese astrology, uses calculations based on the zodiac, planet alignment, and the patient’s time of birth and age, and often prescribes diet, lifestyle and behavioral changes. One practitioner involved in our research, a master of Netkhata veda naya, noted that he is blind to a patient’s needs until a patients’ “numbers are read.” Once read, prescriptions are given for future behavior, such as places to go or avoid, specific foods to eat, as well as certain warnings regarding health and destiny. Most importantly, once a patient seeks out this advice, they must assume the advice to be true and follow accordingly.

4. Vissadara naya relates to spiritual practices such as meditation, and also incorporates alchemical practices using minerals and metals (Linn, 2005; Burma Lawyers Council, 2006). This branch of traditional medicine in Burma and among the Karen plays a strong role in mental and spiritual health concerns. 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 and beliefs of the greater Burmese peoples, including some percentage of Buddhist, Christian, and Muslim populations. Within this system, belief in spiritual entities and agents is linked with beliefs about the causation, progression and treatment of illness, affected by a panoply of spiritual entities including witches, demons, ghosts, and nats—Burmese spirit beings (Spiro, 1967). Spirit influence is believed to include possession and illness. Accordingly, treatment methods incorporate spiritual healing and exorcism.

TABLE 2 Doshas (Mind−Body Constitutions) Used in the “Dat System”

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Vata</td>
<td>Motion (physical and mental)</td>
</tr>
<tr>
<td>2</td>
<td>Pitta</td>
<td>Metabolism (digestion, absorption, and assimilation)</td>
</tr>
<tr>
<td>3</td>
<td>Kapha</td>
<td>Cohesiveness (body’s structure and stability)</td>
</tr>
</tbody>
</table>
Although Desana and Vissadara are sought mainly by Buddhist patients, Karen Christian and Burmese Muslim patients also seek these treatments (Bodeker et al., 2005a). This issue is explored further in the “Delivering Healthcare” section in this article.

These four branches of Burmese medicine were formally incorporated into national health policy in Burma under the Indigenous Myanmar Medical Practitioners Board Act, 1953, amended 1955, 1962, and 1987 (Tun & Kyaw, 2003).

According to traditional Burmese and Karen medical theory, health is believed to be related to interactions between the physical body, spiritual elements, and the natural world. Illness within this system is thought to be caused by a physiological imbalance, which may begin on both physical and spiritual levels. Illness is classified as imbalance and therefore treatable, until the very final stages, at which point it is classified as a disease.

SERVING KAREN REFUGEE NEEDS

Traditional medicine is the primary health system available to many of Burma’s ethnic minorities, including the Karen. Prior research, conducted by the authors and others, provides evidence that Burmese refugees and migrants (mainly Karen) possess a baseline familiarity and reliance on traditional medicine for healthcare (Belton & Maung, 2004; Lopes Cardozo et al., 2004; Bodeker et al., 2005a). Further investigation shows that these populations are adapting traditional medical systems to meet current, ongoing needs in the face of displacement and protracted conflict.

The research findings presented here resulted from a partnership between refugee organizations at the Thai—Burma border, particularly in Mae Sot, Thailand, and the Global Initiative for Traditional Systems (GIFTS) of Health. GIFTS of Health is an Oxford, England-based organization founded in 1993 with the aim of building partnerships at a global level between traditional (i.e., indigenous) health practitioners, scientists, educators, and decision makers in order to improve health services, especially in rural areas of the developing world (www.giftsofhealth.org).

The GIFTS Burma Border Project began in early 2001 at the request of Dr. Cynthia Maung, founder of Mae Tao Clinic in Mae Sot. The Mae Tao Clinic is located in Mae Sot, Thailand, and was founded by Maung in 1989 to serve Burma’s refugee and forced migrant population (www.maetaoclinic.org). Mae Tao is a free clinic supported with international aid and serving a total beneficiary population estimated to be between 150,000 and 200,000.

Dr. Cynthia, as she is known, was concerned that forced migrants within Burma, as well as those living in camps along the Thai border, had inadequate access to modern medical services and drugs, and also did not know the local medicinal plants as they had migrated to new and unfamiliar areas.
The Burma Medical Association, the refugee doctors’ association in Mae Sot, of which Dr. Cynthia was a leader, had passed a resolution in late 2000 to develop knowledge of local medical plants and to provide training for health workers and manuals for local families and communities. The aim was to create knowledge of locally available medicinal plants for use in managing common ailments, such as fevers, wounds, coughs, colds, et cetera.

The GIFTS Burma Project was initially undertaken in partnership with the Backpack Health Worker Teams (www.backpackteam.org), and subsequently with the Karen Department of Health & Welfare (KDHW). Through this project, GIFTS and its partners—Mae Tao Clinic, Backpack Health Worker Teams, and KDHW—aimed to investigate and understand traditional health knowledge and practices of local refugee populations, to offer opportunities for learning and network development among traditional health practitioners along the Thai−Burma border, and to document and create a traditional medicinal plant database with a view to training new practitioners and creating a family home herbal medicine book in the local languages (i.e., Karen and Burmese). As the project evolved, research was conducted on patterns of healthcare use and traditional medicine utilization among refugee and economic immigrant groups.

Project activities included the training of refugee clinic staff in herbal medicine; a pilot survey on refugee and migrant use of and belief in traditional medicine; documentation of the development of networks of herbalists along the Thai−Burma border region; and the creation of a medicinal plant and traditional medicine database for community and health worker use (Bodeker et al., 2005a). Survey and ethnographic data were gathered through case study research between 2001 and 2008, including: (a) a pilot survey of 59 refugee and migrant patients at Mae Tao clinic—the majority Karen, followed by Rohingya, Burman, Mon, and others such as Shan; (b) a series of in-depth interviews with four master practitioners; (c) participatory research during group interviews; (d) second-hand ethnography; (e) archival and document review; and (f) observation. In addition to patient input related to health-seeking behavior and self-care practices, this research compiled input from nearly 170 traditional health practitioners, students, and traditional medicine advocates. In order to protect the intellectual property rights of customary knowledge holders, the actual plants and methods of preparation reported by respondents have not been identified in this article (see Bodeker, 2007).

The traditional practitioners, students, and advocates participating in this research are involved in delivering traditional healthcare to the displaced Karen and Karenni populations along the border. These traditional practitioners and advocates are working to provide a wide range of traditional health services, including: individual practices, herbal clinics and programs in refugee camps, training programs in refugee camps and areas of internally
displaced peoples (IDP), herbal gardens in camps and border communities, and networks of traditional health practitioners (THPs) in various areas.

The practice and meeting points for these various practitioners and resources are located in five Karen refugee camps. These camp-based clinics serve primarily as treatment centers, serving thousands of refugee and migrant cases per year, and address some vital gaps in humanitarian care, as well as serving as sources of cultural continuity and culturally appropriate care. All of these clinics have also been developed as training centers for young Karen men and women interested in becoming healthcare leaders for their camps, communities and futures. Despite the protracted and semi-permanent nature of many Thai–Burma refugee camps and of the IDP settlements along the Burma side of the border, the hope continues among many refugees and migrants that they will at some point return to a democratic Burma. Therefore these THPs and local health leaders believe they must not only strengthen the pool of trained and experienced leaders to deal with current struggles, but also future leaders to rebuild strong and self-sufficient communities in Burma.

DELIVERING HEALTHCARE

Karen refugees and migrants arriving in Thailand suffer from a range of common and acute health conditions including high rates of drug-resistant strains of malaria (Carrara et al., 2006), respiratory infections including tuberculosis, malnutrition, HIV, dengue fever, Japanese encephalitis, hepatitis, leprosy, and psychosocial disturbances resulting from violence and displacement (Petersen, Lykke, Hougen, & Mannstaedt, 1998; Cho-Min-Naing, 2000; Banjong et al., 2003). Today there are over 100 humanitarian organizations involved in delivering health and welfare services to these refugees and migrants (UNHCR, 2004).

The emergency approach taken by many of these humanitarian organizations is vital during the initial phase of most forced migration situations, and such interventions save thousands of refugees’ and migrants’ lives each year (Cookson et al., 1998; Hansch & Burkholder, 1996). Yet in order to facilitate local cooperation and compliance, as many of these situations move into less acute phases, as on the Thai–Burma border, issues of culture, identity, and traditional practice emerge. Evidence shows that local leaders and traditional health practitioners play a valuable role in providing psychosocial and maternal health support within refugee communities, and that neglect of traditional practices can contribute to or exacerbate primary, gender-based, and psychosocial health concerns (Buchenwald et al., 1992; Capps, 1999; Hinton, Hinton, Pham, Chau, & Tran, 2003). Conversely, incorporating traditional health knowledge into health and rehabilitation programs
can improve refugees’ mental and physical health, according to a study at Foundation House, a leading torture and trauma rehabilitation service in Melbourne, Australia. Reporting on traditional and complementary medicine use with women refugees from Burma and elsewhere, Singer and Adams (2011, p. 15) noted:

The stories told by the women of their experiences of herbal medicine . . . connected their past with the present and possibly established hope for the future. Particularly for refugees, re-establishing connections is pivotal in order to begin the process of healing.

The camp-based traditional health clinics and numerous traditional health practitioners involved in our research are helping to address some of these longer term health concerns among Karen refugees and migrants along the border, as well as serving as the main healthcare resource for many of those unable to reach humanitarian care. Within the IDP areas of Karen state, these practitioners and resources are working to deliver some of the only care available. Within refugee camps these THPs and clinics are complementing services provided by humanitarian agencies. As noted by the WHO:

Traditional healers and birth attendants in rural and urban areas . . . are the vital link to supplying the needed services in their communities, and yet their efforts must continue to expand as populations grow, and health concerns continue to increase in complexity and case numbers. (Nelson-Harrison et al., 2002, p. 283)

The herbalists’ group involved in the GIFTS Burma Border Project includes four senior herbalists and master practitioners, each with 15–35 years of training and experience, and who are highly regarded by their communities. Using traditional Karen medical theory and hundreds of identified materials, these THPs, their students and clinics are treating a range of common, chronic and acute conditions in the refugee and IDP areas along the border. These conditions were diagnosed using traditional methods and are therefore not directly translatable to biomedical diagnoses. For purposes of our study (a study on social and public health services, not a clinical study), we collected data on conventional as well as local, culturally relevant diagnoses. The most common conditions treated by key informants are noted in Table 3.

This list reveals that THPs are working to address some of the major health issues facing Burmese refugees and IDPs, particularly in the IDP areas where biomedical health services are often not available (Neumann & Bodeker, 2007; Mahn et al., 2008). Conditions include: malnutrition-related illness (anemia, beri beri, and diarrhea), malaria, TB, HIV, hepatitis B
TABLE 3 Priority and Most Common Conditions Treated by Traditional Health Practitioners (2005)

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Anemiaa</th>
<th>Eczemab</th>
<th>Malariaa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritisb</td>
<td></td>
<td></td>
<td>Mantissb</td>
</tr>
<tr>
<td>Asthmab</td>
<td></td>
<td></td>
<td>Measlesa</td>
</tr>
<tr>
<td>Berti beria</td>
<td></td>
<td></td>
<td>Menstrual/Leucorrheac</td>
</tr>
<tr>
<td>Boilsb</td>
<td></td>
<td></td>
<td>Mental Healtha,c</td>
</tr>
<tr>
<td>Choleraa</td>
<td></td>
<td></td>
<td>Oliguriaa</td>
</tr>
<tr>
<td>Colds/coughingb</td>
<td>Headacheb</td>
<td></td>
<td>Pilesb</td>
</tr>
<tr>
<td>Constipationb</td>
<td>Hepatitisa</td>
<td></td>
<td>Skin disorderc</td>
</tr>
<tr>
<td>Convulsionsc</td>
<td></td>
<td></td>
<td>Spiritual healthc</td>
</tr>
<tr>
<td>Cuts/woundsb</td>
<td>Hypertensionb</td>
<td></td>
<td>STDsb</td>
</tr>
<tr>
<td>Diabetesk</td>
<td></td>
<td></td>
<td>Stroke/paralysisb</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>&quot;Itching&quot;</td>
<td></td>
<td>Swelling (edema)b</td>
</tr>
<tr>
<td>Diphtheriaa</td>
<td>Jaundicea</td>
<td></td>
<td>Tuberculosisa</td>
</tr>
<tr>
<td>Dysenterya</td>
<td>Leprosya</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

aPriority conditions. bChronic and common health conditions often untreated by INGO clinics. cIllnesses with culturally specific connotations.

(including jaundice), leprosy, and mental health issues (including itching, some skin disorders, convulsions, gastric or digestive issues, and spiritual health). THPs are also treating culturally specific diseases that have no direct biomedical translation or treatment, including eye disorders and food/animal poisoning. In the camp and border setting, the majority of THPs refer acute and other serious cases to humanitarian clinics in light of the threat of multidrug-resistant strains and high mortality and morbidity rates of malaria and TB.

For more common, chronic or culturally specific health needs, THPs are seeking to fill in gaps in humanitarian care (i.e., areas where humanitarian clinics are ill-equipped, understaffed, or not versed or trained appropriately). For example, the two largest camp-based herbal clinics served a total caseload of over 6,700 cases in 2006, and the majority of these cases included women’s health issues, nutrition, skin disease, and culturally specific health conditions, indicating a clear area of need for culturally familiar, traditional health services in an otherwise Western setting.

Women are often the bearers of traditional knowledge within homes and communities (Aubel, 2006). During our 2002 pilot survey on Burmese refugee knowledge and use of traditional medicine, 42 female respondents listed over 190 traditional remedies used for common health conditions, and 13 of these women had learned this knowledge from the mother or grandmother (Pipitkul, Oo, Bodeker, & Neumann, 2005). Because this self-and family-care tends to be based in the home, it has been reported that Karen refugee elders prefer home-care as the first line of treatment, and women are often uncomfortable presenting personal health conditions at humanitarian health clinic.
Indeed, women’s health conditions were some of the most commonly treated conditions at the camp-based clinics in 2003, representing 41% and 26% of the total case loads at this clinics, respectively.

According to herbal clinic staff, women’s health is the main area of need unmet by humanitarian clinics. According to a technical advisor for reproductive health for the Burma Medical Association:

The biomedical approach to healing does not seem to appeal to (women) who come from rural areas of Burma, perhaps because of the tradition of health care provision by THPs ... or perhaps because of the impersonal nature of revealing personal matters to someone you may not know (at humanitarian clinics).3 (personal communication with the technical advisor on reproductive health for the Burma Medical Association, 2006)

Mental health, including emotional, psychosocial, and spiritual dimensions, is another vital area of need among Karen refugees, IDPs, and migrants. The SPDC regularly engages in violent tactics such as torture, rape, kidnapping, forced labor, and other forms of physical and mental intimidation (Alden et al., 1996). In 2004, WHO Thailand surveyed 495 displaced persons and found a significant prevalence of trauma events experienced by this population: 7.5% had experienced murder of family or friends, 7.3% had been forced to walk on mine fields, 6.3% had serious injury due to knife/gunshot or fighting; 5.7% had experienced the murder of an acquaintance; 3.2% had been kidnapped; 2.6% had an injury due to a landmine; and 2.8% had been raped (WHO, 2004).4 A few humanitarian aid organizations are currently addressing some posttraumatic stress disorder (PTSD) and other mental health needs in refugee camps. But in May 2006 the Committee for the Coordination of Services to Displaced Persons in Thailand (CCSDPT) and the United Nations High Commissioner for Refugees (UNHCR), the main supervising bodies of aid delivery along the border, found the Thai−Burma International Non-Governmental Organizations (INGOs) “have sporadic and unfocused interventions addressing the psychosocial needs of the camp residents,” (CCSDPT & UNHCR, 2006, p. 6), which may be negatively impacting refugees’ mental health and well-being.

These services are based largely on a Western model of mental health (i.e., psychological and psychiatric diagnoses and treatments). While effective in some instances, multiple studies among Asian populations have proven that this approach often fails to address some of the more somatic and spiritual aspects of these conditions (Hiegel, 1990; Gilman, Justice, Saepharm, & Charles, 1992; Mollica, Cui, McInnes, & Massagli, 2002; Eisenbruch, de Jong, & van de Put, 2004). In fact, the CCSDPT/UNHCR report recommends that psychosocial needs be met through community-based interventions “to avoid the medicalization of mental health” in the camps (2006, p. 6).
Indeed, a broader look at the spiritual dimensions of health is needed to accurately represent Karen perceptions of illness, treatment, and cure. Burmese and Karen spiritualism is based on a complex system of spirit worship. Spirit influence is believed to include possession and illness. Accordingly, treatment methods incorporate spiritual healing and exorcism.

During our survey of refugee and migrant knowledge and use of traditional medicine, we investigated the spiritual aspects of health beliefs and treatment-seeking behaviors. Of the 59 respondents interviewed, 30 were Christian and Buddhist Karen, 16 were Rohingya Muslim, and 13 were Buddhist Burman, Shan, Mon, and other. Although polytheism is not formally tolerated within Christianity and Islam, our study found fairly fluid beliefs and practices among all Burmese ethnic and religious groups interviewed. Among Muslim respondents, we found that five respondents out of 16 believed in Burmese spirits, or nats. Among Christian Karen, 10 respondents noted some form of belief in nats, ghosts, or other spiritual forces, while at the same time confirming their belief in one God. This tolerance of multiple spiritual forces among Christians in Burma is depicted in Pascal Khoo's biography, *In the Land of Green Ghosts*, where he tells of his village priest converting all by allowing for belief in nats (Thwee, 2002). Both Muslim and Buddhist master practitioners involved in our study also noted that migrants of all faiths and ethnicities come to them for amulets, holy waters and cures that were often based outside of these patients' individual religion (Neumann 2003b).

Two categories of spirit entities were identified by respondents as having an effect on health and illness: nats and ghosts. There are 37 nats—or spirit entities—represented in Burmese spiritualism. Nat shrines are placed in homes and throughout villages, and it is believed that if a family or individual is not able to worship or respect their nats regularly, illness may ensue, in particular psychological conditions, gastrointestinal disorders, and fevers. As nat worship is integral to refugees’ beliefs, survey respondents reported risking their lives to cross border conflict zones to make nat donations in their home villages (Neumann & Bodeker, 2007). It was clearly stated that when people do not have a settled home or status, they feel more insecure as nats need to be housed in order to not pose a threat.

Ghosts are held to be the souls of the departed—spirits who, due to not having had anyone to pray for them at the time of death, have been unable to move to a nonearthly plane of existence. Karen refugees who have lost family in conflict or in the trauma of forced migration are faced with the prospect of either being possessed by a ghost, which may cause illness, or risk the person “becoming a ghost,” which eventually leads to death.

The two largest camp-based herbal clinics involved in our research reported treating approximately 20 mental and spiritual health disorders (labeled as such) in 1 year. A deeper investigation of the various gastric, febrile, and nonspecific illnesses—for example, itching, convulsions, skin and eye
FIGURE 1 Treatment Center of Muslim Master Practitioner in Mae Sot, Thailand—This Practitioner Uses Koran Numerology, Burmese Astrology, and Traditional Burmese Medicinal Plants to Treat Muslim, and in Select Cases Christian and Buddhist Migrants From Burma (Color figure available online).
disorders, and poisoning—treated at these and other herbal clinics is needed
to determine broader somatic manifestations of mental and spiritual afflict-
ions experienced among these populations. For example, these two clin-
ics reported treating 1,659 cases (25% of 6,700 total) of general weakness,
gastric disorders, mental disorders, tremors, numbness, nonspecific skin dis-
eease such as itching, “fits,”5 and other, many of which may indeed relate to
mental and spiritual syndromes. These cases, although very real for those af-
flicted, would most likely be turned away or misdiagnosed by humanitarian
clinics as these facilities are not trained or equipped to deal with culturally
constructed or spiritual conditions. This psycho—spiritual dimension in tradi-
tional health care is of importance to the everyday lives of refugees, migrants
and IDPs along the Thai—Burma border and requires understanding in the
management of mental as well as physical health conditions.

Traditional Karen health practitioners are currently working to address
gaps in women’s and mental healthcare delivery in this region. The broader
healthcare service network along the border may greatly benefit from more
active referrals between herbal and humanitarian clinics, in particular in light
of how gender issues and spiritual beliefs affect treatment seeking behavior
and compliance.

Our survey also found that patients employ a very pluralistic approach
to healthcare. Refugees, as well as migrants and IDPs based in remote ar-
eas, tend to visit their closest or most familiar THP at first signs of illness
and, depending on diagnoses, will continue on to a specialist, (i.e., spiritual
healer, alchemist, or massage therapist as these practitioners are available). If
health is not restored, patients may visit the nearest Western, or humanitar-
ian, clinic, and eventually a regional hospital if possible for more severe cases
(Bodeker et al., 2005a). This type of pluralistic health-seeking behavior high-
lights the need for improved reporting, referrals, and coordination between
THPs and Western providers, including training humanitarian clinicians to
query patients about traditional medicine use.

TRAINING FUTURE LEADERS

Informal systems for traditional medicine training exist in many commu-
nities throughout the world, through networks of master practitioners, local
traditional medicine associations and self-regulation by community mem-
bbers (Neumann & Bodeker 2007). THPs in Burma may specialize in one or
a combination of the four branches of Burmese and Karen medicine, and
referral between practitioners is very common. The majority of Karen tradi-
tional health practitioners practicing along the Thai—Burma border area are
informally trained by a master—from within monasteries or through fam-
ily lineage (Neumann & Bodeker, 2007)—and include herbalists, alchemists,
masseurs, spiritual practitioners, traditional birth attendants and midwives,
bone-setters, as well as “master practitioners.” Due to the fighting and military
aggression against the Karen, few of its THPs have the opportunity to engage in Burma’s formal degree programs. It is likely that most of these THPs would not be legally recognized by the Burmese government regardless of training, as the Indigenous Myanmar Medical Practitioners Board Act 74 reserves the right to refuse or restrict any THP from practicing, and THPs delivering healthcare in Karen state are viewed as supporting “the enemy” (Karen Environmental & Social Action Network [KESAN], 2005). Although many Karen THPs may not be formally recognized by the state, some of their informal training programs involve at least the same amount of time, theoretical and clinical study as formal degree programs.

Although healthcare delivery remains the central priority for Karen practitioners and traditional health programs along the Thai–Burma border, the focus on cultural continuation, preserving and perpetuating traditional knowledge, and training a cadre of future leaders are very strong motivations for this network of Karen traditional health practitioners.

This preservation and perpetuation of traditional knowledge is done through a series of training programs based out of herbal clinics in refugee camps and within the IDP areas. The KDHW, which provides healthcare services and education to refugees and migrants along the border, is the main coordinating body for this training, and has developed a hierarchical organization of medical development and training, formal infrastructure development, and methodical and formal pedagogy. There are currently three camp-based herbal clinics and approximately seven IDP-area herbal programs running training for young Karen men and women interested in becoming herbalists and future healthcare leaders. The director of KDHW stated his priorities for these training programs as follows:

1. To select young people from the villages and train them in the practice of herbal medicine.
2. To send them back to their villages after the training to treat the patients and to record how their knowledge is working.
3. To record their knowledge on new self-made herbal medicines.
4. To record local knowledge that is getting lost.

All training programs follow the same general structure, beginning with up to 1 year of on-site training, followed by a minimum of 6 months to 1 year of internship training at herbal clinics and in the field. The training curriculum is structured as follows:

- Theory: Four elements and spiritual health (based in Ayurvedic medicine).
- Diagnosis using traditional methods.
- Collection or cultivation of medicinal plants.
- Preparation of medicines.
- Clinical herbal practice.
- Documentation of knowledge for future generations.
It is of interest to note the absence of Desana and Vissadara in this training curriculum, reflecting perhaps the Christian orientation of many refugee groups and leaders, and also the lack of awareness of these more advanced areas of philosophical knowledge at the community level.

The ultimate goal of these training programs is to deploy new healthcare providers and leaders into refugee, migrant and IDP communities throughout the border region, especially to villages that have no herbalist or other health services. In IDP areas, the military government has displaced entire villages and virtually destroyed all health infrastructures, both traditional and Western. According to the director of KDHW:

There aren’t any NGOs in these [Karen] villages to give support, so the people don’t have enough medicine. When the training is finished, [trainees] return back to their villages and help their people grow and use simple herbs and remedies. They are working hard to improve the lives of their people. (C. Neumann, personal communication, October, 2006)

Throughout the training and internship process, all staff and trainees are required to document and preserve traditional Karen medicine knowledge, and all are engaged in or encouraged to develop close relationships with local herbal practitioners, traditional healers, and elders in their communities in order to learn and preserve important medicinal and cultural knowledge. Some of the reported plants and remedies gained from these communications and work with elders included treatments for malaria, diarrhea, respiratory illnesses, urinary tract infections, and gynecological diseases (Nu Poe, 2003).

Conflict and displacement, in the view of the KESAN, have created a situation where “the elders are not able to pass on their knowledge to the younger generations.” KESAN’S view is that through training, young people “will become human resources of traditional medicine to share and continue passing on this knowledge to future generations” (KESAN, 2005). With support from GIFTS and other international organizations, KESAN produced several thousand herbal medicine manuals in 2009/2010 for family use, in both the Karen language and Burmese. These have been distributed to internally displaced Karen communities up and down the Thai−Burma border and local health and community workers have received training in their use.

Exposure to the refugee camp systems is, for many refugees, their first exposure to the “West”—creating a microscenario of urbanization and Westernization within this contained setting. Through training and practicing traditional medicine, young trainees fulfill parallel purposes of preserving and mobilizing their culture as well as serving some of the basic and crucial health needs of their people. The new traditional health services—both in the refugee camps and in the IDP communities in the Karen State—are having the effect of preserving and revitalizing traditional Karen health knowledge and practice which may otherwise be lost in the face of conflict, migration, and interaction with Western medicine in refugee camp settings.
SAFETY ISSUES

It is important to note that although traditional health systems provide a rich base of health knowledge, safety issues require attention in decisions on the formal application of traditional strategies into integrated health care programs. Safety remains a central issue in the use and evaluation of medical interventions, especially in high-risk populations such as refugee and migrant populations.

The major concern and source of debate surrounding traditional, complementary and alternative medicine, particularly in the world forum, relates to safety and efficacy of medicinal plants and traditional therapies (Shia, Noller, & Burford, 2007; Barnes, 2007). Indeed, the WHO’s comprehensive traditional medicine strategy, released in 2002, sets its primary focus on safety and regulation issues, calling for all nations to develop national regulatory policies and to “create a stronger evidence base on the safety, efficacy and quality of the TM/CAM products and practices” (WHO, 2002).

The Burmese government’s Department of Indigenous Medicine reports having registered 3,962 medicinal plants, mineral, and materials, and has granted production licenses to 632 traditional medicine manufacturers throughout Burma. Some of the most commonly used medicinal plants used in Burma and by THPs involved in our research have been studied extensively in India and the West, to name a few: *Andrographis paniculata*, *Azadirachta indica* (neem), *Curcuma longum* (turmeric), *Ocimum sanctum* (holy basil), *Annona squamosa* (sugar apple), and *Berberis vulgaris* (barberry), among others. (Thaker, 1986; Barnes, 2003) While evidence is growing in support of the efficacy some of these remedies, further study is needed on all before they meet international requirements for safety and standardization.

Safety issues, from both the traditional and Western biomedical framework, have been addressed in most group meetings held during our research period. A number of THPs were particularly focused on rectifying what they identified as false and dangerous use by communities of some medicinal plants, which could act as a poison if not used correctly. One key informant highlighted:

By recording and mentioning this knowledge in the [herbal manual for community use], the community will come to know the herbal plants with poison, and how to use them with caution, by mixing them with other plants. This is very important for the safe usage of poisonous plants that have great medicinal benefit. (C. Neumann, personal communication, October, 2006)

THPs have also requested input regarding key public health and safety information for these topics. This information has been added to the KESAN-GIFTS herbal manual for refugee and IDP use—in particular related to fevers
that may indicate malaria, respiratory infections and the potential misdiagnosis of TB, hepatitis B, nutrition, in particular for children; and emergency obstetric care guidelines.

DISCUSSION

The Karen and ethnic minority peoples of Burma have been and are under siege and this in turn has changed the nature of their health and medical needs from those of a mountainous farming population to the needs of refugees, migrants and war victims. The challenges of living in a state of siege are compounded by exposure to the neighboring epidemiological time bomb of Burma. Accordingly traditional medicine has been adapted to the new context.

The resultant organization of traditional medicine has mirrored a military orientation—a hierarchical organization of medical development and training, formal infrastructure development, and methodical and formal pedagogy. While the structuring of the Karen traditional medical revival has military-like dimensions, the medical content of the programs has deep grounding in cultural knowledge and practice. It is also pragmatic in focusing on available plant resources in the immediate forest and rural environments where settlements are located.

“Medical revivalism” has been defined by Charles Leslie as “modes for professionalizing traditional practice.” Citing revivalist medical movements in India and China, Charles Leslie perceived medical revivalism as “a significant aspect of cultural nationalism in these societies” (1976, p. 319). More recently, the term revitalization has come to be used for endogenous development movements that are not driven by agendas of nationalism or professionalization, but rather an attempt to value, reappraise, and harness for local benefit the existing healthcare resources of a community or society (Shankar, 2001). What is interesting in the revival and revitalization of Karen traditional medicine in the refugee and migrant context in recent years is that key elements of the broader system of Karen medicine have been selected and focused on in the development, training, and practice of the new expression of Karen medicine. The treatment focus is almost entirely herbal and the diagnostic focus is humoral with its emphasis on the dats or Ayurvedic dhatu. This reduced form of Karen medicine is materialistic in emphasis, rather than offering the broader spiritual, philosophical, or animistic approach to healthcare of its parent system. A combination of Christian influences, emergency medicine requirements and the need to streamline medical care to immediate, visible and practical materials and strategies appear to have converged to bring about this metamorphosis of Karen medicine in the refugee context. In essence, what the revival has done is to focus on Bethi tea naya—Ayurvedic medical theory and practice—to the exclusion of the
other three pillars of Karen and Burmese medicine, all of which may be seen as abstract and largely incompatible with Christian beliefs. In addition, the three more metaphysical dimensions of traditional Karen medicine demand a degree of scholarship and expertise that may not be readily available in the refugee context.

At the same time, our pilot survey shows that Karen community members retain their belief in nats, ghosts, and other nonmaterial influences on health and recovery and take action to ensure that these areas are addressed in treatment strategies, particularly with mental health concerns.

These developments are of medical sociological interest in that they add a new dimension to the understanding of the contexts within which medical revitalization can occur and the forms that it may take.

The Karen are not unique in responding to a conflict situation as a spur to the development, or revival, of traditional medicine. Elsewhere, national crises have catalyzed governments into evaluating their indigenous medical traditions as a means of providing affordable and available health care to their citizens. War and national epidemics are two common crises (Bodeker, 2010). In the Nicaraguan war of the 1980s, the government turned to herbal traditions as a means of meeting national medical needs. Inexpensive medicines were produced locally and sustainably in rural areas to treat a wide range of conditions including respiratory ailments, skin problems, nervous disorders, diarrhea, and diabetes.

Vietnam, following its war of independence from France, established an official policy in 1954, for preserving and developing traditional medicine as a basic component of healthcare. This policy was expanded during the 1960s and 1970s, during the war between the North and the South. Emergency medical strategies were generated, including the development of a traditional medical program for the treatment of burns (Trung & Bodeker, 1997).

From the perspectives of both refugee health and community development, the revival and contextualization of Karen traditional medicine within a refugee setting represents an adaptive response by otherwise medically underserved populations. It offers a model of healthcare self-sufficiency that breaks with the dependency relationships characteristic of most conventional refugee health services. And, through the mobilization of tradition for contemporary needs, it offers a dimension of cultural continuity in a context where discontinuity and loss of culture are hallmarks of the everyday refugee experience.

NOTES

1. These numbers are rough estimates as the last census of Burma was conducted in 1931. Karen and Shan groups comprise about 10% each of the total population, while Akha, Chin, Chinese, Danu, Indian, Kachin, Karenni, Kayan, Kokang, Lahu, Mon, Naga, Palaung, Pao, Rakhine, Rohingya, Tavoyan, and Wa peoples each constitute 5% or less of the population (Burma Project, 2006).
These four branches have also been referred to as: dhatu, ayurveda, astrology, and witchcraft.

Perinatal issues in particular, including pregnancy, delivery and postpartum care, are some of the most expansive and intact areas of traditional health service delivery along the border. Various aid organizations are currently working with over 10,000 traditional birth attendants and midwives in these areas.

Self-report of rape is low among this population; actual rates may be considerably higher (Shan, 2002).

The concept of “fits” (often classified as epilepsy in the West) has become a largely disputed area of healthcare for Southeast Asian refugees in the United States (see Fadiman, 1997).

REFERENCES


