# A STUDY OF HEALTH BELIEFS AND HEALTH PRACTICES OF KAMPUCHEAN MOTHERS

REPORT OF A RESEARCH EXERCISE UNDERTAKEN IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN NURSING STUDIES AT MASSEY UNIVERSITY

PRANEE TUDSRI

MARCH 1987

# ABSTRACT

This study was conducted to explore the health beliefs and health practices of refugee mothers from Kampuchea. Three mothers participated in the study. Information was obtained by using unstructured interviews which were tape recorded in most instances. Data were analyzed from the transcripts and interpreted from each participant's viewpoint.

The findings of the study show that the perception of health and illness of these Khmer women is quite different from the Western view. The Asian belief about 'hot' and 'cold' balance has a strong influence on the health practices of the Khmer women, especially in regard to the childbearing practices. To maintain health of the body there has to be a proper balance between these two things, and any imbalance will result in ill-health. Correction of the imbalance is done by the addition or subtraction of heat and cold. This is achieved by making certain dietary changes, or administering certain suitable medicine, or making a balance between body and environment. In addition, this study indicates that these particpants' health care practices are based on a combination of traditional beliefs such as 'coining', the use of home remedies, and the use of Chinese medicine; and the Western health system, which means using the doctor when they are sick. The participants in this study seemed to adjust very well to Western health care. Utilizing Western health care, however seems to be focussed on curative rather than preventive or promotive health. Recommendations and indications for further research are also presented.

ACKNOWLEDGEMENTS

I am indebted to Dr N. Chick, my supervisor for her valuable counsel and assistance, correcting my English, constant support and understanding during the course of this study.

I am also indebted to M. Idour, my co-supervisor, for her advice and encouragement during doing this research.

My special thanks, also to professor N. Kinross for her encouragement, support and understanding.

I would like to express my deepest gratitude to the three Kampuchean women and their families who shared so much of their culture to me. Without their assistance, this study could not have been undertaken.

I am also grateful to:

- A. Tuffin, J. Spicer, J. Hornblow D. Petchleuang, and Dr J.P. Heigel for providing both information and some useful references.

- M. Hilder, P.M. Hickson, J. Eustace for reading and correcting my English.

- V. Sereeprasert for lending me a tape recorder.

- All the staff of Department of Nursing Studies, all Thai friends especially A. Sakulneeya and S. Janprasert and New Zealand friends for their encouragement and invaluable friendship.

I also wish to express my most sincere appreciation to the Eustaces, especially Mum, Mrs G. Eustace, for their hospitality while I stayed with them.

To the Nursing College Division and Saraburi Nursing College, Ministry of Public Health, Thailand, for giving the opportunity to study here. Their assistance is gratefully acknowledged.

My grateful thanks to my parents (Prasert and Prapasri), my mother-in-law (Kampong), my sisters and brothers, my sister-in-law and brother-in-law for their moral support and encouragement while I was in New Zealand.

And lastly, I am forever grateful to Sayan, my husband, for his help in numerous ways, for drawing figures, for reading and correcting English, for sharing aspects of Khmer culture and interpreting Khmer to Thai, and most important, for his love, patience, and moral support throughout the course of this study; and to Pthai, my little wee boy, for his companionship, with me throughout this study.

# TABLE OF CONTENTS

TABLE OF CONTENTS CONTINUED

TABLE OF CONTENTS CONTINUED

# LIST OF TABLES

# LIST OF FIGURES



* Throughout the report the alternative name of Kampuchea is usually used (Refer note p. 4 )

# CHAPTER 1

## INTRODUCTION AND OVERVIEW

"Individuals from different cultures perceive and classify their health problems in specific ways and have expectations about the way they should be helped".

Leininger, 1978:p.116

### A. BACKGROUND OF THE STUDY

The above statement indicates the importance of culture in which each of us is bound. It implies that each individual has their own perception of health and illness which will be reflected in the health practice behavior of that person. Currently the biomedical model which emphasises biological concerns is accepted by many health care providers, especially doctors. More and more nurses are beginning to question its validity. For the provider, these concerns are often considered more real, significant, and interesting than psychological sociocultural issues (Kleinman, Eisenberg, and Good, 1978). In modern Western settings, many health professionals are still primarily interested in the treatment of disease and abnormalities in the structure and function of body systems. Kleinman et al. (Ibid) view the biomedical approach as culture specific and value-laden. According

to health-care providers, there are no alternative forms of healing, and there are no other healers. They have been taught and socialized to believe that modern medicine is the answer to all human kind's need.

The biomedical model, however, represents only one end -the scientific pole - of a continuum. At the other pole is the "traditional" model, the popular beliefs and practices that usually diverge from medical science (Chrisman, 1977). An example of this is the concept of Yin and Yang (Cold and Hot), a well known belief of Chinese people. For them all things in the universe, animate and inanimate, consist of Yin and Yang. If health, peace and harmony are to prevail, these two forces must be in perfect balance (Campbell and Chang, 1973). Health beliefs and practices of individuals vary along this continuum. It is now recognized that they are not based only on knowledge of the physical causes of disease but also on sociocultural influences. The prevailing medical system has begun to recognize the effect of cultural heritage and tradition on personal health habits.

There are many reasons for the increasing interest shown by health care professionals in the cultural aspects of health. Examples include the increasing evidence of the multicultural make-up of the population of many countries and the changing view of nursing from the biomedical model to a "holistic" model (Brallier, 1978; Blattner, 1981; Krieger, 1981). There is a growing awareness of problems or conflicts between health care providers and clients which arise from the distinction between the biomedical basis for health beliefs and the practices of individuals from a different culture. Many health care personnel who provide services in the cross-cultural situations have reported their

amazement at the high degree of noncompliance among these patients, and then have gone on to describe the cultural norms and beliefs that are at the root of many incidents of non-compliance.(McCabe, 1960; and McGregor, 1967). Refugees are a group of people to whom this situation applies.

Since 1975, the number of refugees, especially from Southeast Asia, has increased. They are dispersed to various countries, including the United States, Canada, Australia, and New Zealand. Some of these refugees may settle successfully, but there has also been growing evidence of problems, some of which are related to health. An important problem is the conflict between the beliefs and values of refugees and the health care provider's beliefs and values. Refugees from Southeast Asia clearly illustrate a group experiencing the impact of transition from a non-western society to the more modern environment of western style countries. In addition, before getting to these countries, they have been through many traumatic experiences. All refugees suffer severe losses. Not only have they lost their homeland, properties, businesses, and their social network of kin, friends, neighbours, and employers, but they have also lost their sense of security, self-identity, and even their self-esteem.

Health care providers from every country which accepts refugees are faced with the challenge as to how they may increase the understanding and use of health values, beliefs, and practices relevant to different cultural groups to ensure that individual needs are met. One way of conceptualizing such complexity without totally adopting a biomedical standard of health beliefs is to relate the set of health

beliefs and the practices to their reference groups or reference world (Shibutangi, 1955).

New Zealand is one of the countries that has accepted refugees, and recently a large number of refugees from the Indo-Chinese countries of Vietnam, Laos, and Kampuchea* have been accepted. Department of Labour (1985) reported that New Zealand began accepting Indo-Chinese refugees in 1977 and over 6,500 had arrived in New Zealand by October, 1985. They include over 3,000 Vietnamese, and 3,000 Kampuchean, and 400 Laotians. Approximately 80 Vietnamese and 320 Kampuchean have been resettled in Palmerston North.

Irrespective of these recent groups of refugees, New Zealand has been moving toward a multicultural society. Table 1.1 shows the ethnic composition of the New Zealand population in 1981.

Among these various ethnic groups, there are different characteristics, values, customs, and cultures that can affect the health issues and have implications for the provision of health care services in New Zealand. Maori people as the largest minority group, have been studied and described in detail. The studies have included the folk health beliefs and practices in relation to the health maintenance, illness prevention or restoration of health following an illness episode. This extensive literature was outlined in a book "The

---

* The researcher has chosen to use the word "Kampuchea", "Kampuchean", and "Khmer" rather than "Cambodia" and "Cambodian" in most cases because the Khmer word for Cambodia is Kampuchea.

TABLE 1.1

THE ETHNIC COMPOSITION OF NEW ZEALAND POPULATION IN 1981

| Ethnic Origin Group | Percentage Total Population |
|---|---|
| European | 86.6 |
| Maori | 8.8 |
| Pacific Island Polynesian | 2.9 |
| Chinese | 0.6 |
| Indian | 0.3 |
| Other | 0.4 |

Source: Department of Statistics (1981)

Health of Maori People" (MacKay, 1985). There are some studies relating to the Pacific Island Polynesian, such as the Samoan (Kinloch, 1980, 1985); but none has been found for other ethnic groups.

## B. RATIONALE FOR THIS STUDY

The present study is an investigation of health-illness beliefs and practices particular to refugee mothers from Kampuchea. There are four reasons for choosing Kampuchean mothers.

First: Kampuchea is very close to Thailand, and there are similarities in cultural background, beliefs, and values. The researcher is Thai and so these similarities may help her to understand the problems more readily, and to gain better rapport with the participants.

Second: The Kampuchean women are highly regarded in the society and hold positions of responsibility and importance in the family. In particular the wife is the pivotol member of family. Around her revolves the prosperity, well-being, and reputation of the family (Munson, et al 1971; Bruno, 1984).

Third: There are four Holding Centres in Thailand where most Kampuchean refugees have to stay before they are accepted by another country. It is hoped that results from this study may help nurses working with Kampuchean women in Thailand to prepare the women for

their new experiences.

Fourth: The health beliefs and health practices of Kampuchean refugees have not been studied previously. It is hoped that results from this study may also help nurses working with Kampuchean refugee women in New Zealand to increase their understanding and use of health values, beliefs, and practices relevant to this cultural group.

## C. PURPOSE OF THE STUDY

To increase understanding of how Kampuchean refugee mothers perceive and act in situations related to health and illness, the broad research questions posed here are:

1. In what way are health and illness described by Kampuchean refugee mothers?
2. What do these women do in relation to:
   (1) Health maintenance behaviors?
   (2) Avoiding illness?
   (3) Treating disease or illness?

## D. SCOPE OF THE STUDY

According to the purpose of the research, the case study was considered an appropriate approach. An unstructured interview was employed to gain indepth data. It was considered that this method

helped the researcher to get inside the respondent's private world to investigate ways in which health and illness are conceptualized and reflected in practice.

Three Kampuchean mothers were selected from the list of Kampuchean families according to the following criteria:

:Willingness to participate in interviewing sessions.

:The time span of resettlement in New Zealand (within 2 years).

In addition supplementary data were obtained from other members of the participants' families and from informal observation of the researcher.

Two interviews were conducted with each woman. It was considered that the second interview was useful for both the researcher and the participants to obtain or add more information missed out from the first interview. This second interview, however, depended also upon the willingness of participants.

The language used in interviewing was mainly English and Teochiu (a Chinese dialect) to allow both the researcher and the participants to adequately communicate. However, sometime Thai and Khmer were used if there was someone in the participant's family who was able to speak these languages.

Most of the interviews were tape recorded. These were then transcribed using the respondents' exact words to keep the meaning of each participant's perspective.

## E. STRUCTURE OF THE REPORT

The content of this report has been organized in six chapters. Chapter 1, as just described provides the general background the study, what will be studied, and how it will be studied. Chapters 2 and 3 review literature related to this research. They include information and reports of studies about the refugees, Kampuchea, culture and nursing, and the relationship between culture and health, and illness. In Chapter 4, the overall methodology of the research is presented. This chapter describes the procedure for gaining information and presenting the data and includes discussion of ethical considerations, and of limitations of the method. The findings of the study are presented in chapter 5 and in chapter 6 a discussion of the findings, some implications for nursing and recommendations for research.

# CHAPTER 2

## OVERVIEW OF KAMPUCHEA AND REFUGEES

Corresponding to the purpose of this study, the literature reviewed in this chapter emphasises two aspects; Kampuchea and refugees. This is to provide the background knowledge in these two areas as a basis for further discussion. The chapter is divided into three parts. The first part provides an overview of Kampuchea including the land and the people, their social structure, religion and historical background. The second part focuses on Kampuchea's health care systems with special references to general health beliefs and practices and the medical health care system. These aspects are reviewed up to 1979 (prior to the Vietnamese invasion of Kampuchea). The final section presents an overview of refugees in both Thailand and New Zealand. It discusses with special reference to Southeast Asian refugees, general problems arising when these people arrive to settle in a third country.

# A. OVERVIEW OF KAMPUCHEA*

## A.1 The Land and The People

Kampuchea is a relatively small and compact country on the Indochina peninsular and covers an area of 181,000 square kilometres. It is bordered by Thailand to the west, by Laos to the north, by Vietnam to the east and by the Gulf of Thailand to the South. Much of the country's area is a rolling plain. Dominant features are the large, nearly centrally located Tonle Sap (Great lake), and the Mekong River, which traverses the country from north to south. Mountain ranges exist in the west, north and north-east (Figure 2.1).

The climate is tropical and hot, with a rainy season extending from May to October. The dry season starts from October to April as a result of the dry monsoonal wind blowing from the north west of the country. The average temperature is $28^{0}$c and varies from $23.8^{0}$c to $32.2^{0}$c.

The population of Kampuchea was estimated at 7.1 million in 1972 and 8 million in 1975. However, this was reduced to 6.1 million following the Pol Pot regime. The numerically dominant ethnic group is the Khmer (Kampuchean) numbering 85% of the total population. The remainder consists of Chinese, Vietnamese, and Cham (Khmer muslims).

---

* The review in this section is based on Steinberg (1959), Munson, et al (1971), Language and Orientation Resource Centre (1981), Bruno (1984), Brick and Louice (1984) and, Demaine and Leifer (1986).

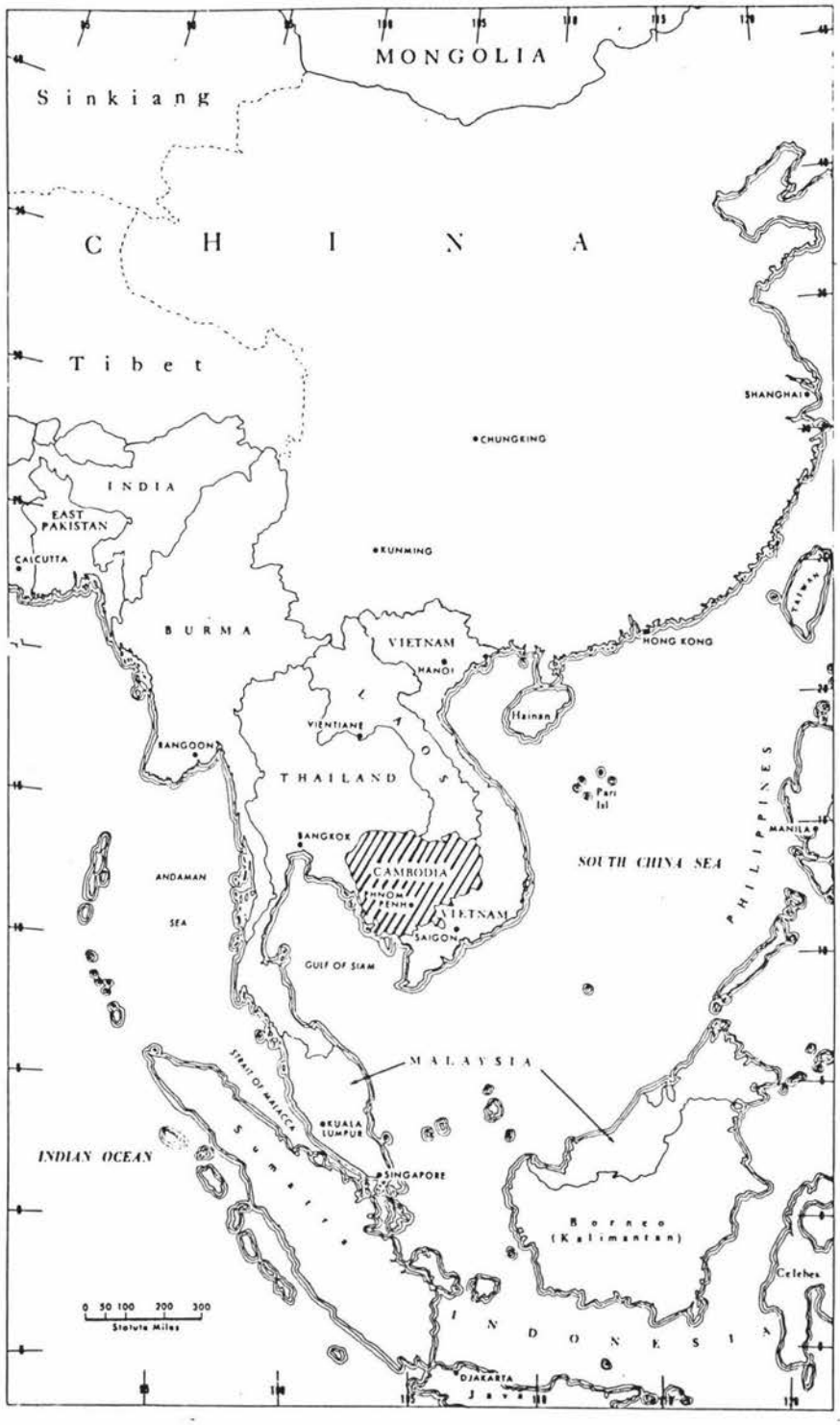


FIGURE 2.1 CAMBODIA'S POSITION IN SOUTHEAST ASIA

SOURCE: Munson, et. al. (1971. p. xviii).

Before 1970, the majority of Kampucheans lived in villages and were engaged in subsistence agriculture, mainly rice paddies and orchards. Food was sufficient in normal times, and the people generally had an adequate standard of living. For centuries they lived quietly and peacefully and seldom wanted to leave their country. Until 1975, only a handful of Khmer lived abroad. After five years under the Pol Pot regime, the country became poor and food was not sufficient resulting in starvation throughout the country.

Khmer is the national and official language of Kampuchea and has its own distinctive spoken and written form. It is, thus, quite different from the Thai, Vietnamese, and Laotian languages. Because of the extensive historical ties of the Kampuchean people to the culture of India, the language has borrowed from Sanskrit many words relating to administrative, political, military and literary subjects. The Kampuchean writing system is complex. There are 66 consonant symbols, 35 vowel symbols (Figure 2.2), 33 superscript (Figure 2.3), and 33 subscripts.

The Kampuchean people have the reputation of being peaceful. They are deeply religious, with few ambitions to improve their lives in a material sense. They accept their situation as Karma, that is the harvest of actions of a past life. They tend not to be aggressive, believing that a better life can come only in reincarnation, through right actions and merit earned in this life.

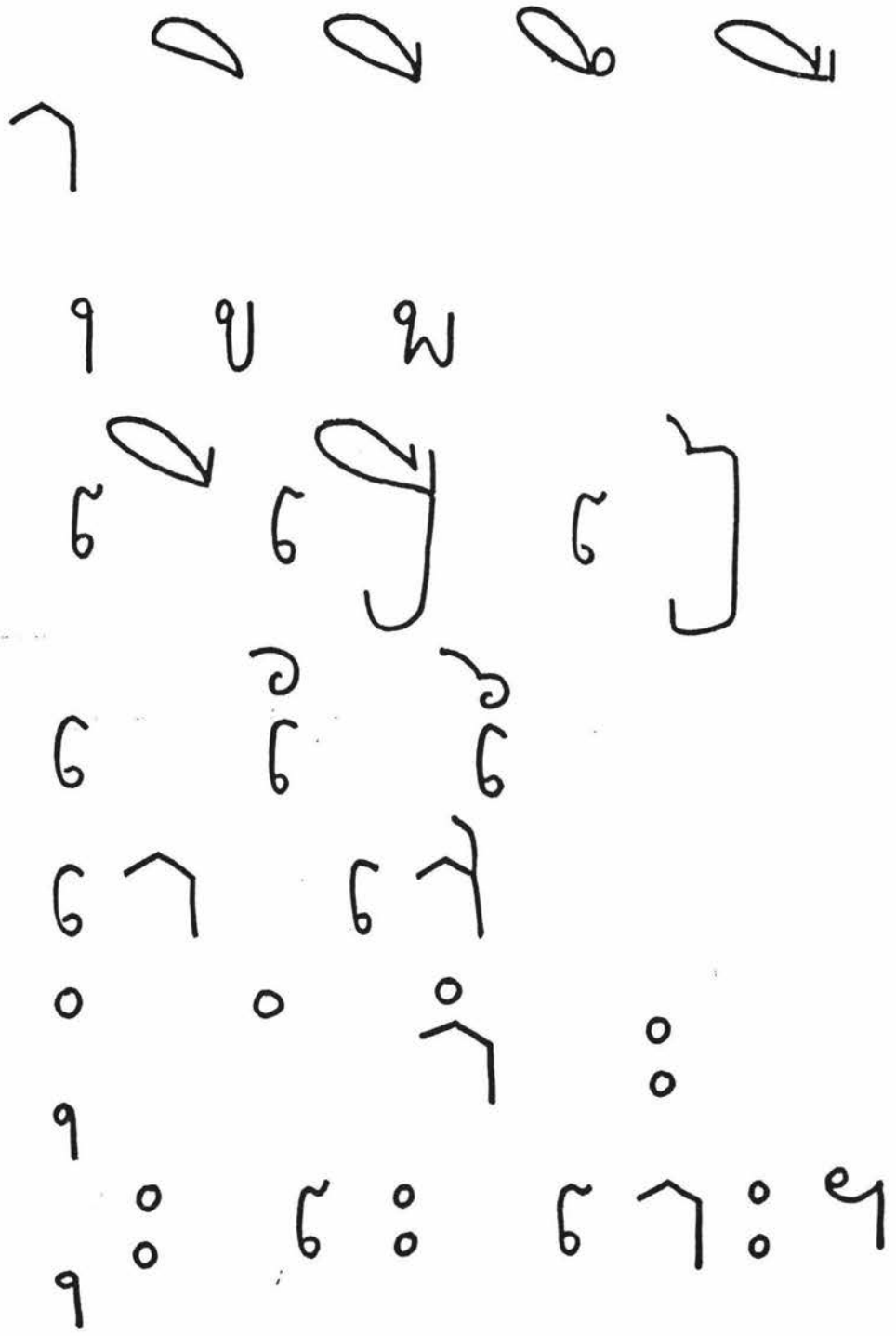

FIGURE 2.2 35 VOWEL SYMBOL OF KAMPUCHEAN WRITTEN LANGUAGE

FIGURE 2.3 33 SUPERSCRIPT OF KAMPUCHEAN WRITTEN LANGUAGE

## A.2 The Social Structure

The Khmer family is typically an extended one with father, mother, grandparents, and children living as a unit in rural areas. However, in urban areas, financial problems may force them into a single household. The family is the basic unit of production and consumption.

In rural areas, the husband generally works in the paddy field preparing the land for planting rice and other crops. The family works together when it is time to transplant the rice. In general, women are fully occupied with household chores and caring for their children and spend less time in the field than do women in many other peasant societies. Each woman is primarily responsible for the education of the children in social and moral matters. In some respects she is the leader of the family. She may, for example, handle all financial matters. As a result, the wife is typically given great respect both within the family and by the community at large.

In the Kampuchean family, children are treated affectionately, and appropriate behavior is encouraged by example rather than by beating or scolding. Sharp reprimands and physical punishments are avoided as far as possible. Boys are expected to be actively involved in community and religious life, while, traditionally, girls best represent the family by marrying someone deserving of their family's respect. Young men and women usually associate in groups, and dating as a couple is uncommon. Public displays of affection are regarded as the mark of the immoral; even the "social kiss" seen so often in public in western countries may be considered shocking.

Kampuchea has a highly stratified social structure with a distinct ranking systems. This is influenced not only by Buddhism but also by the Brahmanism. Each person has a defined place in the social order, with a correspondingly clear set of expectations, behaviour patterns, and duties to go with it. This elaborate system of stratification is evident in many aspects of life, perhaps most apparently in the Khmer language. A complex hierarchy of personal pronouns and verb forms gives proper respect to children, parents, elders, government officials, royalty, and monks. Through choice of diction language can be manipulated to flatter or insult.

### A.3 Religion

Theravada Buddhism has been the official religion in Kampuchea and is followed by nearly 85% of the population. It has made a deep impression on the thinking and behavior of the nation. As discussed earlier, the main elements of Kampuchean society have been the extended family, and the village which, before 1972, was almost self-sufficient. Thus, personal relationships and social attitudes within this framework are moulded by Theravada Buddhism. This religion is more of a philosophy or a value system than a religion as known in the West. The fundamentals of the Buddhist doctrine are the Four Noble Truths taught by the Buddha: life is suffering (dukha); suffering is caused by desire (tanha); suffering can be avoided by eliminating desire; desire can be crushed by strict adherence to a prescribed moral path-right understanding, right purpose, right speech, right conduct, right vocation, right effort, right thinking and right meditation.

Since future life is determined by the good and evil done in the present life, each person is dependent on his/her own endeavours. There is no escape from the law of cause and effect (Dharma). The good for all, whether of higher or lower social rank, is the achievement of personal merit - not the betterment of the human condition, which must be accepted as it is.

Buddhism influences every aspect of life. The pagoda or temple is the centre of the community in rural areas. In large cities, due to the increasing influences of modern life, traditional practices have decreased or taken on new forms. The Buddhist monks also play very important roles in primary education. All boys are sent to the school in their village for at least one term of religious instruction, either as lay students or as novices.

In some remote areas, Kampucheans practise animism, a belief in supernatural beings which include spirits of ancestors and demons, as well as some objects such as trees and stones. Such beliefs, however, are becoming less prominent as Buddhism and Western philosophy expand. Other religions also found in Kampuchea include the Christian, Muslim, and Hindu. The arts, literature, education and the social system are strongly influenced by Buddhist values.

### A.4 Historical Background

Throughout the early centuries of the Christian era, there were three groups of independent people - the Funanese, the Chams and the Khmer - living in the lower Mekong River region. In the middle of the

sixth century, the Khmer emerged as the dominant group in the area and established the kingdom of Chan-La. This kingdom later became "Kampuchea". The founder of the Khmer dynasty, according to legends, was Kambu Svayambhuva. Therefore Kambuja, the French Cambodge, and the English Cambodia are traceable to his name. Kambuja desa (Son of Kambuja) was the name sometimes given to the country in later years. Under Jayavarman VII, Kambuja reached its political zenith. Following his death in 1218, the empire went into progressive decline, never to return to its former glory.

From the middle of the 13th century, the movement of Thai peoples northeastwards began to erode the Khmer dominance. In 1431, Angkor, the capital city was sacked by Thai armies. Although Angkor was recaptured by the Khmer, it never became the capital again. Over the next few centuries the Thai and Vietnamese kingdoms grew while the Khmer declined. The capital was shifted several times, finally being located in Phnom Penh.

In the second half of the 17th century, Kampuchea was invaded by Thailand and Vietnam. Recurrent internal strife and competitive external intervention led to territorial loss to the advantage of both Thailand and Vietnam. By the beginning of the 19th century, Kampuchea was wedged between competing neighbours who exercised a form of dual suzerainty. That suzerainty was superseded by French overlordship from 1863. And in the following year, 1864, Kampuchea was colonized by the French and it was not until 1953 that the independent Kingdom of Kampuchea was reborn as a result of the diplomatic shrewdness of Prince Narodom Sihanouk.

A constituent Assembly was started in 1947 and the parliamentary government began in 1948. However, from independence until 1970, Kampuchea was dominated by the personality of Prince Narodom Sihanouk who stepped down from the throne to become the country's Prime Minister and later "Chief of State".

In 1970, Sihanouk was deposed by General Lon Nol, who used the increasing, penetration of border areas by the Viet Cong to justify his coup. At the same time, the United States launched a massive bombing campaign on eastern Kampuchea aimed at the destruction of Viet Cong sanctuaries along the Vietnam border. The Viet Cong forces were driven further into the country and the very small Khmer Rouge began to gather support.

Normal patterns of life were disrupted by the war, especially in rural areas. By 1972, a third of Kampuchea's population were refugees, often living on the streets in squatter shacks, depending on foreign rice shipments for survival.

In 1975, the Khmer Rouge interred Phnom Penh, completing their conquest of the country. They immediately began a mass evacuation of the city. All inhabitants, including the aged and bed-ridden hospital patients were forced out. For the next few years, Phnom Penh and other towns and cities were almost destroyed. Banks, post offices, schools, hospitals, and shops stayed closed. Under the new leader, Pol Pot, the Khmer Rouge began an extensive campaign to convert Kampuchea into a purely agricultural society.

Therefore, all sections of the population were forced to work in agricultural fields up to 16 hours a day. As a result, death from starvation was common especially among the old and weak. Medicine was almost unobtainable for those who did fall ill. Executions of those who had been soldiers under Lon Nol or who had held government posts were widespread. Estimates of the numbers who died under Pol Pot vary from one to three million. Some Khmer fled into Thailand, and over 200,000 fled into Vietnam.

In April 1979, Vietnamese forces invaded Kampuchea and took Phnom Penh. Crops had been destroyed by the fleeing Khmer Rouge and the planting season disrupted by the fighting and the movement of people looking for their relatives. Large numbers of refugees also began to flow into Thailand, among them remnants of the Khmer middle class, formal civil servants, Chinese small traders and businessmen. Most of them did not want to return to live under the Pol Pot Regime.

In November, the Khao I Dang camp was set up in Thailand becoming at that time the largest Kampuchean city in the world. This will be referred to again in section C.

## B. HEALTH AND PEOPLE

### B.1 Health Care Beliefs

Traditional medical beliefs and practices are a mixture of Chinese and Indian theories, Buddhist and animist ideas, and empirical techniques that have been developed through trial and error (Munson, et al op. cit.; Ferguson, 1982; Bruno, op. cit.; Kemp, 1985). The Khmer, thus, do not seem to have a single, consistent theory about the cause of disease in general. According to Ferguson (ibid.), three kinds of causes of ill health are recognised in Traditional Southeast Asian health care; including Kampuchea, Thailand, and Vietnam, as follows:-

a) Physical: A physical cause is a direct and apparent agent that results in an equally apparent effect. They come from the environment, for example, malaria, fever, scabies, diarrhea and influenza. They need medical treatment.

b) Supernatural: Ill health due to the work of evil spirits or ghosts which enter the body, cause a disturbance, or begin to devour the victim. Sorcerers are frequently thought to be responsible for these spirits.

c) Metaphysical: The philosophy of metaphysical

> causes of ill health stems from the principle of Taoism. Complementary yet opposite forces strike a harmonious balance of all things in the universe. For good health, the body must maintain a balance of the polarities of hot and cold. An imbalance can result from such factors as an incorrect diet or excessive emotion.

Behind much of the diagnosis, explanation, and cure of disease is the idea that the body is composed of the four elements - water, fire, winds, and earth (Bruno, op. cit.) - and that sickness results from an imbalance in the proportions or arrangements of these elements. Imbalance of the body's wind is the explanation for fainting. Such imbalance may occur through magical or natural causes (Hiegel, 1983).

Buddhist or animistic amulets and charms may be a protection against specific ailments, injuries, or misfortune in general. Tattoos are also endowed with special power by the Krou Khmers or Monks, and serve to protect the Khmer from evil spirits and physical harm (Steinberg, 1959; Munson et al. op. cit.; Hiegel, 1980; Bruno, op. cit.; Kemp, op. cit.).

In cases of serious illness the patient or his family may decide either to try to propitiate the house spirit or to solicit the help of the local practitioners (Hiegel, ibid.). The latter is called Krou Khmer, a man reputed to have magical curing abilities or one who has devoted himself to study of herbal medicine (Hiegel, ibid.; Kemp, ibid.). Whether the cure is primarily medicinal or ritual depends on

the diagnosis and presumably to a large extent on the specialty of the practitioner or Krou Khmer (Heigel, ibid.). If the sick person seems to be having difficulties with a spirit or ghost, offerings may be made to cool the spirit's anger or elaborate gifts promised in the event of a speedy recovery. With more stubborn examples of spirit possession, exorcism may be deemed necessary. In such cases the ritual way consists of incantations and sprinkling or bathing the patient in lutral (holy) water, perhaps accompanied by traditional Buddhist offerings of incense, candles, and flowers. A more vigorous treatment involves beating the patient to force out the evil spirit (Steinberg, ibid.; Hiegel, op. cit.; Bruno, op. cit.).

Childbirth usually takes place in the house and is handled by village midwives, called "Jamob" (Nuang, 1986). In Kampuchea, birth attendants never leave the woman alone and provide supportive care such as rubbing her back, washing her face, and so on. The Khmer believe that the woman during birth, is vulnerable to evil spirits (Kemp, op. cit.). The village midwives or "Jamob" are generally schooled only in the use of traditional methods and tools. This equipment is likely to consist of a sharpened bamboo stick, which is used to cut the umbilical cord and a plide (root) on which the cord is cut (Nuang, op. cit.). The village midwife takes exclusive care of the expectant mother from early pregnancy through post partum care (Kemp, op. cit.).

For a period after the birth, mothers and babies are usually given boiled water for drinking and bathing. Immediately after delivering, the woman is kept very warm for 3 days. It is desirable for the woman to perspire at this time. A fire was traditionally put under the bed

(Kemp, op. cit.). Foods that are especially bad during postpartum are meat from wild animals, seafood, or any unfamiliar food. Any food taken should be fresh and "hot" in nature. Large amounts of salt are eaten and a homemade wine containing traditional medicine may be taken. This is in order to restore strength lost during delivery and bleeding (Kemp, op. cit.; Nuang, op. cit.).

The Khmer also believe that exposure to water (rain, tub bath, etc) during a fever or other illness results in water entering the lungs and causing pneumonia. Thus, they treat fever by keeping the patient as warm as possible (Kemp, op. cit.). Eating certain foods (which vary among individuals) during a fever, after delivering a baby, and at other times may cause problems such as loss of consciousness, or clenched jaw called "Teau" which means allergy (Nuang, op. cit.).

## B.2 Health Care System in Kampuchea

As discussed earlier, a belief in spirits is integrated into the worldview of the Khmer as a means of coping with unhappiness. Daily occurences are explained as the influence of supernatural forces and spirits are often held responsible for accidents, bodily sickness, misfortune and insanity. As summarised in figure 2.4 the health care system in Kampuchea before 1975 is divided into traditional and modern (western) health care which was introduced in 1860. The two systems will be discussed separately.

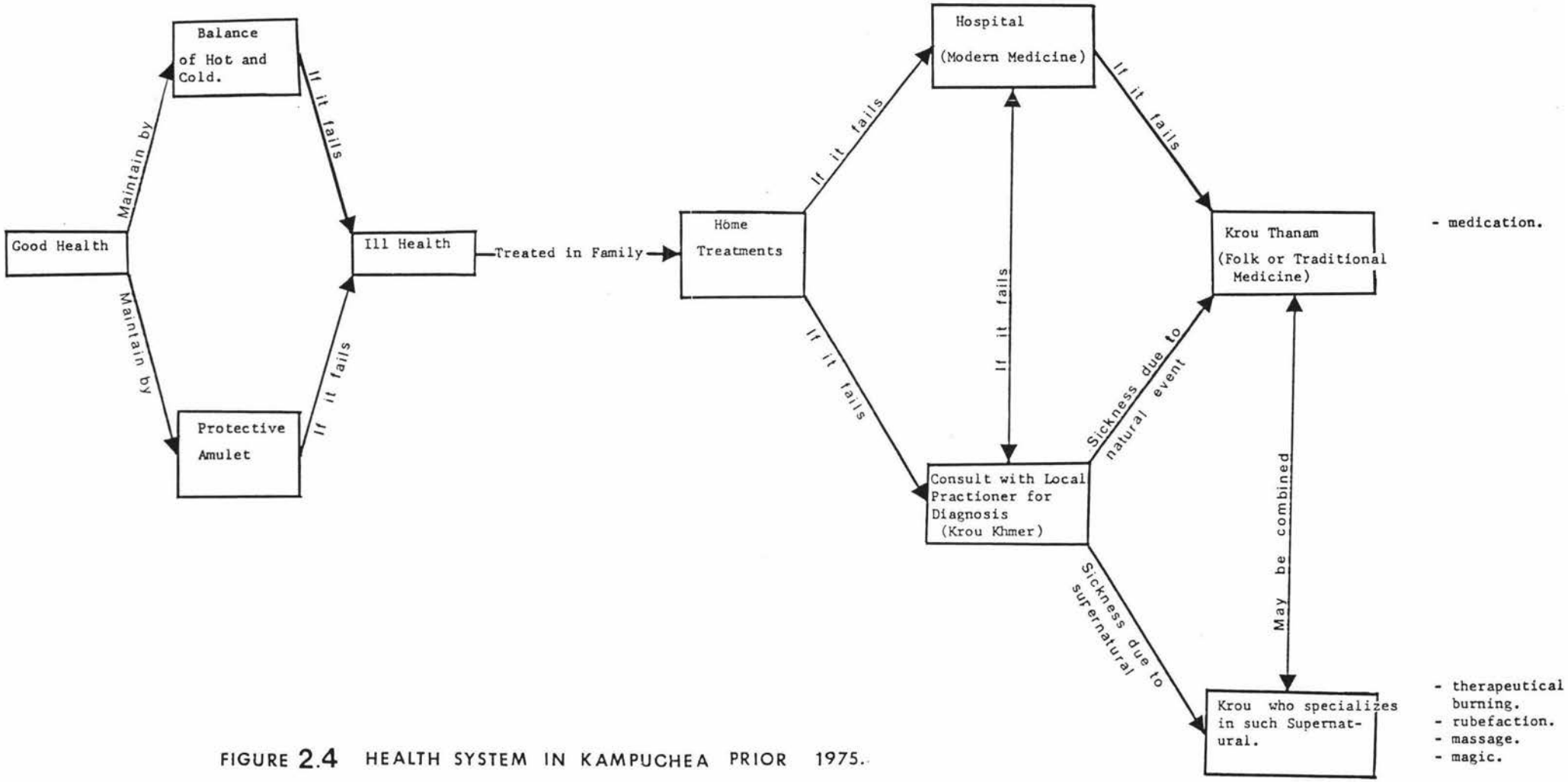


FIGURE 2.4 HEALTH SYSTEM IN KAMPUCHEA PRIOR 1975.

### B.2.1 Traditional health care

Traditional health care is initially practised at home for both preventing and curing illness. In terms of preventing, the maintenance of the body's natural balance of hot and cold is the most important. According to the ancient Taoist theory of Yin and Yang, every natural element, food and drug is classified as hot or cold, and must be administered in proper amounts in order to regain and retain the correct balance (Tung, 1980). This is essentially a form of preventive health care, in which nutrition plays a substantial part. Illness are also termed hot and cold, and are treated by consuming foods or medicines of the opposite nature (Tung, ibid.; Ferguson, op. cit.; Kemp, op. cit.). Ferguson (op. cit.) lists hot and cold illnesses food and medicines as shown in Table 2.1.

As illustrated in figure 2.4 traditional health care or local health care is administered within the family first. Most illnesses are first treated at home, usually by a grand parent or an older member of the extended family, especially by the women who are recognised as being responsible for health care in the family, and with having the greatest knowledge of folk medicine (Bruno, op.cit.; Kemp, op. cit.). The following traditional treatments as named in the Khmer language, have been culled from a variety sources, especially from Hiegel, op. cit.; Ros, 1983; Ferguson, op. cit.; and Kemp op. cit.) and are commonly used at home for minor illness.

TABLE 2.1

HOT AND COLD ILLNESS, FOOD AD MEDICINE
OF SOUTH EAST ASIAN PEOPLE

| | HOT | COLD |
|---|---|---|
| ILLNESS | headache | dizziness |
| | upset stomach | indigestion |
| | constipation | diarrhea |
| | nosebleed | |
| | blisters | |
| | chest pains | |
| | fever | |
| | acne (excess heat erupting through the skin) | |
| | sore throat | |
| FOODS | sweets | eggs |
| | spices (ginger, pepper, etc) | beans |
| | | some seafoods |
| | chicken | gelatin |
| | beef | banana |
| | fats | oranges |
| | mangos | melons |
| | pineapple | most vegetable |
| | papaya | icecream |
| | tangerines | tea |
| | lichi | |
| | guava | |
| | coffee | |
| | alcohol | |
| | ice | |
| | unripe fruit | |
| MEDICINES | antibiotics, and almost all western medicines | herbal remedies, and almost folk medicines |

SOURCE: Ferguson (1982, pp. 12-13).

a) Kos Khyal (rubbing out the wind)

Kos Khyal is a traditional Khmer massage practised by rubbing or scratching with a coin dipped in Tiger Balm. This is to treat headaches or slight fevers, colds, pain, heat exhaustion, fainting, shock, muscle soreness, nausea and vomiting. The treatment is carried out to expel the bad wind that has entered the body and caused ill health. The rubbing is done on the neck, back, chest, forehead, stomach, throat or inner arms until bruises appear. The belief is that the blood which appears beneath the skin is bad blood which needs to be brought out.

b) Chop Khyal (Pinching or Rubefaction)

Chop Khyal is pinching with the first and second fingers until red-purple bruises appear. This causes bruising. It is commonly used for the treatment of pain or other minor ailments such as fever, cough, dizziness, fainting or loss of appetite. For headaches, chop involves placing a small candle affixed to a small platform on the forehead. The candle is lit and then covered with a small container. The flame consumes the oxygen and creates a vacuum, which in turn causes a circular contusion.

c) Plom Tracheak (Blowing ear)

Plom Tracheak is blowing in a person's ear and may be accompanied by hard pinching of the Achilles tendon. This treatment is used for a variety of complaints and is also used to revive a person who has

fainted or who is close to dying.

d) Och (Burning)

Och is burning (more or less) circular areas (1-1.5 cm. diameter) on the abdomen. There are usually two to four burns in vertical lines on both sides of the umbilicus. The burns are made by lighting a specific powdered substance or cotton on the abdomen and are for the purpose of treating or preventing diarrhea or malaria. It is performed by a monk or Krou.

e) Vigorous massages that may cause bruising are used for many ailments.

f) Showering with lustral (holy) water while saying prayers in Pali is practised by a monk or Krou for numerous reasons.

g) Cutting an infant's hair is said to prevent problems, and the failure to do so is believed to cause problems later.

When home treatment fails, the help of an outside practitioner may be solicited. The family of the sick plays an important role in the decision. In the rural areas, indigenous practitioners or healers called "Krou Khmers" are commonly consulted (Steinberg, op. cit.; Hiegel, op. cit., 1984; Kemp op. cit.). The word "Krou" comes from the sanskrit name for teacher or spiritual guide, emphasising an inseparable connection between the spiritual and physical self (Hiegel, op. cit.). These healers constitute the mainstay of the traditional

health care system in Kampuchea prior to 1975. The approach of the Krou Khmer is on two levels. On the first level he determines the nature of the illness and on the second its origin. There are five kinds of Krou Khmer according to their specific roles, but sometimes they are used together. (Kemp, op. cit.). The following Krou Khmer are listed by Hiegel, op. cit., 1981; and Kemp, op. cit.).

a) The Krou Thanam - specializes in treating the patients by using medicament prepared by mixing various products, mostly from plants. Each Krou Thanam is also specialized in the treatment of a particular complaint. In selecting herbs and other medicine they use a theory based on three transformations involving water, wind and fires.
b) The Krou Banebat - determines the origin of the illness through meditation and does not give drugs directly, though he can give advice about them.
c) The Krou Robien - specializes in making Talismans and tattooing which contain magic formulas in Pali. This is to give protection from dangers of natural or supernatural origin.
d) The Krou Thmop - specializes in magical therapy, his intervention is required when someone is a victim of black magic or the suffering is caused by an offended spirit.
e) The Krou Snae - is an experts at making magic charms which act like a love philter.

Thus, after diagnosis the patients will be handled by those Krou Khmers who specialize in such an illness. In general, there are five forms of treatments that can be distinguished viz medication,

therapeutical burning, rubefaction, massage, and treatment by magic.

In terms of medication the folk medicine consists of a wide variety of products, mostly of vegetable origin. The medicinal properties are found in certain specific parts of trees or plants, such as the roots, bulbs, rhizomes, the bark, leaves, flowers, fruits, branches or trunk. Some constituents are of animal origin, such as bones from elephants or horses. Minerals such as sulphur or alum are also used (Hiegel, 1981).

Treatment consists of a variable number of elements. Decoctions are prepared by boiling a substance in water until the liquid is reduced by two thirds. Each patient drinks three to four litres per day of these infusions throughout the whole course of treatment. Certain medicines are presented in dry form. Powders are taken stirred into a glass of $30^0$ rice alcohol or water. Pills or tablets can be obtained by blending powders with honey or palm sugar.

The Thanam Sdah is another medicine with a very special form of application. Hiegel (ibid.) states that the Krou chews one or two vegetable substances such as betal leaf or arek nut and sprays the juice on the lesion requiring treatment. The other medicines for external use are in the form of liquid blends, ointments or pastes. To treat infections of the nose and throat, the traditional healers prescribe "dry inhalations" in certain cases: the substances smouldering slowly in a long bamboo pipe give off smoke which is breathed in by the patient. "Moist inhalations" are also used: the patient then breathes in the vapour from a mixture previously brought

to the boil. For common or minor illnesses; Ferguson (op. cit.) listed several treatments used among Southeast Asian people, as shown in table 2.2. With regard to the therapeutic burns, rubefaction, and traditional Khmer massage already reviewed, it is interesting to note that these treatments can be performed by the member of the family or the Krou Khmer who specializes in such method.

Magic also has therapeutic effects for the Khmers. For them the world is populated with myriad spirits. Not all of these are systematically hostile - so the Kampucheans do not have to live in a permanent persecution climate - but spirits can cause suffering if they are offended. When a child is born with a prolapsed cord i.e. with the umbilical cord encircling the body or the neck, its Krou Kamneut is offended. A special offering must be made to this spirit, which inhabits the child even before its birth. The child will suffer from headaches or be chkuot, which means deranged, if this precaution is not taken. The traditional healer uses the upper stem of a young banana tree, candles, and incense sticks, and then wraps several loops of white thread around it all. This affixing is an evident symbol of the child's body and the umbilical cord, and always has a lasting and spectacular effect upon the child.

### B.2.2 Modern (Western) Health Care System

The modern health care system was first introduced to Kampuchea by French colonists in 1860. Initially, it was to serve the French troops but its services were soon extended to the native peoples. However, the few French physicians were centered in urban areas. Access to this

TABLE 2.2

COMMON FOLK REMEDIES IN SOUTHEAST ASIAN HEALTH CARE

| Condition Treated | Treatment* |
|---|---|
| headache | Rub tiger balm on temples and bridge of nose, and spread upward to either side of forehead |
| sore throat | Drink a mixture of lemon juice and salt. |
| cough | Drink a mixture of ginger, honey and tangerine; or boil ginger and drink the water. |
| cold | Tie a small amount of tiger balm into a handkerchief and tie around neck. |
| cold with high fever | Inhale steam from boiled pungent herbs, such as lemongrass, peppermint and ginseng. |
| fever | Mash small red onions and place on forehead. |
| fever with convulsions | Mash a mixture of red onions, garlic and lemon-grass and place on forehead. |
| nausea | Rub tiger balm under the nose to sniff; or drink fresh lemon juice. |
| very frequent | Rub tiger balm on stomach; or drop a tiny amount of balm into hot water, stir and drink. |
| toothache | Put tobacco, salt, or menthol oil on tooth or into cavity; or put mashed hot peppers on tooth; or swish salt water in mouth. |
| menstrual cramps | Drink a mixture of various herbs boiled in water |
| cuts | Put mashed hot pepper on site to relieve pain. |
| muscular aches, cuts, scrapes, burns, sprains, insect bites, reheumatism | Rub a small amount of tiger balm onto site of discomfort. |

* Not all treatments are practiced by all ethnic groups

SOURCE: Ferguson (1982 p. 17).

care was difficult for rural villagers, and not many Khmers outside the urban centres were exposed to modern health care (Steinberg, op. cit.; Munson, et al op. cit.; Bruno, op. cit.). The Khmer in the rural areas, thus, were dependent upon traditional health practices and medicines which have been reviewed in B.2.1, traditional health care.

When the country became independent in 1953, most expatriate physicians returned to France. Thus, the government was faced with the problems of providing hospital facilities and training medical personnel to replace the French who had operated the medical services. With strong support from various countries including the United States, France, Japan, China, the USSR and Poland, Kampuchea established its first school of medical science in 1957 (Steinberg, op. cit.; Munson et al, op. cit.) and by 1971 there were 450 Khmer physicians to serve a population of 7 million (Bruno, op. cit.).

The Royal School of Nurses and Midwives, and Health Officers was also established. The health officers who received 4 years of medical training with particular emphasis on sanitation and preventive medicine, provided much of the limited medical assistance available in the countryside. Hospital and health centers were increased substantially from 1955 to 1967 (Steinberg, op. cit.; Munson et al. op. cit.).

Western medicine was prohibited during the Pol Pot regime as part of a fanatical campaign to purge Kampuchea of all western influences. All the educated people including doctors, nurses, and health officers were executed.

Following the invasion by Vietnam in 1979, Kampuchea's tightly sealed borders were opened, and close to one and a half million Khmer fled to the refugee camps on Thailand's eastern border. Sick, starving, and near dead from exhaustion, the deeply traumatized Khmer settled in temporary encampments along the Thai-Kampuchea border. Medical teams from around the world made efforts to meet the desperate needs of the refugees. It was here in these refugee camps that many rural Khmer were first exposed to western medical care (Bruno, op. cit.).

## C. OVERVIEW OF REFUGEES

### C.1 Definition

Refugees, as stated by the law under the seventh preference of the Immigration and Naturalization Act, are those people who have a well founded fear of persecution based on political, racial, or religious beliefs; who are outside their country of nationality; and are unable to return to their country of origin because of that fear of persecution.

From the above definition, the world has faced the refugee problem throughout history, but the difference between the early and the present time is the scope and the great difficulties in finding solutions (Binzegger, ibid.). For example, in former times, refugees could merge into the general stream of immigration requiring no passports and visas. With the tight control of sovereign nation states

all over the world, it has become immensely difficult to gain entrance. Thus, refugees have become a special problem of this present day (Binzegger, 1980).

According to the United Nations, there were 10 million people in the world who came within the mandate of the United Nations High Commission for refugees in the mid 1980's (Simmonds, Vaughan, Gunn, 1983). In Asia in 1980 the largest refugee population is in Pakistan (2.3 million) followed by Thailand (0.3 million). Most of the refugees in Thailand are Indochinese including Laotian, Vietnamese, and Kampuchean (United Nations High Commissioner for Refugee, 1986). The latest figures for these refugees are shown in table 2.3.

C.2 Refugees in Thailand

Since the establishment of Vietnam's new regime in 1975, more than 1.12 million Indochinese have fled their homeland in Vietnam, Laos, and Cambodia into Thailand, Malaysia, Hongkong, Indonesia, the Philippines and Singapore. As shown in Table 2.3. Thailand has more Indochinese refugees by far than the other first asylum countries in East and Southeast Asia. Approximately 542,688 refugees in Thailand have departed for resettlement in third countries including United States, Canada, Australia, and New Zealand. There are, thus, currently around 125,961 Indochinese refugees at UNHCR - assisted camps, reception centres and transit facilities in the country. They range in size from the 42,000 hilltribe refugees at Ban Vinai Camp in Loei Province to fewer than 100 at the Bangkok Transit Centre. Laotian refugees (approximately 91,000) constitute the largest group, followed by

TABLE 2.3

NUMBER OF REFUGEES ARRIVAL AND DEPARTURES

| | ARRIVAL | DEPARTURE |
|---|---|---|
| Thailand | 663,874 | 541,272 |
| Malaysia | 212,437 | 205,760 |
| Hong Kong | 112.184 | 109,897 |
| Indonesia | 98,100 | 94,292 |
| Philippines | 36,965 | 34,468 |
| Singapore | 29,109 | 28,894 |
| Macau | 7,056 | 7,885 |
| TOTAL | 1159,725 | 1,022,468 |

SOURCE: Adapted from UNHCR (1986, p.2).

Kampucheans (about 29,000) and Vietnamese (around 7,000) (UNHCR, ibid.). The location of these camps and their number of refugees are presented in figure 2.5.

As shown in figure 2.5, there are only two holding centres, Khao I Dang (KID) and Kab Cherng (KC), for Kampuchean refugees. The rest, except for the Transit Centre at Panat Nikom and Bangkok, are for Laotian and Vietnamese. Figure 2.5 also demonstrates that most of the Cambodian refugees are at KID camp. Thus, detailed information from this camp will be reviewed.

KID camp is located in the Ta Phraya District of Prachinburi Province, approximately 30km East of Bangkok. It was established in November 1979 when the first group of nearly 5000 Khmer was brought in from the border by the Royal Thai Army. Arrivals continued and by the end of May 1980, the camp population had swelled to 130,000 and it was said to be the largest concentration of Khmer in the world. In August and September of that year, approximately 80,000 refugees were transferred to the other holding centres of Sakaeo, Bang Kaeng, Kamput and Mai-Rut, all since closed (Holck and Cates, 1982; Assadi, 1986).

The current population (August, 1986) is just under 26,000. The camp is divided into a total of 13 sections, seven of which are currently in use. Each section is divided into two-three blocks with each block comprising up to 60 groups housing a maximum of 100 people each. Each section has a section office, a water station and often a primary school. Shelters are generally two family units made of bamboo and thatch, and made more durable to withstand the monsoon rains by

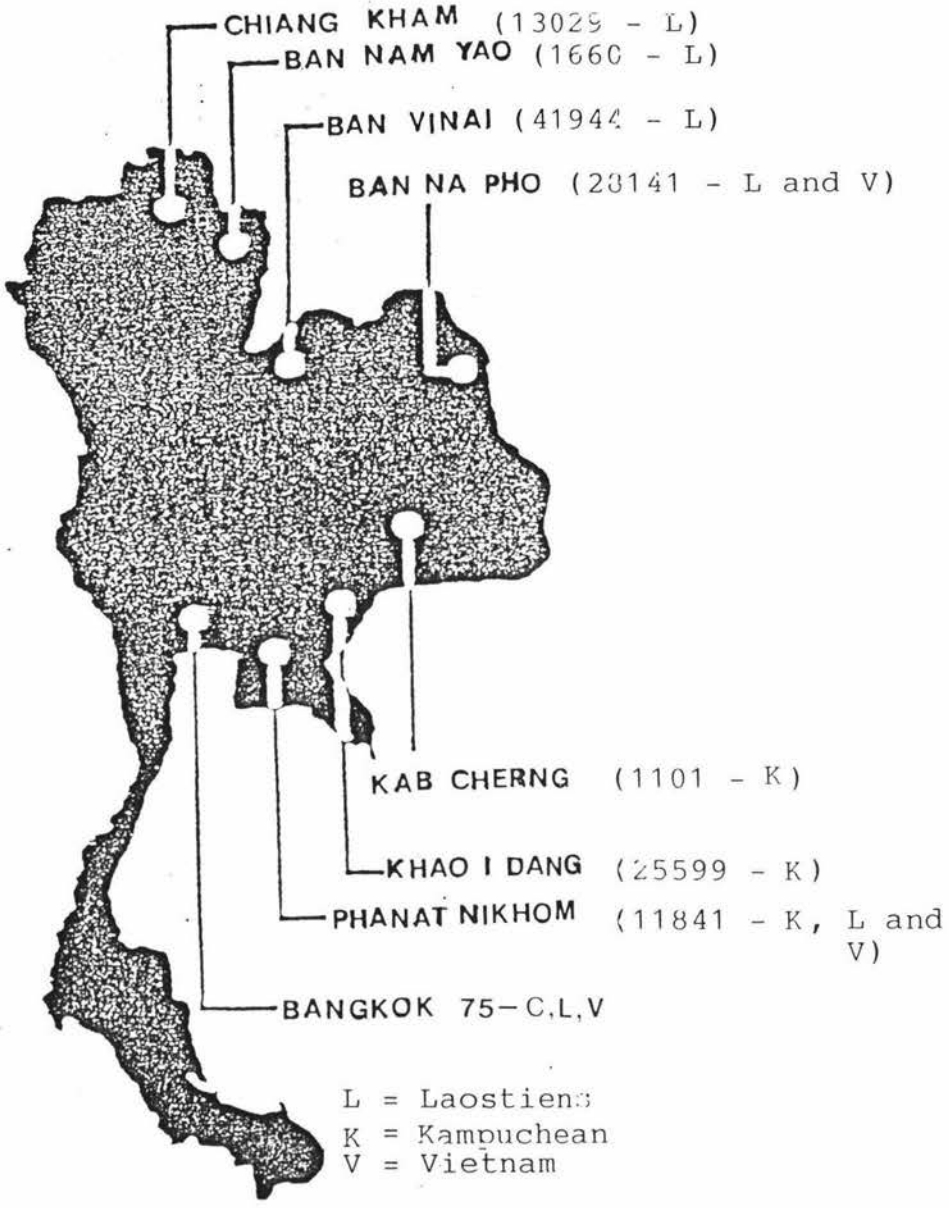


FIGURE 2.5 CAMP'S LOCATION AND NUMBER OF REFUGEES IN THAILAND (As of 31 August 1986)

SOURCE: Adapted from UNHCR (1986, p.3).

raised floors and an underlying bed of brick (Assadi, ibid.).

Medical care was initially provided by the International Committee of the Red Cross (ICRC) (Holck and Cates, ibid.) and later supplemented by a total of 13 voluntary agencies providing medical personnel and supplies, goods, education, sanitation and social services (Assadi, ibid.).

Many Khmers also settled in temporary encampments along a three kilometre stretch of land between the Cardamon range and the Thai-Cambodian border. This area developed into Nong Samet, Nong Chan, and Mak Moon Camps. These encampments are not on land officially recognized as Thai territory, thus the refugees are not afforded the protection of the Thai military. These camps are under the management of one of the three nationalist factions in the Democratic Kampuchea Coalition government in exile (Bruno, op. cit.).

### C.3 Refugees in New Zealand

Since the second world war, New Zealand has accepted over 150,000 refugees and displaced persons from many different countries. For example, Western Europe, Albania, Poland, Indonesia, Soviet Union, Bulgaria, Hungary, Yugoslavia and Czechoslovakia (Department of Labor, 1985). The collapse of Saigon in April, 1975 left New Zealand, like the United States and Australia, with some feeling of responsibility for the defeated anticommunist Vietnamese. Thus, refugees from Indochinese countries, formerly under French protection, began in 1979 (Department of Labor, 1984). By June, 1984 New Zealand had taken 6199

Indochinese refugees. The majority of these refugees are Cambodian (47.3%), followed by Vietnamese (46.9%) and Laotian (5.8%) (Department of Labor, ibid.). Most of these refugees have left as a direct result of dramatic political, social and economic upheavals and have been classified by the UNHCR as refugees (Holck and Cates, op. cit.; Bruno, op. cit.; UNHCR, op. cit.). The majority of these refugees have come via the Khao I Dang refugee camp in Thailand and camps in Malaysia.

Most Cambodian refugees have come via the Khao I Dang refugee camp in Thailand, (UNHCR, op. cit.). Their ethnic group is mainly Khmer. Unlike Vietnamese refugees where most of their leaders escaped when the communists took Vietnam and there has been no bloodbath, all leaders in Kampuchea (i.e. all educators, doctors, nurses, polices, politicians, military, were murdered (Bruno, op. cit.; Kemp, op. cit.). Thus, the majority of Khmer refugees are of low education.

According to a preliminary study conducted by MacRae (1980) on the refugees in New Zealand, all the refugees from Kampuchea speak Khmer. However, a small number especially those involved in business also speak some chinese while the older people also speak French.

MacRae (ibid.) also reported that Kampuchean refugees who passed through the Auckland hostels, Marcellin Hall and Mangere Hostel, from 1977 to 1979 went to locations throughout both the North and South Islands. The largest concentrations include Auckland, with 16 Kampuchean families, Wellington with about 20 Kampuchean families, and Christchurch with 10 Kampuchean families. At Hamilton and Palmerston North, Liev and McLaren (1983), and Hornblow (1986) suggest there are

about 100 and 320 Kampuchean respectively.

### C.4 Southeast Asian Refugee And Health Problem

All refugees, especially those from SEA, have experienced moving, suffering, fever, sickness, and the ravage of war. These experiences brought the attitudes of "living for today" and "survival of the individual" to them. These attitudes conflicted directly with the old Asian tradition of mutual familial dependence. The way of life for most Asians revolved around their family plot of land and their ancestral village. Becoming refugees has led to various problems including health problems.

One very difficult problem is the mental illness experienced by many of the refugees (Hiegel, 1981; Bowman and Edwards, 1984; Nguyen, 1982; 1984). Current research suggests that they are having serious problems trying to adjust to the culture shock of living in the Western countries (Lin, Tazuma and Masuda, 1979; Vignes and Hall, 1979; Rutherford and Thomas, 1981).

The factors that caused the refugees "to be at risk" for mental ill health have been pointed out (Westermeyer and Mintrob, 1979; Gordon, Matousek and Lang 1980; Brown, 1982; Tyhurst, 1982). These factors include the difficulty of learning English, the discouragement of trying to find work to support large families and to regain status, and the reality of total and final separation form a former way of life, family, friends and native land.

Health practices and beliefs of Indochinese refugees have also been reviewed by several workers. (Hoang and Erickson, 1982; Goldfield and Lee, 1982; Schultz, 1982; Cohon, 1983; and Muecke, 1983). These authors provide a brief overview of the historical, religious, cultural and some traditional concepts of health and illness as they influence Vietnam, Kampuchea, and Laos. These are reviewed as the background for their studies which focus on how the refugees are coping with the Western medical care and how to care for Indochinese refugees. Some studies focussed on health practices of Vietnamese. Henderson and Primeaux (1981) pointed out some medical beliefs and practices of Vietnamese. Manderson and Mathew (1981); and Wadd (1983) studied Vietnamese practices during pregnancy, and the postpartum period. With regard to the Khmer, there is a small literature introducing some Kampuchean beliefs and practices related to health care (Hiegel, 1980; Bruno, op. cit.; and Kemp, op. cit). However, study of health care beliefs and practices from the Kampucheans's viewpoint has not been addressed elsewhere in depth.

## D. SUMMARY

Kampuchea, a country in Southeast Asia, has a long history. It is classified as an agricultural country with the majority of people living in the countryside area prior to 1970. Bhuddism is the official religion and strongly influences to the life of the people. The people have their own culture, beliefs, and ways of life. The health care system is divided into traditional and modern (Western) health care. Traditional medical beliefs and practices are a mixture of Chinese and

Indian theories, Bhuddist and animist ideas, and empirical techniques that have been developed through trial and error. Western health care was introduced in 1860, however, many people who lived in the country did not have access to this system.

The normal pattern of life in Kampuchea were disrupted by the war beginning in 1970 and with the rise of communism in 1975. Therefore a large number of people became refugees and fled to other countries including New Zealand.

In the next chapter the concepts of, and relationship among, culture, health, illness and disease will be examined and discussed. Then the importance of culture in nursing are also pointed out.

# CHAPTER 3

## CULTURE, HEALTH, ILLNESS, AND NURSING

Over the past 15 years, cultural diversity has expanded rapidly as an area of interest for nursing (Tripp-Reimer, 1984). Cultural factors are recognized as an integral part of health service planning. As Leininger (1977) states, the importance of understanding and using knowledge regarding cultural diversities, and with thought to minorities in the society, has considerable relevance to the nursing profession and to other health groups. Diversities exist in a number of areas related to race and ethnicity which require continuing study. These areas include the physical differences such as skin colour and hair texture; the heterogenity of health beliefs, for example beliefs regarding general health care practices, what people do to keep well and what they do when they get sick. Therefore, if the care which nurses give to individuals and families from different cultural backgrounds is to be effective and appropriate, the nurses should have a knowledge of the importance of the influence of cultural factors for example, race, ethnicity, religion, language, as well as specific cultural values.

This part of the literature review aims to discuss literature concerning relationships between culture, health, illness, and nursing. The concepts of culture, health, illness, and disease are classified.

The importance of culture in relation to health and illness is also presented. Finally, culture and its relevance to nursing is discussed.

## A. THE CONCEPT OF CULTURE

It has been said that the term 'culture' has not been clear, specific, or agreed upon with respect to meaning (Verma, 1983). As a concept relating to mankind, it has been defined and redefined mainly by anthropologists. For most anthropologists, culture is an abstraction of the behavior of people from different social contexts (Leininger, 1967). Brown (1963) describes culture as "... all the accepted and patterned ways of behavior of a given people." (p.3) According to her, culture functions as a buffer between man and his/her environments and enables members of a group to adapt to their environment. Paul (1958) defines culture as 'a blueprint for social living'. A clearer and more detailed definition of culture is provided by Mead (cited in MacGregor, 1960). She defines culture as a:

> "body of learned behavior which a group of people, who share the same tradition, transmit entire to their children, and, in part, to adult immigrants who become members of the society. It covers not only the arts and sciences, religions and philosophies to which the word culture has been historically applied, but also the system of technology, the political practices, the small intimate habits of daily life, such as the way of preparing or eating food, or of hushing a child to sleep, as well as the

method of electing a prime-minister or changing the constitution".(p.41)

According to Mead, culture is not only biologically inherited but it is also viewed as socially inherited. From infancy people learn to think, act and react in certain ways and without realizing it, they develop an understanding of, and are socialized into behaving in culturally appropriate ways.

Culture, therefore, may be viewed as "a set of rules or standards for behavior" (Tripp-Reimer, op. cit.). According to Tripp-Reimer (op. cit.), culture consists of learned patterns of values, beliefs, customs, and behaviors that are shared by a group of interacting individuals. It may be simply said that all aspects of living have a cultural component (Brink, 1976). In addition Lewis (1976) provides a definition that also implies that a culture is not a static entity, it evolves and changes over time.

As described above, the concept and nature of culture may be summarized in the following theoretical postulations (Herskovits 1955). They are:

: Culture is universal in man's experience, yet each local or regional manifestation of it is unique.

: Culture is stable, yet it is also dynamic, and manifests constant change.

> : Culture fills and largely determines the course of our lives, yet rarely intrudes into conscious thought.(p.306)

The importance of the concept implied here is that every ethnic group has its own unique culture. Each culture codifies reality in its own way, members of different ethnic groups act upon different premises in behaving and evaluating behavior. When members of one ethnic group come into contact with the culturally coded orientations of another ethnic group, some conflicts, such as, misunderstanding, or misinterpreting the behavior or expression of that person may occur, and culture shock may develop.

## B. THE IMPORTANCE OF CULTURE IN RELATION TO HEALTH AND ILLNESS

As stated earlier, all aspects of living have cultural components. These aspects include a person's reaction to health and illness - for example their attitude towards health, their definition of health and illness and health seeking processes. Ahmed, Kolker, and Coelho (1979) state that the concept 'health' and 'illness' or 'disease' can no longer be adequately defined in purely medical terms according to the presence or absence of 'symptoms'. This is a major contribution of anthropological research which has pointed out that within each culture exists specific labels for, and explanation of, behavior (Knutson, 1965; Eisenberg, 1977; Kleinman, 1977; Leininger, 1978), and that the labels of 'disease' and 'health' are culturally determined (Knutson, ibid.). Therefore, the behavior of individuals in regard to

health and illness can be more accurately understood by knowing something about their beliefs and values.

## C. THE "HEALTH" CONCEPT

'Health' has traditionally had a number of meanings, depending on who is defining it, or on the purpose, time, and circumstances governing use of the term. Traditionally, to promote health is to get rid of disease from the body. In Western Culture the first and still most prominent meaning comes from the medical model of the body and the germ theory of disease (Kelman, 1975). Health is defined as the absence of disease, illness, or symptoms (Bauman, 1961; Gore, 1978; Fillenbaum, 1979).

The most widely known definition, however, is that of the World Health Organization (1947): "a complete state of physical, mental, and social well-being, not merely the absence of disease or infirmity."(pp.1-2) This definition has been criticized as idealistic, utopian, and impractical (Wiley, 1970; Doffman, 1973; Kelman, ibid.) since it tends to express what 'health' ought to be, defined in terms of outcome.

Current trends are towards health being defined in a positive sense, such as by Dubos (1965) who stated that health and disease are the expressions of the success and failure experienced by the organism in its effort to respond adaptively to environmental changes.

A more functionally oriented definition is that of Parsons (1972) who views health and illness in the context of social role structure and social control. Health, according to Parsons, is defined as the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he/she has been socialized.

By including the concept of health promotion into cure and prevention of disease, a multidimensional approach was advocated and the generalized concepts of 'holistic' health began. The 'holistic' idea implies a state of feeling complete and balanced. In this view, the assumption is that each person is more than the sum of his or her body parts. Further, to be healthy one must achieve a balance and integration of these parts for a total expression of well-being (Brallier, 1978). Health also is viewed as a product of man's total way of living. In this view, health is described as each person being a unique combination and integration of physical, mental, emotional, and spiritual aspects of 'aliveness' (Winstead-Fry, 1980).

With these different views of health it is apparent that universal agreement about the concept has not yet been reached (Schroeder, 1983). Therefore, it is difficult to know exactly what each individual means when using the term health. Moreover, these definitions also came from the members of various disciplines. They may see health in different ways, as stated earlier, depending on their educational and cultural background and frame of reference. Most importantly the lay people of each culture also have their own distinct definition of health. Their distinctions affect the presumption and interpretation of health needs.

That means any particular definition of health cannot be assumed as equally relevant to all situations. If the nurse and client have different conceptions of the meaning of health, communication between the two may be impaired and each may be working toward a different goal of 'health'. The cultural perspective on health needs to be recognized.

Before going on to clarify the cultural perspective in health and illness, the concepts of 'illness' and 'disease' will be discussed, since the concepts of 'health', 'illness', and 'disease' cannot be considered separately.

## D. "ILLNESS" AND "DISEASE"

Close attention has also been paid in recent years to the concepts of 'disease' and 'illness'. Although these terms are often used interchangeably in everyday language, they are also different both logically and empirically (Twaddle and Hessler, 1977). The distinction between 'illness' and 'disease' has been analyzed by many authors (Fabrega. 1975; Eisenberg, op. cit.; Twaddle and Hessler, ibid.; Kleinman, et al. 1978).

In general, the term 'disease' has been used to describe the pathological processes and entities of the biomedical model; diseases are defined on the basis of deviations and malfunctions of the chemical and physiological systems of the body (Fabrega, ibid.). What constitutes 'normal' physiological and chemical variables is clearly

defined within a fairly narrow numerical range, and is assumed to be shared by all members of the human species. Each disease in biomedicine is "an abstract biological 'thing' or condition that is independent of social behavior" (Fabrega, ibid., p.15). That is, every named disease has its own particular personality and life history, and these entities are largely independent of the personal attributes of the patients suffering from the disease.

By contrast, 'illness' is an altogether vaguer term, embodying the patient's subjective perception or sometimes the perception of those around her/him, of a condition of impaired well-being. Illness, thus, refers to subjective feelings of not being well. These feelings include pain, nausea and anxiety, and when reported by the individual may result in others defining her/him as unhealthy and in she/he seeking medical care (Twaddle and Hessler, op. cit.).

It is commonly assumed that illness is caused by disease. Subjective feelings of illness, however, may exist in the absence of observable biological causes. Fabrega (op. cit.); Field (1976); and Eisenberg (op. cit.) point out that in the Western countries it is possible to feel 'ill' without having an identifiable disease in biomedical terms, and to have biomedically - defined disease without feeling ill. An example of the first case is the perception of symptoms in the absence of pathology such as a raised blood pressure, and an example of the second is the existence of presymptomatic disease, such as early carcinoma.

Biomedicine can be seen as the world - view of the medical

profession. Contrasted with this is the patient's persepective of subjectively experienced ill-health. As Eisenberg (op. cit.) states "patients suffer 'illness'; physicians diagnose and treat 'disease'. Diagnosis is therefore the ordering of the patient's experience into the disease entities of biomedicine, but neglecting those that do not fit within the classification.

In Cassel's view (cited in Helman, 1978), this removes biomedicine from its traditional healing role. According to Cassel, illness is seen in holistic terms as human suffering that includes disease, but has a much wider definition. Now, there is a growing number of health professionals advocating the acceptance of the client's reported state of feelings as a valid problem. As Cassel (in Helman, ibid. p.111.) states '"Disease' is something an organ has; illness is something a man has"..

## E. THE CULTURAL PERSPECTIVE IN "HEALTH" AND "ILLNESS"

Kleinman (cited in Amarasingham, 1980) suggests that each member of a culture carries an "explanatory model" of illness which is typical for the culture and which defines the nature of illness, before its appropriate treatment can take place. This explanatory model concept suggests that patients come into the treatment settings with their own system for classifying and understanding symptoms. Lack of understanding of this concept may lead to many problems in health care, especially health care delivery by health professionals.

Foster (1976) points out how 'illness' in non-Western countries has many dimensions: social, moral, psychological, as well as physical. Explanation of ill-health has been broadly divided into two systems: personalistic and naturalistic systems.

A personalistic system is one in which the sick person is viewed as the object of aggression or punishment directed against him, with illness being caused by the active, purposeful intervention of a sensate agent. This agent may be a super-natural being (a deity or God), a non-human-being (such as a ghost ancestor or evil spirit, or a human being (a witch or sorcerer). There is a tendency for simple societies to provide super-natural explanations of illness beliefs. The spirit world dominates nearly every aspect of life and serves to explain aspects of the world beyond their limited control.

In naturalistic systems ill health is explained in impersonal terms as the effect of a lack of balance of the basic body elements. The balance may be upset from without by natural forces such as, heat, cold and sometimes strong emotions. The three main naturalistic systems are those of humoral pathology, Ayuredic medicine, and Traditional Chinese medicine. Many writers have described these (Skeet, 1981; Henderson and Primeaux, 1981; Aslam, Davis and Stockley, 1981; Sampson, 1982).

In non-Western societies, thus, there are culturally - specific systems for explaining illness, and there are as many of these systems as there are different cultural groups. In fact, there are many studies that exist to document the health beliefs and health practices

in various cultures such as, the Spanish (Baca, 1969); the Chinese (Campbell and Chang, 1973; Chung, 1977); The Native American (Spector, 1985; Primeaux, 1977); the Gadsup (Leininger, 1977) and Bisayan Filipino (Hart 1981); In relation to the present study health beliefs and health practices, only the Asian culture, in particular Southeast Asian, is emphasized.

## E.1. Health Beliefs and Practices of the Asian People

The Asian concept of 'health' "evolved from an Eastern philosophy that elemental forces controlling the universe pervade all aspects of human endeavour" (Campbell and Chang, 1973, p. 246). These forces regulating the universe are the 'Yin' and the 'Yang'. Yin and Yang are opposing forces. Inherent in the concept are the attributed male and female stereotype characteristics which must be balanced by containing a little of the other. Figure 3.1 and 3.2 portray and specify the characteristics of the yin-feminine and yang-masculine principle of Chinese thought and medicine. Health in this system, involves the maintenance of a balance between the 'Yin' and the 'Yang' (Blattner, 1981). An imbalance between the 'Yin' and the 'Yang' results in disharmony or disease (Campbell and Chang, ibid.; Blattner, ibid.).

All components of the universe, including man, are composed of a yin and a yang. The yin is the negative, female force characterized by darkness, cold, and emptiness. The yang, the male force, is positive and produces light, warmth; and fullness. The yin and yang may be conceptualized in terms of the sympathetic and parasympathetic nervous systems. The yang is comparable to the defensive action of the

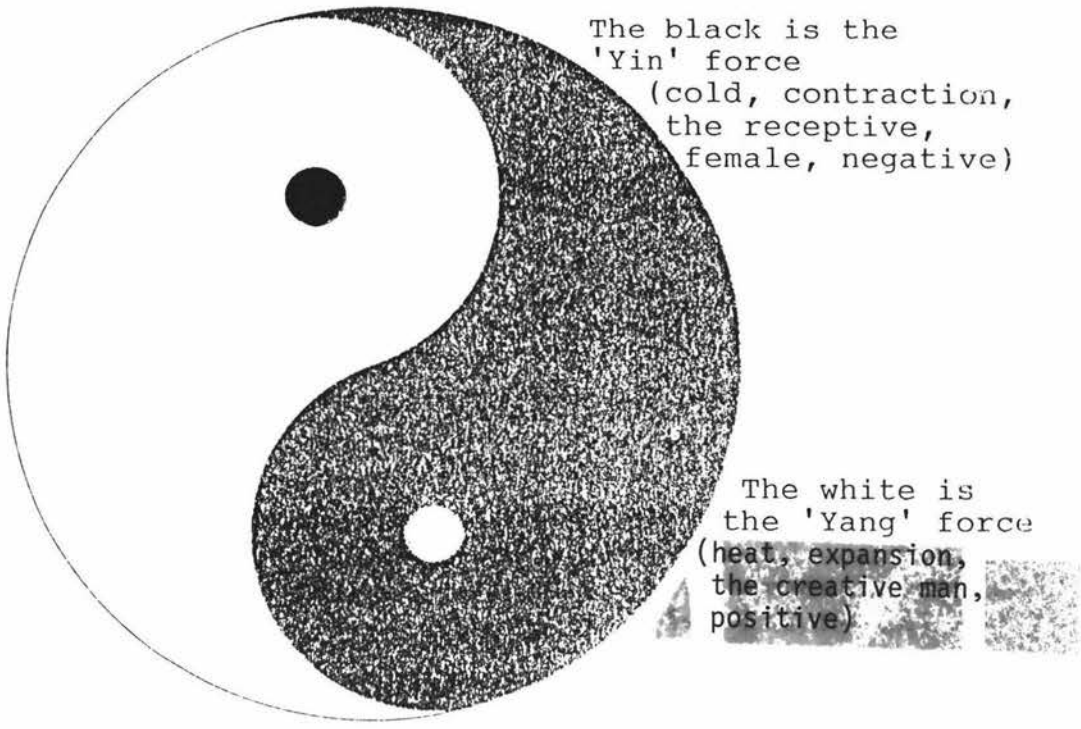


FIGURE 3.1 The 'T'ai-chi T'u" Symbol
SOURCE Blattner (1981, p. 9).

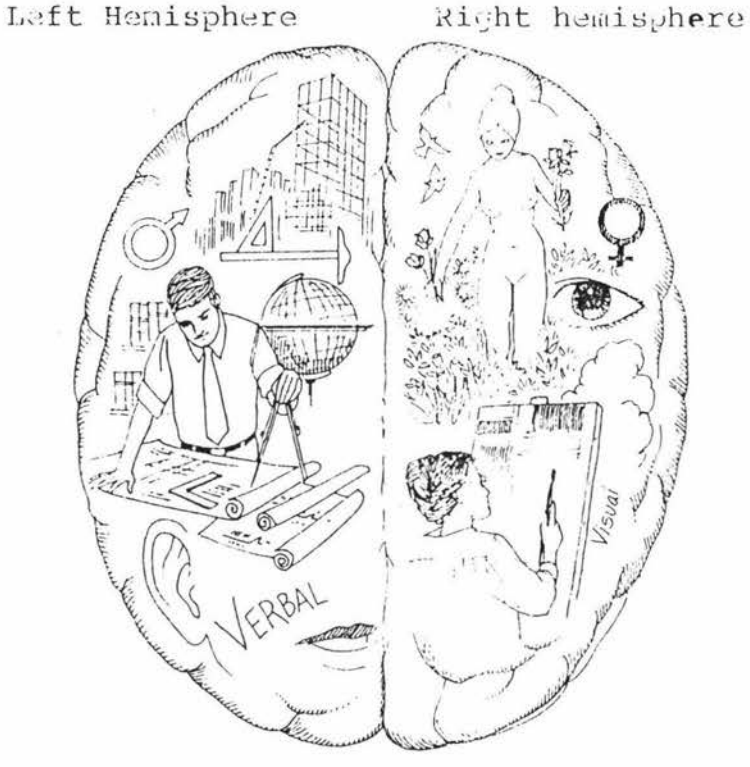


FIGURE 3.2 Left and Right Hemispheres of the Brain and Their Specialized Functions

SOURCE Blattner (1981, p.10 ).

sympathetic system in that it protects the body from external invasion. The yin like the parasympathetic nervous system, is concerned with restoring and conserving bodily energy (Campbell and Chang, ibid.).

The practical application of this philosophy can be seen in a wide range of practices. For example, the body is believed to lack heat when it has lost blood. Consequently, after childbirth Asian women will customarily consume an extremely hot mixture for a month to help them replace the blood which has been lost. A soup of hot ingredients (chicken or pork with pepper) is prepared for the mother to eat almost to the exclusion of any other food (Campbell and Chang, ibid.). Conversly, the body can become too hot and signs of too much heat will be seen by different kinds of overflow from the body, such as, a nose bleed, pimples and the vomiting associated with sunstroke. (Tung, 1980). Western drugs are also considered hot; whereas, oriental herb medicine are considered cold (Tung, ibid.). Patients who believe in the hot-cold system may be resistant to certain kinds of medical advice.

In addition to these beliefs, there are others associated with the temperament of the environment itself. For example, the herbal practitioner would advise that it is dangerous to be exposed to cold when the body is hot since this can cause chest cramp. Similarly, a cold draught of air into the ear may induce an earache.

Many folk health beliefs and practices are related to conception, pregnancy, labour and delivery, and postpartum care. Among Asians, childbirth is not considered an illness, but a period of danger for

both mother and infant. Special foods and herbs such as ginseng are used to safeguard the pregnant woman. Iron in the prenatal period is thought to harden the bones and make delivery more difficult (Chung, 1977). Therefore, many Asian women will be resistant to taking vitamin preparations including iron.

Many Asians, including Vietnamese (Wadd, 1983) and Chinese (Chung, ibid.), believe that body heat is lost during labor and delivery. The Vietnamese use a fire beneath the bed to counteract this, and both Vietnamese and Chinese use "hot" foods to replenish body heat. Hot foods include rice, chicken soup, peanuts, vinegar and ginger. Cold food such as most fruits and vegetables are avoided.

After delivery, Asian clients are encouraged to avoid 'cold' and exposure to unclean things. Showers and bathing, except a sponge bath are discouraged (Chung, ibid.). Water applied to the body is thought to cause loss of nutrients through the skin. Women remain at home for some time after delivery (Chung, ibid.), and avoid early ambulation and strenuous activity to protect internal organs (Clark, 1984). Abstinence from intercourse lasts from two to three months after delivery and the use of contraceptives is discouraged.

## F. CULTURE AND NURSING

The nursing profession has been concerned with health and illness or disease, and culture also affects health and illness as discussed earlier. The need for cultural sensitivity in nursing is obvious,

particularly with the increasing probability of encountering clients from other cultures. Dobson (1983) suggests that cultural variables are important in planning and delivering nursing care and for nursing research for two major reasons: first; culture patterns the ways in which health and illness are defined, influences the perception of ill persons by their reference group, and identifies appropriate health-seeking actions, second; cultural differences between the health provider and the client may lead to misunderstandings and an ineffective relationship.

### F.1. The Importance of Culture for Nursing

It is often pointed out that a blending of cultural factors into care is vitally important if we are to bring greater quality to our nursing practice (Davitz, Sameshima, and Davitz, 1976; Leininger, 1977; Koshi, 1976). The importance of cultural understanding to sound and relevant nursing care and advice has long been acknowledged. In 1894, Florence Nightingale noted that:

> "It is a truism to say that the women who teach in India must know the language, the religion, superstitions, and customs of the women to be taught in India. It ought to be a truism to say the very same for England".
>
> Nightingale, F. (1894)
>
> (cited in Seymer, L.R. (1954) p. 379)

From an anthropological perspective, we know that health and illness are culturally defined and maintained. Each individual's

perception and behavior in relation to illness, health maintenance, daily activities, body discomfort, changes in life, food preference, and various caring and curing treatment practices are all linked with cultural beliefs.

Most nursing and medical services in the present day are largely based on a dominant unicultural orientation, that is on a 'biomedical' model. Nurses and other health care providers also enter the clinical situation with predetermined values, beliefs, and perceptions. That often leads nurses to interpret health and illness according to their own cultural background.

As nurses, however, we are always involved in promoting change in a patient's or a client's behavior, and it is sometimes hard to accept that our culturally rooted ideas are not necessarily seen as being quite so ideal as we may think they are by others whose background is culturally different from our own. Cultural differences between nurses and patients can markedly interfere with the quality of care provided (Orem, 1980). This implies that if a nurse ignores the culturally-determined expectations, she limits her effectiveness, and her patient's progress toward her (his) own culturally -defined state of health. The usefulness of the concept of culture, then, lies in the aid it gives the nurse in understanding her own behavior as well as that of her patient. Cultural understanding, thus, is essential to enable nurses to develop cultural awareness in their work, and widen their appreciation of broad patterns of human behavior. Hodgson (1976) points out three beneficial effects of understanding the cultural background of the patient. These are:

: It makes it easier for the patient to approach nurse ("The nurse will understand"),

: It helps the nurse understand what the patient is saying and why, so actions become more comprehensible and practicable.

: It makes health care more humanistic and personal, giving greater satisfaction to the patient and nurse.

## G. SUMMARY

The concepts of culture, health, illness and disease have been examined. The relationship of these concepts was also discussed. In summary culture has a strong influence on the behaviour of individuals in regard to health and illness. Since nursing is also concerned with health and illness, and awareness and understanding of cultural differences and their significance are essential for nurses if they are to provide holistic care to clients.

The Southeast Asian people have their own unique culture which affects their beliefs and practices in relation to health and illness. The best way to understand the reasons for their behaviour is to learn from the viewpoint of the people. The next chapter will discuss and present the method and the details of procedure used in this study.

# CHAPTER 4

## METHODOLOGY

A crucial component of conducting any research project is the methodology used to obtain valid and reliable answers to research questions. In other words, the researcher needs to have a well designed plan in order to facilitate finding answers to the problems being examined. There are several ways in which a researcher may approach a problem, such as experiments, surveys, historical reviews, and case studies. Each strategy has particular advantages and disadvantages. The choice of design and method of study, will depend upon three conditions: 1) the type of research question, 2) the control an investigator has over actual behavioral events, and 3) the focus on contemporary as opposed to a focus on historical phenomena (Yin, 1984).

As stated earlier, the purpose of the study has been to increase understanding of how Kampuchean refugees mothers perceive and act in situations related to health and illness. The case study design has been considered to be the most appropriate approach to accomplish the purpose of this study.

This chapter now discusses the features of the method selected for the research undertaken for this study. A description of data

collection is then presented, and ethical considerations discussed. Criteria for selection of participants and the description of participants are fully explained, including the procedure of the study. Finally, an outline of how data will be analysed is presented.

## A. A QUALITATIVE RESEARCH

It is pointed out by Parse, Coyne, and Smyth (1985) that nursing has no unique research traditions. It has borrowed various research methods from other sciences, such as anthropology, sociology, medicine, psychology. Among these sciences, there are two broad research approaches: the quantitative (which borrowed from the natural sciences) and the qualitative research (which borrowed from the human sciences) (Bogdan and Taylor, 1975; Oiler, 1981; Field and Morse, 1985; Parse, et. al, ibid.).

In nursing the primary purpose of both qualitative and quantitative research is the same, that is to develop nursing knowledge. However there are differences between these two types of research. The quantitative approaches illustrate a deductive process of knowledge attainment, intended to verify facts and causal relationships stated in existing theories. Quantitative data are processed through statistical analyses and elicit numerical comparisons and inferences. The true experiment is a classical example of this type of research.

Qualitative research, on the other hand, is an inductive process

which generates theory from facts obtained within the natural settings of the phenomena. Data are thus collected and analysed through the creative abstractions by the researcher of the subjects' descriptions rather than statistical notions of the natural sciences (Schwartz and Jacobs, 1979; Field and Morse, op. cit.; Parse, et. al. op. cit.).

Between these two methods, most literature focuses on quantitative methods, and presents qualitative methods as precursors for the "more rigorous" quantitative studies. Qualitative research has been regarded as the handmaiden of and inferior to the scientific method (Oiler, op. cit.; Sandelowski, 1986).

Intrinsically, however, neither approach can be considered superior to the other. Each form is useful for both verification and for generation of theory. Sandelowski (ibid.) has pointed out and discussed four criteria of rigor in scientific presented by Guba and Lincoln (1981). They are 1) truth value, 2) applicability, 3) consistency; and 4) neutrality. Then she presents the strategies to achieve rigor on in a qualitative study.

As already stated, the research question guiding this study was: What are the health practices and health beliefs of refugee mothers from Kampuchea. The nature of this question indicated that the qualitative approach would be more appropriate. It was decided that in order to answer this question, data should be collected and described from the participants' perspective, rather than for the purpose of testing specific hypotheses. Therefore, a case study was selected as the appropriate design to achieve the purpose of the study.

## B. RESEARCH DESIGN : A CASE STUDY APPROACH

A case study, according to Yin (1984), is clearly defined and distinguished from other methods; such as an experiment, a survey and a history, as an empirical inquiry that:

- investigates a contemporary phenomenon within a real-life context; when
- the boundaries between phenomenon and context are not clearly evident; and in which
- multiple sources of evidence are used.

The major characteristic of this method is to provide an indepth investigation of a single unit such as an individual, a group, or an institution (Abdellah and Levin, 1965; Krampitz and Pavlovich, 1981; Wilson, 1985). This is to find out why specific conditions exist or have developed within that unit. This approach is also acknowledged to enable the researcher to study one situation or subject closely and develop insights that would not be possible in a study involving many subjects. (Krampitz; and Pavlovich, ibid.). Such study is characterized by lengthy narrative statements which describe in-depth the subject under study in their natural settings.

The case study of the individual has been traditionally associated with the psychoanalytic tradition in psychology and social psychology. Freud, constructed his theory of human psychic response through the

accumulation of many intensive case studies of individuals The same as in anthropology and medicine, the case study method is utilized as the starting point to direct future research. (Wilson, op. cit.).

The weaknesses of the case study, however, have been pointed out by several writers such as Krampitz and Pavlovich, (op. cit.); Wilson, (op. cit).; Yin, (op. cit.). The major disadvantages of this design which are frequently stated are the possibility of a subjective bias on the part of the investigator, and the inability to generalize the findings beyond the unit being investigated. The investigator's bias will be discussed later in relation to the role of the interviewer since in-depth interview was utilized as a tool for collecting data for this study. Representativeness of the case study is still being questioned. It is not possible for the study to be representative of a large population.

## C. DATA COLLECTION METHOD

Consistent with the purpose of this study, which was to find out about the experiences of refugee mothers from Kampuchea concerning their health beliefs and health practices, in-depth interviewing was employed. This method is advocated in many research texts (Abdellah and Levin, op. cit.; Seaman and Verhonick, 1982; Dooley, 1984; Wilson, op. cit.). It is acknowledged as an effective method to assist the interviewers and allow a great deal of freedom in exploring whatever is relevant to the research question and seems important to the participant. In addition, Yin (op. cit.) also states that

interviews are essential sources of case study information.

Benney and Hughes (1956) define an interview as a relationship between two people where both parties behave as though they are of equal status for its duration whether or not this is actually so. The interaction between the interviewer and interviewee is also an important issue for the conducting of a successful interview.

Henderson and Primeaux (1981) suggest that the interviewers must familiarize themselves with the purpose of interviewing and with methods of conducting interviews, including what to look for during the interview. The interviewer should recognize that the primary purpose of the interview is to gather relevant replies to the questions asked. Accordingly, an interviewer must be quick to recognize whether an answer is adequate given the question's objective, and must be ready to probe or encourage the respondent to elaborate or reformulate an answer. An important point is that the participants should be led to do most of the talking. The role of interviewer is just to direct the interview to a certain extent, but the interview should not be dominated by the interviewer (Henderson and Primeaux, ibid.).

As stated before, the status of interviewer and interviewee should be equal. Therefore knowledge of the society and its culture is essential for an interviewer to evaluate how best to go about interviewing, how the effect of particular characteristics of the interviewer such as age, social class, and attitude may influence an interviewee's responses (Wandelt, 1970). However, the convention of 'equality' by which the interviewer should try to minimize any

inequalities arising from age, sex and ethnicity, social status, and so forth is not always easy to be met. Ackroyd and Hughes (1981) suggest that it is more than useful to know how these social characteristics might effect responses from members of the research population.

In this study, however, age, sex, ethnicity between the interviewer and interviewees, were not problems. Similarity of age, sex, and ethnicity in term of the similarity of culture and languages, helped the interviewer to gain access and develop more rapport. Another similarity between the researcher and two of the participants, unintended in this instance, was the condition of being pregnant. Sharing this same status also helped the researcher to gain information in some aspects of health beliefs and health practices during pregnancy. These participants seemed to be very willing to suggest and give information about this aspect of their lives to the interviewer.

Another important point about reliability of interview information is also pointed out by Wandelt (op. cit.). She indicated that the presence of the interviewer and the verbal or nonverbal cues the interviewer provides to the participants may influence responses. A nod, facial expression, or gesture may reinforce certain responses while discouraging others. This effect may be reduced by training the interviewer. As Feldman (1981) states good interviewing technique comes with practice, with experiences, and with reflection on why interviews succeed or fail.

As the study was cross cultural, concerning people from one culture relocated in another, cultural aspects were emphasized during

interactions with the participants. This helped the researcher in building rapport. Good rapport encourages participants to talk about their culture (Spradley, 1979). It is suggested that the interviewer must pay particular attention to friendly relationships in each cultural scene to learn local, culture-bound features that build rapport. In this study, it seemed that rapport developed not only with the participants but also with other members of participant's families. As trust developed, so did cooperation and participation.

An example of a culture-bound feature is the greeting. As we know, in the Asian culture, the elderly of the family will be given respect. When the younger meets the older, the greeting is "wai". This is the greeting and show of respect to the older which normally used among the Thai, Laos, and Kampuchean. The "wai" is made by putting the palms and fingers of both hands together and raising them to the chest level which is accompanied by a bow and smile. The younger will make the "wai" to the older first, the older then will accept the "wai" of the younger by giving a "wai", but with the manner of only putting the palms and fingers of both hands together with a smile and greeting to the younger. This was done every time when the interviewer met the participants' parents to greet and show the respect to them.

## D. ETHICAL CONSIDERATIONS

In planning any research involving human participants the individual's human right of free choice requires that the decision to

participate be made in the light of adequate and accurate information, Amiger (1977) identifies the generally approved elements of informed consent which are as follows:

1) The subject must clearly understand the precise nature of the study and the potential risk involved.
2) The subject must freely agree to participate without any external pressure.
3) The researcher must explain the potential benefits of the study.
4) Confidentiality and anonymity of the subjects must be assured.
5) The subject may withdraw at anytime.

These elements have been used as a guideline to ensure participants have all the information required to understand the nature of the research, and of the processes to be used in it. A verbal explanation of the research and its purpose was given. This allowed the participants to question, to seek clarification, and to choose to take part in the study, or to decline participating if they wished.

All participants, therefore, had an explanation about the identity of the researcher, the purpose of the study, and the procedure. The researcher's interest in learning about the health and illness beliefs of Kampuchean mothers and in what ways they act in response to their health and illness beliefs was explained. It was also made clear that the information obtained from this study would be especially helpful for nurses dealing with Kampuchean refugees both in Thailand and New Zealand. It is hoped that the findings of this study may help them to

improve the care they give to refugee mothers from Kampuchea.

Since interviewing with a tape-recorder was the method of data collection, each participant was reassured that all information recorded during interview would remain anonymous. Participants' names were to be changed in reporting of the data to protect the anonymity of participants and confidentiality would be ensured. In addition, at the conclusion of this study all tape recording will be erased and any written material that would identify participants would be destroyed to preserve the anonymity of the research participants.

In order to maintain the privacy of participants, the place and time for interviewing were to be decided by the participants. This was perceived to enable them to be more comfortable and least exposed to outside observers.

The right to refuse participation and right to withdraw their data at any stage was stressed. Participants were told that they could refuse to answer any questions or withdraw at any time during the course of the study.

## E. PARTCIPANTS SELECTED FOR THE STUDY

The participants in this study were refugee Kampuchean mothers in a Central North Island city. Three Kampuchean mothers were selected by purposive sampling from the list of Kampuchean families surveyed in April, 1985 together with those who had arrived since that time.

Information on the period of resettlement of these families was provided by an English Second Language (ESL) Tutor from the Polytechnic. Criteria for the selection of these participants included:

a) The period of resettlement of participants selected for the study not to have exceeded 2 years which meant that they arrived in New Zealand no later than July, 1984. This time span was selected as the study intends to concentrate on early adjustment difficulties. It can be assumed that after two years there will have been some adaptation and that different kinds of problems may emerge.
b) The willingness to participate. Each participant selected was introduced by an ESL Tutor. The researcher, then contacted each individual to explain more details of the study and ask permission from them.

## E.1. Description of the Participants

There were three Kampuchean refugee mothers who participated in the study. These three mothers were of a similar age, which was between 25-31 years old. Of the three mothers interviewed, two were Chinese, and one was Khmer.

One mother was educated in a Chinese school for five years, while the other two studied in a state primary school for three-four years. Thus, all three mothers received little formal education. None of them

had learned the English language before arriving in New Zealand.

All participants came to New Zealand with their husbands, and children. Only one participant had relatives - her sister-in-law and her family, living in New Zealand when she arrived. This participant and her family lived with these relatives temporarily before renting their own flat. The other participants each lived with their husband and children in rented accommodation initially. Later each was joined in New Zealand by her parents, sisters and brother. One of the two participants, later, also moved to rent a flat and stay with her own family. Thus, only one participant lives with her extended family. The other two, however, still remain in close contact with their relatives.

These three mothers had experienced childbirth in various situations. One had experienced childbirth at her home in a camp in Thailand and was pregnant at the time of the interview, but had never delivered in N.Z. The other two had experienced childbirth in a hospital in Kampuchea and Vietnam. Of these two mothers, one had just had a childbirth experience in a hospital in N.Z. at the time of the interview.

## F. PRELIMINARY STUDY

Before the major study was conducted, a preliminary study was done to try out interviewing. Two refugee mothers from Kampuchea were contacted and asked to participate in the preliminary study. The same

explanation was given to these two women as to the participants in the major study and the same process of data collection used. This first phase was conducted in order to provide the opportunity for the researcher to gain the experience of interviewing participants. It was considered that this preparation would help the researcher to be more effective in the major study. Problems during collecting data could be recognized and any weakness of the procedures also could be detected.

Results from the preliminary study, also, helped the researcher to consider the various kinds of questions that she could ask to obtain information relevent to the purpose of the study.

## G. PROCEDURE

The study was conducted from June, 1986 to September 1986. People who had been working with refugees were sought to gain access to the participants and relevant information. An ESL tutor who has been responsible for the refugees was contacted. She, then provided a list of the Kampuchean families in this city and brief details of each family such as, the number of members in the family, the period of resettlement, the language they used.

From the list, the names and addresses of three Kampuchean mothers were selected. Before contacting each mother, the ESL tutor told them about the researcher who was going to see them. This was to provide details about the researcher and her background so that the families would not feel that she was a complete stranger when she visited them.

Then, the process of contact was started as follows:

The first contact: The researcher communicated with each participant personally by telephone to introduce herself. tell the participants about general objectives, and ask for permission to visit them at home.

The second contact: This contact was made after gaining permission from the participants. The purpose of the contact was to explain more details about the study. All participants were informed that a study was being undertaken by a nurse-researcher, interested in how they act in response to their belief about health and illness. They were then told that those who were willing to participate would be visited on two occasions, when interviews would be conducted. The researcher requested permission to use a tape-recorder during interview and when this permission was granted, the next appointment was made at a mutually agreed time.

The third contact: This contact was the first interview. The interaction between the researcher and participant began informally with greeting, sharing of general information, and providing an opportunity for the participants to ask any questions that they wanted to. This was aimed at relaxing the participants so that they became used to the researcher and felt free to talk. Ackroyd and Hughes (op.cit.) acknowledge the necessity for this stage.

Although the unstructured interview was used as a source of gaining information, the researcher still had a schedule. However this

was loosely structured, merely listing the topics the researcher needed to cover.

As pointed out in Chapter 1, which deals with the purpose of the study, the topics listed included:

a) Ways in which health and illness are described.

b) Ways in which health is maintained.

c) Ways in which illness is avoided.

d) Ways of treating illness.

Therefore, all questions were unstructured, which did not lead to comparability in the working of questions from one participant to another. This method, thus, provided flexibility in the manner, order, and language of the question. The overall scope of the questions was however determined by the purpose of the study. This interview was not only focused on the topics listed above, but also on the general background of the participants. The participants, thus were asked to tell about themselves first. At this question, tape-recording of the conversation commenced, with the exception of two conditions, where the participants requested otherwise, or where the topic of conversation had moved away from the research area. When the topics had been covered. The interview was stopped. The participants were asked if the researcher could visit at a later date. This next visit, was confirmed by telephone.

Observations and information that was not tape-recorded were written in field notes as soon as possible after the interview. Tapes

were transcribed after the interview took place, and before the next visit.

Fourth contact: This was a follow-up visit, since it was considered that this visit might help both the researcher and the participants to gain or to add more information that could have been missed out from the first interview. In fact, the researcher wanted to conduct this interview within one to two weeks of the previous interview. The appointment, however, had to depend upon the participants. Thus, the duration between the first and second interviews varied from 3-8 weeks.

Both interviews took the format of informal conversation. It allowed the participants to talk and ask questions (back). This is encouraged by Blum (1970), so that at anytime during the interview the participant was free to reciprocate questioning, and was not obligated to discuss any issues she might have objected to. The interview took place in the home of the participants which provided a more private and familiar environment than other situations.

The languages used for the interviews were a mixture of Teochiu (a Chinese dialict) and English, and/or Khmer, Thai and English. This was to provide the opportunity for the participants to use their native languages in which they could speak clearly. The other members of the participants' family who were present at the tome of the study were also allowed to join in the conversation if they wanted to.

## H. DATA ANALYSIS

The major assumption of qualitative research is that knowledge of social facts is best attained when the researcher gets inside the natural setting and attempts to see and understand the phenomenon as the subjects do. Data is then collected and analysed in the natural language of the subjects rather than the statistical notations of quantitative research (Schwartz and Jacobs, op. cit.).

In this study the information gained from the participants was transcribed and typed in the field notes in the participants' own words. This information was used directly for analysis and interpretation in relation to the purpose of the study, namely to describe general health practices and health beliefs of these participants.

## I. SUMMARY

The qualitative research with a case study design was selected as appropriate to achieve the aim of the study. Data were obtained by utilizing the indepth interview. This method was used to gain insight into the participants' viewpoints. The data gained from the interview, then, were analyzed directly from the participants' words.

Three Kampuchean mothers participated in this study. They were purposely selected with two criteria: a) they have stayed in New Zealand less than 2 years; and b) they were willing to participate.

The findings and discussion are presented in chapter 5 and 6.

# CHAPTER 5

# FINDINGS

This chapter presents the findings from interviews with three refugee mothers from Kampuchea. The biographical background of each participant is described and summarized in the beginning. The findings are presented in the order of topics listed in chapter 1, 'The purpose of the study' was to identify:

1 Ways in which health and illness are described by Kampuchean refugee mothers.
2 What these do women do in relation to:
   (1) Health maintenance behavior;
   (2) to avoiding illness; and
   (3) to treat disease or illness.

In addition, some health beliefs and health practices in pregnancy, delivery, and post-partum period are also examined because the findings from these aspects related to both health maintenance behaviors and the ways of avoiding illness.

## A. BIOGRAPHICAL BACKGROUND

The biographical background of the three participants is presented separately. The aim is to provide information about the participants that may relate to what was found from the study. The participants were given the role names of Mrs A., Mrs B. and Mrs C.

### Mrs A.

Mrs A., a 31 year old Kampuchean woman, was born at Kas Kong province in Kampuchea. Her family are farmers. They all speak Khmer as the main language. Mrs A has two older sisters, 4 younger sisters, and one brother. She studied in a school for only three years when she was young. She didn't work outside the home, just helped her parents. The religion of Mrs A. and her family is Bhuddism.

Mrs A. fled to Thailand in 1979 and stayed in Sa Kaeo Camp for 3 years, then moved to Khao I Dang Camp for 2 years. She married a Khmer man in 1979 at Sa Kaeo Camp. Her husband was also a farmer. Now she has one son, aged 5 years old, and one daughter, aged 3 years. Both were born in the camp in Thailand. Her mother was a traditional midwife and delivered her children.

She and her family were accepted and arrived in New Zealand in October 1984. At the time of the interview, she was 4+ months pregnant.

### Mrs B.

Mrs B. is a 26 year old Chinese-Kampuchean mother. She was born in Phnompenh. Her parents died many years ago. She was the youngest daughter of the family with 2 sisters and 3 brothers. When she was young she was educated in a Chinese school for 5 years. Thereafter, she helped her sister who owned a cosmetic shop in Vietnam. Mrs B's family was Chinese and spoke Cantonese, Teochiu, and Khmer fluently. They are all Buddhist.

Mrs B. fled from Kampuchea to Vietnam in 1979. She married a Chinese Kampuchean man in 1981. Subsequently a son (now 2 years old) was born. The family which included Mrs B.'s sister-in-law arrived in N.Z. in January 1986.

Mrs B. is a shy woman. She has small features, black hair. She talks in quite a loud voice. Mostly she uses Cantonese and Teochiu in her family. She can speak a little English such as, Hallo, how are you..., but felt embarrased using English. During her stay in Palmerston North, she has not attended any English class, just stayed at home, taking care of the house, and looking after her son and her sister-in-law's daughter.

Mrs C.

Mrs C. was born in Kompongsom, Kampuchea. Her parents are Chinese and have eleven children. This family speaks fluent Teochiu (a Chinese dialect) and Khmer. Mrs C's father can also speak Thai quite well. In Kampuchea, their occupation was selling fish. Mrs C learnt in a school for only 4 years, then she left and worked by helping her parents.

She married a Chinese Kampuchean when she was 19 years old. Her husband was fisherman when he was in Kampuchea. Now, they have one son and one daughter, aged 4 and 3 years, both born in Kampuchea. They fled from Kampuchea in 1983, and stayed in Nam Poh Camp in Thailand for 10 months. Thereafter, they moved to Panutnikom Camp for a few months. They were accepted and arrived in N.Z. on 21st March, 1985. Now, her husband has been working in a car factory and Mrs B. has been working in a hospital as an assistant in the kitchen. Mrs C. is now 25 years old. This family are Buddhist.

The biographical background of these three participants as described above is summarized in Table 5.1.

As shown in the table, these three participants were similar in age, education, religion and marital status. Two participants had lived primarily in rural areas, while the other came from an urban area, the Capital of Kampuchea. Figure 5.1 illustrates the location of these participants' home town. Only one participant is pure Khmer, while the other two are Chinese-Khmer. The length of stay in the camp was different with two mothers staying for 5 years and one staying for only 2 years.

## B. INTERVIEW RESPONSES

Each participant had two interviews. Most information was gained directly from the three refugee women. Some information however, was

TABLE 5.1

BIOGRAPHICAL BACKGROUND OF THREE REFUGEE MOTHERS FROM KAMPUCHEA

| BIOGRAPHICAL CHARACTERISTICS | Mrs A | Mrs B | Mrs C |
|---|---|---|---|
| Age | 31 | 26 | 25 |
| Ethnic | Khmer | Chinese-Khmer | Chinese-Khmer |
| Education | Primary School (3 yrs) | Chinese school (5 yrs) | Primary School (4 yrs) |
| Religion | Bhuddism | Bhuddism | Bhuddism |
| Language | Khmer | Khmer, Cantonese and Teochiu | Khmer and Teochiu |
| Home Town | Kos Kong Province | Panom Penh | Kompongsom |
| Marital Status | Married | Married | Married |
| Number of Children | 2 (plus present pregnancy) | 2* | 2 |
| Length of stay in the Camp | 5 years | 5 years | 2 years |
| Length of stay** in New Zealand | 1 year and 8 months | 5 months | 1 year and 3 months |

* The youngest one was born during data collecting period (after first interview)

** Counting from arrived month to June 1986

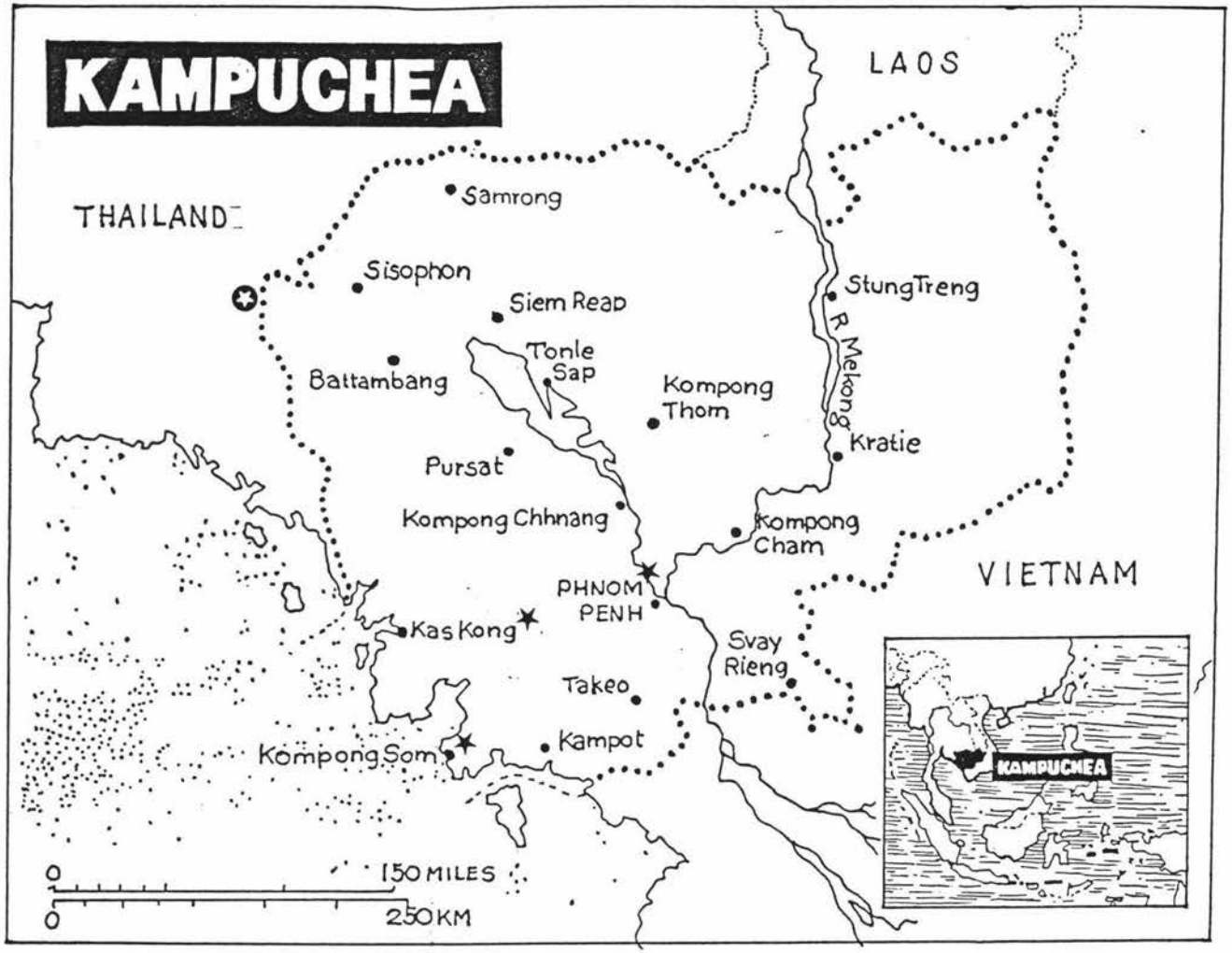


FIGURE 5.1 TOWN AND CITY OF THE PARTICIPANTS (*), AND THE REFUGEES CAMP (✪).

also added or contributed from other members of the families. Since all of them used English as a second language, the English written in the conversations may not be really correct both in terms of grammatical and spoken language.

B.1 Ways in Which Health and Illness are Described

It seems to be quite difficult for these three women to give a definition of health or illness. In order to help them to verbalize their feeling about what constituted good health, they were asked about their sickness to lead on to how they felt about their health. Similar views of health were defined from two participants.

When Mrs A. was asked how she felt about her health, she expressed her feeling as:

"Yeah! I am happy now. No problem for my family."

'No problem', for her, also meant that:

"I think we are all happy now."

She also said that being healthy is not being sick. As she said:

"I thought I haven't got any sickness so I think I am healthy."

And this was similar to Mrs B., who said that:

"If you do not have any sickness that means you can be healthy."

Mrs B. also added that: "If you can eat, you have not got any sickness. So you are healthy."

Mrs C. was unable to explain how she defined "health." The concept of 'health' however was expressed by her uncle. Mrs B's uncle was in the first Kampuchean group who arrived and settled in New Zealand. He had a small business, and has just sold it in order to move to set up his new business in Australia. According to Mrs C's uncle,

"Health is very hard to say. Sometimes not just the rule is healthy or not healthy. What the Asian people think about healthy, Chinese people think about healthy, Chinese people say that "Sing tea kiang kung jiew ooh Pung Chia" (That means "Healthy is wealthy"). If you are healthy, it is the capital of yourself... Like if you have to earn something you have to be healthy. At least, you know for a start you have to be healthy."

How 'illness' is described by these three mothers seemed to be equally difficult for them. No one could express her opinion about this concept. However, Mrs C's mother defined illness as the converse of 'healthy' as following:

"It is opposite, if you are ill you have to lose your money, you have to go to see the doctor, buy medicine, and you cannot work either."

B.2 Ways in Which Health was Maintained

Doing nothing to keep their health was the similar answer from these three refugee mothers, as following:

Mrs A; (the answer was interpreted by her sister as):

"She (Mrs A.) said that she didn't do anything to keep healthy, but eat, and do something like other people do also, so she didn't get anything wrong with her body. She eats rice, and meat, and other food like other Cambodian eat also."

When being asked this question, Mrs B. smiled and answered that:

"No... I don't do anything."

Mrs C. also answered that

"No, I don't do anything. My body just never got sick."

Diet, however was taken as an important practice for maintaining health by Mrs A. The relationship between diet and health was

verbalized in addition by Mrs A., with a focus on various kinds of food and having three meals a day she said that:

> "Like you eat food everything. You have to eat three times a day, don't skip the meal."

She added that every kind of food was important for her and should be eaten together, as she said:

> ".. meat, vegetable, egg should be eaten together."

Mrs A. seemed to adapt very well to New Zealand food. She stated that:

> "Sometime, the nurse told me about for my eating in my family, such as vegetable in New Zealand. I can eat it. It is good for me. For food, vegetable, egg meat, everything, I like it."

Having been invited to have a meal with them two-three times. I observed that they can adapt some kinds of ingredients such as, vegetable, vermicelli to cook their traditional food. All of these participants also plant some vegetables that they used quite often in their cooking, such as, lemon grass, mint, coriander, chilli, garlic and bean sprout. The main food was rice of which they bought many big bags to keep in their houses. Hot food, such as curry was normally the main dish that was eaten with rice. Garlic and fish sauce were the main ingredients used for cooking with every dish. Instead of using

tomato sauce, pepper, or salt to add the flavor to the food, as is usual in New Zealand they had fish sauce mixed with chilli powder or bird-chilli, or soy sauce on the table.

Relating to the kind of food and the way of cooking, Mrs C. had some difficulties with New Zealand food. She stated that:

> "Yes I can eat everything, meat, fish, vegetable. But I don't like lamb meat here."

The reason she gave was:

> "It is too strong smell."

She also commented that the way she cooked was different from New Zealanders:

> ".. here (N.Z.), they cook the meal different from us. I don't like to go and eat outside."

When she was asked to specify how it was different, she raised her experience from work as:

> "I worked in a kitchen of the hospital. When they cooked rice, cooked fish, but it is Kiwi's way. I don't like it." And: "Because the rice that they

cooked is not cooked. Sometime they let me cook, I cooked it until it is cooked. And that day I can eat."

Using some kinds of herbs combined with food was another way that Mrs B. mentioned of maintaining her health. During the interviewing, Mrs B. was pregnant, and when asked if she did anything to keep herself and her baby healthy during this time, she answered that:

"No, not now, but after having baby I will."

She continued that after having baby....:

"We always eat steamed chicken, with 'Tung-keu."

The Tung-keu which she mentioned is the name of a chinese herb, it is a type of ginseng.

In addition, some self-care practices used during pregnancy, delivery, and post-partum period were also explained by Mrs A. and Mrs B. These could be interpreted in the way of both keeping healthy and avoiding illness. Therefore, this will be described in an additional topic.

B.3 Ways in Which Illness is Avoided

In talking about illness prevention, these three participants gave different opinions. For Mrs A., great emphasis is placed on "being

clean." As she said:

> "When I eat anything I must clean. I have to check all. Everything for eat should clean. If thing is not good, I don't eat."

She clarified "the thing is not good" as:

> "Something like it got bad smell, or when we kept it too long."

She also added that:

> "I also clean everything I used in my house, like glasses, plates, everthing I used in my family. I have to clean clothes, my sheets, something once a week, and some clean everyday."

And:

> "Your body, too. You have to clean. I will clean myself, my children."

While cleanliness is a way of illness prevention for Mrs A., Mrs B. did not have any comment on this topic. She only laughed loudly

and said that:

"No, nothing"

Mrs B, however, pointed out from her previous illness's experience that to avoid illness was to keep her body healthy. She said:

"...When I was in Vietnam, I got sick quite often. I always had a fever and a chill. It is as if, when I am not healthy, I will get a chill.

This was similar to Mrs C., who, at first did not have any idea as she said:

"I think, I am just not ill. I don't know."

The hot and cold system, however, was commented by her after relating to her health status at that time. Mrs C. was getting a cold at the time of the interview, so she was asked what she would do to prevent this illness occuring again. She said that:

"I think I have to keep myself warm...."

"Keeping body warm", then, was a way to prevent illness by Mrs C. She also stressed this point again later when talking about her children's sickness. To prevent children from getting sickeness, she suggested to:

"keep them warm, wear a lot of clothes, and don't allow them to play outside during the winter or cold weather. Because if they touch cold again, they can become sick."

In addition, eating three times a day and at the right time were also added as a way to prevent illness by Mrs C's mother.

"You should have a meal at the right time and should not skip the meal."

B.4 The Cause of Illness

Another aspect that often related to the way of illness prevention is the knowledge about the cause of illness. The cause of illness, among these three participants was perceived differently by each one of them and depended on individual experiences of illness. These experiences related to the way that they prevent illness, too.

The following points were verbalized by the three refugee mothers as the cause of illness.

Mrs A. said that:

"You can get sick very easy if the thing you used is not clean. Or if I eat something dirty or I eat something no good for me a lot, I can get sick."

'Diarrhea' was an illness experience of Mrs A. She, however, could not explain what was the cause of diarrhea, but she mentioned that:

> "Something wrong with your food and you eat it, you can have diarrhea."

Mrs A. also added that:

> "Sometime if you have not enough of food to eat or you didn't eat something enough like vegetables you can get sick."

Although Mrs B. could not express what she did to prevent illness, she pointed out a few things that can be the cause of illness. These include amount of food, hot and cold system and mental causes. As she said:

> "They have not enough food to eat."
> ".. They eat too much hot food, they may get a cough. Or they may have diarrhoea if you eat too much cold food."

And:

> "Sometimes if you have something to worry, it may cause you to be sick. Like my mother, she worried about her mother (Mrs B's Grandmother) because my grandmother,

> she couldn't see and stay with my uncle. My mother worried whether my uncle can bring my grandmother out or not. She did worry, longer, she could not eat, then she got diarrhoea."

She stressed that: "When people get worried, they always can't eat."

Hot and cold food were also commented on as a cause of illness by Mrs C. She said that:

> "Sometimes if you touch too much cold or too much hot you can get sick very easy. Like your food, if it is too cold when you eat it, it can make the wind in your stomach and make you sick."

The environment, hot and cold weather, was also explained as a cause of illness. As she said that children can get cold if:

> "children went to play outside and touch too much wind."

When relating to her experience of daughter's sickness, she said that:

> "I think, because it was quite hot there (in Thailand). When it was hot my daughter always got high fever, and sometimes she became unconscious, she didn't know

herself when I called her...."

"Here, I never see anyone sick like this. It is quite cold. There is very very hot...."

Germs also were mentioned by Mrs C. This was told by a doctor whom she went to see when she got cold. She, however, hasn't had any idea about this, just:

"I don't know. But I think it might be something that make you sick."

B.5 Ways of Treating Illness or Disease

There were two major ways of treating illness or disease used in combination among these three participants. These were western and traditional treatments. The western treatments (such as, go to see doctor, go to buy western medicine from the chemist) might be used before following other traditional treatments (such as using home remedies) or after the failure of using the traditional treatments.

For Mrs A, she seemed to have strong confidence in the western doctor, as she said:

"If I'm sick or I've got stomachache, I must tell the doctor, I must go to see doctor."

During this study Mrs A. was pregnant with her third baby. Her first two children were delivered at home in the camp in Thailand by a

traditional midwife who was her own mother. For this baby, however, she planned to go to hospital. She stressed that:

> "I must go to hospital." And
> "I must go to see doctor." She explained that:
> "... too hard, when the baby is born. Because in Thailand the home is no good. Here the house is good."

She added that:

> "It is very hard when baby born. blood alot .....
> In Thailand, there is bed, small bed, I can have baby born at home. Now, no, I can't."

However, she also gave another reason as:

> "Because just enough for me." This means she only wants three children.

Seeing the doctor was also a way of coping with illness for Mrs B. and Mrs C. When related to the illness experience of these two mothers, Mrs B, who often experienced dizziness said that:

> "I went to see the doctor to see whether I had less blood."

And Mrs C's mother answered instead of Mrs C. that if their children got sick, they will:

"Take the children to see the doctor first."

In some situations, self-treatment was used. The participants used this way because of learning from their previous experiences. The comment below was added by Mrs A's sister:

> "We got something like we cut a little bit leg or finger, then, we put some, umph.. special medicine that we known before."

An example was raised, because Mrs A's mother had just burnt her finger, so:

> "We go to the chemist and buy medicine."

It was explained later that she was advised by her sponsor to buy this medicine. It is a kind of burn cream.

This was similar to Mrs C's situation, when she got cold. She said that:

> "My mother used to get cold and she went to see the doctor. She got this medicine, which made her better, so she bought for me."
> And "My mum bought this medicine from the chemist shop."

Traditional treatments were also utilized in combination with western treatments, for example coining and using herbs or chinese medicine were mentioned by these three participants.

Mrs A. told about her experience when having a baby at home. She vomited when the baby was nearly born, so:

> "My husband he used a small coin and rub here (she pointed at her chest)."

And this method did help her feel better. Her sister explained in addition that sometimes they used balm or oil to apply to the skin first then used a coin to rub or scratch on the chest, back, neck or arm. This method was called "kos khyal" in Khmer.

Mrs C. had also used this method recently, in Chinese she called it "Kao soa." This method was used to relieve her muscle pain, which occured from the cold. She related that:

> ".. I used "Kao Soa." I used a coin to rub my body, around here." (she pointed around her neck, shoulder and chest). ".. my first time. I did last night because I felt very terrible. The other days I didn't do it."

She explained that this method helped to rub wind from your body. In Khmer she also used this method when her daughter had a high fever:

"My daughter always got high fever when she was in Khmer. I used Kao soa...."

However, she realized that this method was not approved of by Western doctors, as she said:

".. But, you know, New Zealand doctor didn't like us to do this."

And

"Ung moh*, they have not "Kao soa." They said that it is not good. If I "Kao soa", I dare not tell the doctor. They don't like it. If they know, they are angry."

The illness problem of Mrs B. was dizziness. She said that when she was young she had an accident, a car knocked her down, but it was not very serious. And since then she has got headaches quite often. Coping with this problem, she said that:

"I just take medicine by myself."

---

* "Ung Moh" is a chinese word used for people from Western countries. It means "red hair."

This medicine was chinese medicine that she bought when she was in her country. Now, she said that she could not get this Chinese medicine in New Zealand. However, she was still able to cope with this illness. She said that:

> ".. If I get a headache, normally, it will be only for one day, I can recover. If I don't take medicine, I just sleep for half a day then I feel better."

In Kampuchea or in the refugee camps that they stayed in before arriving in New Zealand, these mothers also had various ways of treating illness. These practices were different according to this illness problems. However, most practices were traditional treatments or using home remedies. A traditional healer was an alternative source of help for these mothers when they had illness problems. As Mrs A. said that:

> "In Cambodia I haven't got a doctor family and if I will go to see the doctor in the town, very far from my house. I can't. I find something from old woman or a man."

The explanation about the traditional healer was added by Mrs A's sister. This folk healer had knowledge about various diseases and could prescribe the medicines for curing them. A form of treatment used by Asian folk healers involved herbs. As Mrs A's sister explained:

> "Khrou Khmer, you know Khrou Khmer, who know something for diarrhea, for peticheae and all diseases that make the children had the sneeze. So they find medicine from the mountains and put together in the water and give to people who have illness."

This healer could prescribe the medicine for various illnesses as Mrs A's sister added:

> "It is according to the people who have disease. When I got vomiting. I got different medicine also. Yeah! it is up to the people who has problem."

The difficulty of getting a doctor was also reported by Mrs C. As she said:

> ".. In Khmer you couldn't get the doctor to come to see you. It was quite difficult."

Therefore, home treatment was utilized for some illnesses. From Mrs C's experience, her daughter had high fever and became unconscious, that made her very frightened. Her mother helped her by using home treatment. She told that:

> "... My daughter always got high fever, and sometimes she became unconscious, she didn't know herself when I called her. I was very scared. I called my mum, she was very good. She used lemon grass pounded until it

was fine, and put lemon juice from half a lemon and sugar. Then she opened my daughter's mouth, and poured into her mouth, then she began to know herself."

## B.6 Some Health Beliefs and Health Care Practices in Pregnancy, Delivery, and Post-partum Period

Two participants who were pregnant contributed some health beliefs and health care practices in pregnancy, delivery, and post-partum period. These beliefs and practices also related to health maintenance and ways of avoiding illness. Each period is described separately.

### B.6.1 Pregnancy period

During pregnancy, the health status of the baby seems to be very important for the mothers. Various kinds of herbs are suggested and utilized by most. This is believed to keep babies healthy. In order to keep her baby healthy, Mrs A. said that:

"My mum told me something from the tree."

And these herbs were prescribed by traditional healers called "skomket"

"... In Kao I Dang, the old man skomket, you know skomket. The old man, they used from the tree and cut it a little bit, a little bit, and I put it in the water."

She told me that she drank this water. This was for "The baby and up to the baby born already can use." That was, ."... until the baby is five months."

Mrs B, also suggested Chinese medicine that keeps the baby healthy during pregnancy healthy. She explained that this medicine is made from 13 kinds of herbs. She suggested to me that during pregnancy:

> "You should eat 3 tablets. These will keep your baby healthy. But the medicine is quite big, it is difficult to eat. You can make it small. You can eat it when you get pregnant at 3 months, 6 months, and 9 months."

For the food during pregnancy, in Kampuchea there were some kinds of foods that were prohibited for mothers. It was believed that these foods could be the cause of allergy to mother. Mrs A's sister explained that:

> "Like the people who have the baby for the first time at when they eat rabbit ... you know the rabbit. It can make mother sick. They can't eat until the baby is eight months old."

Mrs A. also added that:

> "I don't know why, all the people, for a long time, told."

B.6.2 Delivery

The fear of mothers in this period is the difficulty of delivery. This is especially in an area that lacks technology or modern medicine. One mother attributed various kinds of home treatment that helped mothers to have an easy birth. These included:

: Sesame seed This was called "Lagho" in Khmer. Mrs A. told that:

"I can put in the water. I put on the stove, then I drink this hot water, when the baby born easy."

More information also was additionally explained by Mrs A's parents, especially from her mother who was a traditional midwife in Kampuchea. They said that 'Lagho' helped the baby to be born easier. There are many ways to prepare 'Lagho'. Apart from boiling as Mrs A. used, they can soak "Lagho" in alcohol and drink, or grind it and mix with cooked rice and eat it.

: Dried basil seed This was called "krobjee" in Khmer. Mrs A. said that this seed was prepared by:

" put in the water and drink it."
It was to make the baby born easy too."

Mrs A's mother also added later that this water can be drunk any time during pregnancy. It also prevents constipation. She

demonstrated to the researcher how to prepare this seed to drink. She put one teaspoon of the black seed in half a glass of water and put one teaspoon of sugar, then stirred it. She waited until this seed became swollen. The size of seed became bigger, like the size of sesame seeds. This water with seed should be drunk by mothers.

:"Coconut oil. This was called "Preng dong" in Khmer. Mrs A. said that:

> "When I stayed in the camp, I used coconut a little bit every morning. I eat little bit, little bit." This meant she drank it "every morning" and "when the baby is nearly born or one week or two weeks after the baby born, I can use it."

For this pregnancy, Mrs A. planned to use sesame seed, as she said:

> "I will use this (she pointed at the sesame seed that she brought to show the researcher) to put in hot water. It is easy for me when the baby is born."

B.6.3 Post-partum period

There were a lot of beliefs and practices related to the health and illness of mothers and babies during the post-partum period. This is discussed under three headings as the participants talked about them. These are diet, activity and rest and other.

B.6.3.1 Diet

This aspect was commented on much by 2 of these participants. One thing that was commented on similarly was 'hot' and 'cold' food. The term 'hot' and 'cold' discussed here referred to both 'hot' and 'cold' in temperature and hot through the kind of food such as ginger, pepper. This kind of food is believed to help the balance of the body. As Mrs A. said that:

> "After the baby is born I am cold. I don't use anything cold, just the hot" And
> "If I am hungry, I can ask my mum to cook the hot thing, like ginger, black peppers, I can eat."

This was similar to Mrs B. who said that:

> "Well, I eat food with more pepper or ginger. Someone said that after birth we lose our blood, we eat these foods and it may help." And, "We can eat pork" .... "fried pork with ginger."

She added that in the first week after having a baby, chicken also was prohibited.

> ".. You can't eat chicken after having baby for seven days. So after seven days you will be allowed to eat chicken."

She stressed that after birth the food that she could eat was very restricted. She could eat only three things, but cooked in different ways. These were pork, chicken, and ginger or pepper. She stressed that:

> "..., only these three things. You should not eat vegetable and beef."

And the way of cooking was explained that:

> "Like, sometimes we fried chicken or pork with ginger. Sometime we steam chicken which we put pepper and sugar with."

She also added that: "Sometime I used "Tung-kue"* or Pei-Che"*. I steamed it with chicken, or pork, and eat it."

These two kinds of herbs were explained more fully by Mrs B's sister-in-law, who said they were always used for mothers who had just had a baby. Mothers can use either "Tung-kue or "Pei-Che" to cook with food such as chicken or pork, normally steamed, then they should eat the meat and juice. Since it was considered as very hot, it should be eaten at least for one week after birth. Another way to prepare "Pei-Che" was also explained. They may soak "Pei-Che" in alcohol for at least 3 months. After having a baby the mother can drink a small glass of this alcohol every day with a meal.

Cold food was prohibited for mothers, as Mrs B. said:

---

" Tung-kue " and " Pei-Che " are kinds of Chinese herbs that were considered " hot ".

"Don't eat too many vegetables" Because,

"it is too cold for your body."

These two participants suggested that this included water. Mrs A. said that she "used only hot water." While Mrs B. described how to prepare water to drink after having the baby. This water seemed to be 'hot' both in temperature and through the kind of food used to prepare.

"... there (that means in her country), we will use rice and roast it. We roast it until it is brown, then add sliced ginger and roast them together until they become brown. Then add them to the hot water and cover it. We drink this water."

She continued:

"There, we drank alot, so we didn't feel hot inside. But here we don't drink it, so our body is quite hot. We ate only chicken, or pork fried with ginger. Sometimes we got constipated for three-four days.

She also mentioned:

"So, there sometimes, even though we ate too much hot food, it doesn't matter. But here sometime if you eat too much hot food, you may be in trouble."

Keeping the 'hot' and 'cold' balance in the body, thus, seemed to be quite important for Mrs B. However, she couldn't explain why, as she said:

> "I don't know why. It may be the place is different. I don't know. But if we eat too much hot food, we may get hot and the baby too. We may have constipation for 3-4 days."

B.6.3.2 Activity and rest

This aspect was commented on a lot by Mrs B. It was emphasised that working after having a baby should be avoided, especially for the first baby. She suggested to the researcher that:

> "Someone said that for the first baby we should not work too much."

The reason she gave was:

> "Because if we work too much you may get back pain after that. For me this is my third one, so I was not afraid about that. If it was my first baby I would not work too much."

She also gave an example that she experienced when she was in the camp in Vietnam.

> "When I was in Vietnam, I met one woman who just had her first baby. Her husband let her do the work only 4-5 days after the birth. She had to wash napkins, and so on. After that one month that lady looked very old."

Mrs B. commented about having a longer period of lochia.* It seemed to relate to having too much activity after birth. As she said:

> "There (she means in her country), after 7 days, the blood will stop. Here I had for three weeks. It came for three weeks."

And she didn't know why, but she commented that:

> "..there, I rarely worked. We always lie down. We didn't work much. "But here we have to walk, we have to work."

Going outside after having a baby was also prohibited by Mrs B's family. She told me:

> "When we have baby we should not go outside for at least one month."

---

* Lochia is a blood loss after the birth of baby. It is rather like a heavy menstrual period. This will last for perhaps a fortnight.

However, this can be flexible, if it is necessary for the mother to go,

> "..if you go, you should have cloth to cover your head."

Mrs B. kept strictly to this rule. She said that:

> "It is not good if you go. Because you will touch the wind. It is not good. If you go out your ears will touch the wind and that can make you get earache. Otherwise the wind will touch your head, and you may get headache."

She gave an example that:

> "Like my mother, she couldn't go out for three months."

Having a shower after having a baby was prohibited too. Mrs B. said that:

> "..there (meaning in her country), after having a baby we don't have a shower. We could not have a shower for at least half a month."... "and for the first month you could not wash your hair as well."

The belief was that:

"...it can cause headache."

Mrs B. followed these practices when she was in her country. But here she has adapted to the modern way, as she said:

"..I had a shower only two days after the birth."

Social pressure seems to be a factor as she added.

"If you don't take a bath, the nurses may complain you that you are dirty."

And this was the same reason that she followed this practice when she was in her country. As she said:

"..I just do what the old people said. They told me that if we have a shower early after having a baby you may become old faster (laughed)" and "if you washed your hair earlier you may also get older faster or get headache also."

For Mrs A., these activities were not mentioned, only using warm water for having a shower. Mrs A. said that:

"When I have a shower, I will have some hot water and some cold water."

### B.6.3.3. Other practices

#### B.6.3.3.1 Relieving after pains

How to relieve after pains was suggested by Mrs A. This practice also related to the 'hot' and 'cold' status of the body. As she said:

> "After the baby is born I am cold. I don't use anything cold, just the hot. Every morning I can.. I put on the fire. I stayed in camp I put ..Eh.. Eh what you call? Like small small tree and put it in the fire about 15 minutes. Then you stopped the fire and put it in material and put on your stomach."

This thing was called "Moh" in Khmer. Mrs A. used the "Moh" to put on her stomach every morning as she explained more:

> "I will put it on my stomach every morning for an hour between 5 to 6 o'clock. Or sometime you can put the fire under your bed..."

To adapt to the new situation, in New Zealand, she said that:

> "In N.Z. I can put the hot water in the hot bag and put on my stomach."

Cold things were mentioned as a cause of after pain. As she added:

"If I used something cold I will get sore in my stomach" (which is how she referred to "uterus" which is called 'sabone' in Khmer).

B.3.3.2 Caring for the baby's cord

Mrs B. experienced her first child birth in the hospital in a Vietnamese refugee camp. In Vietnam she lived with her sister who helped her take care of the baby, such as bathing the baby. She said that she never bathed her first child, and one reason that she gave was:

"There, after having the baby, he still had the cord."

So she was afraid of putting the baby in the water. The baby's cord was cared for by her sister. She continued that:

"..You had to put something on it and wrap it with a cloth. We had to be careful; the baby couldn't be put in the water..." And : ..."In Vietnam, my sister used ginger and put it in the fire until it became black, and pounded it until it was fine. Then, she put it on the baby's navel."

Mrs B., however was now able to bath her second baby. She said that:

"..Here (meaning in N.Z.) you can put baby in the bath. The baby's cord can touch the water. It doesn't matter."

Beacause: "Well, here they have medicine...." and ".".. there, they did not give us any medicine. After you had had the baby, no one was interested in you."

B.6.3.3.3 Breastfeeding

Another practice pointed out by these two participants was breastfeeding. Breastfeeding was accepted and acknowledged as the good food for baby. Mrs A. breastfed her first two babies in the camp. She said that she preferred to give breastfeeding although there was powdered milk for sale. She said that:

"Oh! my milk is better."

She also planned to breastfeed her new baby. She explained that:

"Because it is a young baby. I don't like to use powder milk."

Mrs A. thought that breastmilk should be given to the baby until five to six months, then powdered milk can be supplemented.

"If the baby is five to six months, I can use that milk (means powdered milk) a little bit, a little bit."

Mrs B. also breastfed her first son and has breastfed her new baby, too. She commented on breastfeeding:

> "Yes, it's good. And convenient. If you give bottle feeding, you have to prepare it. Sometimes the baby cries and cries while you are preparing it."

For Mrs B, she was told that breastfeeding could be given to the baby for one year. As she said that:

> "Someone said, breastmilk should be given until the baby is one year old."

She also mentioned a different practice that she experienced from the hospital in Vietnam. She told that:

> "Here (meaning in a New Zealand hospital) they put the baby to your breast after birth, but still no milk comes. The milk will come after three days."

But:

> "There (meaning in a Vietnam hospital) the first three days you could not breast feed to your baby. It should be after that.

And:

> ".... There, we gave the baby rich glucose first."

B.6.3.3.4 Birth control

These three participants seemed to know about only two methods of birth control. The pill was acknowledged and used well among them. Injection was also mentioned but was not used due to the side effects of medicine. Other methods were not commented.

Each participant experienced of using pill. Mrs A. said that she used this method for a long time and preferred this method rather than injection.

> "...I used to use medicine for a long time. My blood came down every month."

Mrs B. was not asked this question. However, from taking her to have a postnatal check, I knew that she also selected to use pill, and that she used to use pill when she was in the camp in Vietnam.

Mrs C. also had experienced using the pill and has still used it until now.

> "I eat medicine. I went to see the doctor and got this medicine to eat every day."

Side effects of injection were mentioned by Mrs A. and Mrs C. who had had experienced with this method. Mrs A. pointed out a few side effects of injection that:

"...at first I stayed in Sa Kaeo, I used injection to stop the baby. It is no good for me. Every night I feel very hot. I can't sleep".

And:

"...When I used injection, no good, sometimes blood did not come every month."

Another side effect that she mentioned was "putting on weight; as she told that:

"If....And sometime my sister very big."

Mrs C. also mentioned that:

"When I was in Khmer, I had injection. It was not good for me. So I changed to having medicine." And:
"I did not feel well after having the injection."

Since this participant had mentioned before that she would have only three children, thus she was asked if she had considered sterilization. She refused to have sterilization, and the reason she gave dealt with her past experience since she used to have an operation, so:

"...Because I stayed in the camp I had an operation at my throat and I am scared for a long time."

## C. SUMMARY

The beliefs and practices in relation to health and illness of Kampuchean mothers were presented in this chapter. The findings were taken directly from what the participants said. In this study, these three participants contributed the variety of information related to what they believed and practiced in relation to health and illness. These are summarized in Table 5.2., 5.3.

The next chapter contains the discussion, conclusions, and finally a list of recommendations which may help the future study.

TABLE 5.2

SUMMARY OF FINDINGS

| | Mrs A | Mrs B | Mrs C |
|---|---|---|---|
| Description of good health | Feel happy, no problems. Absence of sickness | Absence of sickness | Healthy is wealthy |
| Description of illness | Can't explain | Can't explain | Illness is unwealthy (loss money) |
| Health maintenance behaviours | Diet: eat various kinds of food (balanced meal) : eat three times a day | - Nothing<br>- Using herb combination with food after having baby<br>- Using Chinese medicine | Nothing |
| The cause of illness | - Food: dirty : expired<br>- Not enough to eat<br>- The 'cold' caused after pains | - Food: eat too much 'hot' or 'cold' food<br>- Not enough food to eat<br>- Anxiety<br>- Accident | - Touch too much 'hot' and 'cold' food or weather<br>- germ |
| Avoiding illness | Keep everything clean | - | - Keep body warm<br>- Eat three times a day |
| Treating illness<br>: Western way | - See doctor<br>- Buying medicine from Chemist | - See doctor<br>- Buying medicine | - See doctor<br>- Buying medicine |
| : Traditional way | - See traditional healer<br>- Using herbs<br>- Coining | - Rest<br>- Using Chinese medicine<br>- Using herbs | - Coining<br>- Using home remedies |

TABLE 5.3

BELIEFS AND BEHAVIOURS RELATED TO CHILDBEARING
OF THREE KAMPUCHEAN MOTHERS

| PERIOD | BELIEFS OR BEHAVIOURS |
|---|---|
| Pregnancy | - Take Chinese medicine at three, six, and nine months to keep the baby healthy.<br>- Use various kinds of herbs prescribed by traditional healers to keep the baby healthy.<br>- Avoid eating 'rabbit' (during pregnancy until the baby born up to eight months) to prevent an allergie developing in the mother. |
| Delivery | - The following things are believed and utilized in order to help an easy birth:<br>: 'Lagho' (sesame seed)<br>: 'Krobjee' (Dried basil seed)<br>: 'Preng dong' (Coconut oil) |
| Post partum | - There is a loss of blood and energy during delivery which is believed to make the mother's body 'cold'. To avoid the 'cold', it must be replaced with 'hot' things.<br><br>Diet:<br>- Pork, chicken, ginger, black pepper are considered 'hot' food that the mother should eat after having the baby. It is believed to increase the blood in the body.<br>- Chicken may be avoided during the first week after the baby's birth.<br>- Use some kinds of herb such as 'Tung-keu' or 'Pei-Che' to cook with food such as pork or chicken to eat after baby's birth. It is believed to increase the blood and energy.<br>- Vegetables are avoided because they are considered as 'cold' food.<br>- Avoid cold water after delivery.<br>- Prepare hot water to drink after delivery by putting roasted rice and ginger to prevent constipation, in the hot water.<br><br>Activity and Rest:<br>- Avoid working or strenuous activity after delivery especially for the first baby to prevent back pain and growing older.<br>- Avoid working after delivery to prevent a longer period of lochia.<br>- Avoid going outside for one month to prevent the body touching the wind which can cause sickness to the mother, such as earache, headache.<br>- Avoid having a shower for half a month, and avoid washing hair for one month to prevent headache, and getting old.<br>- Use warm water when having a shower after delivery.<br><br>Others:<br>- Use 'Moh', (hot wood in which is wrapped in the cloth or some material); or hot water bag to put on the stomach; or put fire under mother's bed to reduce 'after pain'.<br>- Use fine pounded roasted ginger to put on the baby's cord.<br>- Breastmilk will not come until three days after birth. |

# CHAPTER SIX

## DISCUSSION AND GENERAL CONCLUSION

The responses presented in chapter five offer some insight about what was perceived and how these refugee mothers acted in relation to health and illness. They also expressed some special beliefs of their culture. The answers from an individual, however, may not be scientific, and there were no 'right' or 'wrong' answers. Therefore, the main emphasis in analysing the findings in this chapter is upon what was reported by them.

The discussion will be presented in the order in which topics were revealed in the interviews. A summary of each topic will be given before proceeding to discuss these findings.

### A. WAYS IN WHICH HEALTH AND ILLNESS ARE DESCRIBED

There were two definitions describing the concept of 'health' from these participants' viewpoints. Two participants defined 'health' as the 'absence of sickness'. Of these, one first compared being healthy with the happiness of herself and her family. 'Healthy is wealthy' was another definition which was given by a member of one participant's family.

The concept of "illness" could not be described by these three participants. One participant's mother attributed the meaning of 'illness' as the converse of the meaning of 'health' which was defined by a member of her family. 'Illness' according to her, was unwealthy, or 'loss the money'.

In general, the Asian concept of health has been influenced by Taoism from China (Ferguson, 1982) and for the religious, Buddhism (Blattner, 1981). Chinese medicine teaches that health is a state of spiritual and physical harmony with nature and that health can only be achieved through harmony of the body, mind, and environment (Ros, 1983; Spector, 1985).

Although, these three mothers did not state any definitions that related to this concept, they all mentioned the following three things, - body, mind, and environment, - when talking about health and illness. In terms of body, two participants defined the concept of health as 'the absence of sickness' while a participant's uncle defined it as 'the capacity of working to earn money'. Mind may be linked to what they felt as happiness; nothing to worry about, the life going well. The experience of a hard life in their country and in the camp may also have had an influence on the following expressions.

> "..In 1984, I came to New Zealand, I am happy. Because I lived in the camp very hard in my family. And, when I came to New Zealand, all my family very happy. Because in New Zealand easy for my husband working and for my family."

"I like it here (means in New Zealand). We have work, we have food to eat. I have nothing to worry about. All my family have already moved here."

And, when discussing life in the camp, it was mentioned that:

"It was quite difficult to earn money."

The balance of body and environment was also very important for them to maintain their health. This aspect, however, will be discussed in the next topic.

'Health as the absence of sickness' was probably close to the western or medical concept which tends to define health in relation to sickness (Bauman, 1961; Kelman, 1975; Gore, 1978; Fillenbaum, 1979). According to these participants, they had all experienced a few illnesses in their own countries. When they moved to New Zealand, they found that they were rarely ill, or the symptoms that they used to have disappeared. As these mothers said: "for me I never sick," and "...But here, I have never had any sickness like that."

"Healthy is wealthy" was defined by a Chinese man who was a relative of a participant. His definition of health related to money and investment. This might be related to sex, occupation and his position in the family. As the head of his family, he had just sold his small business, and had planned to take up another business in Australia. His socio-ecomic status was quite good. According to him, health seemed to be related to the capacity of earning money. Money

seemed to be an important factor to his living. Although the participant herself did not so define this concept, but money also seemed to be important for her and her family. As she said, she would like to have another baby, but this plan was opposed by her husband and her mother.

> "...my husband and my mother said not now, we have to work first, and earn some more money."

The concept of illness, though, was not identified directly, but it seemed to be related to the failure of harmony of body, mind, and environment. The participants mentioned health status, anxiety, and keeping the balance between body and environment as the causes of illness. The greatest emphasis of keeping the body balanced was placed on the concept of 'hot' and 'cold' which were mentioned a lot in the aspect of health maintenance behavior, the cause of illness, and avoiding illness. These two concepts may be linked to 'Yin' and 'Yang' derived from Chinese principles. This finding appears to be similar to most studies which deals with the Chinese, or Asian people (Campbell and Chang, 1973; Chung, 1977; Chen-Louie, 1983; Spector, op. cit.) and the Southeast Asian group (Orque, 1983; Muecke, 1983; Kemp, 1985).

An interesting concept of 'illness' was defined as 'unwealthy' or 'loss of money.' This definition also related to the concept of health that was defined by the same family. The definition of "loss of money" relates to both the cost of health care and loss of earning power. This means when they are sick they could not work and they also have to

spend money for medical care. It is quite interesting to note that this family viewed illness in relation to cost. This may be related to their having had few hospitals and physicians in Kampuchea with the additional cost of travel to obtain assistance, and the high cost of Western medical care. This may also be the reason why some traditional self-care practices are still commonly utilized among the Southeast Asian refugees (Muecke, ibid.).

## B. WAYS IN WHICH HEALTH IS MAINTAINED

It was found that these women maintained their health by:

- eating various kinds of food
- eating balanced food
- eating three times a day
- taking chinese medicine
- using herbs combined with food

Some findings from this study seemed not to be related to the principle of Yin and Yang. Eating properly, a balanced diet, and eating three times a day were pointed out as the way to maintain good health by a Khmer woman. In fact, what she mentioned is also a basic principle for the maintenance of health outlined by Boddy and Nevatt (1985). However, the answer may be considered from the reality point of view. Since the establishment of Pol Pot's new regime in 1975. The life of Kampucheans both in their country or in any refugee camps was hard and full of uncertainties. They could not plan for the future,

but only how to survive from day to day. An experience that most refugees may have encountered for themselves or may have seen affecting other people was starvation. It is reported that between 1975-1979, 1-3 million of a population of 7 million Kampucheans were murdered, tortured, or were allowed to die from starvation or disease (Van der Westhuizen, 1980). Life in the refugee camps also relies on help from various agencies or organizations. Food has to be shared but it is often not enough for the family, so many refugees have been faced with the problem of health and undernourishment (Bruno, 1984).

Another two ways to maintain health pointed out by a Chinese Khmer woman were the practices she would follow during pregnancy and the postpartum period. This will be discussed later in a separate topic.

One participant could not define what she did to keep healthy. According to her answer, 'doing nothing' might simply mean that she did not do anything special to keep herself healthy. When related to her background, she seemed not to have experiences of sickness like the other two participants who had at least two to three experiences of sickness before arriving in New Zealand. Her length of stay in the camp was also less than the other two participants combined with the economic status of relatives who had settled down in New Zealand. That meant that she and her family might have received some sporadic support from her overseas relatives.

## C. WAYS IN WHICH ILLNESS IS AVOIDED

Most people are likely to relate their experiences of illness and what they think are the cause of that illness to the way that they prevent illness. Only two main behaviors, however, emerged as means of preventing in the relating of their experiences of illness and the causes of them. Nevertheless, other causes of illness that they reported seemed to help in interpreting the practices that they might follow in relation to avoiding illness. These three aspects, experiences of illness, causes of illness and ways of avoiding illnessess, are listed and shown in table 6.1.

There are many theories in Southeast Asia that explain the cause of illnesses. They are either naturalistic (blaming a bad wind, for instance), supernaturalistic (influence of gods, demons, spirits), or metaphysical (hot or cold theory), or a combination of all three (Ferguson, op. cit.; Ahoy and Jung, 1985).

Among these three participants, the naturalistic and metaphysical were pointed out as the explanation of the causes of illnesses. However, some explanations were expressed in relation to a specific incident, for example anxiety, eating dirty food, not enough food to eat. This may be due to most people usually finding it difficult to think about the topic in more general terms, so that incidents may be the things that they perceived and they thus learned through experiences. In addition, the illnesses reported in this study were just a group of symptoms rather than the name of diseases known in Western medicine. It is said that, in Southeast Asian countries

TABLE 6.1

EXPERIENCES OF ILLNESS, CAUSES OF ILLNESS AND WAYS TO AVOID ILLNESS

| EXPERIENCES OF ILLNESS | CAUSES OF ILLNESS | WAYS TO AVOID ILLNESS |
|---|---|---|
| Cold | - Touch too much wind | - Keep body warm, wear a lot of clothes, and avoid to touch the cold weather |
| | - Germ | |
| Cough | - Eat too much 'hot' food | |
| Diarrhea | - Food : dirty<br>: expired<br>: something wrong in the food<br>: eat too much 'cold' food | - Keep everything clean |
| Dizziness | - Loss blood<br>- Accident | |
| Wind in the stomach | - Eat 'cold' food | |
| Fever | - Hot weather<br>- Weak | |

patients are rarely told the name of their illnesses, of the medicine given, or of the diagnostic procedures performed on them; consequently they rarely know that what was done for them and why. (Muecke, op. cit.). A participant who had probably had a toxic goiter and was treated by operation could not tell what was wrong with her, nor how and with what she was treated.

Connected with the Chinese belief, these Khmer women also viewed an overabundance of either 'Yang' or 'Yin', which they reported in 'hot' and 'cold' terms, as the cause of illnesses. For example, an excess of 'Yin' resulted in cold and/or diarrhea. Too much 'Yang' caused a fever and/or a cough. These are also explained in more detail in various pieces of literature (Li, Schlief, Chang, and Gaw 1972; Campbell and Chang, op. cit.; Chen-Louis, op. cit.; Ferguson, op. cit.; Kemp, op. cit.).

Illness prevention, thus, is likely to involve modification of food intake in order to maintain or restore equilibrium by rebalancing the body's component parts. Although these participants did not mention any practices in relation to the modification of food, it was likely that it could be practiced by them.

It was interesting to note that the beliefs in the supernatural causes of illness were not mentioned in this study. Perhaps this belief has undergone further change according to the availablity of Western medical care and the forces of Western society around them. This result was also found among the Southeast Asian (SEA) refugees in the United States (Schultz, 1982). Schultz points out three reasons

that caused the SEA refugees' beliefs to be in flux. They are: (1) Refugees who want to follow the cultural rules of the country feel they must believe in Western medicine; (2) Refugees are forced to change their beliefs here because sorcerers or other healers of 'supernaturally induced' illness are not living in the United States; (3) Many refugees think that the supernatural causes may not exist in the United States.

## D. TREATING ILLNESS

When illness occurred, there were two alternative practices that these mothers followed to treat the illnesses or symptoms. There were Western medical care and traditional care. Western medical care was seeing a doctor and utilizing Western medicines. Traditional care included home remedies, herbal medicines or chinese medicines, and folk practices. The results from this study were similar to many studies that reported that most Khmer use traditional and modern medicines concurrently. (Hoang and Erickson, 1982; Goldfield and Lee, 1982; Cohon, 1983; and Bruno, op. cit.). The practices of these mothers, however, seemed to differ between what they did in Kampuchea or in the camp and what they did in New Zealand.

In Kampuchea, they appeared to rely more on traditional medicine and self-care, while in New Zealand both traditional and Western medicine were utilized in combination. This may be related to the following reasons. One reason was the difficulty of access to Western medicine in Kampuchea, which was pointed out earlier (Steinberg, 1959;

Munson et al, 1971; Cohon, ibid.; Bruno, op. cit.). In addition, the decreasing number of medical personnel and hospitals during wartime made the Khmer depend more on traditional health practices rather than Western medicines. Moreover, it was pointed out that many Kampucheans do not understand the theory of disease, and fail to understand the relationship between disease and scientific technique (Steinberg, ibid.;Muecke, op. cit.; Boyer-Chuanroong, 1984). Thus, although these people accept Western medical techniques, it is usually as a supplement to, rather than as a substitute for, their traditional measures.

It may be argued that it is easier to gain access to medical care in New Zealand, yet the Kampucheans still utilized their traditional ways. The following reasons, however, were mentioned which need to be recognized. The language barrier was pointed out by one participant. She said that before going to see the doctor, she had to prepare the words to describe her problems to the doctor. The conflict in treatment was also mentioned, when one participant who utilized the traditional practice of 'coining' said that the doctor may get angry if he knew that she used 'coining'. This may result in a delay in seeking medical health care. Another interesting comment mentioned by the same participant was that, who else could they go to see here if not the doctor. This may imply both positive and negative attitudes, either that she accepted the Western medicine or that she had no choice to select the other ways that she could find in her own country.

In general, however, these mothers seemed to adjust well to the new situation in New Zealand. Both traditional medicine and Western medicine were used in combination. Western medicine seemed to be the

first priority if the illness occurred to their children, or they did not know what to do with their illnesses. Hoang and Erickson (op. cit.), and Muecke (op. cit.) pointed out that the main reason most refugees from Southeast Asia go to see a doctor is to get medicine for a symptom. This is also a reason mentioned by these participants. SEA people usually believe that Western medicine is very powerful and cures quickly. They learned that it did work, so consequently they preferred to go and buy medicine to cure themselves. Self-medication, thus, seemed to be another way that these mothers practiced in this country. This may also be related to their having had access mostly to over-the-counter medication in Southeast Asia (Muecke, op. cit.). However, this may also be related to a problem that is frequently pointed out, that Southeast Asian people often delay seeking health care. (Hoang, and Erickson, op. cit.).

Although Western medicine seemed to be utilized more and trusted by these mothers, some traditional practices were still used by them. Two major forms of traditional practices that were performed by them were folklore techniques and use of herbal medicine. These were similar to most Southeast Asian refugees who settled in the United States (Hoang and Erickson, op. cit.; Muecke, op. cit.).

In fact, there are many folklore techniques for curing the illnesses of the Kampuchean people, such as 'kos khyal' (skin rubbing or coining); 'chop khyal (skin pinching); Balm application; and 'Och' (burning). 'Kos khyal' was the only one used by these women. This method seemed to help the patient to decrease anxiety and relief from the symptoms that 'often go untreated in cosmopolitan systems of

medical care' (Ros, 1983, P.2). Considering the procedure they use, this method may be compared to the use of therapeutic massage in Western medicine, and in nursing practice. For example, coining may be used for the same reason as 'counterirritation' which is used in nursing practice. 'Counterirritation' in nursing is superficial irritation intended to relieve some other deep seated inflammation.

Another way these refugee mothers treated illness was by taking traditional herbal medicine. This method related in particular to the practices during pregnancy, delivery, and the pospartum period which will be discussed later.

## E. HEALTH BELIEFS AND PRACTICES DURING PREGNANCY, DELIVERY AND POSTPARTUM PERIOD

As summarized in Table 5.2, chapter 5, there were many beliefs and practices concerned with child rearing used among these three participants. The most distinctive health practices which were consistent with other studies were related to postpartum health practices. These practices largely involved activity and dietary changes. Some of these practices were still retained, but some were abandonned. It is likely that they still follow the practices when they can do it. It also seemed to be all right to abandon some practices because of the availablity and accessibility of Western medical care.

Most information attributed in these aspects was shared from two

mothers who experienced pregnancy and child birth at the time of interview. The practices during pregnancy and delivery were discussed more by the Khmer mother, while the postpartum practices were explained more by the Chinese-Khmer mother.

The findings from this study showed that the theory of balance of Chinese medicine called Yin/Yang can be obviously seen as an important influence toward the beliefs and practices of these mothers in these aspects. This concept, however, seemed to have more influence on the Chinese-Khmer mother than the Khmer mother. The Khmer mother was likely to rely more on folk practices and traditional Kampuchean medicines. This may be related to the influence of family and social structure around her. The Khmer participant was brought up in a rural area in Kampuchea and her mother was also a traditional midwife. Her family seemed to be familiar with traditional treatments and traditional healers. Traditional medicines, therefore, which were prescribed by the indigenous healer, Krou Khmer, for instance, were mentioned as a method to keep mother and baby healthy. While traditional Kampuchean medicines were suggested by the Khmer mother, the use of Chinese medicine was also advised by the Chinese-Khmer mother to ensure a strong and healthy baby. This finding, is also similar to the study of Goldfield and Lee (op. cit.) who reported that taking herbs was a health maintenance behavior practiced during pregnancy among Southeast Asian refugee women.

In summary, each of them had their own way and beliefs to keep her baby healthy during pregnancy. It is quite difficult to discuss the effect of these medicines on the health of mothers and babies. Both

traditional Khmer medicine and Chinese herbal medicine are very elaborate and complex. These have been described in Hiegel (1981). These medicines, are mostly unfamiliar to Western doctors.

The practice during delivery was also interesting. In Kampuchea, especially in rural areas and during war time, childbirth was mostly practiced at home using traditional medicines. To ensure that the practice was as safe as possible, there were many practices utilized to help an easy-baby-birth. These practices may vary among individuals. The practices reported in this study, have not been found in the literature. Sesame seed, dried basil seed, and coconut oil were used to help an easy-baby-birth. It is interesting to note that dried basil seed and coconut oil seemed to have the same characteristics. That is, they have smooth and slippery characteristics. This reason, in fact, is not likely to be a good explanation from the scientific point of view, but it may well be that folk health practices have therapeutic values as yet unknown to scientific researchers.

As stated earlier, a balance of hot and cold in the body plays a large part in postpartum practices among these Kampuchean mothers. The findings of this study are also similar to those of Chung (1977); Manderson and Mathews (1981) and Wadd (1983), in regard to postpartum practices among Southeast Asian people, particularly the practice and beliefs regarding the importance of avoiding cold drafts, cold drinks, particular foods, and bathing.

Special foods and herbs are used at this particular time because of their hot and cold properties. It is the Chinese belief that when

'Yin' is in excess, hot foods such as chicken broth and ginger should be given and cold foods such as fruits and vegetables should be avoided.

Herbs also can be used as food and as medicine. They are often used to balance the body and prevent illness (Chen-Louie, op. cit.). Brewed in soup, as well as cooked in meats, these preparations are used to increase energy and balance the 'hot' and 'cold' condition of the body according to the kinds of herbs.

The temperature of the environment is also considered to have an effect on the mother after delivery. After birth, therefore, mothers would be advised to stay at home, because it is dangerous to expose oneself to cold according to the Chinese principle of 'Yin' and 'Yang.' It is believed that postpartum convalescence consists of a 30 day period during which health practices for the mother are carefully directed toward decreasing the 'Yin' forces in her body. This is due to the belief that the pores of a new mother remain open for 30 days after her delivery. The open pores are easily subjected to the cold from outside. Accordingly, going outdoors or taking a shower are prohibited practices for the mothers.

However, postpartum confinement to bed and to the home is a practice apparently in flux (Wadd, op. cit.). This change may be related to the lack of family support in Western countries. Childbirth practices for Kampuchean mothers also include the use of heat, such as putting specially treated charcoal under the bed where mothers lie, or using hot materials to put on the mother's stomach. This procedure is

called 'roasting' or 'drying.' This is believed to restore her reproductive organs. It should be noted, too, that the heating method is also found in modern health practices. To reduce pain after delivery the nurse might give a hot waterbottle to put on the mother's stomach. This is to increase blood circulation in that area.

Breastfeeding, another aspect of child rearing practices, was found among the Kampuchean mothers in this study. However, there is a difference between the findings of this study and others (Wadd, op. cit.; Muecke, op. cit.). In Wadd's study, breastfeeding appears to be decreasing and bottle feeding seemed to be more preferable. This change is reported as relating to the working mother, and the influence from her sponsor. Muecke (op. cit.) also pointed out that most Southeast Asian refugees in the United States prefer to bottle-feed their infants because of its perceived convenience and conformity to American norms. Considering these reasons, the Kampuchean mothers in New Zealand may also be influenced by society here, as the rate of breastfeeding in New Zealand is increasing and quite high. In 1982, the breastfeeding rate was reported as 80% (Royal New Zealand Plunket Society, 1982). In addition, the status of these mothers as housewives and staying at home may be another reason that they can select to breastfeed their babies. And three is a very small number from which to generalize.

## F. CONCLUSION AND RECOMMENDATIONS

Although the findings of this study are limited by the small number, and limited age distribution of participants, the results provide some clues about the health practices and beliefs of the Kampuchean women. The findings show that the beliefs and practices related to health and illness of these three Kampuchean mothers in New Zealand have still been influenced by the principles arising from the Chinese "hot" (Yang) and "cold" (Yin) concepts, in particular in the area of childbearing practices. Some of these beliefs were still practiced, but some also had been abandoned. In addition, some indiginous practices and utilization of home remedies in healing were reported. "Coining" and the using of herbs or indiginous medicines were commented on most often. However, the participants in this study seemed to adjust very well to Western health care. They utilized Western medicine and respected and trusted the Western doctor. Utilizing Western health care, however, seem to be focussed on curative rather than preventive or promotive health. These recommendations are suggestions for nurses who are working with Kampuchean people both in the field and in the clinic.

1. It is obvious that there are differences between the Khmer and the Western views of the nature of health and illness and differences in their cultural values, beliefs and practices. In working with these people, health and illness should be assessed and treated with respect. However, the health beliefs and practices of these participants may be influenced by other factors, for example social, educational and political factors which should be taken into account. The nurse, thus,

should view illness and wellness of the Khmer in connection with what the latter believe and should not see illness as an isolated physical or psychological phenomenon. For example, nurses working in the maternity field should be aware of "hot" and "cold" concepts pertaining to childbearing. "Hot" foods should be predominant in the diet of Khmer childbearing women. By learning more about these nurses may be able to give more senstive and comprehensive nursing care, at the same time enjoying more significant and satisfying work.

2. The understanding, open and sympathetic consideration of folk beliefs is likely to help bridge the conflict and communication gap between health care providers, client and family thereby increasing trust. As trust is established, the individual and her family may be more open to the replacement of a potentially harmful folk practice by a medically validated one. As Kemp (1985) states "modern health care is highly regared by most Cambodians ...", and "problems related to modern health care are more often due to misunderstandings rather than lack of acceptance" (Kemp, 1985 p.43). If nurses can understand which beliefs and systems impede Khmer people obtaining care, it may be easier for them to plan and deliver health care that meets the need for these people.

3. A major problem for the Khmer adapting to Western society is that of communication. Not only cultural barriers but also language barriers compound the difficulty of adequately meeting the health needs of the Khmer people, especially the Khmer women. As a result of their more limited educational background and the fact that these women are housewives and are rarely exposed to the wider New Zealand society,

their English is less adequate than the Khmer men. Thus, it is very difficult for nurses to communicate with and understand these people. Familiarity with the language of the client is one of the best ways to gain insight into culture. Although knowing something of the client's language is important, it may not be possible for the nurse to learn the language of every client with whom they are working. In these circumstances trained bilingual interpreters may help both the nurse and the client to understand each other. However, some suggestions pointed to by Werner and Campbell (1970) may help to minimize the ambiguity of meaning whether speaking through an interpreter or directly with a patient with limited English. They are:

- using basic words and simple sentences, and using nouns rather than pronouns,
- paraphrasing words that carry much meaning (e.g. "workup") in order to be precise about the specific meaning intended,
- avoiding use of metaphors, colloquialisms, and idiomatic expression,
- learning and using basic words and sentences in the patient's language: this induces the patient to take greater care in making their use of language accurate,
- inviting correction of your understanding of the matter at hand.

4. Because many Indochinese refugees, including the participants in this study, come from rural areas of countries where health care systems are underdeveloped or very difficult to access, preventive health care may be unheard of. Health education is important with

these people. However, effective health education should be carefully planned. One of the most important things that needs to be recognised in planning health education programs is that the consumer beliefs must be respected and taken into account. In addition the common health related pamphlets (such as family planning, breastfeeding) should be published in Khmer and distributed to them.

5. This recommendation is directed towards Thai nurses who are working with refugees in Thailand, that is in the refugee camps. Tyhurst (1982) states that there are significant gaps in service, particularly at point of transit - from home to refugee camp, from refugee camp to the receiving country, from point of entry to designated places of residence in the new homeland. He suggests that to alleviate much turmoil for refugees the persons who are working at these various "stations" should use their experiences to formulate a general plan for help as a continuum (Tyhurst ibid.). In order that care for refugees moving from Thailand to New Zealand may be coordinated, there needs to be cooperation among nurses and other health care providers from both countries, New Zealand and Thailand. In the meantime, however, the nurses working in the refugee camps in Thailand need to learn and understand the culture and the way of life of the country that the refugees are going to. This will help them to plan care for refugees before they go to face their new situation. The nurses should understand the need to adjust their habitual ways of thinking and behaving and also gain insight into the meaning of the behaviour patterns and symbols that govern their own actions. Their accustomed ways of counselling and treatment may need to be adapted to the refugee situation.

6. Although this study has pointed out some of the health practices and beliefs of the Khmer, it still is not enough and further inquiry is suggested. This study indicates the importance of the following recommendations for replication or expanding the dimensions of the present research.

6.1 To continue further investigation of the health beliefs and practices of the Khmer, increasing the number of participants, including different sex, age groups, and different length of stay in New Zealand.

6.2 Studies should also be focussed on the way these refugee's perceptions of health and illness are changing.

6.3 Mental health problems and their perception should be studied.

# REFERENCES

Abdellah, F.G. and Levin, E. (1965). Better Patient Care Through Nursing Research. New York : Macmillan.

Ackroyd, S. and Hughes, J.A. (1981). Data Collection in Context. London and New York : Longman.

Ahmed, P.I; Kolker, A. and Coelho, G.V. (1979). Toward a New Definition of Health : An Overview In. P.I. Ahmed, & C.Y. Coelho, (eds.) Towards a New Definition of Health Psychosocial Dimensions. New York and London : Plenum Press.

Ahoy, C. and Jung, U. (1985). Community Health Nurses Working with Refugee Populations. In. E. Archer and R.P. Fleshman (eds.) Community Health Nursing (3rd edition). U.S.A.:Wadsworth Health Science Division.

Amarasingham, L.R. (1980). Social and Cultural Perspectives on Medication Refusal. American Journal of Psychiatry. 157:353-358.

Amiger; S.B. (1977). Ethics of Nursing Research : Profile, Principle, Perspective. Nursing Research. 6:330-336.

Aslam, M.; Davis, S; and Stockley, I. (1981). In the Best of Traditions? Nursing Mirror. 153:34-36.

Assadi, J. (1986). Khao I Dang (Khmer) Holding Center Ta Phraya District, Prachinburi Province. Bangkok: UNHCR.

Baca, J.E. (1969). "Some Health Beliefs of the Spanish Speaking." American Journal of Nursing. 69:2172-6.

Bauman, B. (1961). Diversities in Conceptions of Health & Physical Fitness. Journal of Health of Human Behavior. 2:39-46.

Benney, M. and Hughes, E.C. (1956). Of Sociology and Interview. American Journal of sociology. 62:137-42.

Binzegger, A. (1980). New Zealand's Policy on Refugees. Wellington:New Zealand Institute of International Affairs.

Blattner, B. (1981). Holistic Nursing. U.S.A.: Prentice-Hall.

Blum, F.H. (1970). Getting Individuals to Give Information to the Outsider. In. W.J. Telestead, (ed.) Qualitative methodology : First-hand Involvement with the Social World. Chicago : Markham. pp.83-90.

Boddy, J. and Nevatt, E. (1985). Self-Care in Health and Illness. In. J. Boddy (ed.) Health: Perspectives and Practices. Palmerston North; New Zealand : The Dunmore Press Ltd.

Bogdan, R. and Taylor, S. (1975). Introduction to Qualitative Research Methods. New York : John Wiley & Sons.

Boman, B. and Edwards, M. (1984). The Indochinese Refugee : An Overviews. Australian and New Zealand Journal of Psychiatry. 18:40-52.

Boyer-Chuanroong, L. (1984). Health Promotion in a Cambodian Refugee Camp: A Child-to-Child Approach Journal of School Health. 54:253-255.

Brallier, L. (1978). The Nurse as Holistic Health Practitioner, Expanding the Role again. Nursing Clinics of North America. 13:643-654.

Brick, J. and Louie, G. (1984). Language and Culture Kampuchea : Background Notes for Teachers in the Adult Migrant Education Program. Sydney : Department of Immigration and Ethnic Affair.

Brink, P. (1976). Transcultural Nursing : A Book of Readings. Englewood Cliffs, N.J. : Prentice Hall.

Brown, G. (1982). Issues in the Resettlement of Indochinese Refugees. Social Casework. 63:155-159.

Brown, I.C. (1963). Understanding other Cultures. Englewood Cliffs, New Jersey : Prentice-Hall.

Bruno, E. (1984). Acculturation Difficulties of the Khmer in New York City. New York : American Friends Services Committee.

Campbell, T. and Chang, B. (1973). Health care of the Chinese in America. Nursing Outlook. 21:245-249.

Chen-Louie, T. (1983). Nursing Care of Chinese American Patients. In. M.S. Orque, B. Bloch, and L.A. Monrroy (eds.). Ethnic Nursing Care. A Multicultural Approach. St. Louise : The C.V. Mosby.

Chrisman, N.J. (1977). The Health Seeking Process: An Approach to Natural History of Illness. Culture, Medicine and Psychiatry. 1:351-377.

Chung, N.J. (1977). Understanding the Oriental Maternity Patient. Nursing Clinics of North America. 12:67-75.

Clark, M. (1984). Community Nursing Health Care for Today and Tomorrow. Reston, Verginia : Reston.

Cohon, J.D. (1983). Southeast Asian Refugees and School Health Personnel. The Journal of School Health. February : 151-158.

Davitz, L.J., Sameshima, Y. and Davitz, J. (1976). Suffering as viewed in six different cultures. American Journal of Nursing. 76:1296-1297.

Demaine, H. and Leifer, M. (1986). Kampucha:Physical and Social Geography In. The Far East and Australaisia. (Seventeenth Edition). London:Europa Publications Limited.

Department of Statistics (1981). Census of Population and Dwellings Provisional Statistic Service. Wellington:Deparment of Statistics.

Department of Labour (1984). Acceptance of Refugees as Settlers in New Zealand, Wellington : Immigration Division, Department of Labour.

Department of Labour (1985). Refugees. (Leaflet No.23). Wellington : Immigration Division, Department of Labour.

Dobson, S. (1983). Bringing Culture into Care. Nursing Times. 79:53-57.

Dolfman, M.L. (1973). The Concept of Health : An Holistic & Analytic Examination. The Journal of School Health. 43:491-497.

Dooley, D. (1984). Social Research Methods. Englewood Cliffs : Prentice-Hall.

Dubos, R. (1965). Man Adapting. New Heaven, Conn.:Yale University Press.

Eisenberg, L. (1977). Disease and Illness. Culture, Medicine, and Psychiatry. 1:9-23.

Fabrega, H. (1975). The Scope of Ethnomedical Science. Science. 189:969-975.

Ferguson, E. (1982). Southeast Asian Health Care : A Cultural Guide. U.S.A:Indochinese Cultural and Service Centre.

Feldman, E.J. (1981). A Practical Guide to the Conduct of Field Research in the Social Sciences. Colorado : Westview Press.

Field, D. (1976). The Social Definition of illness. In. D. Tuckett, (ed.) An Introduction to Medical Sociology. London:Tavistock.

Field, P.A. and Morse, J.M. (1985). Nursing Research. The Application of Qualitative Approaches. London & Sydney : CROOM HELM.

Fillenbaum, G.G. (1979). Social Context of Self Assessments of Health Among the Elderly. Journal of Health and Social Behavior. 20:45-51.

Foster, G.M. (1976). Disease Aetiologies in Non-Western Medical Systems. American Anthropologist. 78:773-781.

Goldfield, N. and Lee, W. (1982). Caring for Indochinese Refugees. American Family Physician. 26:157-160.

Gore, S. (1978). The Effect of Social Support in Moderating the Health Consequences of Unemployment. Journal of Health of Social Behavior. 19:157-165.

Gordon, V.C; Matousek, I.M. and Lang, T.A. (1980). Southeast Asian Refugees : Life in America. American Journal of Nursing. 80:2031-2036.

Guba, E.G. and Lincoln J.S. (1981). Effective Evaluation. San Francisco : Jossey-Bass.

Hart, D.V. (1981). Bisiyan. Filipino and Malayan Folk Medicine. In. G. Henderson, and M. Primeaux, (eds.). Transcultural Health Care. Medical/Nursing Division, Menlo Park : Addison-Wesley pp.148-161.

Helman, C.G. (1978). "Feed a cold, starve a fever" - Folk Models of Infection in An English Suburban Community, and Their Relation to Medical Treatment. Culture, Medicine and Psychiatry. 2:107-137.

Henderson, G. and Primeaux, M. (1981). Transcultural Health care. Medical/Nursing Division. Menlo Park California : Addison-Wesley.

Herskovitz, M.J. (1955). Cultural Anthropology. New York : Alfred, A. Knopt, Inc.

Hoang, G.N.; Erickson, R.V. (1982). Guidelines for Providing Medical Care to Southeast Asian Refugees. Journal of the American medical Association. 248:710-714.

Hodgson, C. (1976). Transcultural Nursing. The Canadian Experience. The Canadian Nurse. 76:23-25.

Holck, S.E. and Cate, W. (1982). Fertility and Population Dynamics in Two Kampuchean Refugee Camps. Studies in Family Planning. 13:118-124.

Hornblow, J. (1986). Personal Communication.

Hiegel, J.P. (1980). The Role of Traditional Medicine in Relief Operations : Introduction to Khmer Traditional Based on Experience in Refugee Camp in Thailand. Bangkok:UNHCR.

Hiegel, J.P. (1981). The ICRC and Traditional Khmer Medicine. International Review of the Red Cross XXI. No. 224:251-262.

Hiegel, J.P. (1983). The Role in Mental Health Programs of Traditional Healers and Traditional Medicine Centers in Refugee Camps in Thailand. Presentation given at a UNHCR Seminar on Mental Health of Refugees. Manila July, 1983.

Hiegel, J.P. (1984). Collaboration with Traditional Healers:Experience in Refugees' Mental Care. International Journal of Mental Health. 12:30-43.

Kelman, S. (1975). The Social Nature of the Definition Problem in Health. International Journal of Health Services. 5:625-642.

Kemp, C. (1985). Cambodian Refugee Health Care Beliefs and Practices. Journal of Community Health Nursing 2:41-52.

Kinloch, P. (1980). Samaon Health Practices in Wellington. Department of Health Occassional Paper No 12. Wellington, New Zealand : Department of Health.

Kinloch, P. (1985). Talk Health But Doing Sickness. Studies in Samoan Health. Wellington [N.Z.]:Victoria University Press.

Kleinman, A.M. (1977). Depression, Somatization and the 'NEW Cross-Cultural Psychiatry' Social Science and Medicine. 11:3-10.

Kleinman, A., Eisenberg, L. and Good, B. (1978). Culture, Illness and Care. Annal International Medicine. 88:251-258.

Knutson, A.L. (1965). Individual, Society and Health Behavior. New York : Russell Sage Foundation.

Koshi, P.T. (1976). Cultural Diversity : The Nursing Curricula. Journal of Nursing Education. 15:14-21.

Krampitz, S.D. and Pavlovich, N. (1981). Readings for Nursing Research. St. Louis : The C.V. Mosby.

Krieger, D. (1981). Foundations for Holistic Health Nursing Practices : The Renaissance Nurse. Philadelphia : J.B. Lippincott.

Language and Orientation Resource Centre (1981). The People and Cultures of Cambodia, Laos, and Vietnam. Washington:Center for Applied Linguistic.

Leininger, M. (1967). The Culture Concept and Its Relevance to Nursing. The Journal of Nursing Education. 6:27-37.

Leininger, M. (1977). Cultural Diversities of Health and Nursing Care. Nursing Clinics of North America. 12:5-18.

Leininger, M. (1978). Transcultural Nursing : Concepts, Theories and Practices. New York : John Wiley & Sons.

Lewis, L.M. (1976). Social Anthropology in Perspective. Harmondsworth : Penguin Books.

Li, F.P., Schlief, N.Y., Chang, C.J., and Gaw, A.C. (1972). Health Care for the Chinese Community in Boston. American Journal of Public Health. 62:536-539.

Liev, M.H. and McLaren, M.C. (1983). Khmer Rufugees in the Waikato:Their Opinions. Research Paper, University of Waikato, Hamilton.

Lin, K.; Tazuma, L., and Masuda, M. (1979). Adaptational Problems of Vietnamese Refugees. I. Health and Mental Health Studies. Archive General Psychiatry. 36:955-961.

Mackay, P. (1985). The Health of Maori People. A Reviews. New Zealand : Northland Community College.

MacGregor, F.C. (1960). Social Science in Nursing. Applications for the Improvement of Patient Care. New York : Russell Sage Foundation.

MacGregor, F.C. (1967). Uncooperative Patients : Some Cultural Interpretations. American Journal of Nursing. 67:88-91.

MacRae, (1980). Indochinese Refugees in New Zealand:A Preliminary Study. The paper prepared for the Department of Anthropology, University of Auckland through the Student Community Service Programme.

Manderson, L., and Mathews, M. (1981). Vietnamese Attitudes Toward Maternal and Infant Health. medical Journal of Australia. 1:69-72.

McCabe, G.S. (1960). Culture Influences on Patient Behavior. American Journal of Nursing. 60:1101-1104.

Muecke, M.A. (1983). Caring for Southeast Asian Refugee Patients in the U.S.A. American Journal of Public Health. 73:431-438.

Munson, F.P. et al (1971). Area Handbook for Cambodia. Washington : Government Printing Office.

Nguyen, S.D. (1982). Psychiatric and Psychosomatic Problems among Southeast Asian Refugees. The Psychiatric Journal of the University of Ottawa. 7:163-172.

Nguyen ,S.D. (1984). Mental Health Services for Refugees and Immigrants. The Psychiatric Journal of the University of Ottawa. 9:85-91.

Nightingale, F. (1894). Health Teaching in Towns and Villages. Rural Hygiene. In. L.R. Seymer (ed.) (1974). Selected Writing of Florence Nightingale. New York : Macmillan.

Nuang, K. (1986). Personal Communication.

Oiler, C. (1981). The Phenomenological Approach in Nursing Research. Nursing Research. 31:178-181.

Orem, D.I. (1980). Nursing : Concepts of practices. New York : McGraw-Hill Book Co.

Orque, M.S. (1983). Nursing Care of South Vietnamese Patients. In. M.S. Orque, B. Bloch, and L.A. Monrroy, (eds.). Ethnic Nursing Care. A Multicultural Approach. St. Louis : The C.V. Mosby.

Parse, R.R., Coyne, A.B.; and Smyth, M.J. (1985). Nursing Research. Qualitative Methods. Bowie, Maryland : Brady.

Parsons, T. (1972). Definition of Health and Illness in the Light of American Values and Social Structure. In. E. Gartley Jaco, (ed.). Patients, Physicians and Illness. A Source Book In Behavioral Science & Health. (2nd edition) New York : The Free Press.

Paul, B. (1958). The Role of Beliefs and Customs in Sanitation Programmes. American Journal of Public Health. 48:1502-1506.

Primeaux, M.H. (1977). American Indian Health Care Practices. A Cross Cultural Perspective. Nursing Clinics of North America. 12:55-65.

Ros, T. (1983). Coining. Khmer-American Health. 1:1-2.

Royal New Zealand Plunket Society (1982). Statistics of New Baby Cases and Feeding Figures, New Zealand 1979-1982, Wellington.

Rutherford, D. and Thomas, P. (1981). The Case for Exploratory Fieldwork - Understanding the Adjustment of Vietnamese Refugees in the Washington Area. Anthropological Quarterly. 54:94-102.

Sampson, C. (1982). The Neglected Ethnic Cultural and Religious Factors in the Care of Patients. London : McGraw-Hill Book.

Sandelowski, M. (1986). The Problem of Rigor in Qualitative Research. Advances in Nursing Science. 8:27-37.

Schroeder, E. (1983). Concepts of Health and Illness. In. A.T. Culyer (ed.). Health Indictors. Oxford : Martin Robertson.

Schultz, S.L. (1982). How Southeast-Asian Refugees in California Adapt to Unfamiliar Health Care Practices. Health and Social Work. 7:148-1.

Schwartz, H. and Jacobs, J. (1979). Qualitative Sociology. New York : The Free Press.

Seaman, C.C.H. and Verhonick, P.J. (1982). Research Methods for Undergraduate Students in Nursing. New York : Appleton-Century-Crofts.

Shibutangi, T. (1955). Reference group as perspectives. American Journal of Sociology. 60:562-570.

Simmonds, S., Vaughan, P., and Gunn, S.W. (1983). Refugee Community Health Care. New York : Oxford University Press.

Skeet, M. (1981). Traditional Medicine. Nursing Times. 77:583-588.

Spector, R.E. (1985). Health and Illness in the White Ethnic Communities In. R.E. Spector, (ed.). Cultural Diversity in Health and Illness. (2nd ed.) Norwalk, Connecticut : Appleton-Century-Crofts.

Spradley, J.P. (1979). The Ethnographic Interview. New York : Holt, Rinehart and Winston.

Steinberg, D.J. (1959). Cambodia : Its people, Its society Its Culture. New Haven:H and of Press.

Tripp-Reimer, T. (1984). Research in Cultural Diversity Western Journal of Nursing Research. 6:130-132.

Tung, T.M. (1980). Indochinese Patients : Cultural Aspects of the Medical and Psychiatric Care of Indochinese Refugees. U.S.A: Action for South East Asians, Inc.

Twaddle, A. and Hessler, R.M. (1977). A Sociology of Health. St. Louis : Mosby.

Tyhurst, L. (1982). Coping with Refugees. A Canadian Experience : 1948-1981. The International Journal of Social Psychiatry.

UNHCR (1986). Refugees and Displaced Persons from Indo-China. (Leaflet).

United Nations High Commissioner for Refugees (1986). UNHCR. Activities in Thailand. Information Office. (Leaflet July 1986).

Van der Westhuizen, M. (1980). Kampuchean Refugees - an Encounter with Grief. The Australian Nurses Journal. 10:53.

Verma, G.K. (1983). Intercultural Counselling : British Perspectives In. R.J. Samuda, and A. Wolfgang, (eds.) Intercultural Counselling and Assessment Global Perspectives. New York : C.J. Hogaife, Inc.

Vignes, J. and Hall, R.C.W. (1979). Adjustment of a Groups of Vietnamese People to the United States. American Journal of Psychiatry. 136:442-444.

Wandelt, M. (1970). A Guide for the Researcher. New York : Appleton-Century-Crofts.

Wadd, L. (1983). Vietnamese Postpartum Practice. Journal of Obstetric Gynecologic and Neonatal Nursing. 12:252-258.

Werner, O. and Campbell, D.T. (1970). Translating Working Through Interpreter and the Problem of Decentering. In. R. Naroll and R. Cohen (eds.). A Handbook of Method in Cultural Anthropology. New York : Columbia University Press.

Westermeyer, J. and Mintrob, R. (1979). "Folk" Criteria for the Diagnosis of Mental Illness in Rural Laos : On Being Insane in Sane Places. American Journal of Psychiatry. 136:755-761.

WHO (1947). Constitution of the World Health Organization. Chronicles of WHO. 1:1-2.

Wiley, C.M. (1970). The Definition and Measurement of Health and Disease. Public Health Reports. 85:100-104.

Wilson, H.S. (1985). Research in Nursing. Menlo Park, California : Addison-Wesley.

Winstead-Fry, P. (1980). The Scientific Method and Its Impact on Holistic Health. Advances in Nursing Science. 2:271-279.

Yin, R.K. (1984). Case Study Research. Design and Methods. London : SAGE Publications.