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

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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.

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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

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* 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.