Characterizing the healthcare experiences of Karen migrants to Middle Tennessee

by
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Abstract

The Karen are a collection of ethnic groups from the mountainous regions of eastern Burma and Thailand. As a result of the ongoing civil war, persecution, and extensive human rights violations happening in Burma, many Karen flee the country as refugees, and some of them have been resettled in Middle Tennessee where they form a tight-knit community. Patients from diverse backgrounds may have unique experiences with their health and receiving healthcare. This qualitative interview study seeks to explore the resources being utilized by the Karen community in Middle Tennessee, any needs they may feel, and any other aspects or unique experiences relevant to the health and healthcare of Karen people. Interviews conducted with individuals who identify as Karen and have received healthcare in Middle Tennessee and providers who have treated Karen patients revealed that: Karen patients benefit from social supports such as caregivers and Karen-English interpreters; communication is a major challenge for patients and providers; and Karen patients may benefit from extra patience and support from their providers and culturally-sensitive health education, particularly when it comes to managing chronic health conditions.

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I. Introduction

Have you ever heard of the Karen people? No, not Korean people. Over recent decades, Middle Tennessee has become home to an increasingly diverse profile of people with respect to their culture and backgrounds. The Karen are one of the groups who have come to settle and form community in Middle Tennessee. Migrants to the United States from other cultures, including those who come as refugees, likely bring with them beliefs and life experiences that influence how they experience their life in America. These differences may have implications for the health of people like the Karen as they receive treatment as patients. Thus, it is important to learn about this community and identify and share any aspects to their experiences that are relevant to healthcare providers in managing the health of this patient population.

II. Background/Literature Review

Who are the Karen?

The Karen (pronounced Kah-Ren, with emphasis placed on “Ren”) are an ethnic group hailing from the forested and mountainous regions of eastern Burma, or also called Myanmar by some people, and live primarily in the Burmese-designated Kayin and Kayah states. Karen traditionally live as rice farmers in village communities (Neiman, Soh, & Sutan 2008). Though the Karen is described as a singular ethnic group, it can also be considered an umbrella term for a diverse class of subgroups with their own language, cultural, and political differences. The primary languages spoken by Karen people are S’kaw Karen, Eastern Pwo Karen, and Western Pwo Karen, with S’kaw Karen being the *lingua franca* (the common language) for those from communities where Pwo Karen is dominant (Neiman, Soh, & Sutan 2008). Karen people profess various faiths, including animism, Buddhism, and Christianity. (Neiman, Soh, & Sutan 2008).

Figure 1. Administrative Map of Burma from 2007. Public domain image shared on Maps-of-the-World.net.

History of the Karen

During the years 1824 to 1948, the land area now called Burma or Myanmar was ruled under the British Empire. When the British ended colonial rule in 1949, after the Second World War, they had promised to consider the interests of the over 100 distinct ethnic groups or nationalities residing in Burma. However, the British left and the push for sovereignty by the Karen and other groups were ignored. Tensions quickly erupted between the Burmans and the Karen, and militarized groups like the Karen National Union (abbreviated KNU) have been engaged in bloody conflict since (Neiman, Soh, & Sutan 2008). To this day, the military junta's forces in Burma frequently attack and burn Karen villages, driving villagers into the jungle where they face malnutrition and malaria. It is not uncommon for women to have been raped, and there are stories of Karen people being used as human landmine detectors (Chance & Guyer-Stevens 2025). It is important to note that not all Karen people associate with military groups, either in-support-of or against the Burmese government, yet that has not stopped them from becoming victims of war.

In 1984, the first major wave of Karen refugees crossed the Burma-Thailand border, fleeing oppression, and settled in temporary shelters run with the cooperation of the Royal Thai Government, Bangkok-based agencies, and international aid organizations (The Border Consortium 2020). Today, over 100,000 refugees can be found living in these camps, with 81% of them identifying as Karen (The Border Consortium 2025). Karen people living in Thai refugee camps have little social mobility or opportunities to plan for their future. The Thai government does not provide a path to citizenship, and Karen refugees cannot legally work in Thailand, making it hard to contribute to the economy or benefit from commerce. The camps are still growing in population and face issues like overcrowding, underfunding, and inefficient management (Settles 2025).

Karen Settlement in the United States of America and Tennessee

Growing communities of Karen people have formed throughout the country including in the states Minnesota, New York, and Tennessee (Karen Organization of Minnesota, (n.d.); Karen Community of Tennessee, (n.d.); Utica Karen Community, (n.d.)). Conversations with members of the local Karen community revealed that the first large wave of migrants came to Middle Tennessee in 2007 as resettled refugees (T.B, personal communication, September 21, 2024). The Catholic Charities of Nashville was responsible for resettling the Karen in Middle Tennessee and helping with the initial transition, but because the Karen were placed outside of Nashville, mostly in Smyrna, TN, the Karen leaned on the assistance of local churches and their own community to adjust to life in America (Chaney & Olson, 2025). Today there are estimated to be between five and fifteen hundred Karen people living in Tennessee, but those numbers could be even higher due to secondary migration from other US states to Tennessee. It is thought that most of the Karen speak S’kaw Karen and were resettled in the USA from the Mae La refugee camp in Thailand.

The local community is ever-growing as people lay down roots and have children, and friends and family continue to migrate to Tennessee from Thailand, Myanmar, and other parts of the United States. Certain individuals within the community have stepped into leadership roles by volunteering to organize cultural events like summer language school for the children, helping other members to access services like TennCare, and more (T.B. & P.D., personal communication, September 21, 2024). As the younger generation has been maturing here in Tennessee, an increasing percentage of the Karen are fluent in English and many have begun to occupy roles within the larger local community as college students and law enforcement officers, for example (T.B., personal communication, September 21, 2024).

Asian Immigrant and Refugee Healthcare Research

A review of health research with refugees in the United States from throughout Southeast Asia found that compared to the whole U.S. population, mental and physical health are generally worse among this group (Bang, Huang, Kuo, Cho, & Garcia 2023). The same review found that common physical problems among these patients are hypertension, high cholesterol, bone and muscle problems, and pain, while PTSD and depression are the most common mental health problems (Bang, Huang, Kuo, Cho, & Garcia 2023). Asian Americans may be experiencing barriers to healthcare including lack of insurance or financial security, language and literacy gaps, and a broad range of cultural attitudes toward medicine that deviate from the western view (Lee et al., 2010).

For example, many Asian Americans utilize alternative or traditional practices like herbal treatments or acupuncture, either in substitution of or addition to western medical treatment (Lee et al., 2010; Hsiao et al., 2006).

Karen Healthcare Research

Among the health literature, there were some, but not many, studies conducted with Karen patients in the United States. In one study, researchers interviewed 21 Karen adults between the ages of 20-71 to report any needs the community felt related to their health and wellness and found that while interviewees found great support in forming a social network and community among other Karen people, interviewees face barriers like language and education that make it difficult to secure work. Even among those Karen who were working, they reported lack of financial resources as a barrier to care. Inability to pay combined with not enough guidance for navigating the health care system may lead Karen people to avoid seeking preventive health care and regular checkups. (Theitsche, Mitschke, Slater, & Teboh 2011).

In another study, providers in Minnesota reviewed the charts of Karen patients at a family medicine clinic and analyzed data collected by the Minnesota Department of Health. Providers observed language as a major issue, confusion about differences in naming between Karen and American culture, and varying beliefs about medicine. Most Karen were exposed to some degree of Western medicine form their time in Thai refugee camps and thus seem to be open to receiving Western medicine. Additionally, some

Karen people may practice herbalism or traditional healing traditions. Authors also noted "poor compliance with medications or limited insight into their condition." A common practice that providers may or may not be aware of is the chewing of betel nut, which can leave teeth and gums stained and increase risk for oral and pharyngeal cancers (Vermont Department of Health 2014). Researchers found that Karen patients may have trouble understanding the management of their chronic conditions like hypertension, diabetes, or gout, and struggle with the idea of taking medicine. Lastly, they observed that patients may be facing mental health struggles but are reluctant to share about them or seek help. (Power, Moody, Trussell, et al. 2010).

One interview study with Karen people from three US cities with the largest Burmese populations (they are Fort Wayne, IN, Buffalo, NY, and Amarillo, TX) focused on Karen refugees' use of traditional medicine after migrating to the USA and their views on western and traditional medicine and obstacles to healthcare they are facing. Researchers found that participants had positive attitudes toward western medicine and their treatment by American providers despite experiencing frustrations related to communication and a language barrier. Seventy-seven percent of respondents primarily relied on traditional and herbal forms of medicine before moving to the USA while only fifteen percent of respondents maintained the traditional medical practices while living in the USA. Some respondents quit using traditional medicine because they were concerned how doctors or other Americans would respond, and others did so because the medicinal resources they used back in Burma and Thailand are less accessible here in the USA. Respondents also noticed a correlation between nutrition and their health. Fifteen of thirty-nine interviewees were confused or dissatisfied with their access to health insurance, reporting issues such as affordability, unclear coverage, confusion over treatment costs, and lack of support in obtaining insurance (Wodniak 2018).

In the final interview study I read, researchers conducted in-depth interviews with Karen women, their doulas or interpreters, informants within the Karen community, and medical providers to characterize their perspectives on perinatal care. In the context of this study, which was perinatal care for Karen women in Buffalo, NY, Karen women expressed that they are grateful for and understood the care they received. However, conversations with their doulas revealed that there may be more to the story. Karen women may seem agreeable despite having concerns because of low self-efficacy, past trauma, or cultural expectations. Doulas form a relation with the patient and mediate communication between patients and providers. Karen women could express questions and concerns to their doulas that they may not be inclined to share with their providers (LaMancuso, Goldman, & Nothnagle 2016).

To my knowledge, there is no literature discussing the health or healthcare experiences of Karen people living in Middle Tennessee. It is not yet clear if Karen patients in Tennessee face the same boundaries or feel the same needs as Karen in other communities throughout the United States. We also do not know how much support is available to and being utilized by Karen patients in Middle Tennessee, or what providers have observed while treating this population. This work seeks to address all these gaps in the literature and provide an overview for people who are curious to learn about the Karen people and for providers who are treating patients from this population.

Research Questions

The questions posed by myself, the primary investigator, to guide this investigation included:

- What resources are currently being utilized by Karen people, and what needs, if any, are left unmet?
- What other aspects are affecting the health and healthcare experiences of Karen people?
- What is unique about the patient experiences of Karen immigrants?

III. Methodology

This study was approved by Middle Tennessee State University's Institutional Review Board (protocol no. FY2025-75; see Appendix C).

Recruitment.

To familiarize myself with the Karen community and establish a network of people to recruit for interviews, I contacted community members on Facebook, attended cultural gatherings like a potluck style fundraiser at the park and the Karen New Year celebration, and joined a local church that many Karen people attend. After receiving IRB approval, I messaged individuals I knew through Facebook and requested an interview. The only requirements were that participants were at least 18 years of age and have conversational ability in English.

After the first two interviews and a lull in recruitment, we realized that more perspectives needed to be heard to have a full picture of the patient experience for Karen people. We decided to recruit and interview healthcare providers who have worked with patients from the Karen community. I visited local family practices and asked if they have worked with anyone who is Karen, and if they said yes, I requested an interview. One Karen interviewee mentioned the name of the clinic that they go to, so I visited this clinic with their permission and requested an interview with one of its providers.

Participants

A total of ten (n = 10) participants from suburban and urban parts of Middle Tennessee were involved in eight interviews. Every participant was arbitrarily assigned a pseudonym to respect their privacy while maintaining a human connection to the quotes. The pseudonyms chosen are not necessarily culturally accurate, especially since I am not familiar with many Karen names. Four individual interviews were conducted with Karen people who received healthcare services: we will call them Taylor, Lola, Opal, and Malee. All of them are women between the ages of 22 and 56 who identify as Karen, are from a refugee background, and attend a Christian church. Taylor and Lola have been in Tennessee since elementary school and are fluent in English and proficient in Karen (I did not ask them to specify whether they speak S’kaw or Pwo Karen) while Opal and Malee came to the USA as adults and have a less advanced English proficiency. Three out of four of the women are seeing a primary care provider on a regular basis. Taylor has been working as a registered nurse for the past year, and Lola is obtaining a Master’s degree as she prepares for medical school. Opal and Malee are both mothers who are working part-time jobs.

One interview was conducted with both a family care provider, Janelle, and a Karen woman, Kim, who works at the clinic as an interpreter and home health caretaker. Janelle’s practice sees a primarily geriatric Karen population. Kim is known by many throughout the local Karen community for helping others to prepare for the U.S. citizenship exam, visit the doctor, pay bills, and more. Another interview was conducted with two staff members at Janelle’s clinic, Rachel and Joseph, who have experience with the Karen patients who come into the clinic. Rachel helps to see the clinic’s operations, outreach, and organization. Joseph works as a project manager for the clinic’s expanding home care services, oversees business aspects of running the clinic, and has helped Karen patients and their family prepare their taxes for the latest fiscal year.

Two more interviews were conducted individually with providers at family clinics. Fiona practices at a family medical clinic that caters to Lao, Thai, and other minority populations which consistently includes the Karen. Monica practices at a family clinic that has received and treated people from the Karen community since they first settled in the area. The clinic also sees patients from several other refugee and immigrant populations. All providers who were interviewed said that they see both new and returning Karen patients.

Interviews.

Following IRB approval in late January 2025, interviews were conducted through the months of February and March 2025. They were conducted in a public setting like a coffee shop or in the participant’s home. Semi-structured interviews followed a script of questions tied to the study’s research questions, with different questions directed to Karen individuals and to providers (see Appendices A and B). Interviews did not strictly follow these scripts, and additional questions not listed in the appendices were asked when a response warranted further exploration. Before each interview began, participants were detailed on the nature of the study and asked to fill out an informed consent and for their permission to record the interview. They were informed that their real names would not be revealed and that recordings would be deleted after a transcript was created. The shortest interview was with a provider and took only five minutes while the longest interview continued for about an hour. Recordings were manually transcribed into a word document.

Analysis.

Interview transcripts were analyzed by inductive thematic analysis. Over multiple readings of each interview, I identified as many ideas as possible that were relevant to the study's research questions and noted anything else relevant to Karen people's experiences that came up in these conversations. Then, I organized themes and their representative quotes from all interviews into one Excel spreadsheet. One goal of this qualitative work is to find information relevant to the research questions that can be extrapolated to Karen people living in and receiving healthcare in Middle Tennessee. As a condition for extrapolation, special attention was paid to findings that appeared in the literature review as well as in interviews with Karen participants and their providers, a strategy known as triangulation (for example, a communication barrier was mentioned in literature on Karen and other Asian immigrant/refugee populations, and also in many of these interviews, so I can confidently extrapolate that this is a widely experienced problem among the Karen community in Middle Tennessee). It was not determined whether further interviews would reveal new themes. Some themes appeared in one or two interviews but were not explored in other interviews, and these findings were shared, too. Therefore, in the following section, I intend to share my findings generously and indiscriminately as they relate to healthcare and Karen people's experiences.

IV. Findings

Perspectives on Healthcare and Resource Access

When asked about community support, resources that they benefitted from, and other aspects of their healthcare experiences that they appreciated, Karen participants had the following to share. Kim is a leader in her community who works with one clinic as a home health caregiver and an interpreter for other Karen people. Kim noted patience as a strength of Janelle, the clinic's provider, and she shared about her own experience as a patient.

"She has patience a lot. Sometimes we cannot communicate. Even some caregivers speak little English, she is still patience a lot." – Kim (32 y.o. Karen participant; community leader, interpreter, and home health caregiver)

"In Tennessee, perfect. I don't have any problem. I don't see any problem. Even when I went to be a patient by myself and had a C-section, the nurses [were] so sweet. They clean and do their job so good." – Kim (32 y.o. Karen participant)

Malee and Lola, two other Karen participants, appreciated the increased availability of resources and comprehensiveness of physical exams in Tennessee compared to her experience back in Thailand.

“You go to the hospital, they check in, they x-ray. They check everything they see. My doctor, too, one year they check everything. Go to eyes, ears, about the stomach, the x-ray, everything. It's very good.” – Malee (56 y.o. Karen participant; mother, grandmother, part-time worker)

“Over there in Thailand…because in my country, the Mae La camp doesn't have the x-ray. They only take out the blood, check the blood sugar, for malaria, typhoid, stuff like that. About the other ones, like the liver, the kidney, about those ones, they send [you] to another hospital. Need to go driving in the car maybe four or five hours.” – Malee (56 y.o. Karen participant)

“I had a cousin who was disabled. It was when I first came to America, as a young kid. She got sick and they had to take her to the hospital in Mae Sot, or a bigger hospital than what they had in the camp. And I guess that compared with the American system, there weren't a lot of available resources, you know?” – Lola (22 y.o. Karen participant; pre-med Master’s student)

For some Karen people, belonging to a faith community may be a valuable resource. Participants mentioned receiving support from, or giving support to, other members of their church at some point. The church can also provide a space for Karen people to regularly gather, and to hold classes and special events or meetings.

"Since I grew up in the church, I was able to get closer to the Karen community. I feel like most of my Karen community is because of the church. I get to see them every week and they know who I am. Everyone knows everybody, and everybody tries to help everybody out as much as they can or are able to." – Taylor (22 y.o. Karen participant)

"I help my church members sometimes because some people can't drive, and [I'll] take them to the doctor…" – Opal (33 y.o. Karen participant; mother and part-time worker)

Community- and family-based support are arguably the most important resources being utilized by Karen people in receiving healthcare and managing their health. Karen people, especially those who are bilingual in S'kaw Karen and English, often find themselves stepping into multifaceted roles serving as transportation to doctor's appointments, interpreters, educators, and/or health advocates. This role, along with other observations and resources related to communication will be explored deeper at a later point in the findings section.

The extent to which public/governmental services are currently providing support to the community, or have in the past, did not come up in these interviews. Monica, one of the family care providers, shared an anecdote from early in her time treating the Karen as patients. When a Karen teenager presented with tuberculosis, the health department became involved. Monica urged the health department officials to contact an interpreter who served as a student liaison and who would be able to help approach the situation and the families involved. To Monica's disappointment, the health department never contacted this individual, suggesting that government services have failed to protect the Karen community's interests in the past.

Lack of financial resources was not noted by any Karen participants or providers as a problem. On the other hand, providers said about their Karen patients' ability to pay:

"Most of the patients have insurance, at least that sector of the population that come in sometimes…" – Monica (provider)

"They are willing to pay for whatever treatment you give them. You know, whatever you recommend, they're willing to follow. A lot of them have insurance either through work or through the state or just straight cash." – Fiona (provider)

In other instances, Karen patients may struggle to identify or access the proper healthcare resources. Lola shared the story of a community member who has been dealing with urinary tract bleeding and intense pains on-and-off for the past year. The diagnosis she received was a urinary tract infection (UTI), but multiple emergency room visits and antibiotic treatment have not eliminated the problem.

"I heard where a parent of a friend, this past year, she went to the emergency room for a UTI and nobody knows what is going on. And then she is just dealing with the pain. And sometimes…they don't know what resources there are. Because the emergency room or maybe just your regular doctor might not be able to [treat you]." – Lola (22 y.o. Karen participant)

Sources of Health Information

When they were asked where they learn information about their health, or where they go when they have a question about their body or a medication, younger Karen participants answered differently than the more mature participants:

"For my health, Dr. Google… The first things that pops up, it shows the medications, diagnoses, [symptoms]…" – Taylor (22 y.o. Karen participant)

"Well, the internet. And also my friends and other people. I feel like I'm a lot more informed when it comes to like, the health system because of being a pre-med." – Lola (22 y.o. Karen participant)

Taylor and Lola, the younger participants in this sample, preferred an Internet search to answer their burning health questions. Their health sciences background no doubt informs them, too. Opal and Malee, on the other hand, would rather ask their doctor directly.

"I asked the doctor, this, like he gave me medicine, right. About this medicine, he told me this is for the gastric, the stomach hurt. And then before you eat the food, take the medicine and wait thirty minutes and eat." – Malee (56 y.o. Karen participant)

That being said, Karen adults and youth alike are utilizing their social networks to share health information. Lola, who herself said she learns from her friends, shared this observation about older members in her community:

"For the older people, definitely from Facebook. And whatever they hear. Sometimes it is true and sometimes it's not true." – Lola (22 y.o. Karen participant, pre-med student)

Internet searches, online and physical social networks, and doctors were mentioned as sources of health information. Other sources may be utilized that did not come up in interviews. No specific websites or community members were pointed out as sources.

Though it was not extensively discussed in these interviews, traditional medicine practices are also shared among community members. Taylor had the most to say about traditional medicine. She shared one treatment that was passed down from elders and then shared throughout her community here in Tennessee:

"I think the most recent [experience with herbal medicine] was during COVID. A lot of people would boil lemongrass, ginger, turmeric, and lemon. Once it is starting to cook, you set the pot on the ground and sit by it, then cover yourself with a pot so you inhale that steam. They were like, this is how you get rid of COVID. It helped, I guess... I don't know if it made a difference or if it was just timing, but a lot of us were doing that because we were telling each other. I think for other respiratory problems, they do that, too. Not just for COVID. But that was my first time being exposed to it... They said they used to do that back in the village." – Taylor (22 y.o. Karen participant, registered nurse)

In her experience, though, Taylor revealed that not all the traditional or home remedies she has tried were effective:

*"And then my dad, when I was dizzy, he made—you know mums, the flower? The leaves smell really strong. The wild ones, not the ones you would find in Home Depot. He would take the leaves and smash them up, put them in a cloth, and made me smell it so that my dizziness would go away." (*Interviewer: *"Did it work?") "No, it made me more dizzy! I was like, Dad, this is not working. He said, 'It works for me.'"* – Taylor (22 y.o. Karen participant, registered nurse)

Taylor also had something to say about general American and some Karen people’s attitudes toward practicing traditional or herbal medicine:

“[Americans] also don't believe in natural remedies. Other cultures believe in those things. I know Karen people, they definitely do. My mom is like, ‘I don't want to take these medications.’ They mix something in drinks to make their blood pressure or sugar go down. At least, they believe it. Her blood pressure is still bad, but she started last month.” – Taylor (22 y.o. Karen participant, registered nurse)

In the quote, Taylor describes her perception that broadly, Americans are not accepting of “natural remedies” that are widely accepted by Karen and other cultures. However, she cannot speak to its effectiveness, at least in the case of her mother’s remedies taken to lower blood pressure.

Communication between Patient and Provider.

In every one of the interviews with Karen participants and providers, the subject of communication was discussed. Because a large portion of the Karen population are not fluent in English, and particularly those who are older and more likely to be patients, language forms a significant barrier to care.

“Language is definitely the number one [challenge].” – Fiona (provider)

In some cases, a telephone interpreter is provided. Depending on the setting, interpreters may be offered in all cases, upon request, or when a major procedure like a surgery is being discussed.

“When we need [a translator] we ask them. They call a translator for us. Like when we have to do a surgery, big stuff like that, they call a translator for us. But when you see, like, every three months, just a normal checkup, they don't call. Trust me.” – Opal (33 y.o. Karen participant)

“If you go to the clinic, they will call a translator on the phone if they don't have a provider that can communicate…They have Burmese, they have Thai [and Karen], they have any.” – Kim (32 y.o. Karen participant)

“So, the doctor asks me when I go, right, 'Do you need the interpreter to translate?' I say yes and then they call for me. Not too long, maybe one minute or two minutes and we are talking.”- Malee (56 y.o. Karen participant)

“When all else fails, there's an app where you communicate and it's interpreting. But it's not very good. We usually try to make sure someone is here because things get lost in communication.” – Monica (provider)

These quotes suggest that translation services are available and easily accessed by patients, at least at the places where these participants have been treated. Monica showed a preference for physically present interpreters over using a phone application to communicate with her Karen patients. Telephone translation services have been offered in the Karen language. Thai and Burmese telephone translation is also offered, languages which some Karen may speak. Fiona, one of the providers interviewed, shared how her clinic has a unique resource in that its staff can speak Thai and thus have another means of navigating the language barrier:

"Some of them speak Thai, so we are able to communicate with them because most of them speak Thai. But a lot of them don't so they communicate through a translator. They will bring someone, family, friend, or someone." – Fiona (provider)

"It is hard for us to communicate with them if they don't speak at least English or Thai. Broken English is fine, we are able to navigate that, but a lot of them don't even speak broken English." – Fiona (provider)

Karen who cannot speak English may rely on their children, other family members, or people within the wider community to serve as interpreters during their visits to the doctor.

“We usually use, if [the patient]'s an adult, their children often will interpret whether that's an adult child or grade school age. On occasion there are other family members who come or there's a couple other people within the community that have been coming here as an interpreter for a while” – Monica (provider)

It was encouraging to find that at least one clinic in Middle Tennessee, Janelle’s family practice, has an interpreter on staff to mediate interactions with Karen patients. Kim, who was interviewed for this study, works at Janelle’s clinic and is readily available to translate:

“...usually they have someone with them, but [Kim] always helps translate. So, she is definitely always in the room. Because the caregivers may only have a little understanding of English. So [Kim] helps them to understand better, helps them answer the questions better.” – Janelle (provider)

Interpreters often find themselves doing more than simply translating between patient and doctor. As Lola shared, they also help their family or community to navigate the healthcare system:

“Usually, I take my family like my aunt and then I usually fill out forms, like explaining to them what the form is for and then like, talking to the person at the front desk what they are there for. And translating for them… I am translating what the doctor is saying to

them or what they want to get [from] seeing the doctor." – Lola (22 y.o. Karen participant)

Further, interpreters are faced with a linguistic roadblock. Beyond the consideration that people assuming the role of interpreter may not be fully fluent in Karen themselves, the Karen language may lack the vocabulary to describe medical terminology:

"It is challenging whenever I don't know how to translate it to them in Karen. Because my vocab in Karen is very limited." – Lola (22 y.o. Karen participant)

"I try to help people by taking them to their appointments when I can because they do not know much about medical terminology and diagnoses. So, I am grateful that I was able to go to school, go into nursing, and now become a nurse because I feel like I have more knowledge and can be more reliable... Most of the time I am there to be a translator, and also because there are a lot of words in English that are not a thing in Karen." – Taylor (22 y.o. Karen participant)

While Taylor felt that her background in nursing helps her to be a reliable support for her community members, there are children, teens, and adults who help as translators but are not as knowledgeable about medical terms. The lack of direct translation for many words hints at a general unfamiliarity with diagnoses and medical language, at least the language used in western medicine. Our conversations did not explicitly reveal whether vocabulary is related to Karen people's ability to express themselves to providers, directly or through an interpreter. The interviews did reveal, though, that there are gaps in some patients' understanding of their conditions or treatment, and this could be related to the challenge of explaining new concepts to patients which cannot be translated directly into Karen. Lola spoke about the experiences of people within her community who have had trouble with understanding about their health:

"This year, [my cousin] has had to go to the doctor a lot because of her daughter. And then, she knows the basic English. But when it comes to medical terms, understanding the medical conditions that her daughter has, she struggles to understand that. And sometimes she doesn't really have anybody else to understand what exactly is going on." – Lola (22 y.o. Karen participant)

"With surgery and everything, sometimes you go to the doctor and they are like 'You need this surgery,' and [Karen patients] don't get a full understanding of what exactly the surgery is and stuff like that. And then they get scared of 'should I do it or not do it?' And then sometimes that prevents them from getting treatment." – Lola (22 y.o. Karen participant)

Some Karen patients may feel unsupported or lost among all the information they are receiving during their doctor's appointments. In some cases, like Lola's example of patients who are recommended for surgery, lack of understanding can lead to a reluctance to receive treatment. Lola had some advice for providers while talking with patients whose first language is not English, emphasizing the need to meet them at their level of comprehension:

"When communicating, especially with someone who doesn't speak English, be as simple as, you know, explaining it in a way where they can try to understand it." – Lola (22 y.o. Karen participant)

In contrast to the story of Lola's aunt and her daughter struggling to understand during appointments, Taylor shared an example that shows how having someone who is able to ask questions can help with this problem:

"When I take that aunt to the doctor, she prefers me take her because I would ask a lot of questions. She has kids that know English, but she is like, they are too shy or they don't know what to ask... When I go, she feels better because she gets her questions answered." – Taylor (22 y.o. Karen participant)

Her quote also reveals that children of Karen patients, while having the valuable skill of being bilingual, may not be the ideal choice in every situation for representing or interpreting for a patient. According to Taylor, due to generational differences in Karen and English language proficiencies, there is a limited range of individuals who have dual language proficiency to fulfill the interpreter role:

"It is a little complicated because basically the age after me and maybe like 10 years above me is the age where they both know Karen and English. But the ones after me, they don't really know Karen anymore, so it is hard for them to translate for their parents. And then the ones above that, they don't know English at all, so they don't know how to translate. So there is this age gap where there are a few of us that know both [languages]." – Taylor (22 y.o. Karen participant)

Taylor expanded on the decline in Karen speaking ability among younger members of the population, raising the question of what it could mean to the future of the Karen community:

"That's probably going to be a future problem. Especially here, because there is no Karen school. There is a summer class for little kids. They are little kids, they learn it and their parents make them go, but if they don't use it every day, they just kind of forget." – Taylor (22 y.o. Karen participant)

Chronic Disease Management and Other Considerations for Karen Patients' Health

When asked about their observations from treating the Karen patient population, providers noted a few chronic conditions that they have seen most prevalently. Primarily, these were diabetes/blood sugar management, high blood pressure, and gastrointestinal issues. Each of the Karen participants revealed that they either dealt with one of these conditions themselves, or someone they know is dealing with one of these conditions.

"Cholesterol, blood pressure, gout. And a lot of gastro[intestinal] issues. Aches and pain. Joint pain. We have seen a lot of them with back pain." – Fiona (provider)

“About my stomach hurt. The gastro disease.” – Malee (56 y.o. Karen participant)

“I have, what do they say, blood pressure a little bit. Diabetes a little bit. Not so high. The doctor doesn’t give me medicine yet.” – Malee (56 y.o. Karen participant)

“I have to go see [the doctor] every three months. I have high blood pressure and diabetes.” – Opal (33 y.o. Karen participant)

Providers tend to suggest dietary changes to remediate problems like high blood pressure and diabetes, and for some patients, this works.

“When we go to see the doctor because we have our high blood pressure…she tells us what we have to eat, like eat more vegetables and drink more water.” – Opal (33 y.o. Karen participant)

“[The doctor] tells me to exercise, don't eat fast food, and I follow the doctor. It's better. It works.” – Malee (56 y.o. Karen participant)

For other Karen patients, it is more difficult for them to change the eating habits and types of food they are familiar with.

“My mom, she loves her rice. That plays a big role in blood sugar, and [Karen people] don't know that. They think it's not sweet, it's rice. But it has gluten in it. And they eat so much and don't have extra activity to burn it out.” – Taylor (22 y.o. Karen participant)

“[My mom] doesn't do the things that doctors tell her like have a low carb diet because her blood sugar and her A1C are high. She grew up eating a bunch of rice. That is just her nutrition. But you know, back there [in Thailand or Burma], they eat and then they walk everywhere, too. Here, they eat and they drive. Or they go to sleep. They don't walk here so it's different. Over there they can eat as much rice as they want because it is an energy source and they walk everywhere.” – Taylor (22 y.o. Karen participant)

Traditionally, rice has been a staple food in the diets of Karen people, with its cultivation being central to their lifestyle. Considering this, some Karen people struggle with the idea that rice could be causing them health problems. As Taylor points out, lifestyle and activity levels are different here in America compared to when the Karen were living in Burma or Thailand. Monica shared about her approach to explaining healthy diets to Karen patients and simultaneously identified a need that she feels impacts the care of this community:

"Then trying to get better patient education things, especially for diabetics. Usually, 'Get one handful of rice instead of two. Get two handfuls of vegetables,' and do it that way. Because there's not really any good literature in the language to communicate the normal diet. You know, there's the American diet...but that's not ethnic-specific diets that people need to do and understand." – Monica (provider)

When it comes to taking medication for managing chronic conditions, some people within the Karen community may be reluctant:

"Whenever the doctor diagnoses them with high blood sugar or high blood pressure--high blood pressure is a bigger thing they know about--but high blood sugar, thyroid problems, stuff like that. They are like, 'Oh, I'll survive, I don't need this medication. People back in our village never were told they had these problems and lived until they were 90." – Taylor (22 y.o. Karen participant)

> *"Whenever they get prescribed something that they have to take forever, they're like, 'I don't even want to start. I have to take it until I die? And I am like, yeah, you have to take it until you die. Unless you change your lifestyle. But it is hard for them to change their lifestyle because of how they work. They work every day for 8 hours or 10 hours a day. Then they come home, they eat, they sleep, and they do it again all week. They don't have time to exercise. And then they have problems with their hand hurting or their feet hurting, but for them it is normal because they are working…"* – Taylor (22 y.o. Karen participant)

As these quotes describe, patients' reluctance to take medication is sometimes paired with poor understanding of their condition or poor adjustment to a healthier lifestyle. Here is what Monica had to say:

"If anything, they tend to not take medication as regularly or if it's pain, 'I'll just deal with it, I don't want pills.' And those kind of things. But for the most part, for me and anyone in the medical community, the key is to develop trust. If you don't trust somebody, why even do the meds? Try to explain why and what. Why do you need to take the medicine? Sometimes it works and sometimes it doesn't, but that is with any population."
– Monica (provider)

Fiona, one of the providers, pointed out another behavior she has observed among Karen people that could impact their health:

"I also see, I know chewing tobacco has been very [prevalent] with their population. Both men and women." – Fiona (provider)

A few patients may present with mental health concerns relating to their experiences before coming to the USA. Monica told about a heartbreaking but very real example that she has seen among her patients:

"Then PTSD...we've had a few patients that were tortured before they came to the United States and they will never be the same. And the family just surrounds them and take cares of them." – Monica (provider)

Taylor shared her own take on mental health in the Karen community, though it is not clear from her quote which subgroups she is referring to:

"And there's definitely more mental problems here for sure, compared to other cultures. Maybe because it's not talked about, especially in Karen culture. There's no word for depression. You just ask them, 'Are you sad?' They don't know what it is, so it is just life for them if they are depressed." – Taylor (22 y.o. Karen participant)

Overall, by interviewing these Karen individuals who have had experience being patients themselves and/or helping other Karen patients and providers who have worked with this community, we found that Karen people are utilizing social resources to receive healthcare. Troubles related to communication form the most obvious barrier to care, leading many Karen individuals to rely on their children, extended family, or other members of their community to interpret for them during medical visits. Lastly, Karen patients who are living with chronic conditions may need extra instruction and explanation to help them with managing their health.

V. Discussion and Implications

The findings from this research are aligned with the implications of other research studies and publications on the Karen population. Thus, I feel confident to extrapolate this study's findings to broadly resemble the experiences of Karen people receiving healthcare in Middle Tennessee. Many Karen immigrants will likely resonate with these findings; however, this work is intended to inform about a whole group as a patient population, and providers should still get to know each patient as an individual person and case.

The number one takeaway from this work is the importance of communication between healthcare providers and their patients. Even if patient and provider are both fluent in English, patients may not remember or fully understand everything a provider tells them. This issue is only exacerbated with Karen patients who do not have a grasp of the English language. Access to telephone translation services or the presence of caregivers and interpreters who can translate between Karen and English helps, but it does not eliminate the understanding gaps that are observed among patients. Providers should take extra care to be patient during their interactions with Karen patients, taking time to explain in the simplest terms possible and making an effort to invite and then address any questions or concerns that the patients may have. Because family or community interpreters have an established relationship with the patient, they may be preferred or more valuable than a telephone interpreter in some instances. For example, they can alert providers to questions or concerns that the patient may not feel comfortable addressing directly to the doctor. Janelle, one of the family practice providers, remarked that in her experience with Karen patients' caregivers, they are "really intuitive to [the patient's] care and caring for them."

It should be mentioned, too, that Karen patients may come in with their teenage or younger children as an interpreter. While this may be their best option for a translator, and the children may interpret adequately, providers should recognize that this is one example of the many responsibilities that can fall upon the children of immigrants as they help their parents to navigate life in the USA. Karen youth may not feel burdened by this extra responsibility since they are able to help their family and community members, but as our interviews revealed, the role does not come without its difficulties. Interpreting for a health appointment requires some familiarity with medical terminology and an advanced Karen vocabulary, and many Karen are learning as they go.

Common conditions discussed within the Karen population in Middle Tennessee include diabetes, hypertension, gastrointestinal complications, and chewing tobacco. PTSD was a mental health condition observed with some patients. The main treatment approach for problems like diabetes and hypertension are to suggest dietary changes and/or place patients on long-term medications to help regulate blood sugar and blood pressure levels. It should be noted that diet, including the ingredients and dishes that are consumed by people, are tied to people's cultural identities, and for immigrants, their foods may be one of the ways they keep their culture alive in their new home. Monica, another provider I interviewed, acknowledged this when she highlighted the need for educational literature in the Karen language that is also culturally sensitive. Literature on the Karen as patients has suggested that gastrointestinal complications like stomach ulcers are likely related to stress and a highly spicy diet (Neiman, Soh, & Sutan, 2008). The chewing of tobacco and of betel nut, either separately or combined, is a common practice within the Karen and other groups from South and Southeast Asia that has been associated with increased risk of oral, esophageal, and stomach cancers (Neiman, Soh, & Sutan, 2008) (Vermont Department of Health, 2014). In Monica's example of PTSD among her patients, she talked about how the families are usually very supportive of the affected patient. Not every patient will have such extensive support, though, and as Taylor pointed out, the Karen language may lack words for describing mental health. Patients could have a difficult time opening up or expressing their mental health concerns. Providers should be aware of these conditions that can appear among Karen patients and should consider the cultural context associated with them.

One provider mentioned that she would like to become more aware of Karen culture, especially if there are any do's and don'ts that she should consider when interacting with Karen patients. Cultural aspects in this sense did not come up during interviews. Fortunately, there are many publicly available sources on the Internet (see 'References'), and my experience with Karen individuals has shown that they are excited when people show interest in learning about their culture.

When it comes to Karen people's sense of identity, many individuals experience that they must explain to people outside of the community who the Karen are and where they are from, since most people in Tennessee are unaware of the ethnic group. A commonly cited misconception is that Karen people are Korean, despite differences in language, culture, physical characteristics, and historical homeland. Taylor said she sometimes feels like "I don't have an identity," and Lola shared how growing up in America came with struggles to fit in and coming to appreciate the blend of both Karen and American identities. Kim felt it was important to make the distinction: "We are from Kawthoolei… We are not Burma. We can speak their language Burmese, but we are not Burma. We speak Karen." Others should be aware that addressing Karen people as Burmese could be met with a negative reaction.

Providers who treat Karen patients can benefit or become better-prepared by learning of these findings or doing their own research on the Karen people. That being said, the providers interviewed for this research shared the sentiment that "the goal is to provide good care to everyone" regardless of "the background, the race, [or] the ethnicity." (quoted from Janelle, provider) Monica, who has years of experience working with various immigrant populations in addition to the Karen, said she wants all her patients to feel like "whatever they say is safe and valid" and that "[she wants] to hear them and know what is going on." With the intention of keeping patients at the center of the healthcare experience and a focus on clear and open communication, providers can ensure that their Karen patients are receiving just as good care as anyone else.

VI. Limitations and Future Research

Because participants were selected by convenience sampling of my limited connections within the Karen community, all the participants were women and relatively young, and the perspectives of only five Karen individuals are presented here, these findings are not representative of all Karen people's lived experiences. Recruitment was limited to individuals who can speak English, meaning that the voices of a significant portion of the Karen community who do not speak English were not heard. Even among the Karen interviewed who could speak English, there was a clear overrepresentation of Taylor and Lola's quotes compared to Opal and Malee, who speak English but not at the mastery level of the two younger participants. Taylor's and Lola's interviews were longer, and they had many insights about their community and anecdotes to share. That does not suggest that Opal and Malee did not have valuable insight to give, but points to the problem of English proficiency and need for an interpreter in future work with this community. Participants may not have fully understood the questions being asked. It is likely that if interviewed in their mother tongue, they would have had an easier time expressing themselves.

These findings do provide insight, though, into how some people from this community are experiencing healthcare in the USA and more particularly Middle Tennessee. Future work could hear from a more diverse range of perspectives, with men and women and people all over the age and faith spectrum represented. Hearing from individuals who are disconnected from a faith community altogether could be valuable, as that seems to be a significant social resource that not every individual is benefiting from. Future work could also explore how the health and healthcare experiences of Karen patients compare to those of American and Middle Tennessean patients more broadly.

VII. Conclusion

The Karen are a group of people who have experienced immense hardship, yet through their resilience have continued to thrive and work together to tackle new challenges they have faced here in Middle Tennessee. They enrich the region through sharing their culture, hard work, and community-oriented spirit. As with any group, there are certain considerations about health and providing healthcare that are unique to the Karen, but through conducting these interviews, I found that there are aspects of Karen people's healthcare experiences that seem to be more universal. Within every community, I assume, there are people who leave the doctor's office without a full understanding of what just happened, who are reluctant to take their prescription medicines, or who help advocate for their family members during a doctor's visit, to name just a few examples.

Conducting this project from start to finish was challenging, informative, inspiring, and also humbling. Even with four years of pre-medical coursework and a year of working with patients in a hospital, I was quickly shown that there is so, so much that I have yet to learn. Physicians are not magicians, and even with the best intentions to provide quality care, some challenges do not have a simple solution. To know and share these conversations with some of the local Karen community has been an immense privilege. Conversations with providers helped me to imagine myself in their shoes one day and reinforced the idea that each patient is a unique individual and equally deserves the best care available. From now on, I will continue to devote my energy to serving minority and underserved peoples throughout my life and career.

My hope is that this work will raise awareness about the Karen community and their experiences with health and healthcare. Not only do I hope to shed light on their struggles, but I hope that I have highlighted their strengths as well. After reading this, I hope you can better appreciate the lived experiences of our Karen neighbors who have become an integrated part of our communities here in Middle Tennessee.

"Everybody, we are all the same. Whether Thai, Vietnamese… we are the same." – Kim (Karen community leader)

"It's a privilege to take care of people who don't speak English as a primary language…I'm always amazed at the sacrifices, especially of groups of people, to go through the jungle and usually lose one or more family members on the way and then wait in a refugee camp for fifteen to twenty or twenty-five years. Not so they can have freedom, but so their children can have an opportunity of freedom and education." – Monica (provider)

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Appendix A: List of Terms

Themes: In qualitative analysis, this refers to ideas or categories used to organize findings.

Triangulation: A strategy used in qualitative analysis to apply credibility to a finding. When distinct sources, ideally three or more, can point to the same finding or conclusion, the finding is considered to be well-established or able to be extrapolated (see 'Extrapolation'.)

Inductive thematic analysis: A qualitative analytical approach where qualitative data are analyzed without previously identified categories in mind, which would be deductive thematic analysis. Instead, data are categorized into ideas or themes based on what the data reveal.

Extrapolation: In qualitative analysis, this refers to the extension of findings within a study sample to a broader population. It is not to be confused with the term 'generalizable' that is used when dealing with quantitative data and statistical significance.

Karen: A term referring to a collective of people subgroups from eastern Burma and western Thailand who are united under common culture, language, and goals.

Burma: Refers to the country in Southeast Asia, situated between India and Thailand by the Andaman Sea, where most Karen people live or have lived. In some sources, this country is referred to as Myanmar. However, since that name was chosen by the oppressive Burman military government, and most local Karen prefer to use Burma, the country will be referred to as Burma throughout this work.

Burman: A term referring to the most numerous and most powerful ethnic group in Burma. It should be noted that it is the Burman military junta and its affiliates, not all Burman people, who have fought with and committed crimes against the Karen.

Post-Traumatic Stress Disorder (PTSD): A mental health condition that can arise as a result of traumatic experiences in one's past. Types of symptoms and their intensity vary by individual and experience.

Doula: In this context, refers to a non-medical caregiver who provides guidance, emotional and physical support, advocacy, and generally provides for the needs of a patient during a health-related event. This term is used synonymously with 'interpreter' in the Discussion section of this paper because of its use in the literature and the multi-faceted role that Karen interpreters take on.

Appendix B: Questions for Interviews with Karen Individuals

To start off, can you tell me a little about yourself? Where were you born?

- Where did you live before coming to Tennessee?
- How long have you been here?

Now, we will warm up with some shorter questions. Remember, you do not have to answer if you are not comfortable. If you do not want to answer, we can move on to the next question.

- Are you currently employed/working?
- Do you have a primary care provider (who you visit routinely or > 1x in the past two years; MD/DO, NP, or PA)?
- Is there anything that has bothered you for a long time (related to your health)?
- Do you have a family? If so, how is your family structured/how is the family dynamic?
- Are you involved in a faith community?

What sources do you use to inform your health decisions?

Do you ever get sick (or injured)? If so, **what** do you do, and **who** do you turn to to help you feel better?

Can you tell me about a time you went to see a doctor in the clinic, hospital, or emergency room?

- Which parts of that experience were most helpful?

  - Is there anything that would have made the experience more positive for you?

Have you ever helped or received help from someone within your family or community to get care related to their health? Can you tell me about that?

  - What role did you/they play in that experience?

What other resources and organizations, if any, have been valuable in managing your health?

Is there anything you would like doctors and nurses to do that would make your next visit to the hospital, clinic, or emergency room more positive?

Is there anything that doctors and nurses have done in a previous visit that you would like them to continue doing?

Appendix C: Questions for Interviews with Healthcare Providers

Do you see patients from the Karen population regularly?

Do you see new or returning patients?

What is the age range of Karen patients that you see?

How is the communication between you and your Karen patients?

Do the patients usually come alone or with other people?

What are some things you have noticed while working with this community?

- Have any cultural attitudes or beliefs come up while you are treating this population?

Are there any specific needs (or struggles) you feel are still there for providing Karen patients with the best possible care?

Appendix D: Institutional Review Board Approval Letter

Office of Research Compliance
2269 Middle Tennessee Blvd.
Sam H. Ingram Bldg (ING) Room 010A
Box 124
Murfreesboro, TN 37132
www.mtsu.edu/irb

Date: January 23, 2025
PI: Laura Clark
Department: Center for Educational Media
Re: Initial - IRB-FY2025-75
Characterizing the healthcare experiences of Karen migrants in Middle Tennessee

The Middle Tennessee State University Institutional Review Board has reviewed and approved by Expedited Review the above referenced research study. The approval is effective starting January 23, 2025.

Decision: Approved
Category: 6. Collection of data from voice, video, digital, or image recordings made for research purposes.
7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt.)

Findings:
Research Notes:

The following apply to your approved study:

1. In accordance with 45 CFR 46.110 and the regulations for Expedited Review (Common Rule), this project does not expire and continuing review is not required by the IRB.
2. Any unanticipated harm to participants or adverse events must be reported to the Office of Compliance.
3. All modifications to the approved study must be submitted for review through Cayuse IRB for approval before their implementation. Adding new researchers constitutes a modification to the protocol. Per MTSU Policy, a researcher

is defined as anyone who handles the data or interacts with participants. Everyone meeting this definition for this project must have completed the required CITI training and received IRB approval prior to becoming actively involved in the project.

4. Closure of the study must be submitted within Cayuse when the study ends or when personal identifiers are removed from the data and all codes and keys are destroyed.
5. Federal regulations require human subjects records be retained for at least 3 years after completion of the research. Once de-identified, the data can be kept longer for further analysis.
6. If your research is funded by a sponsor, they may have specific data retention policies that supersede the standard IRB guidelines.
7. If your study involves protected health information (PHI), you must adhere to HIPAA regulations when storing and destroying data.
8. Data should be destroyed using a secure method that permanently erases information. Keep a record of when and how research data were destroyed.

Sincerely,

Middle Tennessee State University Institutional Review Board