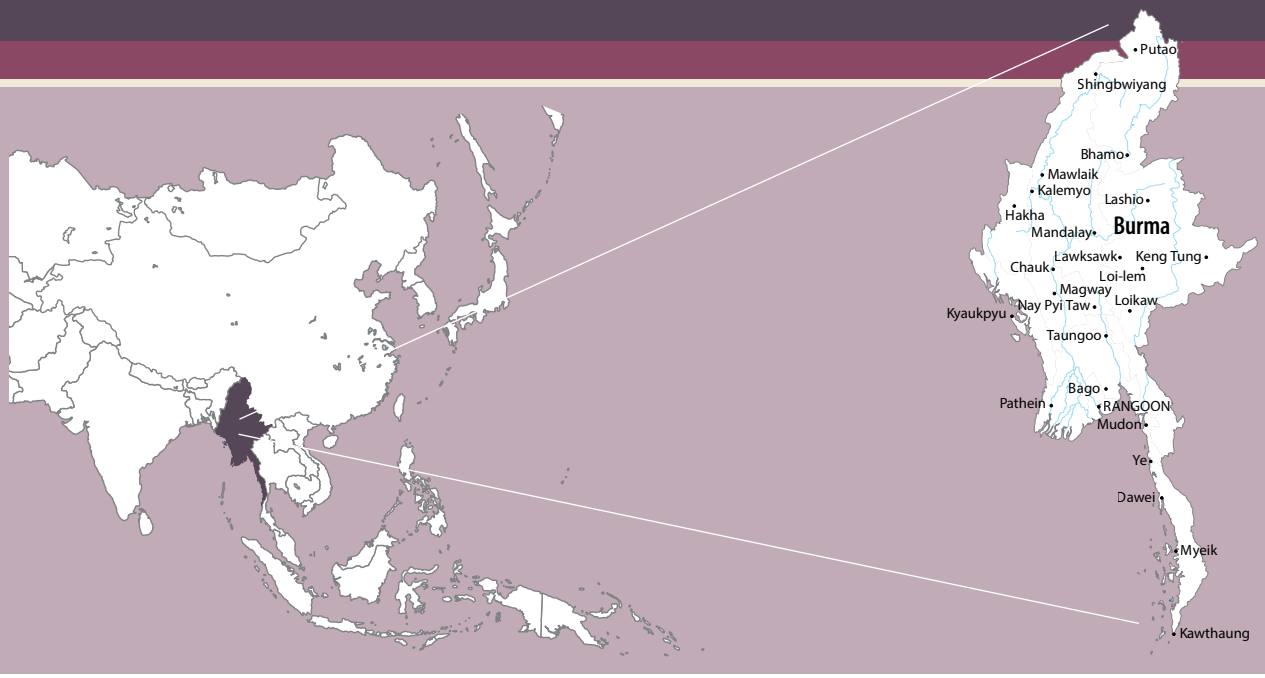
Burmese food and cultural profile: dietetic consultation guide



This resource is a guide for dietitian/nutritionists to provide culturally appropriate and effective services to community members from Burma's many and varied ethnic groups. It follows the ADIME format and provides information about the food and food practices of people from Burma (also known as Myanmar or The Republic of the Union of Myanmar) who have settled in Brisbane (Australia).

The profile follows the chronological steps in individual case management.

These include:
1. ***Booking a client appointment***
2. ***Preparation for the consultation***
3. ***Assessment***
4. ***Diagnosis***
5. ***Intervention***
6. ***Monitoring and evaluation***

1. Booking a client appointment

Key considerations

- Interpreters: Few people born in Burma speak English proficiently, so it is likely an interpreter will be required. Burmese is the most common language of Myanmar (Burma); however, there are many other languages spoken, including Karen languages, Karenni, Chin languages and Rohingya. You will need to organise an interpreter appropriate to the client's ethnicity, but be aware that you may need a telephone interpreter, as local interpreters in many of these languages may not be available.
- It may be useful for women to attend their husbands' appointments, as they are usually the primary cooks.
- Traditionally, people from Burma do not have family names. Therefore, all members of a family may have names that bear no obvious relationship to each other.[1]

2. Preparation for the consultation

Working with an interpreter

It is important that a trained and registered interpreter is used when required. The use of children, other family members or friends is not advisable. Health services must consider the potential legal consequences of adverse outcomes when using unaccredited people to 'interpret' if an accredited interpreter is able to be sourced.

If you have limited experience working with an interpreter, it is recommended that you improve these skills prior to the appointment. There are many online orientation courses available and Queensland Health has produced guidelines for working with interpreters that can be accessed here.

This information is to be used as a guide and is not intended to describe all members of the community. There will be cultural differences between people belonging to different regions, religions and social groups, as well as between individuals within any culture.

Traditional greetings and etiquette

Given there are a large number of ethnic groups and corresponding languages, make sure to check with the interpreter what the appropriate greeting would be prior to the consultation.

A friendly, professional approach is expected from health professionals, such as shaking hands to greet the client and using titles, such as Mr and Mrs to address adults.

The following etiquette is particularly important for Burmese Buddhists: [1]

- It is disrespectful for legs to be stretched out with feet pointed towards a person.
- The head is considered the spiritually highest part of the body, and sensitivity is advised if it is necessary to touch the head.
- It is considered polite to give things (food, an appointment card, diet sheet) to others, with two hands rather than just one.

These additional points of etiquette are relevant for Karen people:[1]

- Karen people normally walk behind those who are their seniors and elders.
- Karen people may answer a question with "no" to be modest when an affirmative answer may seem more appropriate.
- Do not go into the bedroom or kitchen of a Karen home unless you are specifically invited.[2]
- Take your shoes off before entering a Karen home, even if you are told otherwise.[2]

It is often not appropriate to establish direct eye contact with Chin people, especially older community members.[1]

English	Burmese Pronunciation
Hello (formal/polite)	Min-ga-la-ba shin (said by a woman) Min-ga-la-ba cam-yah (said by a man)
Thank you	Chay-zoo-tin-bah-dey
Goodbye	Ta-ta (informal)

Background

Ethnicity	There are over 135 ethnic groups in Burma.[3] The largest ethnic group is Burmans or Bamar, who make up around 68% of the population.[1] Other ethnic groups are Shan (9%), Karen or Kayin (7%), Rakhine (4%), Chinese (3%), Mon (2%), and other groups including Chin, Kachin, Indian and Kayah or Karenni make up 5%.[1] It is worth noting that while people might be born in Burma, they don't necessarily identify as 'Burmese', rather they will identify with their ethnic group.
Religion	Buddhist 89%, Christian 4%, Muslim 4%, Animist 1%, other 2%.[4] Approximately 70% of Karen people are Theravada Buddhist, Buddhist-Animist or Animist, and the remainder are Christian.[1] The Karenni people are mostly Animist.[1] The Rohingyan Burmese are predominantly Muslim.[1]
Language	There are around 100 different languages spoken in Burma.[5] Burmese is the most common language of the country; others include Karen, Shan, Kachin, Chin, Mon and Karenni languages.[5]
History of conflict[6,7,8]	The Myanmar population is ethnically complex, with a long history of conflict between different ethnic groups. The indigenous people are the Karen. Historically, various populations have settled or invaded the country, and Myanmar has been ruled in part by the Mon, the Burmans, the Mongols and the Shan. In the 18th century, the country became part of British India. During the Second World War, the Japanese invaded the country and a Burmese army was formed and joined forces with the British to expel the Japanese. Independence from the British was achieved in 1948. Despite democratic parliamentary rule, years of internal conflict followed. Military rule from 1962–2011, which repressed all democratic opposition and suppressed ethnic minority groups, gave way to an army-led transition to representative government. Ceasefire deals between the government and rebel ethnic groups were signed in 2011 and 2012, and again in March 2015, with varying degrees of success. Tensions between all groups remain.

Background – *continued*

Migration history	Over a million people from a variety of ethnic groups have been displaced from their homes in Burma.[7] Many have spent years in refugee camps on the border of Thailand before migrating to Australia.[7] Other countries of transition are India, Bangladesh and Malaysia.[1]
Gender roles	Both men and women or older children may be involved in the preparation of food and shopping in both Burma and Australia. Men may cook more for large gatherings and are more likely to cook meat.
Household size	According to Myanmar's 2014 census, the average household size was 4.4 people.[9] In the Kachin State and Chin State, the average was 5.1 people per household.[9] Seventy per cent of the population live in rural areas.[9]
Population in Australia	At the time of the 2011 Australian census, there were 21,760 Burmese-born people living in Australia, with 1,897 residing in Queensland and approximately 1,471 in Brisbane.[10]

Health profile in Australia

Life expectancy	In Burma, life expectancy is 63.9 years for males and 69.9 years for females.[9] Life expectancy is higher in urban areas (72.1 years) than in rural areas (65.5 years).[9] No information is available on life expectancy for Burmese-born people in Australia.
New arrivals	Burmese refugees settling in Australia have been shown to suffer from vitamin D deficiency and high rates of treatable infectious diseases, including *Helicobacter pylori* infection (implicated in causing gastric ulcers), latent tuberculosis and *strongyloidiasis* (a chronic, parasitic infection that can cause gastrointestinal symptoms such as pain, bloating, constipation and diarrhoea).[11]
Chronic disease	Refugees from Thai-Burmese border camps may suffer from, or be at risk of, depression and post-traumatic stress disorder (PTSD). Some Burmese community members in Brisbane report an increased risk of diabetes, high blood pressure and weight gain associated with an increased length of stay in Australia.
Oral health	Refugees from Burma are unlikely to have had access to oral health services in their own country and may not see oral health as a priority. Increased access to and consumption of sugary drinks and snack foods in Australia will further impact on their oral health.
Social determinants of health and other influences	Clients from Burma may present with vast differences in social circumstances (education levels and income), reflecting different ethnic backgrounds, transition experiences and length of stay in Australia. In general, newly arrived refugees are likely to be on a low income, and levels of formal education will vary.

Traditional food and food practices

Religious and cultural influences

There are regional and religious variations in food consumed due to the wide variety of ethnic groups that live in Burma. For example, the Muslim Rohingyan people eat much more fish, seafood and chilli. They also observe Ramadan, like other Muslims around the world. Chin/Zomi people in Brisbane report eating a type of fermented meat sausage, and Karenni people in Brisbane report eating many different types of fermented vegetables and chewing beetle nut in Burma.

Traditional meals and snacks

Breakfast	In Burma, people may eat toast or noodles at breakfast and may not count this as a 'meal'. (This may be in addition to the two meals per day reported below.)
Main and other meals	Most ethnic groups eat similar dishes of rice and curry, usually served with a soup, salad and/or stir-fry, with variations in meat and available vegetables. The Karen people traditionally eat two meals of curry and rice per day, and the second meal is the main meal. Elders are served first; then the father, followed by the children. Monosodium glutamate may be used in cooking.
Main and other meals – *continued*	**Eating practices:** In rural areas, people eat around a communal pot, using their fingers, and it is rare to see a fork or spoon. In other areas, spoons are the most common utensils. In urban areas, people eat at a table using plates and bowls, and communal food is placed in the middle of the table. Karenni people report the morning and evening meal as the biggest meals of the day. People doing manual labour, such as farmers, may eat three meals per day. As with most ethnic groups, soups, stir-fries or salads may be eaten as part of the main meal with curry and rice. Although meat is expensive and less available in Burma, goat, fish, pork or chicken are used in traditional dishes.
Fruit and vegetables	Bamboo shoots, mustard leaves, pumpkin leaves, cucumbers, beans, gourds, yams, eggplants, cassava leaves and rosella leaves. Many vegetables are also fermented. The Karenni people may grow some of their own vegetables and fruit. Common fruits include papayas, mangoes, durians and bananas. Jack fruit is cooked and used in savoury dishes.
Snacks	Green tea leaf salad (*Lephet thoke*), glutinous rice around a palm sugar stick, street food such as pork skewers, *Mohinga* (rice noodles in a fish-based, curry-flavoured soup) and fried tofu.
Beverages	Water and Burmese tea (green). Tea is usually drunk without milk and unsweetened. Coffee is often drunk with condensed milk but no sugar. Most people are not familiar with yoghurt; however, when they lived in Burma many people drank a fermented milk drink. The Karenni people in Brisbane report making and drinking their own rice wine in Burma.
Celebration foods and religious food practices	Festivals are often religious and/or cultural, taking place around a full moon. *Thingyan* (Water Festival) takes place over three to four days in April and celebrates the start of the new year. It features the throwing of water over people to symbolise the washing away of sins. The day of Buddha is celebrated in May, commemorating his birth, his enlightenment and his achievement of nirvana. *Wagaung Maha Dok* ('Draw a Lot' Festival), a week-long religious festival, takes place in August. *Thadingyut* (Festival of Lights) takes place in October to celebrate the end of a period of fasting for Buddhists. February is Harvest Festival time, when harvest foods are made into *Htamane* (a glutinous, rice-based savoury snack). Karenni people celebrate the *DeeKu* Festival, which occurs in September or October each year, where *deeku* (parcels of sticky rice) and rice wine are consumed.

Common traditional foods

Htamane, made from glutinous rice, fried coconut shavings, roasted peanuts, toasted sesame seeds, ground nut oil and ginger		A glutinous, rice-based savoury snack, and a seasonal festive delicacy in Burma.
Fungi and bean curd soup (Karen cuisine)		An example of a traditional soup.
Chilli paste (most ethnic groups use some kind of chilli paste)		May be used as a condiment, sprinkled on top of meals, and may contain dried, salted fish.
Laphet (Burmese tea leaf salad or pickled tea salad), made from fermented green tea leaves and crisp fried garlic, peas and peanuts, toasted sesame and sometimes dried shrimp or fish		*Laphet* is served in many ceremonies. It is also eaten as a snack or after a meal, when it is called *Laphet thoke*, and is prepared with fresh tomatoes, garlic, green chilli and shredded cabbage. It is dressed with fish sauce, sesame or peanut oil, and a squeeze of lime. *Laphet* is available in individual-serve sizes, without any fresh vegetables, from specialty stores in Australia.
Deeku (Karenni), made from sticky rice packed into green leaves and boiled; once cooked, dipped in sugar to eat		The *deeku* are tied together in threes, to symbolise unity among Karenni groups who joined together to fight in civil wars.
Mohinga (Bamar)		An opaque, curry-flavoured fish broth with rice vermicelli and hearts of banana tree stems, seasoned with onions, garlic, ginger and lemongrass. It is often served with hard-boiled eggs or fried fish cake. *Mohinga* may be eaten at breakfast or as a snack throughout the day.
A clear Karenni soup		Made from chicken stock, ginger, onion and mustard greens

* Photos of *Htamane* and *Mohinga* with permission from http://www.shwemyanmar.info/index.php and www.ccfoodtravel.com , respectively.

Common traditional foods – continued

Street food in Burma		Meat on skewers, fried tofu
Potato salad (Shan or Karenni)		Potatoes are served as a side rather than a staple part of the meal

Food habits in Australia

Food practices	**Common foods:** Rice and curry, soups with chilli, stir-fries and salads. **Meal patterns:** Burma-born people may eat toast, noodles or fried rice in the mornings, but may not consider this a 'meal', reporting that they do not eat breakfast. Young people may eat a packaged breakfast cereal. **Eating practices:** People may still boil tap water in Australia or purchase bottled water.
Adaptations to diet in Australia	**Substitute foods:** Potatoes may be used in place of yams. Many Burmese communities in Brisbane may use half Jasmine and half Basmati rice, instead of all Jasmine rice. Most other vegetables are available in Brisbane. **Changes to diet:** The Chin, Karenni and Bamar communities in Brisbane reported eating fewer vegetables and more meat and fruit since living in Australia. Serve sizes are also generally reported to be bigger. **Other influences:** Young people in particular may drink soft drinks, and most drink fruit drinks and juices. Thai style, sweetened and milky tea/cordials served with jelly pieces may also be popular with the younger generation.
Cooking methods	Boiling, frying, fermentation, drying and use of marinades.
Shopping/meal preparation	Both men and women or older children may be involved in the preparation of food and shopping in both Burma and Australia. Men may cook more for large gatherings and may be more likely to cook meat.
Food in pregnancy	Pregnant women may observe dietary restrictions, including the avoidance of traditional spicy foods. Karen women may believe that every sight, sound, touch, taste or smell, and every thought and action of the mother, has some effect on the foetus.
Breastfeeding and first foods	**Breastfeeding:** Most babies are breastfed in both Burma and Australia. Breastfeeding usually continues for about two years. **Introduction of solids:** It may be seen as desirable to have a big baby, so solids may be introduced early in an attempt to 'fatten up' infants. A common first food is puréed wild rice. Young children may be given soft drinks or fruit drinks at 1 to 2 years of age.

During the consultation

3. Assessment

Key considerations

- **Anthropometry:** It is acceptable to measure or weigh people; however, it is not polite to touch them on the head. It is acceptable to measure height with a stadiometer if the health professional explains how/why this is done.
- **Meal patterns:** How meals are defined varies between cultures. It is important to ask more generally when food and beverages are consumed throughout the day rather than ask about set meal patterns (breakfast, lunch and dinner).

When taking a diet history, be sure to check the following:

Prompt	Why?
☐ Region of origin, i.e. what state of Burma is the client from, and is it coastal or inland?	Different ethnicities come from different states, and dietary habits may vary accordingly.
☐ Amount and type of vegetables consumed	Traditional diets were high in vegetables and lower in meat. Vegetable consumption may have reduced since moving to Australia. Fermented vegetables may be routinely consumed.
☐ Amount and types of fruits consumed	Fruit is more widely available in Australia, and consumption may have increased.
☐ Amount and type of oil/fat used in cooking	A blended vegetable oil (with an unhealthy fatty acid profile) may be used for cooking.
☐ Amount, type and frequency of intake of rice	Rice is eaten at most meals. Changes in the type of rice eaten has occurred for some Karenni and Karen migrants, with the mountain/red/higher-protein rices traditionally eaten being substituted for larger serves of jasmine rice in refugee camps and in Australia.
☐ Amount of sweet food consumed (e.g. biscuits, lollies, cakes and celebration foods)	Access to these foods has increased in Australia, generally, but they are especially popular with younger people.
☐ Amount of salt added to foods and use of salty condiments	Salt or condiments such as fish sauce or fish paste are added regularly to dishes or used to marinate ingredients.
☐ Takeaways/soft drink consumption	Access to these foods has increased in Australia. Young people in particular like to drink soft drinks and may eat takeaways.
☐ Dietary changes due to cultural or religious events	Check observation of Buddhist or other religious festivals and what foods are consumed at this time. The Muslim Rohingyan observe Ramadan, like other Muslims around the world.

4. Diagnosis

The following examples may be used as a guide for common PESS* statements. 'Problems' are taken from the *Nutritional Diagnosis Terminology eNCPT 2014*, which is available free in the members' section of the Dietitians Association of Australia website.

	Examples of common Problems (P) for PESS* statements	Common (A)Etiologies (E) for PESS* statements
Overweight and obesity	• Excessive energy intake (NI-1.3) • Excessive oral intake (NI-2.2) • Unintended weight gain (NC-3.4) • Overweight/obesity (NC-3.3)	• Relative abundance and low cost of high sugar foods and drinks and meats in Australia result in higher intakes. (NI-1.3) • Acculturation pressures to eat 'Australian' foods, especially for children and adolescents, may lead to high intakes of takeaways, confectionary and soft drinks. (NI-1.3, NI-2.2. NC-3.3) • Increased meal sizes on arrival to Australia because of greater availability of affordable foods (NI-2.2) • Traditional high intake of rice at meals (NI-5.8.2) • Fasting for religious reasons, especially by Muslims (NI-5.8.3) • Changes to higher GI rices on arrival in Australia due to their lower cost and taste preference (NI-5.8.3) • Blended vegetable oil (with an unhealthy fatty acid profile) may be used for cooking because it is cheaper than healthier choices. (NI-5.6.3) • Taste preference for foods cooked with high sodium sauces/flavourings (fish sauce and fish paste) (NI-5.10.2) • Large amounts of salt added during cooking due to taste preference (NI-5.10.2) • Short stay in Australia and unfamiliarity with government generated dietary guidelines and health promotion campaigns (NB-1.1) • Long stays in refugee camps with inadequate food rations (NI-5.2)
Type 2 diabetes	• Excessive carbohydrate intake (NI-5.8.2) • Intake of types of carbohydrate inconsistent with needs (e.g. high consumption of high GI rices) (NI-5.8.3)	
Cardiovascular disease	• Excessive mineral intake (sodium) (NI-5.8.5) • Intake of types of fat inconsistent with needs (e.g. high saturated fatty acid intake) (NI-5.6.3)	
General	• Food and nutrition-related knowledge deficit (NB-1.1) • Malnutrition on arrival in Australia (NI-5.2)	

* PESS: Problem, (A)Etiology, Signs and Symptoms

For the Signs and Symptoms (SS) for PESS statements, use standard clinical measurements. Make sure the Signs and Symptoms relate to the identified Problems and not their (A)Etiologies.

5. Intervention

Nutrition education

Motivating factors for a healthy lifestyle	The Zomi/Chin people value thriftiness, so dietary advice that is consistent with saving money may be more likely to be accepted. The Muslim Rohingyan are unlikely to see longevity as a motivating factor; as with other Muslims, lifespan is seen as preordained by Allah. Because access to health services is better than people have previously experienced in Burma or in refugee camps, people may feel they are healthier in Australia. As a result, they may benefit from some education on the 'healthy migrant effect', i.e. how migrants are healthier than the average Australian when arriving in Australia, but may have poorer long-term health from changes to diet and reduced physical activity in Australia.
Preferred education methods	**Need for interpreters:** An interpreter is likely to be required. You will need to organise an interpreter appropriate to the client's ethnicity, but be aware that this may need to be a telephone interpreter, as local interpreters in many of the languages may not be available. **Types of resources:** Pictorial and visual resources may be useful. **Counselling style:** Be aware that saying "no" is often a way of being modest.
Literacy levels	The adult literacy rate in Burma is 89.5%, with males having slightly higher literacy levels than females.[9] Literacy rates for Karenni people are often low.[1]
Health beliefs	The health of a person is controlled by the four elements of fire, water, air and earth, and imbalances cause illness and disease. Certain foods are classified as 'hot' or 'cold' and can affect health conditions. Hot foods are generally those that are salty, sour, or high in animal protein. Cold foods are generally bitter or sweet. The Karenni people in Brisbane report using galangal to sniff to alleviate colds and sickness, and applying a wild tamarind poultice to heal cuts. Karen people believe illness can have spiritual as well as biological or physiological causes, and Karen who are in hospital will appreciate a visit from a relevant religious leader.[2]

6. Monitoring and evaluation

Methods for monitoring

- Check if the client has access to transport (especially if referring to an outpatient clinic); otherwise telephone follow-up may be more appropriate.
- Confirm the client's preference for having an interpreter present at their next appointment. For short follow-up consultations, telephone interpreting services may be more appropriate.
- Encourage wives to attend their husbands' follow-up appointments, because the woman is often the primary cook in the family, even though food shopping and preparation is often shared.

Additional resources

- Queensland Health *Working with Interpreters: Guidelines* (http://www.health.qld.gov.au/multicultural/interpreters/guidelines_int.pdf)
- To find out more about multicultural health, Queensland Health's Multicultural Health page has information for the public and for health workers, including the *Multicultural health framework*. Go to http://www.health.qld.gov.au/multicultural/default.asp
- To find out more about the Myanmar-born community generally in Australia, visit https://www.dss.gov.au/our-responsibilities/settlement-and-multicultural-affairs/programs-policy/a-multicultural-australia/programs-and-publications/community-information-summaries/the-myanmar-born-community

Additional resources – *continued*

- Health care providers in Queensland can view a community profile on Burmese Australians relevant to them at https://www.health.qld.gov.au/multicultural/health_workers/profiles-complete.pdf
- Information about practices in pregnancy, birth and post-natal care of Myanmar-born people can be found at http://www.health.qld.gov.au/multicultural/health_workers/cultdiver_guide.asp#pregnancy

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For more information contact:

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Please note: The web links in this document were current as at March 2015. Use of search engines is recommended if the page is not found.

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