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Refugee health and religion: Karenni Catholics in Omaha, United States

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Abstract

This article argues, based on the author's research and years of engagement with resettled Karenni refugees in Omaha (U.S.) and illustrated by a characteristic case of a health emergency, that refugees' religious beliefs and networks can increase access to resources needed to boost their resilience, improve their health, and advance their sense of wellbeing, and subsequently encourages agencies working with refugees and other migrants to pay attention to refugees' religious beliefs and networks and closely collaborate with religious organizations. The author conceptualizes religious values and networks as social capital and calls for qualitative studies to explore the role of religion in improving resilience, health, and wellbeing of refugees and migrants.

Keywords: *refugees; religion; health; social capital; Karenni.*

Introduction

Omaha, Nebraska, is a major refugee resettlement site in the United States (U.S.) due to the comparably low cost of living, existing employment opportunities in line with refugees' skills, engaged resettlement agencies, and an efficient and effective resettlement process. From 2002 to 2016, 11,075 newly arrived refugees from 35 countries resettled in Nebraska, 6,038 of them in Omaha (Refugee Processing Center, 2018). In 2012, 764 were resettled in Nebraska. This number increased to 997 in 2013, 1,076 in 2014, 1,200 in 2015, and 1,441 in 2016, with Nebraska becoming the nation's top refugee resettlement state per capita with 76 refugees per 100,000 residents (Grace, 2017; Nohr, 2016; Office of Refugee Resettlement, 2015; Pew Research Center, 2016). During the past few years, refugees from Burma represented a significant percentage of resettled individuals and families. In 2015 alone, 652 of the 1,200 newly arrived refugees originated from Burma. From 2002 to 2016, 3,939 refugees from this nation resettled in Omaha (Office of Refugee Resettlement, 2015). These numbers do not accurately reflect the total refugee population; they only refer to new arrivals, not refugees who moved to Nebraska after resettling in other states or who decided to move to other states after resettling in Nebraska. Recent changes in U.S. policies related to refugee resettlement indicate a significant reduction in new arrivals in Omaha, as well as constrained resources negatively impacting resettlement processes and agencies (Grace, 2017).

The largest group of refugees from Burma in Omaha is ethnic Karen. The second largest group is Karenni, the focus of this article. Like many ethnic classifications, Karenni is a collective term that does not represent a single, homogeneous ethnic group, but refers to several linguistic groups in Kayah State, Burma, the country's smallest ethnic state with lower access to educational,

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economic and other resources, compared to other states (Dudley, 2007). Forced to leave their homes, due to marginalization by the central government targeting mainly ethnic and religious minorities, and a civil war between the army of the central government and local militias in Kayah State, most of the Karenni in Omaha lived for years in refugee camps, struggling with extreme spatial and other constraints. In 2015, 72% of the approximately 500 Karenni in Omaha had lived for five or fewer years in the United States (Ngelay, Sanders & Rödlach, 2016[2]). When the first families arrived in Nebraska, they did not know about each other and struggled to communicate with their neighbors, social workers, and others who tried to support them. In 2015, about 52% of them rated their English language skills as poor, about 25% as average, and only about 22% as good; the latter were mainly adolescents. Only one individual rated his English language skills as excellent (Ngelay, Sanders & Rödlach, 2016). The lack of English language fluency is just one of many interrelated barriers that represent a significant challenge to their wellbeing, including their health (Su et al., 2017; Willis & Nkwocha, 2006). Addressing their basic needs, such as health, housing, and schooling, is complicated through communication problems, lack of transportation, and limited familiarity with how systems operate in the United States (Brouwer & Rodwell, 2007; Singer & Wilson, 2006).

According to a community survey, the Karenni in Omaha have a strong religious identity (Ngelay, Sanders & Rödlach, 2016). About 76% of them identified as Roman Catholic, about 14% as "traditionalist," about 8% as Baptist, and less than 1% as Buddhist. The religious composition of the community in Omaha reflects the religious demographics in Karenni State. The Catholic Church has a long tradition in Burma, going back to the 16th century with Italian missionaries successfully working in the Karenni region since the 19th century (Nant, n.d.). The Baptist missionaries arrived in the mid-19th century in Karenni State (Luther, 1880). The Karenni traditional religion is associated with pre-Christian deities and spirits creating, maintaining, and sustaining life, strongly related to the agricultural seasonal cycle (Dudley, 2000). As less than 1% of community members in Omaha did not respond to the survey question probing their religious identity and affiliation, it can be concluded that religion is central to their self-understanding and identity. Catholic Karenni attend religious services in English at Omaha churches, specifically at St. Cecilia's church. The Baptist Karenni regularly celebrate services in the Kayah language led by a Karenni pastor. Both groups pray regularly at home in their own languages, either as a family or with other Karenni. They also follow religious Christian traditions from their home country. For example, Christian Karenni of various denominations visit the homes of Karenni families around Christmas to sing carols. In addition, they follow their cultural traditions, such as the Kay Htoe Boe festival. The festival is held to venerate traditional creator deities, give thanks for blessings received during the past year, appeal for forgiveness, and pray for rain and a good agricultural season. Celebrated by the Omaha community for the first time in 2018, a wooden pole was erected and adorned with objects symbolizing the Karenni cosmology, and men danced around it, playing drums, gongs, and bamboo flutes, while women sprinkled water to keep the dancers cool and ritually cleanse them and all present (Keng, 2018). As most of the Karenni are Christian, the meanings and purpose of the festival are reinterpreted and associated with Biblical traditions, though the Baptist Karenni in particular feel ambiguous about participating in this cultural religious event due to their fundamentalist interpretation of the Christian Bible and considering their faith as opposed to other religious traditions, which contrasts with the Catholics' broader interpretation of the Christian scriptures and identifying commonalities rather than differences with other religious traditions. In 2015, the

[2] The survey includes Karenni households in Omaha and Lincoln. However, as most Karenni families live in Omaha, I generally refer to this survey as an Omaha survey.

Karenni community in Nebraska organized and hosted the Karenni National Day in Omaha with the help of local agencies, Karen leaders, and Karenni communities from other states. The Karenni not only celebrate their history, identity, culture, and language during these religious and cultural events and activities, but these events also provide the Karenni with an opportunity to strengthen their community and to nurture supportive bonds among them, which in turn strengthens their resilience when facing challenges to their wellbeing.

This paper argues that religion is an important factor in understanding resilience and wellbeing dynamics among the Karenni in Omaha and other refugee groups that exhibit a strong emphasis on religious identity and affiliation. Religion provides them with both norms and social networks to access resources needed to successfully respond to difficulties and adversities and to enhance their wellbeing. Religious affiliation and identity can be conceptualized as social capital that increases resilience and wellbeing.

Theoretical Considerations

There is no single commonly agreed upon definition of social capital (Adler & Kwon, 2002; Dolfsma & Dannreuther, 2003), but most highlight the importance and relevance of shared norms and values, as well as social networks for gaining access to social support (Durlauf, 2002). The distinction between norms and networks corresponds with the distinction between cognitive and structural components of social capital (Uphoff, 1999; Woolcock, 1998). Norms and values encourage and prescribe cooperation among members of a specific network and with others (Coleman, 1990; Suter & Magnussen, 2015). Smidt (2003), exploring the relationship between religion and social capital, notes that religious affiliation provides important services and resources to members, such as social networks, social support, and physical care. Further, religious beliefs shape what priorities are given to life and influence how members relate to those outside their community. Also, religious behavior can contribute to social capital formation through encouraging volunteering, charitable behavior, and other acts of mercy.

In particular, Putnam's (1993, 2000) distinction between "bonding" social capital, referring to social capital among members of a group who are "like one another in important respects," and "bridging" social capital, referring to social capital between members of one's own group and other groups, has frequently been drawn on to understand social support dynamics within a single network and between different networks (Putnam & Gross, 2002: 11). Because the two concepts imply different resources, forms of support, and obligations, drawing on them requires access to and ease in being part of different types of networks, as well as familiarity with their norms and values (Ferlander, 2007). It has further been observed that moving from bonding to bridging social capital can be difficult. The development of bridging social capital often compromises and limits bonding social capital (Leonard, 2004). The dynamics between the two types of social capital is further complicated because they are not as clearly distinguishable from each other as the theoretical concepts imply (Rödlach, 2018). Social capital has been used to explore the strengths of refugee communities and the barriers they face (Smith, 2013).

Methods

In 2015, a group of faculty and students at Creighton University and their community partners explored how social capital influences refugee resettlement dynamics.[3] Subsequently, I got to know

[3] Laura Heinemann, Claire Herzog, Margo Minnich, Celeste Mitchell, Laeth Nasir, and Alexander Rödlach conducted the study with Chaitri Desai and Melanie Kim. The study was approved by Creighton University's IRB (#695028-2).

and became familiar with several members of the Omaha Karenni community; I have been involved with the community since then on various levels and in several functions, particularly with the Catholic Karenni Society and the Karenni Society of Nebraska. For example, two students and I did a survey[4] of the whole Karenni community in Omaha (Ngelay, Sanders & Rödlach, 2016). During the past three years, I recorded my observations and conversations with members of the community and analyzed the resulting transcriptions using the Grounded Theory approach (Glaser & Strauss, 2012). The 2015 social capital study, the 2016 community survey, and my observations of community events and conversations with community members from 2015 to 2018 form the basis of this article.

Religion and Health

Karenni community members' prime concern is related to health, followed by concerns associated with financial problems, family issues, and education for their children and themselves (Ngelay, Sanders & Rödlach, 2016). Addressing these concerns is a priority for many in the community, but is complicated by a wide range of barriers, such as those outlined earlier. Additionally, most of the Karenni lack familiarity with a physician and, when asked what they would do if they were sick, more than half of the respondents said that they would go directly to the hospital emergency room. About 38% responded that they would visit one of the clinics in the area. Respondents probably thought of a serious health issue, selecting the first response, then of a less serious one, selecting the latter response. The fact that nearly 90% of respondents would go directly to a health care facility suggests that the majority of Karenni in Omaha have not developed a relationship with an individual physician or another provider and, therefore, tend to visit the clinic or the emergency room of a hospital only if they or household members experience ill health. This also suggests that they wait until the health issue is serious enough to justify such a visit. Many in the community find it difficult to communicate in English, so they rely on interpretation services provided by the hospital[5]; a family member, generally a teenager; or a community member, by and large one of the few adults fluent in English. With more serious health concerns, a wide range of resources is needed. When such needs arise, social capital in the form of religious values and networks becomes particularly relevant. I want to illustrate this argument by describing and interpreting my observations of and conversations during a particular health emergency.

When one Karenni woman in Omaha became unconscious and fell in her home, she was immediately taken to the hospital. Emergency surgery was performed and the woman was in an induced coma for about two weeks. During this time, members of the Karenni community provided support by recognizing and addressing material and other needs resulting from the woman's accident and her absence from her household. Much of the support was provided through the woman's religious community. The patient and her family identified as Catholic and actively participated in the affairs of the Catholic Karenni community.

This religious identity, affiliation, and participation enabled the family to access various forms of support. First, the Karenni Catholics offered social, material, and spiritual support. It is likely they also would have done so for Karenni who are not Catholics, due to their shared ethnic identity

[4] This survey was conducted in response to some Karenni leaders expressing interest in having their community surveyed in terms of size, education, health, and social issues faced by community. The questionnaire was developed together with the community leaders and the goal was to collect data that the community then can present to educational and health-related organizations in the city in order to solicit support.

[5] This has not been easy as interpreting services used by the health care facility often do not include Karenni speakers, due to their small numbers, or confuse the Karenni language with another language. For example, a Korean language interpreter was once called in using a phone service.

and experiences as refugees, but probably to a lesser degree. In other words, the shared religious identity increased and accelerated access to needed support. Second, the local parish, where most Karenni attend services, was informed of the health crisis experienced by the patient by a volunteer Catholic chaplain in the hospital. Subsequently, the coordinator of the parish's Faith Formation[6] program came to the hospital to pray with the patient and her family and explore their needs resulting from the health emergency. She recognized the communication difficulty and breakdown between health care providers and the patient's family. She was familiar with the Karenni community in Omaha through volunteering with the Faith Formation program at her church, enabling her to effectively mediate between the patient's family and health professionals. Coincidentally, she is also a registered nurse and was aware of the limitations of her mediation due to Health Insurance Portability and Accountability Act (HIPAA)[7] policies; however, because of her professional familiarity with the health system, she was able to engage in informal conversations with nurses and others to obtain relevant information without compromising HIPAA policies. She quickly realized that the patient's illness resulted in material and financial issues that needed to be addressed.

Upon her request, the parish's Saint Vincent de Paul Society[8] provided nutritional assistance and monetary support to the family; advocated for the family with the housing authority as the family struggled to pay rent because the patient was unable to work and support them; and shared with the family valuable information on how to deal with hospital and medical expenses, communicate with Medicaid, and arrange follow-up therapy and its payment for the patient. In short: if the patient and her family had not belonged to the Catholic Church, the Catholic Karenni community might not have provided the family with the needed support at the same level, and the parish might not have become involved. In other words, being Roman Catholic enabled access to social capital.

The distinction between the cognitive and structural components of social capital (Uphoff 1999), or to say it differently, the church's norms and networks, provides insights into how Karenni Catholics in Omaha obtain needed social support, improving their health and subsequently their overall wellbeing. As Christians, the Karenni are guided by biblical values that emphasize supporting the marginalized and sharing resources to address their needs. This emphasis is strongly evident during their religious services and other events, when leaders of the Karenni Catholic community frequently explicitly refer to it. They underscore that Christian life is characterized by a commitment to supporting those in need, which has significance beyond the current moment: it is tied to one's relationship with God and ultimately to one's salvation. I observed during my interactions with the Karenni, including those who are not Catholic, that they also emphasize the importance and value of providing support to other community members because of their ethnic ties, shared national identity, and refugee experience. These values motivate individual members to provide social support (e.g., visiting a community member who is sick, interpreting when someone experiences a problem at a place of employment, and speaking with a teacher when misunderstandings with Karenni children occur). In short, the synergies between religious and cultural values as well as a shared refugee experience foster the provision of social support (Kusserow, 1999; Lindholm, 1997). In addition to such values and norms, the Karenni Catholics

[6] This concept refers to the church's goal to help its members learn about their faith and its implication for their lives through the study of the Scriptures and the teaching of the church.

[7] HIPAA outlines standards for the electronic exchange, privacy, and security of health information in the United States.

[8] This Catholic organization encourages members of the church to offer person-to-person service to those who are needy and suffering in the tradition of its founder, Frédéric Ozanam, and its patron saint, Vincent de Paul.

are part of social networks within the Catholic community. The youth regularly meet for religious instruction within the Karenni Catholic community and take part in the Faith Formation program at the parish. Further, community members come together to practice hymns and socialize before and after religious services and take part in events at the Catholic Church. In addition, the leadership committee meets as needs arise and interacts with the pastor and the church council to discuss Catholic Karenni concerns. Most individuals know they can rely on others in these Karenni and church groups and networks in times of need.

However, such generalized dynamics of cognitive and structural social capital do not capture the complexities of providing and receiving social support. First, while most Karenni speak the Kayah language, there are others who belong to a different ethnic group, such as the Kayan (Lwin, 2011). They are either indigenous to Kayah State or identify themselves as Karenni because of other reasons, such as being born in Karenni State or having relatives or in-laws there (Ekeh & Smith, 2007). Thus, receiving social support within the community is not always simple and straightforward; this is due to communication problems caused by linguistic and cultural differences within the community. Second, receiving social support within the church is complicated because the local church leadership does not speak Kayah and most Karenni do not speak English. While the Karenni attend mass and other services at the church, they tend to be passive participants due to their limited ability to express themselves in English. The pastor has recently addressed this passivity by encouraging members of the Karenni community to sing a song and do a reading in their language during the main Sunday service once a month. Nevertheless, the Karenni tend to be marginalized in the church and operate in its background, which is symbolically expressed by them literally sitting in the back of the church. Subsequently, their ability to develop ties and connections within the church social network and its leadership is limited, making it difficult for them to ask for and receive social support. Third, in addition to explicit linguistic differences, cultural differences between the Karenni and other church members and its leadership complicate access to social support.

In addition to cognitive and structural social capital explored in the earlier paragraphs of this section, it is worthwhile to explore the relevance of Putnam's (2000) distinction between bonding and bridging social capital for understanding the Karenni's access to social capital. The Karenni and the church share the same cognitive and structural social capital; after all, they are Catholics and belong to the worldwide Catholic Church. On the other hand, there are significant linguistic and cultural differences between the Karenni and the local church. In other words, the church is both home as well as an outside community, and social capital associated with the church can, therefore, be conceptualized as bonding as well as bridging social capital. It must be noted that the church recognizes the Karenni as full members with rights and obligations, and the pastor in charge of the church shows significant and appropriate concern for the needs of the Karenni community. The pastor acknowledges that Karenni children and adults represent the majority of participants in the church's Faith Formation program, and he values and appreciates the Karenni presence in this church program. The church, however, is also aware that communication with the Karenni requires an interpreter and the expectations of the Karenni regarding spiritual and other services may not always match services the church is used to providing. The Karenni appreciate the services they receive but they also feel marginalized in the church, not well understood, and unable to live their faith according to their values, traditions, and preferences. They consider the parish part of their identity where bonding social capital is at work, at the same time, they also see themselves as outsiders, where bridging social capital needs to be developed, nurtured, and drawn upon.

The complex and complicated dynamics of bridging and bonding social capitals can further be illustrated by two priests who are originally from Burma, live in Wichita and Iowa, and occasionally visit the community in Omaha. One of them is not a Kayah speaker but identifies with the Karenni, as he has roots in Kayah State in Burma. He communicates with the Karenni in Burmese, the majority and main official language of the country. However, this language is not understood by a significant portion of the community. Thus, the social support he provides is to some degree related to bonding social capital; he is part of the community though not an intimate member of the community due to his background. At the same time, as he is a priest and provides services in close cooperation with the local church, he serves as link between the community and the church; his social support has strong connotations of bridging social capital. The other priest is an ethnic Karenni. He visits the community both in his role as a priest and because he is a blood relative of several of the Karenni in Omaha. The social support the second priest provides is more akin to bonding social capital.

Considering the complex and convoluted dynamics of bonding and bridging social support, it is helpful to conceptualize the two concepts as ends on two extremes on a scale, with a "pure" form of bonding social capital on one end and a "pure" form of bridging social capital on the other end. What we observe can be located somewhere on a continuum or scale with these two ends. This is comparable to Geys' and Murdoch's argument (2010), which states we have to go beyond a simplistic dichotomy of bonding and bridging social capital, and any analysis needs to include an investigation of network heterogeneity, as well as interconnections between networks. The Karenni example from Omaha corroborates this argument.

Conclusions

Resettled Karenni refugees in Omaha illustrate how refugees' religious identities and affiliations influence social capital dynamics. Social capital dynamics influence their resilience when they experience difficulties and their overall wellbeing. This concept is exemplified in this article through references to health and is illustrated through a specific example of a health emergency. The article argues that simplistic and decontextualized use of the concept of social capital does not accurately show how religious identities and affiliations can increase refugees' wellbeing. The dynamics of cognitive and structural social capital, as well as bonding and bridging social capital specific to a particular refugee group, need to be explored to comprehend how religion can increase resilience, enhance wellbeing, and improve health.

In general, because religion is central to several refugee and migrant communities (McLellan, 2009), engagement with religious organizations is important for those trying to support these communities. However, commentators observe that the United States Office of Refugee Resettlement and the Immigration and Naturalization Service are not likely to consider religion as a significant variable in their policies (Burwell, Hill & van Wicklin et al., 1986). On the other hand, many agencies assisting refugees and migrants are faith-based and likely to pay attention to religion as an important factor for refugees' wellbeing. Faith-based agencies and religious organizations provide services and assistance to refugees and migrants to unlock social support for refugees. Religious organizations are likely to be strong partners for resettlement agencies, not only because of their values and practices, but also because they directly benefit when refugees, who are members, enjoy a high degree of resilience and wellbeing. After all, refugees boost membership numbers of congregations, increase participation in services and other events, and significantly enrich the congregation otherwise.

The limitation of this study is its focus on refugees who belong to an international religious group, the Catholic Church, which enables refugees already belonging to such a group to relatively easily associate with the local community of the church. Further research is needed to understand how refugees' religious groups that do not belong to an international religion can access social capital in the area where they are resettling. Of particular importance is exploring how refugees' religious groups that are considered by residents in their resettlement area as "alien" or "antithetical to local morals and beliefs" affect resilience and wellbeing.

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