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Cultural Attitudes of Vietnamese Migrants on Health Issues

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Abstract

Health issues are so strongly imbedded in a culture that when people migrate from their own cultural environment to a new one, they tend to perceive and interpret health issues in light of their original cultural values and norms. This intercultural interference can be both positive and negative and the degree of interference varies according to factors such as age, gender, education background and the length of time spent in a new cultural environment. This study examines the ways in which Vietnamese migrants in Australia perceive various aspects of health issues such as treatment, health care, role of health workers, and interpersonal relationship between patients, family members and health workers.

Keywords: culture, health, migrants, intercultural discourse, communication

Introduction

Like many aspects and issues in society such as education, entertainment and politics, health is deeply imbedded in its cultural discourse. The word 'health' is primarily associated with sickness, disease and medical treatment. It conjures up visions of isolation, frustration, pain, and anxiety. When migrants enter a new cultural environment, they do not leave behind the concepts and attitudes based on their original culture. These are cultural lenses through which they make sense of their new existence. Health is an area of intercultural interference in their perception of health concepts and attitudes.

This paper presents a small case study of an extended family of Vietnamese health workers and patients in Australia. It is primarily a narrative research as the main source of data is derived from informal interviews, reflection diaries and observation notes of the researchers.

Migrants and health issues

According to Manuel Carballo and Aditi Nerukar (2000), the incidence of new cases of tuberculosis infection (TB) in nine European Union (EU) countries in all 15 EU member states fell from 34.8 out of every 100,000 persons in 1974 to 14.3 out of every 100,000 in 1995. In Denmark, the incidence of new cases increased steadily over the past 5 years, and the proportion of cases in foreign-born persons rose from 18% in 1986 to 60% in 1996. In England and Wales, approximately 40% of all TB infections are estimated to occur in people from the Indian subcontinent. In the

Netherlands, where the incidence of TB rose 45% between 1987 and 1995, over 50% of known cases of infection occurred among immigrants. The TB profiles in Germany and France are similar, and migrants are 3 times and 6 times, respectively, more likely to be diagnosed with the disease than are non-migrants.

Numerous studies have been conducted on health issues relating to migrants. Some studies cover different areas and ethnic groups. For instance, Talamantes (2001) studied health care of Southeast Asian American elders (Vietnamese, Cambodian, Hmong and Laotian). Ailinger and Causey (1995), Ailinger (1988) examined health concepts of older Hispanic immigrants. Nelson et al (1997) conducted a case study of recent Vietnamese immigrants in the USA. Olson (1999) examined the perception and experience of old-age dementia in the Hmong community in Milwaukee, USA. A study by Allan (1998) attempted to identify explanatory models of overweight among African American, Euro-American, and Mexican American women.

Research has also paid attention to different types of health problems facing migrants. For example, Alcozer (2000) studied type 2 diabetes among Mexican American women. Byrd et al (2004) studied cervical cancer screening beliefs among young Hispanic women. Munib (2005) conducted a study on the effects of immigration and resettlement on the mental health of South-Asian communities in Melbourne, Australia.

A small community study of recent Vietnamese immigrants in Boston, USA found the following: 32% smoked (54% males, 9% females); 24% used alcohol; 17% were depressed on the Vietnamese Depression Scale, with those older than 40 having more depression; ova and parasites were found in 51% (63% of them required treatment); 70% tested positive on the TB test (39% required treatment); 83% had been exposed to hepatitis B and 14% were chronic hepatitis B carriers (Nelson, Bui, & Samet, 1997).

There are a number of studies of Vietnamese migrants' health. Most studies were conducted in the USA. Calhoun (1985) conducted a study on the Vietnamese women's attitudes and behaviours on health issues. Long et al (1999) investigated different tuberculosis in Vietnamese men and women. Ta and Chung (1990) focused on death and dying from a Vietnamese cultural perspective.

In Australia, Lê and Lê (2004) conducted a study on intercultural health metaphors.

According to the authors, a metaphor indirectly or implicitly indicates our perception and attitudes, particularly in relation to the social values. If a hospital is perceived metaphorically as a home, this metaphor brings with it positive features held by the metaphor users such as warmth, care, security, and kindness. On the contrary, if a hospital is perceived as a clinical factory, it reveals negative images and feelings such as cutting the flesh, indifferent, fear, cool blood, etc. The study attempted to understand the cultural meaning of the Vietnamese metaphors that Vietnamese migrants used to interpret and value health concepts and issues in the Australian context.

The study

It was a qualitative study which involved six Vietnamese families. The main criterion for inviting the families to participate in this study was that they know the researchers very well and treat them as members of the family. The researchers wanted to collect verbal data as 'truthful' as possible. It was expected that family members would feel free to express themselves to 'close friends'. Thus, informal interviews were imbedded in family conversations. However, to ensure that the data collection process would not be turned into an aimless chit-chat, the researchers explained the aims of this study to all the participating families beforehand.

The 'interview conversations' were conducted at weekend gatherings which are common among Vietnamese families in Australia. It is referred to as 'interview conversation' in the sense that the interview is totally imbedded in the normal home communicative activities of the participants. The advantages of this approach are:

- The home discourse is intact. In other words, the researchers are imbedded in the home context and become members of the home discourse.
- The participants feel free to discuss issues in their home context and do not feel threatened by being seen as playing the role of research participants.
- The notes, transcripts and interpretations can be checked by the participants for accuracy and authenticity.

The researchers attempted not to interfere with the communicative interaction or home talk in these families. However, the researchers had the following aspects which could be incorporated in the conversations as conveniently and practically as possible:

- stories that Vietnamese migrants often tell about their health, health issues and health services in Australia;
- communication and linguistic problems facing Vietnamese migrants in Australia in terms of health and health care;
- cultural issues on health concerning Vietnamese migrants in Australia;
- health behaviours and lifestyles which are associated with health problems of Vietnamese migrants.

The interview conversations were conducted in Vietnamese. However, there were a great deal of code-switching from English to Vietnamese and vice-versa. Most of the code-switching tended to involve English medical and health services terms such as hospitals, insurance, Medicare, bulk billing, dentist, intensive care, ambulance, etc.

The data collection lasted for four months. It was transcribed and the analysis was conducted with the use of NVivo.

The coding process involved the following strategies suggested by Strauss and Corbin (1998):

- open coding;
- axial coding: relating categories to their subcategories;
- selective coding: the process of integrating and refining the theory.

This corresponds to the use of nodes in NVivo. Nodes are used where researchers store ideas and categories. Nodes present people, issues, and other significant things in the study.

- Free nodes: for ideas not belonging anywhere (open coding)
- Tree nodes: to catalogue categories and subcategories (axial coding)
- Case nodes: to store material about each case. E.g. Doctors (underneath each doctor)

The results

The data analysis indicated the following themes reflecting the thoughts and feelings of Vietnamese migrants in Australia.

Cultural conflict

As stated, when migrants move from their home countries to a new country, they bring with them their values and meanings which can cause a great deal of cultural interference. The interference varies according to the gap between the two cultures.

According to Carballo and Nerukar (2000), cultural background plays an important role in predisposing some immigrants to some diseases such as depression, chronic anxiety, and neuroses. Alcohol and drug abuse may also be used as coping responses that in turn exposes migrants to other health problems such as HIV/AIDS. However, in general, the trauma and exclusion that all immigrants face increase their risk of behaviours that, in turn, increases their susceptibility to all diseases.

> It is crazy here in Australia. In Vietnam, we can get medicine that we want. Pharmacy shops are very happy to sell medicine to clients. Some pharmacists even became my doctors. I was sick; I went to my pharmacy assistant first. I see no difference between them and the doctors. Actually they seem to know more than the doctors. In Australia, if you need to see a specialist, you have to go to a GP first. What a waste of time! If you want some antibiotics, you need prescriptions from your doctors. This is ridiculous! (Female, aged 71)

The Vietnamese dinner discourse is considered as an easy venue for spreading diseases. Vietnamese people use chop sticks to pick up foods from several dishes displayed on a big round tray. Dinner is a sharing experience in terms of food, verbal interaction and physical togetherness. This could be seen as health risk behaviour as diseases can spread among family members.

> I feel very uncomfortable to eat with Australians as they tend to talk less at dinner time. They don't seem to open their mouths while chewing the food. Each person gets food on each's own plate! Everybody seems to mind their own business at the dinner table. Once, we invited a couple to have dinner at our house. I picked up foods with my own chop sticks and placed them in their bowls. They did not seem to appreciate it and my son quietly signalled me to stop doing it. Later on, he told me that it is considered not hygienic to do that in Australia. (Female, aged 63)

Health behaviours and lifestyles

Smoking is a common scene in Vietnam. It is very popular among men. Smoking is seen as a social norm and is taken for granted in many formal and informal social interactions. It takes places at work place, home, entertainment centres, parks, etc. For teenagers, it marks the transition between childhood and adulthood and signals maturity and personal independence. Vietnamese people tend to accept smoking as a 'natural' aspect of living.

Australia is conscious of health problems associated with smoking, which affect not only smokers but also non-smokers in a smoking environment. The Australian Medical Association (AMA) is leading a strong campaign against smoking. For Vietnamese migrant smokers, a new awareness has emerged: smoking can create social isolation as well as health hazard.

> In Vietnam, I could smoke wherever I wanted. Actually it was strange if I didn't smoke when all my friends smoked when we met. But in Australia, I feel very uncomfortable to smoke, particularly when I am with other Australians. My smoking can become a big nuisance to them. I remember clearly the big embarrassment when a host told me not to smoke in the living room of his

> house. I was asked to go outside or threw the cigarette away. I thought it was normal for a visitor to smoke. (Male, aged 64)

In Vietnam, women do not smoke but they are surrounded by male smokers in numerous social contexts. Vietnamese female migrants indicated their support against smoking in Australia.

> I'm very pleased that I'm not surrounded by unbearable smoke as I was in Vietnam. It is good that my husband starts to reduce smoking and this saves a lot of money apart from reducing health problems. When he saw the horrible ads about how smoking affects the lungs, he was so frightened. He never listens to me but when his doctor told him to give up smoking, he listened. A number of our male friends have stopped smoking and I think this will influence others to do the same. (Female, aged 57)

Emotional isolation

Emotional isolation is one of the factors easily causing loneliness and depression to Vietnamese migrants, particularly older people or those with a disability. In a conversation, a grandmother stated that her worst fear was to stay at hospital for treatment. To her, it was like 'hell' as she was surrounded by 'strange people'. She preferred to die in her own country among her own people than to 'disappear quietly' in a hospital.

> My daughter told me to stay a bit longer at the hospital but I did not like it. I felt like a prisoner. True! I wanted to be discharged so that I could go home. I felt very depressed there as everything was so strange to me. I could not watch TV like others. I kept quiet the whole two days there. (Female, aged 85)

Older Vietnamese migrants are deeply concerned about the prospect of having to leave their family and stay in a nursing home. Traditionally, Vietnamese culture encourages family members to care for old people till death. This expectation still exists in the minds of old Vietnamese migrants. However the young generation tends to accept the Western views about caring for old people in poor health. The responsibility shifts from family-based care to institutional care.

> I love my mother very much. But realistically it would be impossible to look after my mother while I have to go to work full time and there are so many things to do in the house. If my mother would have to go to a nursing home, I know it will be very sad for her but I could not help it. Otherwise the family would collapse with having to take care of her. (Male, aged 53)

Linguistic alienation

Gomez and Freidenberg (1995) conducted a study on language as a communication barrier in medical care for Hispanic patients. They pointed out that communication is essential in understanding and improving the health of Hispanic people in America. Similarly, Flores et al (2000) emphasised the importance of language and culture in paediatric care when they conducted case studies from the Latino community.

Language permeates various social communicative interactions. Language means to people when it can perform various social functions for them. This includes initiating and maintain interpersonal communication and social relationship. Moving to a new linguistic and cultural environment creates huge problems when migrants are deprived of language use which is commonly taken for granted in their home countries.

> I feel like a deaf person when I go to a shop or a doctor. I use a lot of gestures to tell them what I want. It works in a number of cases but still I feel so frustrated when I have to discuss or argue with people around me. Language is

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> not a tool. It is power and now I don't have it in this country! In a way, I have been bullied into accepting things that I don't know or don't like. (Male, aged 74)

Linguistic alienation becomes more prominent in public health places such as doctor surgery and hospital.

> Vietnamese people living in big cities like Melbourne and Sydney have a lot of advantages over those living in Tasmania. In big cities, Vietnamese health workers are everywhere: nurses, pharmacists, social workers, health interpreters, and dentists. It is not different from living in Vietnam. But in Tasmania, when you are sick, only your family can help. The Caucasian doctors do not speak Vietnamese. So you feel very uncomfortable to try to tell them what goes wrong. When I am not well, I keep it to myself. It will go away – I hope. Perhaps I should go to Vietnam to live. (Female aged 85)

Trust

Trust is a very significant feature of interaction between health workers and clients. It is much more so with migrants whose beliefs, language, education and social practices are vastly different from those in the new cultural environment. This requires intercultural awareness and understanding from health providers and migrants. As Lausch et all (2003) showed in their study, during their seasonal employment, nurses learned to establish and operate satellite nurse-managed centres. Due to the migrant health nurses' daily contact with their clients, they were able to establish rapport that led to a trusting relationship. This enabled them to provide culturally sensitive and lifestyle appropriate care to the migrant farm worker population.

Western medicine and medical treatment are widely used among Vietnamese migrants. However, there are intercultural issues which are still causing problems to some Vietnamese migrants, for example, informed consent for cancer patients, mixed use of Western and traditional Vietnamese medicines, communication of personal health matters with health workers.

> I don't know how much I should share information about my private life with health workers. They seem to be interested in my health but I feel uncomfortable to tell them too many things. Last time, my wife suffered from cancer. I was shocked when the doctor told my wife that she had cancer and would die within a year. I was so angry. He should not have told her direct. I am her husband and I should have been the one to tell her. I don't trust the doctors to do this kind of things. (Male, aged 53)

Conclusion

Social epidemiology has provided useful insights into health problems facing people of different socio-economic backgrounds. Australia is a multicultural society in which migrants from various parts of the world have chosen this country to become their second or third country. They have contributed a great deal to the cultural enrichment of Australia. However, migrants have also brought along to Australia their own cultural values and social practices which may not be awared of by ordinary people and those working in public services, including health workers. This study attempts to provide some insights into the problems facing Vietnamese migrants in Australia, particularly on health issues.

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