VIETNAMESE WOMEN LIVING IN CANADA: CONTEXTUAL FACTORS AFFECTING VIETNAMESE WOMEN'S BREAST CANCER AND CERVICAL CANCER SCREENING PRACTICES

by

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Abstract

The aims of this qualitative research were to explore (a) how Vietnamese women participate in breast cancer and cervical screening, what leads Vietnamese women to seek health care, from whom they seek help, and the social support networks that they draw upon to foster their health care practices, (b) whether Vietnamese women find the current preventative cancer services suitable and accessible to them, (c) how Vietnamese women's breast cancer and cervical cancer screening practices are influenced by social, cultural, political, historical, and economic factors which are shaped by the conceptualisation of race, gender, and class, and (d) how differences between Vietnamese women's perspectives and those of health care providers influence women's health care experiences.

By 2001, the estimated number of Vietnamese immigrants living in Canada was 151,410, approximately half of them women. Data from the U.S. and Australia show that breast cancer and cervical cancer are major contributors to cancer morbidity and mortality among Vietnamese women. Studies also suggest that Vietnamese women are at risk due to their low participation rate in these cancer preventative screening programs.

Informed by Kleinman's explanatory model, postcolonialism, and feminism, in-depth interviews were conducted with 15 Vietnamese Canadian women and 6 health care providers. The study reveals the following major factors determining how Vietnamese women participate in breast cancer and cervical cancer screening programs: cultural conceptualisations of health and illness, social values and beliefs about the woman's body and social relationships; gendered roles and expectations; diminished social support networks; low socioeconomic status; and inaccessibility of health care services. At the theoretical level, I propose that health care professionals should (a) recognise that women of different ethno-cultural background are active participants in health care, (b) put less emphasis on western rationality and more on the recognisation that women's health care decision making is a dynamic process that varies under different circumstances, and (c) recognise that women's health care behaviour is influenced not only by their cultural knowledge and values, but also by their socially constructed position, race, gender, and class. At the practical level, I propose (a) that collaborative working relationships with physicians and improved physician-patient relationships are essential for successful promotional strategies for Vietnamese women, and (b) that a health education strategy must incorporate Vietnamese women's

different ways of knowing. At the institutional level, increasing accessibility to these cancer preventive programs demands that health care policy makers increase institutional funding to support programs that provide services to immigrant women.

Recommendations for future research include (a) a population-based survey to assess the current status of Vietnamese Canadian women's breast and cervical cancer screening practices, and to investigate the relationship between identified factors and Vietnamese women's cancer screening practices, (b) the development and implementation of a health promotion and disease prevention program that incorporates the findings of this study into its promotional strategies, and (c) an experimental study to evaluate the effectiveness of the newly developed promotional strategies on breast and cervical cancer screening among Vietnamese Canadian women.

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Acknowledgments

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In dedication to...

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Prelude

It's beginning with my last gaze
Upon the land I once called "home"
Sadness
Gladness
Fear
But my new home
will be filled with
laughter,
warmth,
and security.
I envisioned.

Look at me!
Can you see a silent smile?
Yes, I laugh
but my laughter has no sound
Yes, I am warm...within these walls
Secure...if my loved ones around

Please! Sir, which way do I go?
Left?... Right? Back or forth?
Back and forth
Back and forth.
Loss....
in this strange world.

I cannot tell you how I feel
my anguishes, my joys, my wishes
For words piled up inside
Cannot come out!
cannot come out!
cannot come out!
I am locked up inside.

Talk to me in any language...yours, mine, ours.
I will only smile and nod.
But the sound of your voice
means that your are present and that you care.
It fills this empty space
that keeps me locked up inside.
For without voices...
You
Me
We
are all locked up inside.

Tam Truong Donnelly

Chapter One: Introduction

An increase in the number of immigrants to Canada has changed Canadian social structure and approaches to health service delivery. Ensuring that immigrants from different ethnocultural backgrounds have equal access to appropriate health care services is an important issue for both the government and health care disciplines (British Columbia Ministry of Health and Ministry Responsible for Seniors, 1997).

Between 1979 and 1985, approximately 85,000 South East Asian refugees arrived in Canada, most of them Vietnamese. "Refugees" as defined by the Citizenship and Immigration Canada (CIC), are people in or outside Canada who fear returning to their country of nationality or habitual residence. These are persons needing protection. Canada, through its refugee protection system, provides safe haven to those with a well-founded fear of persecution, or are at risk of torture or cruel and unusual treatment or punishment (Citizenship and Immigration Canada, 2004). By contrast, the term "immigrants" refers to persons who seek lawful admission to Canada to live as permanent residents (Citizenship and Immigration, 2004). Most of the Vietnamese who came to Canada between 1975 and 1985 were refugees. It is important to note that in this dissertation, I use the term "immigrant" to cover persons who are admitted to Canada in either the refugee or the immigrant category. I have given much thought to the use of this term. While I fully realized that the experience of a refugee versus an immigrant might be different due to the legal differences for immigration, I decided to use this term to cover Vietnamese refugees and immigrants because as my data show, Vietnamese who came to Canada as refugees and Vietnamese who came to Canada as immigrants (the majority of them came under family class category) face similar cultural, language, and economic challenges. Furthermore, even though Vietnamese who arrived as refugees received more support from the government than those who arrived as immigrants who received support from family members, this kind of support only lasted for a short time. Thus, there are very few differences in the eligibility for services and other institutional support by both groups.

Although the term immigrant can generate negative stereotypical assumptions, using the term "immigrant" enabled me to avoid the term "refugee," a word which often implies that a refugee is usually a "survivor of oppression, plunged into poverty, purified by their suffering, and boundlessly grateful for safe haven" (Beiser, 1999, p. 170). The problems arise when there is evidence to show that the refugees are not "pure" or not "grateful" to the host society. There is a growing public ambivalence towards refugees.

Despite the fact that many Vietnamese refugees have successfully integrated into Canadian society and are good citizens, public misinformation about Vietnamese gang-related problems casts shadows on their image (Beiser, 1999). Sympathy turns to negativity and doubt. Not only are Vietnamese now viewed as trouble makers by some Canadians, but they are also viewed as a burden.

A national survey by the Gallup organization of Canada in 1994 revealed that 39% of Canadians believe that "refugees were using up more than their share of the country's health and social services" (Beiser, 1999, p. 168-169) and 43% feel that the presence of Southeast Asian refugees in Canada costs the Canadian taxpayers too much money (Beiser, 1999). Furthermore, one-quarter of the Gallup poll respondents do not believe that "Southeast Asian refugees are interested in giving something back to Canada" (Beiser, 1999, p. 169).

By 2001, the estimated number of Vietnamese immigrants living in Canada was 151,410 and 25,675 of these immigrants made their home in British Columbia (Statistics Canada, 2001 Census). Before coming to Canada, the majority of these immigrants suffered from poor health, disadvantaged economic situations, limited education, and lack of adequate medical care. Data from the U.S. and Australia show that breast cancer and cervical cancer are major contributors to cancer morbidity and mortality among Vietnamese women, especially cervical cancer. Studies have also suggested that Vietnamese women are at risk due to their low participation rate in cancer preventative screening programs.

The new Health Goals for British Columbia were developed in 1997 as the result of an extensive public consultation process. The Ministry of Health's mission is "to maintain and improve the health of British Columbians by enhancing quality of life and minimising inequalities in health status" (British Columbia Ministry of Health and Ministry Responsible for Seniors, 1997, p. 5). Equality is a basic social value underlying the Canadian health care system. Equality in health care means that, in principle, all citizens should be given equal access to health care regardless of wealth, race, gender, or ethnic origin (Storch, 1996). However, according to the 1991 BC Royal Commission on Health Care and Cost, there is evidence that immigrants living in British Columbia do not have equal access to health care services.

Many health care providers have recognised that immigrants often encounter difficulty accessing health care services and provision. Barriers to access the health care delivery system include limited language skills, different cultural health beliefs and practices, lack of cultural acceptance and appropriate health care services, and lack of social resources (Anderson, 1998; Hirota, 1999; Stephenson, 1995).

Furthermore, ethnic inequality, unequal health care provider-client power relations, restructuring of the health care system with its emphasis on lowering health care costs have been identified as barriers to providing health care services for Asian immigrants. Despite the fact that BC's health care system has changed its services to some extent to accommodate the health care needs of the different ethno-cultural background clients, the BC Provincial Health Officer's 1996 Annual Report of 1995 revealed that "the health care needs of adults and children living in...ethnic neighbourhoods are not being well-served by the current system" (p. 1). Anderson and her colleagues (1993) argue that a significant number of immigrant women had difficulty in their encounters with health care professionals. The women, especially non-English speakers, were unable to obtain the services they needed because health care professionals often failed to understand that the position and condition in which the women worked and lived could be a major deterrent to the appropriate management of illness. As a result, the current health care system, which is based on the Western ideology of health and illness, frequently fails to accommodate the health care needs of clients of different ethno-cultural backgrounds (Anderson, 1991). In addition, dominant mainstream cultural conceptualisations can also situate and define immigrants' experiences within the health care system (Donnelly, 1998). In this dissertation, I use the term "health care providers" to mean health care professionals who provide health care to immigrants either directly or indirectly.

In Canada, breast cancer is the second leading cause of cancer-related death for Canadian women over 50 years of age (National Cancer Institute of Canada: Canadian Cancer Statistics, 1998, 2003). Approximately 21,100 women developed breast cancer and 5,300 women died of this disease in 2003 (BC Cancer Agency, 2003). Breast cancer is primarily a disease of older women. The estimates for 2000 indicate that for all types of cancer, only 1% of new cases and 0.3% of deaths occur prior to age 20 (National Cancer Institute of Canada: Canadian Cancer Statistics, 2000). The risk of developing breast cancer increases with increasing age. According to the 2000 Canadian Cancer Statistics, for breast cancer, 22% of cases occur in women under age 50, 45% occur in women aged 50-69, and 32% in women aged 70 and over. Although data on Vietnamese Canadian women's breast cancer incidence and mortality rate are limited, study shows that even though Asian American women's breast cancer incidence rate is lower than that of American women, the mortality rate tends to be higher for Asian American women (Perkins, Morris, & Wright, 1996 cited in Wismer, 1999).

Even though cervical cancer is not ranked as the leading cause of cancer-related death, it is among the most common cancers for women in the countries where Papanicolaou (Pap) smears are not

routinely performed (BC Cancer Agency, 2000). Studies from the U.S. have revealed that the incidence and mortality rate for cervical cancer is notably higher for Asian American women than for White American women (McPhee, Stewart, Brock, Bird, Jenkins, & Pham, 1997; Perkins et al., 1996 cited in Wismer, 1999). Studies from Australia also indicate that Vietnamese-born women have a significantly higher incidence of cervical cancer (Cheek, Fuller, Gilchrist, Maddock, & Ballantyne, 1999; Lesjak, Hua, & Ward, 1999).

The Canadian national forum on cervical cancer screening in 1995 confirms that the Pap test reduces the incidence of cervical cancer significantly (Lee, Parsons, & Gentleman, 1998), and early detection can reduce breast cancer mortality by 25-30% (BC Cancer Agency, 1999, 2004). This points to the necessity for early detection and treatment of these diseases in its early stages.

Early detection of breast cancer and cervical cancer through screening is recommended by the Canadian Department of Health and Fitness, the Canadian Public Health Association, the Canadian provincial cancer agencies (Appendix A, p. 227), and the United States 1996 Preventative Services Task Force (Wismer, 1999). Women over 20 are recommended to have regular annual clinical breast examination (CBE) by doctors or qualified health professional (BC Cancer Agency, 2004). It has been suggested that women over age 20 should also practice breast self examination (BSE) monthly (Liu, 1999). However, monthly BSE is more controversial. Recently, it has been argued that BSE might not be an effective prevention measurement due to its inaccuracy. There is evidence to show that BSE does not reduce mortality from breast cancer and may increase women chances of having a benign breast biopsy (Thomas, Gao, Ray, Wang, Allison, Chen, Porter, Hu, Zhao, Pan, Wu, Coriaty, Evans, Lin, Stalsberg, & Self, 2002). Although 70% of breast cancers occur in women over 50 with no risk factors (i.e., family history of breast cancer, not having children, having first baby after age 30), regular mammography is recommended for women according to their age/risk group or at least every 2 years after the age 50 (BC Cancer Agency, 2004). Cervical cancer is much less common than breast cancer, largely because of the success of cervical cancer screening (BC cancer Agency, 2004). Pap tests are recommended at least every 2 years by the BC Cancer Agency for all sexually active women until age 69. Women over 69 may stop having regular Pap smear if all their previous smears have been normal (BC Cancer Agency, 2004).

In North America, Asian women's preventive care needs remain poorly understood and their health problems have received less attention (Taylor, Hislop, Jackson, Tu, Yasui, Schartz, Teh, Kuniyuki, Acorda, Marchand, & Thompson, 2002). Data from Statistics Canada 1994/1995 National Population

Health Survey illustrate that Asian women are less likely to have Pap tests and the number of Asian-born women who never had a Pap test were almost nine times higher than those of Canadian-born women (Lee, Parsons, & Gentleman, 1998). A community-based survey of 776 Chinese women in British Columbia (Hislop, Teh, Lai, Labo, & Taylor, 2000) revealed that the proportion of Chinese women receiving Pap testing is lower than the provincial average (74% of the women had at least one previous Pap smear and 56% had a smear within the last 2 years).

Although the U.S. national surveys which investigate mammography and Pap test use from 1987 and 1992 show a decrease in differences in screening practices by ethnicity (Martin, Calle, Wingo, & Health, 1996), the 1993/1994 Behavioural Risk Factor Surveys revealed that the group of "Asian/Other" women were less likely to have mammography compared to the general American women (Davis, 1996 cited in Wismer, 1999).

I conducted a thorough literature review but was unable to locate Canadian data on Vietnamese women's breast cancer and cervical cancer screening. The sparse data from the U.S. and Australia suggest that Vietnamese women have a lower rate of participation in these cancer screening services (Cheek et al., 1999; Jenkins, Le, McPhee, Stewart, & Ha, 1996; Lesjak, Hua, & Ward, 1999; Yi, 1994). Studies from the U.S. indicate not only that Vietnamese women's cancer screening practices are not up to the recommended guidelines, but also that they were less likely to have had screening tests for these cancers compared to the general American women's population (Jenkins, Le, McPhee, Stewart, & Ha, 1996; Yi, 1994). The result from a telephone survey of 933 Vietnamese women living in California shows that 70% of these women had at least one clinical breast examination, whereas only 30% had a mammogram and 53% had a Pap test (McPhee et al., 1997). A more recent study by Sadler, Dong, Ko, Luu, and Nguyen (2001) with 275 Vietnamese American women revealed that the rate of having a mammogram among these women was below recommended level and only 36% reported having adequate knowledge about breast cancer screening. Furthermore, a questionnaire survey of 355 (Lesjak et al., 1999) and an interview survey of 199 Vietnamese-born women living in Australia (Cheek et al., 1999) revealed that the Vietnamese women had a lower level of participation in cervical cancer screening than that of the general population women. This low rate of screening suggests that Vietnamese women may be at risk for lack of early detection and treatment of cancer in its early stages.

It has been obvious to the health care professional that successful treatments and effective health care can only be achieved if it is appropriate and accepted by the person who receives health care. This

awareness is essential, especially in providing health care to clients of a different culture. Different views of health, illness, and priorities between health practitioners and clients can create obstacles to helping relationships if a mutual solution cannot be reached. The point to remember is that, "the benefits of Western biomedicine cannot be realised unless practitioners are able to provide care in such a way that it is socially and culturally acceptable to their clients" (Anderson, 1990, p. 137). As such, it is important to include in any health inquiry both the clients' and the health care providers' perspectives.

This study was conducted in Vancouver, British Columbia (BC), Canada. Vancouver is located on the west coast of BC, the westernmost of Canada's 10 provinces. It is know for its spectacular mountain skyline, Pacific Ocean view, blooming flowers and mildest weather in Canada. The city's mean temperatures average 20° C in the summer and 2°C in the winter. Beautiful views and mild temperatures have attracted many immigrants who came from warm climate countries. As a result, Vancouver is quite cosmopolitan with a mix of many multicultural groups. The immigrant population makes up 38% of Vancouver's 1,986,965 total population. Regarding the diversity of language, 61.2% of the population speak English, 1.3% speak French, and 37.5% speak non-official languages (British Columbia Ministry of Communities, Aboriginal, & Women's Services, 2001).

A profile of immigrants in BC communities in 2001 shows that 50% of female immigrants are employed and the average income of these employed women is $24,790 per year. The three top occupations for female immigrants were clerical (12%), general sales and services (12%), and manufacturing machine operators (5%) (BC Ministry of Communities, Aboriginal, & Women's Services, 2001). More recent data show that Vancouver has experienced the largest increase in low income of all metropolitan areas in Canada (Statistics Canada, 2000). Furthermore, 37.4% of all recent immigrants were in low income; double the proportion of 17.8% two decades earlier (Statistics Canada, 2000).

Table 1.1

2001 Canada, British Columbia, and Vancouver Population Profile

	Canada	British Columbia	Vancouver
Total population	29,639,035	3,868,875	1,986,965
Immigrant population	5,448,480	1,009,820	38,289
Share of total population	18%	26%	38%
Vietnamese population	151,410	25,675	22,140
Share of total population	0.5%	2.5%	3%

Source: Statistics Canada, Census of Population and Housing
BC Stats www.bcstats.gov.bc.ca

The purposes of this research were:

1. To explore how Vietnamese women participate in breast cancer and cervical screening. Specifically, what leads Vietnamese women to seek health care and from whom do they seek help, and what social support networks do they draw upon to foster their health care practices.
2. To explore whether Vietnamese women find the current preventative cancer services suitable and accessible to them.
3. To explore how Vietnamese women's breast cancer and cervical cancer screening practices are influenced by social, cultural, political, historical, and economic factors which are shaped by the conceptualisation of race, gender, and class.
4. To explore how differences between Vietnamese women's perspectives and those of health care providers influence women's health care experiences.

Vietnamese Canadian women's health care practices and the ways in which they participate in breast cancer and cervical cancer screening programs are influenced by their cultural knowledge and values about their bodies, about health care provider-client relationships, and their conceptualisations of health and of what causes diseases and illnesses. An understanding of how their cultural knowledge and values shape their world view and experiences can help the promotion of breast cancer and cervical cancer screening among these women.

It has been pointed out that different conceptualisations of health and the sources of illness can pose a barrier to seeking treatment from Western health care (Stephenson, 1995; Uba, 1992). LaBun (1988) in an earlier qualitative study conducted with Vietnamese women living in Canada revealed that Vietnamese women's understanding of health influenced the ways in which they view and use Western medicine and traditional health care practices. Studies by Maltby (1998) and Stephenson (1995) showed that the Vietnamese conceptualisation of health and illness, cultural beliefs, values, and expectations towards treatment shaped the ways in which they practice health care. Stephenson's study also revealed that the different environments and circumstances from which Vietnamese immigrants come created many health problems and barriers to accessing health care.

To understand how a different culture and cultural conceptualisations of health, illness, and disease influence Vietnamese women's health care decision making, I draw on the explanatory model developed by Arthur Kleinman (1978, 1980). Kleinman's explanatory model provides the conceptual framework for an understanding of how clients from different ethnocultural backgrounds practice health care. As immigrants, and as women who came from a so-called Third World country, Vietnamese women's situated social position is one that is marginalised and subordinated to the mainstream society. To investigate how contextual factors —cultural, social, political, historical, and economic— at the intersection of race, gender, and class influence Vietnamese Canadian women's lived experiences and health care practices, I draw on postcolonialism and feminism.

The main method of investigation was individual in-depth interviews with Vietnamese Canadian women and health care providers. The interviews were conducted with 15 Vietnamese women and 6 health care providers. In the present study, eight women came to Canada as refugees and another seven women came via the sponsorship program under family class. The findings of this research will be disseminated to health care professionals, health care policy makers, and other scholars interested in the areas of migration, gender, and health. The findings will also be used to develop a program of research that aims to develop cultural appropriate and acceptable cancer preventive service for Vietnamese Canadian women. This research will provide information on the utilisation of health care services and women's social support networks that foster health care practices, on women's health-seeking behaviour and decision-making, and on pertinent changes in policies and institutional practices. It may contribute to the empowerment of Vietnamese Canadian women through making their voices heard, and to improving quality and accessibility to health care services for Vietnamese immigrant women.

An understanding of cultural knowledge, values, patterns of family kinship, religion, and of social, political, and historical processes will assist in identifying health care strategies that could be applied to health promotion and disease prevention among Vietnamese immigrants. In the following chapters, I explore some of these issues in the hope of shedding light on Vietnamese women's responses to living in Canada, and the ways in which they practice health care.

This research was approved by the University of British Columbia Ethics Review Committee (Appendix B, p. 229). Each participant was given an explanation of the study before informed consent was obtained. To preserve anonymity, all identifying information was removed from transcripts and code numbers were used (Appendix C, p. 230). All participant names used in this dissertation are pseudonyms. The following is the outline of chapters in this dissertation.

Chapter two is the review of literature. In this chapter, I highlight certain historical, cultural, economic, social, and political issues affecting settlement and adaptation processes of Vietnamese immigrants. To situate this research in the Canadian context, I discuss some of the experiences of Vietnamese women living in Canada and their knowledge of breast cancer and cervical cancer, and of screening for these cancers. In chapter three, I address the theoretical perspectives that underlie this research. Chapter four reveals the method that was used for data collection and analysis. The results of this dissertation are discussed in chapter five, six, seven, eight, and nine. Chapter five addresses how culture knowledge and values influence Vietnamese women's lives and health care practices. Chapter six underscores the influence of gendered roles and expectations on the Vietnamese women's health care practices and cancer preventative screening. Chapter seven addresses social support networks that women draw upon to practice health care. In chapter eight, I discuss how socioeconomic status affects Vietnamese women's health care practices. Chapter nine clarifies how the women participants and their health care providers view health care responsibility. I show how being "different" affects health care services provided to immigrant women. Chapter 10 is the concluding chapter and includes my discussion and recommendations.

Chapter Two: Literature Review

Vietnam, an "S" shaped country of Southeast Asia, covers 33,000 sq. kilometers. Three quarters of the country are covered in mountains and hills. The rest is open plains and crop growing deltas. There are two main deltas, the Red River Delta in the northern part of the country and the Mekong River Delta in the South. The country is 1,600 kilometers long and 50 kilometers wide in its narrowest part. With the Truong Son mountain to the West, the Pacific to the East, and powerful China to the North, Vietnam is considered a strategic position in the heart of Southeast Asia, and is a "crossroad" between Western and Eastern civilisation (Huu Ngoc, 1996). About 86% of the population is Viet – the main ethnic group. The rest consist of numerous ethnic minority groups including Thai, Tho, Lu, Nung, Nhang, Meo, Muong, Yoa, and Lalos (Huu Ngoc, 1996; Sharma, 1988). The participants in the present study are of the Viet ethnic group.

Although appearing on the surface to have some common identity, there is diversity among Vietnamese Canadian women, who come from different backgrounds, have different experiences, and encounter different obstacles. Thus the information in this section represents an admittedly selective rather than exhaustive account of Vietnamese social, cultural, historical, and religious issues and experiences. My emphasis is on general factors that influence and/or construct the lives of Vietnamese in Canada.

To understand Vietnamese immigrants' health care experiences and cancer preventative practices in Canada, one must understand the historical, cultural, economic, social, and political issues affecting their settlement and adaptation processes in Canada. This chapter is divided into four main sections. In the first part of this section I review some general information on Vietnamese historical issues. The second section addresses Vietnamese cultural and religion tradition. It explores how certain cultural conceptualisations and religious principles might have shaped the Vietnamese social relation and experiences. This section also briefly describes Vietnamese kinship patterns, family dynamics, the development and expectations of gender roles. I address how the female body is conceptualised in both Western and Eastern world, which influence the ways in which Vietnamese women participate in breast and cervical cancer screenings. To locate this research in the Canadian context, the third section addresses some of the experiences of Vietnamese living in Canada. Special attention is paid to the Vietnamese women's experiences. In the fourth section I review some general breast cancer and cervical

cancer information. I descibe what is known currently about Vietnamese women breast and cervical cancer screening practices.

A. Vietnam: A Brief History

To briefly capture the Vietnamese historical path, Huu Ngoc has provided this summary: One thousand years of Chinese domination; 900 years of national independence; 80 years of French colonisation; 30 years of war of independence and revolution; and since 1975, a period of rebuilding the country's social and economic structure (Huu Ngoc, 1996, p. 352).

Vietnam's one thousand years under Chinese domination lasted from 111 B.C. until the tenth century. During this time, numerous revolts led by either mandarins or peasants resulted in brief periods of independence. Among the most memorable revolts was the Trung Sisters' quest for national unification and independence in 41 A.D. However, Chinese rule did not end until Ngo Quyen defeated the Chinese in 931 A.D. and became King of Dai-Viet – the independent Vietnam (Sharma, 1988).

The next 900 years of national independence, which extended from 938 to 1858 A.D., were marked by peasant resistance to the feudal lords and landowners, civil wars, and defending the country against Chinese invasions. It was also the period where Vietnamese Emperors expanded their territories to the South. In Vietnam's state of independence, Chinese influence nonetheless remained significant, manifesting itself especially in the mandarin education system, in religion, and in cultural patterns (Nguyen Khac Vien, 1974; Sharma, 1988).

The French colonial control of Vietnam extended from 1885 to 1954, leading to the establishment of French Indo-china. The French, with total control of Vietnam, systematically administered the colonial regime that consisted of intense exploitation of the country's economy (Sharma, 1988). Rubber and other crop plantations, coal, and mineral mines were developed to supply the French market with raw materials. Thousands of Vietnamese peasants were driven from their land and forced to work in the difficult and dangerous conditions on these plantations. A folksong revealingly sings:

> "It's easy to go to the rubber plantations,
> But hard to return from there.
> Men left their hides, women their bones."
> (Mai Thi Tu, 1990, p. 191)

Not only did the entire Vietnamese economy change under the French rule, but the societal structure did as well. The French presence created two main groups of people – a group that consisted of French-educated individuals who benefited from the presence of the French, who also enforced French rule and embraced Western technologies and knowledge, and indigenous peasants who worked as servants and labourers. The gap between rich and poor was also widened by the introduction of capitalism.

However, the changing picture of the Vietnamese society would not be complete without mentioning other impacts of the French on Vietnam. Western technology was introduced under French direction. A network of new roads, railroads, and ports were developed. The French government reinforced and modernised the dike systems, and built extensive irrigation and drainage work. Public services such as hospitals, schools, and scientific research institutes were developed. Public sanitation was also improved and outbreaks of epidemic diseases were less frequent (Hammer, 1966). As a result of these changes, the Vietnamese population doubled and Vietnam's production of rice and corn increased greatly. One can argue that the French rulers brought about these changes to benefit themselves – they needed to increase the production of raw material to export to France and therefore did not have Vietnamese people's interests in mind when they forced these changes. It is a fact that "under French direction, Vietnam became a large-scale exporter of agricultural products and raw materials. The country assumed a typical colonial economy" (Hammer, 1966, p. 116).

During the 30 years war of independence and revolution from 1945 to 1975, Vietnam was in shambles. As Gloria Christie (1996) quite accurately stated, "the country... industry had been largely destroyed, the economy was shattered ... the population was dislocated and fragmented, agriculture was disrupted to a large degree... and social structure distorted" (p. 49)

In reading Vietnamese history, one is astonished at the long record of cultural domination and the Vietnamese people's persistent resistance to it. From its beginning Vietnamese history seems filled with wars against foreign forces to achieve national independence. A Vietnamese artist observed, "Vietnam wars are always people's wars. We always seem to be fighting nations much bigger and more powerful than [we are]. That means everyone must be united and everyone must participate in the struggle...Our struggles are far more political than military" (Luce, 1990, p. 169).

Significantly, everyone including women and children participated in these wars. The legendary story of the two sisters (Hai Ba Trung) – Trung Trac, Trung Nhi, and later on – Ba Trieu, changed

Vietnamese history as women were then recognised not only for their economic contributions, but also for their roles as leaders. Images of Vietnamese women leaders remain prominent in numerous insurrections and resistances to invasions of foreign nations.

It is misleading to construct an image of Vietnam as a country which has always been subjected to invasion by others. Vietnam had also followed its own course of colonising other lands. Dating back to the Ly, Tran, and Le dynasties, from the 11th century to the 17th century, the need for more rice-growing fields, the expansion of economic markets and military potential led the Vietnamese of the North to colonise the South, across the Transversal Pass (Deo Ngang) to the heart of Mekong River Delta, leading to the shape of Vietnam today (Huu Ngoc, 1996).

B. Vietnam: Religion and Culture

It is essential to review Vietnamese religious make up because religious principles have not only had an impact on how Vietnamese women are perceived and situated within a society, but have also shaped their experiences within the family system and kinship organisation. The influence of gender roles and expectations on Vietnamese women's health care behaviour is revealed when one examines how religious principles influence women's beliefs and values, and social position.

In general, religious beliefs and practices in Vietnam reflect its long history of indigenous development and colonial domination. Religious beliefs in Vietnam are primarily a combination of Confucianism, Taoism, Buddhism, Catholicism, and Protestantism. Vietnamese people have also traditionally worshiped nature and ancestors. The concept of heaven "Troi" is connected with morality and justice. It is a place where one will eventually be judged. Reward will be given to moral, dignified, and caring souls. Punishment will be given to the soul of individuals who, when alive, did not respect their parents, and were immoral and uncaring.

Because the majority of the Vietnamese are Confucians and Buddhists, Confucianism and Buddhism weave heavily into Vietnam social fabric. The integration of these teaching principles shape Vietnamese social practices and social relationships. All of which, in turn, have directly or indirectly influenced how Vietnamese women practice health care and participate in breast and cervical examinations.

1. Confucianism

Many Vietnamese are influenced by and practice Confucianist principles. "For the Vietnamese, Confucianism represents much more than a doctrine inscribed in venerable texts; it is a legacy of history, a fundamental legacy to be understood, [and at times] fought against and overcome in the course of the historical change" (Nguyen Khac Vien, 1974, p. 16).

Confucius taught that man is a social being, formed by society, and bounded by social obligations. The Confucianism code of ethics and morals for people consists of many specific duties (Rutledge, 1985). These duties are to serve the King, honour the parents and the elders, be faithful to the spouse, take care of the family, serve the country, and help to maintain peace in the world. Individual tasks are, then, to study, improve one's self, so that they can assume those duties and fulfill social obligations (Nguyen Khac Vien, 1974). As observed by Nguyen Khac Vien (1974), "Confucianism was something that was lived. On the columns of houses, on engravings, on the doors of monuments, inscriptions reminded us at each step of the teachings of the Confucian tradition. Confucian expressions and quotations abounded in everyday language as well as in literature" (p. 16).

For ten centuries Confucianism was the intellectual and ideological backbone of Vietnam. Confucianism was the official doctrine of the traditional Vietnamese educational system which was open to all persons except theatrical people and women (Nguyen Khac Vien, 1974). As a result, women were excluded from attaining an education and administrative positions.

Under Confucianism, Vietnamese society was divided into two main categories – one that consisted of a small group of literate elite and the other much larger group of peasantry (FitzGerald, 1972). Vietnamese history is filled with the depiction of peasantry struggle. As observed by Nguyen Khac Vien, "the peasants' struggle for their rights weaves in and out of Vietnamese history like a piece of red thread. Unless we can grasp the concept of peasants' struggle, we cannot understand Vietnamese history" (1972, p. 20). Thus, Confucian orthodoxy brought extreme pressure to submit to authority. In the name of Confucius, Vietnamese peasants and women were denied a number of rights and subjected to numerous tests of discipline.

Under feudal society, the high value placed on education, which is internalised by Vietnamese people, is directly linked to Confucianism and the societal administrative system. Education was highly valued among the Vietnamese because of the conception that education would not only make the individual a better person, but also bring status, power, and wealth to the family. Therefore, many

families, no matter how poor, did everything they could to send their children (mostly boys) to school. When a child showed promise, the family would make great economic sacrifices to enable him to continue his studies. This child then devoted all of his time to studying. He was exempted from physical work. To have a mandarin in the family was the highest honor and economically beneficial for the whole clan. Therefore, for centuries, to become a mandarin was the greatest ambition a boy could have. As for Vietnamese girls, a verse from a popular folk song gives us insight into their hopes and dreams: "I long for the brush and desk of the scholar, and not for lush rice fields and fish-filled ponds" (Nguyen Khac Vien, 1974. p. 29). The very best that a girl from a "good family" could hope for was to marry a scholar on the chance that he would one day become the mandarin. Nevertheless, a girl who married a scholar had a very difficult life. Because her husband devoted all his time to studying, she was the sole supporter of the family, also looking after the children and her in-laws. Many of them worked from early morning till the late hours of the night. Moreover, a woman was governed by the "Three Obedience" code of conduct – dictated by Confucianist. As young child, she was to obey her father; as a wife, she was to obey her husband; and as a widow, she was to obey her eldest son (xuat gia tong phu, ma phu tu thi tong tu) (Eisen, 1984; Thuy, 1976). This code denied her the possibility for self-determination and independence.

2. Mahayana Buddhism

It is important to note that Confucian and Buddhist practices and beliefs are not exclusive. About 70% of Vietnamese are considered Buddhist (Rutledge, 1985). The founder of Buddhism is Siddhartha Gautama Buddha. The essential teaching of Siddhartha Gautama is comprised in eight principles – the Eightfold Path which are "right views, right aims or intentions, right speech, right action, right livelihood, self-discipline, self-mastery, and contemplation" (p. 32), and the Four Noble Truths which are "(1) existence (life) is suffering; (2) suffering is caused by inherently insatiable desires; (3) desire must be suppressed in order to end suffering... [and] (4) the way to achieved this is to follow the Eightfold Path" (Ashby, 1955 cited in Rutledge, 1985, p. 32).

Buddhism was the dominant religion of Vietnam until the thirteenth century. Towards the end of the thirteenth century, Buddhism went into decline. By the fifteenth century, it was no longer the dominant religion and Confucianism took over (Nguyen Khac Vien, 1974, p. 21). During the French colonisation period, Buddhism was not supported by the French government. After the separation of the country in 1954, Buddhism diverged in the North and in the South. In the South, Buddhist monks engaged quite

actively in political action and notoriously several Buddhist monks set themselves on fire to protest certain political actions and the repression of Buddhism by the government. In the North, the practices of Buddhism, although not encouraged by the communist government, were integrated as part of the religious life of the people.

3. Taoism

Taoism taught that the human being and the universe are in harmony. There are unchangeable laws that govern the universe and nature, and individuals should try to live within these laws as best they can. Because one cannot change laws and forces of nature, it is best that one should stoically accept one's fate in life. The world and humanity exist through the interaction of two forces – Yang and Yin. "Yang is masculine, active, warm, dry and positive; while Yin is feminine, dark, cold, inactive and negative" (Rutledge, 1985, p. 30). Women, in the eye of Taoists, were viewed negatively since they were associated with dark, cold, inactive, and negative forces. Although Taoism pressured the Vietnamese to be passive, to accept their fate for the benefit of unity and harmony, from a psychological perspective, Lao Tze's teaching might have provided Vietnamese people with coping strategies that deal with difficult life circumstances. In many cases, there was perhaps nothing that a peasant or a woman could do to change the oppression in their lives.

4. Christianity

A missionary, Father Alexander de Rhodes, first brought Christianity to Vietnam in 1626. It grew under the French colonial regime (Rutledge, 1985). In 1954, many Christians from the North of Vietnam migrated to the South. In the South, Christianity had a dominant status, because the South Vietnamese government and its president's family were Christians. Meanwhile, under the communist regime, Christianity in the North went into decline. Since Christianity was conceptualised as French – the coloniser's religion, its practices were not welcome and came under attack by Vietnamese writers. Several stories and books depicting immoral practices and corruption of the church organisations were published. Although Christmas was still celebrated by the people to some extent, certain Christian practices were perceived quite negatively.

5. Communal Life

Vietnam culture and tradition are generally influenced by ethical and moral codes taken from Confucianism, Taoism, Buddhism, and Christianity. However, the two dominant religious ideologies that govern the life of Vietnamese are Confucianism and Buddhism. Every traditional village has a "*dinh*" (Communal House), which represents Confucianism and a "*chua*" (Pagoda) which represents Buddhism. Confucianism places emphasis on "strict social hierarchy, absolute loyalty to the loyal dynasty and the family, and ...conformity to rules prescribed by the village," whereas Buddhism places emphasis on "compassion and universal kindness where hatred did not dissolve into hatred but into love" (Huu Ngoc, 1996, p. 309).

Vietnamese cultural practice and production are socially constructed, and derived from social activities. Vietnamese communal life in general, often centered on the village, was lively and cohesive. Villagers' main activities were organised around the growing of rice in irrigated fields. Collective organisation of agricultural waterworks and clusters of houses provided stable, organised communities that gave support to each household in the village. This form of collective life in the villages often consisted of several thousand people linked by clans' affiliation. Labour trade between families in the clan during harvesting season was the norm.

Traditionally, the leaders of these villages were often Confucian scholars (Nguyen Khac Vien, 1974). From 1945 to 1975, under communism in the North, French then U.S. control in the South, leaders were often the officers of the government in power. After 1975, with the fall of the South Vietnamese government, Communist Party Members took total control of the country's administrative system. In a more contemporary Vietnam, the village remains an informal association of families and forms the individual basic community in the rural areas (FitzGerald, 1972), whereas in urban areas only relatives from both sides of the family form the individual's informal social support network.

The Vietnamese words, "*dat nuoc*" – "*dat*" meaning land and "*nuoc*," water, communicates how valuable land and water are to the Vietnamese people. Their lives depend on the fertility of their land and the amount of water they have. Most of the country's 33,000 sq. kilometers are covered in forest and mountain land; the remainder of the land has to support its population of about 40 to 50 million people. Vietnam's main agriculture is the cultivation of rice in the irrigated water fields. The land is the most valuable possession that one can own and water is the gift that "*Ong Troi*" (the God of heaven) can give.

However, if water is almost as valued to Vietnamese people as oil to the Westerner, it is also one of the fiercest enemies of the North Vietnam people.

"The Red River delta, cradle of North Vietnamese civilisation was periodically threatened by great floods" (Nguyen Khac Vien, 1974, p. 20). The Red River is very unpredictable. It could be as gentle and loving as a mother giving milk to her child, or it could be as fierce as the angry Genie when it is swelled with water during the rainy season. To survive, the North Vietnamese people had to build thousands of miles of dikes along the river and in all of its surrounding provinces. During the rainy season, from May to October, the water level could rise a foot a day. Annual rain fall averages about 72 inches (Nguyen Khac Vien, 1974). During the dry season, if a dry spell lasted 15 days longer than usual, the whole crop would be lost, creating famine in many provinces. Thus, the people of North Vietnam constantly fought with unpredictable weather to survive in this harsh land (Nguyen Khac Vien, 1974).

The lives of the North Vietnamese people were fundamentally shaped by the wars and invasions they endured, their constant struggle with nature and floods, and severe economic problems. Into this social milieu, communism was established and further changed the culture such that new social relations replaced the traditional social hierarchy.

Compared to the people of North Vietnam, the people of South Vietnam had relatively easy lives. Their land was more fertile, there were fewer people, and the Mekong River was much more subdued and regulated than the Red River of the North. Therefore, their production of rice and other crops was much higher than the North. Before the American war started, they were able to export 1.5 million tons of rice annually. However, the war also created economic problems along with many other difficulties. By 1965, South Vietnam started to import rice instead of export it (Sharma, 1988).

Although evidence shows that over the years, there are many changes within the Vietnamese social structure (Hirschman & Loi, 1996), for many Vietnamese, Confucianism and Buddhism weave heavily into their social fabric and the family remains the basic social structure – the foundation of their society. To some Vietnamese, to leave the land and the family is to leave one's personal identity and to lose a place in life. The wars have not only destroyed the Vietnamese land, but the Vietnamese society, and it destroyed the traditional Vietnamese family. All of these factors influence the Vietnamese people's health care practices and behaviour.

6. Vietnamese Family Practices and The Changing Status of Vietnamese Women

Vietnamese economics, history, religion, and politics influence people's kinship patterns and family dynamics. Centuries of struggle with an unpredictable nature, frequent warfare, and economic problems created many changes in the Vietnamese social structure. Some changes are viewed as positive, while others as negative. Whatever the changes might be, the Vietnamese are remarkable for their persistence and fierce determination to conquer difficulty and to preserve their families. Although one can never generalise that all Vietnamese follow a universal pattern, there are certain common characteristics of the Vietnamese family structure and gender dynamics.

The ethnically Vietnamese kinship system is patrilineal and patrilocal. However, it has been shown that comtemporary Vietnamese kinship system is more complex, such that one cannot categorize Vietnamese families into any model (Luong, 1984). Traditionally, *Truong toc* – the head of a family, who hold titles to the land, was always a male. In a contemporary Vietnamese society, which follows socialist perspective, *chu ho* is used. The term *Chu ho* is usually refered to "the person who represents the household in dealings with the larger community" (Hirschman & Loi, 1996, p. 235). A survey conducted in 1991 by Hirschman and Loi (1996) in Vietnam shown that many Vietnamese women held such a title at the time the survey was taking place. The authors also found that "female headship in Vietnam is not primarily a sign of absent husbands and disadvantaged economic conditions" (Hirschman & Loi, 1996, p. 236). However, as it has been pointed out, *chu ho* is often responsible for household activities in dealings with government agencies (such as fills out forms, pays taxes and fees). Women's *chu ho* may not enjoy high social status or hold decision-making power within the household (Hirschman & Loi, 1996).

From a more personal experience, my grandmother (from my mother's side) was a *chu ho* – the head of a household which was consisted of herself, my grandfather, my family, and two uncles. Aside from taking care of the family activities of daily living, my grandmother was also responsible for attending community meetings and volunteer works. Other women (my mother and I) were responsible for helping my grandmother with housework. Furthermore, the political climate of Vietnam under communism might have impacted people's decision on who would be the best person in the family to be *chu ho*. Especially after the fall of Thieu regime in the South, many Vietnamese men (who work for former U.S. controlled government) found themselves facing difficulties in dealings with the government officials. Thus, although the war and the social constitution have changed Vietnamese family structure over the years, Confucian

thoughts and tradition remain in existence (Hirschman & Loi, 1996). In both North and South of Vietnam, family members still live close to one another to form informal social support networks.

To understand the Vietnamese family dynamics, its gendered roles, and its expectations, it is important to examine the changing status of Vietnamese women throughout different historical periods. It is also important to keep in mind that information on Vietnamese culture is often contradictory because it reflects different perspectives. Some traditional Vietnamese literature might not accurately portray Vietnamese women and their role within the family and society, because these writings are often the product of the Confucian elite male (Coughlin, Walsh, & Cook, 1996). Contemporary Vietnamese literature, on the other hand, might be the reflection of the Communist Party Members, with their Marxist-Leninist perspective.

The status of Vietnamese women has been discussed from different perspectives. As Judith Shepherd (1992) points out, there are authors such as Marr (1981), in his book entitled *Vietnamese Tradition on Trial*, who felt that, in general, Vietnamese women have held a relatively high status, and they were able to retain their status under various colonial societies. However, Mai Thi Tu (1990) in *The Vietnamese Women: Yesterday and Today* does not share this view. Mai clearly points out that Vietnamese women were expected to be submissive, and have been oppressed by men throughout different eras in Vietnamese history.

Under Chinese domination and the Confucianist formation, Vietnamese society is a highly hierarchical patriarchal society. For many centuries, Confucian emphasis on duty and family and class hierarchy denied women social and political equality. For decades, a woman existed mainly in and for her family and society. A comment by Mrs. Hai, one of the study's participants, illuminates this traditional ideology at work:

> Mrs. Hai: For me. I am most concerned about my children... I think about the family situation for my children. I am concerned with looking after the family, eating, and cooking. Because I am a woman, I have to pay attention to those things...Vietnamese women, we go to the market, we cook. We organise our family. We take care of the family financial situation, how to spend, making sure we don't have too much debt. I think Vietnamese women spend more carefully. They don't just spend the money for whatever. We know how to control the family financial situation. If we have money we know how to save it for the future. We don't spend all our money. We are concerned with our children's future. We are also concerned with our parent from both sides [the wife and the husband sides]. We are concerned with our sisters and brothers. We are also concerned with our friends, people around us, and the people at the church. (pause). That's it. (Translated and edited quote from W-Hai-3-A-1)

The Vietnamese women's fate under the feudal society was uncertainty, and dependent on men's will. A young girl would listen to her mother sing of the certain fate of Vietnamese women:

> "A woman is like a drop of rain
> No one knows whether it will fall into a palace
> Or the mud of the rice fields"
> (Folksong. Cited in Mai Thi Tu, 1990, p. 186)

Confucianism had many negative effects on the social position of Vietnamese women in their society. Under the Confucian legacy, Vietnamese women were put in a social position that denied them power and independence. They were not allowed to own land and were denied education, and thus could not assume any administrative position (Eisen, 1984; Mai Thi Tu, 1990). The Confucian ideal of a desirable woman was one who was "*Cong, Dung, Ngon, Hanh.*" *Cong* means versatility in the home. A desirable girl possessed many talents to perform a wife's duty – she was a good cook, a good seamstress, able to make money, and a hard worker. *Dung* means beauty – a desirable girl would have not only physical beauty, but inner beauty as well. *Ngon* means speech – a desirable girl should speak with an eloquent, soft voice; she would never talk in an angry tone. *Hanh* means "good" behaviour (Thuy, 1976). A desirable girl was a gentle and caring individual, who would act kindly toward any living thing. It is clear that these standards were very difficult to achieve. For centuries, Vietnamese women internalised and lived with these Confucian ideologies. They were expected to raise the children and participate in all of the family activities that were inclusive to women (Mai Thi Tu, 1990). However, the women's economic contributions granted them a higher status than Chinese women. As suggested by Chi, "the most distinctive characteristic of the Vietnamese culture in comparison with other East Asian cultures [was] the active role of the women in the Vietnamese society. In theory, a Vietnamese female is supposed to be as submissive to male authority as her Chinese sisters. However, there is a great difference between theory and practice" (Cited in Shepherd, 1992, p. 88).

Exploitation of women under a feudal society also manifested itself in the practice of polygamy and concubines (Eisen, 1984; Mai Thi Tu, 1990). Under feudal society, Vietnamese men were allowed to have as many wives as they could afford. Wealthy men can have several wives and concubies (Hammer, 1966). It was not uncommon to see a rich man with several wives living in the same household. These wives and the children can also form a family labour force. However, the French and later, the communist government abandoned this practice of polygamy. The most famous Vietnamese literary masterpiece by

Nguen Du depicted a life full of suffering, hardship and exploitation of a talented and beautiful girl – Kieu. In her sorrow, Kieu cried for both herself and her friend:

> "How tragic is the destiny of women!
> Creator, why are you so cruel to us?
> Wasted are our green years, withered our pink cheeks.
> This woman who lies here was in her lifetime the wife of all,
> Yet, after her death, her soul wanders in loneliness.
> (Cited in Mai Thi Tu, 1990, p. 188)

Under the French rule, Vietnamese women's lives and status were not improved. Colonisation brought new forms of exploitation which were added to their suffering from age-old traditions. According to Eisen (1984), Vietnamese women's lives under the colonial regime were unbearable. Peasant women lived in such poverty and starvation that they were forced to work on the French owned plantations and mines. It was estimated that by 1945, 60% of the plantation workers were women. The conditions in mines were so brutal that they were referred to as "hell on earth." Increased poverty also forced thousands of women into prostitution and slavery. For a few pounds of rice, a man could buy a woman as a slave or concubine. Prolonged and extreme exploitation by the French rulers, coupled with the Japanese's invasion toward the end of the Second World War in 1945 led to the unforgettable famine in which two million people died of starvation within a year (Eisen, 1984; Kolko, 1971). The French rulers destroyed Vietnam's land, its social structure, and the country's basic foundation – the Vietnamese family. Husband and wife, parents and children were separated due to poverty and war. In one of the most popular novels written from an anti-colonial perspective – *Tat Den* (The Light is Out), a peasant women's life was portrayed in all its misery and heartache. In order to get the money to pay a corrupt official, the mother was forced to sell her daughter for one piastre (less than a dollar) (Eisen, 1984).

At the 1954 Geneva Accords, both the French and the Communist Vietnamese signed the "Agreement on Cessation of Hostilities." This agreement was intended to settle military hostilities between the French and the Vietnamese. However, the most important feature of the agreement, which changed many Vietnamese people's lives, was the establishment of the demarcation line along the 17th parallel. This line divided the country to that of the North and that of the South (Kolko, 1971).

Following the 1954 Geneva Accords, the life and status of Vietnamese women became differentiated between the North, which was under communist regime, and the South, which was under American control. Women in the North were actively involved in the struggle for national liberation and later, the Central Committee of the Vietnam Communist Party. The Party recognised women's problems and declared that equality of the sexes was one of its 10 revolutionary principles (Mai Thi Tu, 1990). Ho Chi Minh, the founder of the Vietnamese communist regime, urged women not only to recognise their oppressive sources, but also to actively resist these forces. Thousands of peasant women participated in the military against the French and then the Americans. Vietnamese women's contributions in armed insurrection and/or production work to support soldiers fighting in the wars were not ignored. Many were publicly rewarded by the Communist Party Members and by Ho Chi Minh himself. Women's lives remained difficult as they continued to till the land, look after the children and the parents, and undertake tasks formerly reserved for men, but for many of them, their status was no longer that of slavery and their dignity was not degraded. On the one hand, the Vietnam Worker's Party recognised that "one must work out a practical plan, raise the women's ideological, cultural and technical level, help them to free themselves from the burden of household chores, thereby assuming an even bigger role in the administration of production work and state affairs" (Mai Thi Tu, 1990, p. 196); on the other hand, Ho Chi Minh advised that "the woman should not wait for a government or party decree to liberate her; she must struggle for her own freedom" (Ho Chi Minh, cited in Mai Thi Tu, 1990, p. 197). However, even with these new ideologies and discourses, many women who lived in the North of Vietnam continued to suffer. Mrs. Chi who lived in the North of Vietnam testified:

> Mrs. Chi: "nong dan" (peasants) women were suffered the most and the poorest. Especially, "nong dan" women whose husband died in the war. When the husbands die in battle, their wives were left with the children. These wives were among the most suffered ... During the day, at work, they were still smiling and talking. At night, they were crying. You know, in one village, there were few hundreds of these women, each one of them had 7 or 8 children. These women, their husband had died or soon will die. They (the husbands) would get drafted then few months later, a letter would come home to their wives telling them that their husbands had died. They were the ones whom suffered to a great extreme. They cried at night, sometimes I heard them cry all night .... Yes, Vietnamese women suffered a great deal. You know there were villages that didn't have even one man alive. If there was one man who survive and came back to the village as a disabled soldier, that village is very lucky .... Oh God, there was an old woman, she had 7 sons. All of them died. She could not bear it when her last son died. She took a chair to the village community house ... She cried out her pain publicly and blamed the government for her suffering. She yelled out loud of her pain "Oh the government, I have 7 children, you killed all of them. You, the government, you took all 7 of them. Who is going to look after me now?" She was around 60 or 70 years old. She was old and weak ... but she still had to work on the rice field. Seven children, all of them died. How painful. (Translated and edited from W-Chi-3-A-1)

The life of Vietnamese women from the South took a different direction. During the war, under the South Vietnamese government regime and America, women of the South were also among the greatest victims (Mai Thi Tu, 1990). The war had destroyed the family and the land. In the countryside, the crops and the rice fields were ravaged with toxic chemicals, houses were burned, men, women and children were killed. Thousands of women in the villages were victims of rape. Thousands of villagers fled their homes to live in concentration camps. Nearly half a million women became prostitutes to survive, many of them turning to drugs to cope with their suffering (Mai Thi Tu, 1990). Women whose husbands were soldiers in the South government army were also left with the responsibility of looking after their family.

In the next section, prior to a more in-depth discussion of the literature review on Vietnamese women's breast cancer and cervical cancer screening issues, I will address how women's body is conceptualised in both Western and non-Western societies. How people deal with illness is directly linked to the ways in which they view how bodies are conceptualised and experienced (Csordas, 1994), and the ways in which women view and practice breast and cervical cancer preventive care are influenced by their embodiment experience. Here, the term "embodiment" refers to "a methodological standpoint in which bodily experience is understood to be the existential ground of culture and self, and therefore, a valuable starting point for their analysis" (Csordas, 1994, p. 269).

7. Conceptualisation of the Female Body: Body as an Experiencing Illness Agent

In Western cultures, the conceptualisation of the human body is shaped by Western science and biomedicine. Western science and medicine have largely functioned within the mechanistic Cartesian worldview and philosophy of dualism. This perspective treats all "living organisms as physical and biochemical machines, to be explained completely in terms of their molecular mechanisms" (Capra, 1982, p. 121). Within this view, the human body in Western society is seen as a complicated "machine" with physical and chemical interactions (Capra, 1982; Good & Good, 1993). This mechanistic conception of the body and its functions centralise the biological/physical body, all the while pushing the mind to the background of clinical theory and practice (Scheper-Hughes & Lock, 1987). Moreover, Descartes' philosophy of dualism views the human body as composed of two separate entities: the palpable body and the intangible mind (Holden, 1991; Scheper-Hughes & Lock, 1987). Disease and illness are parts of either a malfunctioning mind or a body that can be treated independently from the rest of the body (Capra, 1982; Good & Good, 1993). The healthy or sick body, the normal or abnormal body are often

differentiated based on physical symptoms. Thus the human body is the site of problems that need to be identify and treated (Good & Good, 1993).

The scientific medicine conceptualisation of body as a biological organism with hierarchically organised system of control impacted how changes in the body are perceived (Martin, 1990). In particular, changes in women's bodies are often described using negative metaphors that denote failure or breakdown of body control system; for example, menopause is seen as ovaries become "unresponsive", as the body's failure to produce the female hormone estrogen (Lock, 1993), and menstruation is seen as failure to produce offspring (Martin, 1990).

In non-Western cultures such as Chinese culture, there are a variety of body concepts, and the most prominent has its root in Confucianism and Taoism (Ots, 1994). Thomas Ots (1994) explains some Chinese key concepts of body through the discursive practice of traditional Chinese medicine. In Chinese medicine, the heart and mind are the two important elements of both body and its social well being. While the heart is considered the most important internal organ, the mind is placed within the heart. Through harmony and balance of the Seven Emotions, body unity and function are achieved. These emotions are said to express themselves through bodily changes. Any amount of excess emotion, which disrupts the harmony, is considered pathogenic. Excessive emotion damages internal organs and compromises the heart-mind relationship. Thus, emotional behaviour is heavily stigmatised. According to Taoism, excess emotion and desire, which are external elements, affect the body health and well being. To be strong and healthy, one must take care of one's body by eliminating emotions and desires, by staying calm and becoming unattached (Ots, 1994). Within Taoism, one's mind is thought to travel in the body through fixed routes. To Chinese, the physical body is, then, the basic working material. "Should he achieve the purest clarity of heart-mind, yet his body fall ill, he could never reach the stage of *shenxian*, thus, he could not become a Spirit-Immortal" (Ots, 1994, p. 119). As Ots suggests, even though Chinese body concepts somewhat similar to the basic pattern of subject-object relation of the West, their specific understanding of the lived body is different than those of Westerners.

Traditional Vietnamese medicine has also adopted the Chinese "heart-mind controls emotion" model. Thus, Vietnamese also strive to attain an emotion-free body. Since the expression of strong emotion is discouraged, a Vietnamese woman may smile or appear calm when she may actually experiencing inner turmoil (Calhoun, 1986; Waxler-Morrison, Anderson & Richardson, 1990). In addition, a healthy body is achieved through balancing Am (yin) and Duong (yang), or Dark and Light, or Female

and Male and the equilibrium of "hot" and "cold." The notion of "hot" and "cold" does not refer to temperature, but to the nature of the elements. Excess in either hot or cold can cause damage to the body's internal organs, which in turn manifests as physical symptoms. For example, excess "hot" cause constipation, dark urine, or hoarseness; a "weak heart" may cause fainting, dizziness, or anxiety; a "weak kidney" may cause sexual dysfunction; and "weak nerves" may cause headache (Waxler-Morrison et al., 1990). Because the soul and the body are considered to be one, alteration or removal of a body part is believed to cause the soul to escape from the body and death to result (Waxler-Morrison et al., 1990).

Margaret Lock (1993) compared the current discourses about female aging in both North America and in Japan. Her analysis revealed that female body discourses are not only profoundly shaped by cultural beliefs about the aging body and its function in a particular society, but they are also products of what she termed "local biologies" and medical discourse. Examining how the aging body is conceptualised in North America, Lock observes that the dominant discourse focuses almost exclusively on the biochemical processes of aging – which is often viewed as universal, inherently anomalous, and potentially pathogenic, and as having implications for future ill health. Aging of the female body, from the biomedical perspective, has often been discussed in light of physical changes (such as menopause and menstruation) that take place with the disappearance of the 'female' hormone, as well as its negative consequences, its replacement therapy, and recently, its cost to the national economy (Lock, 1993).

Although aging is a natural and unavoidable process, within Western biomedical discourse, aging is something that is unwelcome. Discussion about female menopause as "a progressive physical deterioration" of women's body caused by "ovarian deficiency", is often about loss, failure, and senility (Lock, 1993). These discourses convey an ideology which emphasises that aging is unnatural and unhealthy.

On the contrary, women in Japan have been viewed as biologically endowed with the ability to nurture. Thus, women's life cycle is celebrated with what they accomplish in terms of nurturing ability and services for others rather than for themselves (Lock, 1993). Because aging itself is not thought of as anomaly, but as a natural part of life, a social state of maturation, attention towards changes in women body are primarily concerned with future ability to work and to contribute to society. Distress of the female aging body is not entirely linked to the decreased in hormone level, but rather due to a destabilisation of the autonomous system which affect both sexes. As such, menopause is not only discussed much less

frequently in Japan, but when it is discussed, the focus is much different than in the West. For example, stiff shoulders, headaches, and ringing in the ears are discussed instead of "hot flashes" (Lock, 1993).

Thus, women's bodily concepts are not universal and static but are culturally specific. Not only has the conceptualisation of body reflected particular cultural beliefs and values, but also the scientific knowledge about health and illness that are particular to that culture. In Western societies, individualism, natural science and the biomedicine model shape the ways in which women's body are perceived and experienced. However, in other cultures such as Chinese, Vietnamese, and Japanese cultures, different cultural values, and understanding of health and illness have resulted in different understandings of women's lived bodily experience.

Not only do different individuals and societies embody illness in different way, but the ways through which individuals embody illness varies in different social, cultural, political, economic, and historical contexts. How individuals embody illness is also very much dependent upon how one knows and lives one's diagnosis and prognosis (Gordon, 1990). In other words, it is the nature of the illness and what it means to an individual of a particular culture that influence how one experiences and practices health care. There are many ways that one might experience illness. Some individuals might experience disease as a breakdown and rupture in everyday life, other see disease as disembodied (a mental effort to keep disease at a "distance" by not knowing its name and its diagnosis or denial), while still others embody an illness, inhabiting it, and/or co-habiting it (Gordon, 1990).

The nature of cancer, its social stigma and the social, cultural context in which patients live influence their embodiment of illness and practices (Gordon, 1990). Because cancer is viewed as an incurable disease, cancer is often associated with suffering, pain, hopelessness, and death, therefore, it often evokes strong emotional reactions. In some cultures, the battle with cancer is the fight between "good" and "bad," between "malignant" and "benign"; "cancer is an illness of divisions, of disunity, of otherness" (Gordon, 1990, p. 276). Although the more recent view of cancer as a challenge, as an illness that can be beaten with early diagnosis such as breast cancer and cervical cancer, knowing one's diagnosis of cancer evokes images of future separation and isolation from the social networks (Gordon, 1990). In a society where social relationships are fundamental this is social death itself. Viewed in this context, the experience of cancer is that of disembodiment in which cancer is viewed as the "other," as something that is from "outside" to "inside," which at times, can be best managed by denial or avoidance.

Thus, "the body [is] simultaneously a physical and symbolic artifact, ... both naturally and culturally produced, and ... securely anchored in a particular historical moment" (Sheper-Hughes & Lock, 1987, p. 7).

C. Vietnamese Living in Canada

Vietnam began its new era with the march of the North Vietnamese troops to Saigon (now called Ho Chi Minh City) on April 30th, 1975. The downfall of the South Vietnamese government and withdrawal of the American troops from Vietnam marked a new period of Vietnamese history. Taking control of an entire country that was almost totally destroyed by war, the Vietnamese government was faced with enormous social, political, and economic problems. To deal with these problems, drastic measures were used. The new government, with its triumphant military force, enforced many extreme economic, political, and social changes. These changes created an influx of Vietnamese refugees seeking political and economic asylum in the Western world.

According to the 1991 Government of Canada's profile of immigrants from Vietnam, there were two large influxes of immigrants to Canada. The first wave of these immigrants entered Canada between 1975 and 1980, the second wave between 1984 and 1985. Before 1978, several hundred Vietnamese lived in Canada. Most of them were students or highly trained professionals living in Montreal (Chan & Indra, 1987). Between 1979 and 1984, the Canadian government and private sponsors took in approximately 60,000 Vietnamese immigrants. By 1991, 113,595 Vietnamese had made Canada their new country, with the hope of building a better life for themselves and for their families – including family members left behind in Vietnam. Most of these immigrants left Vietnam for political and/or economic reasons. A large portion of these immigrants came without their immediate and extended family. Many of them had suffered hardship, extreme violence, and cruelty prior to leaving their homeland and during their flight. Many Vietnamese immigrant women suffered from exposure to direct combat, and were victims of rape and other forms of sexual assault and violence. As estimated by the United Nations, at least 39% of the women who fled Vietnam by boat were abducted or raped by sea pirates (Compton & Chechile, 1999, p. 191).

Despite horrific past experiences, Vietnamese immigrants generally integrated fairly well into the Canadian society and way of life (Johnson, 1999). As Johnson points out, Vietnamese Canadian

immigrants integrated into Canadian culture in a way that enabled them to embrace aspects of both cultures –Vietnam's and Canada's. Rather than giving up their ethnic origin and cultural identity in order to assimilate into the new society, Vietnamese immigrants retained aspects of their cultural values and beliefs, while interacting with and adopting certain aspects of mainstream society. Although there is evidence to show that adaptation to a new life and the resettlement process have been relatively successful for the majority of Vietnamese, social, cultural, and economic changes are inevitable. The impact of these changes is both positive and negative. To gain insight into the living and health care experiences of the Vietnamese immigrant women, this section seeks to understand how certain economic, social, and political issues affect their settlement and adaptation processes, which will, in turn, affect their health care experience and practice of cancer prevention.

1. Economic Experiences

The economic adaptation of immigrants has been considered an important indicator of how well immigrants have adjusted to their new lives (Deschamps, 1987). Research into this area has been encouraged because the establishment of a stable economic status is often a shared aim of the government and the immigrants. As such, the immigrants' ability to enter the work force and to generate income are viewed as one of the best indicators for the success or failure of the integration process (Deschamps, 1987).

Samuel (1987) asserts that there are two important factors leading to successful economic adaptation. One factor is the ability to find employment in the occupation for which the immigrants have been trained, and the second is proficiency in either English or French. Vietnamese immigrants have problems in both of these areas. Downward occupational mobility is a common phenomenon for Vietnamese (Beiser, 1999; Chan & Indra, 1987; Gold, 1992; Johnson, 1988, Kibria, 1993; Samuel, 1987). Chan and Indra's study of 25 Vietnamese men and women living in Montreal, Quebec, showed that regardless of the respondents' educational background and previous occupation in Vietnam, the majority of their respondents were employed in lower echelon jobs at a minimum wage. They were often employed as garment factory workers, janitors, dishwashers, and factory labourers. Similarly, Johnson's (1988) study of Vietnamese living in Vancouver, BC revealed that 57% of the 772 Vietnamese respondents were working in low paying jobs such as labourers, dishwashers, kitchen helpers, cleaners, janitors, fruit and vegetable pickers, and sewing machine operators. Furthermore, the Government of

Canada's profile of Vietnamese immigrants disclosed that 36% of men and 32% of Vietnamese women work in manufacturing, and Vietnamese immigrants are more likely than other immigrants and Canadians to work in manufacturing (Government of Canada, Statistics Canada, 1996).

Although by 1991, the majority of Vietnamese immigrants could speak at least one official language, with 85% conducting a conversation in either English and/or French (Government of Canada, Statistics Canada, 1996), limited proficiency in one of Canada's official languages has been considered a negative factor affecting the Indochinese immigrants' employment opportunities (Samuel, 1987). There is evidence to show that the unemployment rate of immigrants who had poor or no knowledge of English is four points higher than those who have fluent knowledge of the language (Samuel, 1987). However, another study has shown that insufficiency in English does not affect the employment rate, but rather the wages and the opportunities for occupational advancement (Johnson, 1988). Johnson (1988) found that an ethnic community, such as Chinatown, with Asian-owned business has helped immigrants with limited language skills to find employment within the Asian community. The disadvantages of such opportunities are lower wages, long hours of work, and no opportunity for advancement. Thus, the establishment of the Asian community with its labour force has helped to increase the immigrants' employment, although not necessarily with high paid and/or desirable employment.

A group of researchers in British Columbia conducted a 10 year longitudinal study of socioeconomic conditions of Vietnamese immigrants, their employment patterns, savings practices, and the impact of unemployment. The study reveals that self-employment is "one of many avenues taken to provide for the family's economic situation" (Johnson, 2000, p. 9). According to the Government of Canada's profile of Vietnamese immigrants, they have limited language skills (only 66% could carry on a conversation in English) and the majority have a lower level of education (only 8% had a university degree, and 21% had less than a grade 9 education). Furthermore, their professional training is not marketable. These barriers, coupled with the experience of being discriminated against in the labour force have made the idea of self-employment desirable (Johnson, 2000).

Johnson (2000) revealed that the majority of their respondents rated self-employment as more satisfying, helping them to achieve greater financial success, more prestigious, and offering more flexibility at work. The literature on self-employment suggests that self-employment is desirable for immigrants because (a) it provides income and helps immigrants to avoid the problem of being unemployed, and (b) it helps immigrants achieve a sense of independence, autonomy, and opportunity to

accomplish their political and personal and family goals (Gold, 1992). Thus, self-employment is valued highly by the Vietnamese and considered a more desirable mode of employment (Johnson, 2000).

Although Vietnamese immigrants living in Canada experience both positive and negative impacts of the changes in their economic status, they generally adjust fairly well economically. Many have successfully achieved economic independence. However, a large portion still have incomes below Statistics Canada Low-income Cut-offs and Vietnamese immigrants' income level is still lower than people who are born in Canada (Government of Canada, Statistics Canada, 1996).

By 1991, there were 113,595 Vietnamese living in Canada. Most of them live in populous provinces such as Ontario (45%), Quebec (18%), Alberta (17%) and British Columbia (13%). Only about 6% of the Vietnamese made other provinces their home (Government of Canada, Statistics Canada, 1996). The 1991 Canadian Census also revealed that, in general, Vietnamese are less likely to be employed as compared to the other immigrants and people born in Canada. Of the Vietnamese people aged 15-64, 66% of the men and only 54% of the women were employed and many of these people were working in manufacturing. At the time of the Census in 1991, 36% of the Vietnamese men and 32% of the Vietnamese women were working in these areas versus only 15% of men and 4% of women born in Canada. Also, while 33% of Canadian-born women held professional or management positions, only 15% of Vietnamese-born women held such positions (Government of Canada Statistics, 1996).

Table 2.1

1991 Canadian-Born and Vietnamese-Born's Occupational Distribution

Occupational	Canadian-born men	Vietnamese-born men	Canadian-born women	Vietnamese-born women
Employed fulltime/fullyear	58.7%	54.9%	45.2%	45.4%
Manufacturing	15%	36%	4%	32%
Professional/ Management	27%	17%	33%	15%
Average income	$29,837	$20,358	$17,457	$14,276

Source: Statistics Canada, Citizenship and Immigration Canada: Profiles Vietnam, 1991

The 1991 National socioeconomic profile of Vietnamese in Canada shows that many Vietnamese women are among the low socioeconomic status groups (Government of Canada Statistics, 1996).

Evidence also shows that the income level among Vietnamese living in Canada, especially women, is lower than the general population. In 1990, an annual average income of the Vietnamese was $17,600 ($23,700 for the general population) with the women's average income being $14,300. The situation is even worse for Vietnamese aged 65 and more. Their income averages $7,700 per year. As such, a large number of Vietnamese women live in poverty, below Statistics Canada Low-income-Cuts-off (Government of Canada Statistics, 1996).

The more recent data from the 1996 Canadian Census shows an increase in the Vietnamese population in Canada to 136,325 with about half of the population (68,175) being female. The data also showed that among 49,425 Vietnamese females who are 15 years and over, only 21,845 of them are employed. The census also reveals that most of these women who are employed work at services industries which include: manufacturing industries (8,050); whole sale and retail trades industries (3,850); accommodation, food, and beverage service industries (3,365); other service industries (2,460); health and social service industries (2,045); and business service industries (1,110).

Table 2.2

1996 and 2001 Vietnamese Women's Occupational Distribution

Occupation	1996	2001
Vietnamese population in private households by census family status	136,325	151,205
Vietnamese female population	68,175	76,485
Employed Vietnamese female	21,845 (100%)	32,045 (100%)
Manufacturing industries	8,050 (36.8%)	10,655 (33.2%)
Whole sale and retail trades industries	3,850 (17.6%)	4,650 (14.5%)
Accommodation, food, and beverage service industries	3,365 (15.4%)	4,315 (13.5%)
Other service industries	2,460 (11.3)	3,000 (9.4%)
Health and social service industries	2,045 (9.4%)	3,175 (9.9%)
Business service industries	1,110 (5.1%)	3,000 (9.4%)
Total	20,880 (95.6%)	28,795 (89.9%)
Other occupations	965 (4.4%)	3250 (10.1%)

Source: Statistics Canada (1996, 2001). Ethnocultural Portrait of Canada: Topic Based Tabulations http://www12.statcan.ca/english/census01/Products/standard/themes/DataProducts.cfm?S=1&T=44&ALEVEL=2&FREE=0

Although in 2001, the average income among Vietnamese working women has increased to $28,269, the average income for all Vietnamese female is $18,560 (which is an increase from $14,300 in 1991 Canada Census). However, the data reveal that almost one fourth of all Vietnamese female living in Canada (18,095) are surviving with the income less than $9,999 per year.

Table 2.3

1996 and 2001 Vietnamese Female's Income

	1996	2001
Vietnamese women's average employment income	$16,207	$28,269
Vietnamese female's average income	$14,054	$18,560
Vietnamese female with income less than $ 5,000 per year	10,635	10,210
Vietnamese female with income between $5,000-$9,999 per year	7,425	7,885

Source: Statistics Canada (1996, 2001). Ethnocultural Portrait of Canada: Topic Based Tabulations http://www12.statcan.ca/english/census01/Products/standard/themes/DataProducts.cfm?S=1&T=44&ALEVEL=2&FREE=0

In contrast, the Vietnamese immigrants' economic status is much more encouraging in the United States. The United States' Office of Refugee Resettlement (ORR) revealed that Vietnamese immigrants have twice as high a rate of participation in the labour force as compared to the other South East Asian refugees (Robinson, 1998). By 1994, only 4% of the Vietnamese were unemployed and the number of Vietnamese who received cash assistance and non-cash assistance (such as Medicaid, Food Stamps, public housing, etc,) was substantially lower than other Indochinese refugee groups (Robinson, 1998).

2. Social-Cultural Experiences

In the traditional Vietnamese family, it is expected that the husband is the main breadwinner; the woman's economic contribution is viewed as secondary to that of the husband. During the Vietnam war, the situation changed with many Vietnamese women becoming the main providers for the family. In Vietnam, submerged in the social ideology and culture conceptualisation that supports the domination of men over women, Vietnamese women's status remains one that is conformist to the authority of their husband and their parents. In Canada, there is evidence to show that Vietnamese immigrant's family structure and relationships have changed dramatically (Gold, 1992). These changes have not only affected their family dynamics, functions, and roles, but also their psychological and social relations. As

with many Western families, to make ends meet, both husband and wife need to enter the labour force. According to Gold (1992), because of the employment situation coupled with the influence of Western values and ideologies, Vietnamese women's role as breadwinner took on a different meaning in Western society – one that comes with a change of status and more power for women. This role reversal and changing status have created hostility between husbands and wives in some Vietnamese families. Marital conflict, emotional, and psychosomatic problems for both men and women have occurred, especially for men, who were habituated to their dominant role. As a result, wife and child abuse, alcoholism, self-destructive behaviours, and depression have occurred in some families (Gold, 1992).

It has been observed that the traditional Vietnamese family, as an intact harmonious and extended patriarchal family, might have ceased to exist when Vietnamese people came to live in Australia (Coughlin, Walsh, & Cook, 1996). Based on the data obtained from personal observations spanning two decades, Coughlin et al. call into question the general assumption of the Vietnamese family in which the elderly are well respected and children are well behaved and studious. The fact that 5,000 elderly Vietnamese-Australians are either homeless or abandoned by their children, and about the same number of Vietnamese youth run away from home indicates that the Vietnamese family is becoming dysfunctional. It has been argued that social disruption, Western ideologies and values, and the effect of urbanisation have changed the nature of the Vietnamese family structure. Coughlin et al. argue that Vietnamese families are now largely comprised of a two-generation nuclear-family which consists of parents and children, and that the number of single-Vietnamese parents is increasing. Not only is the traditional close relationship with the extended family becoming more distant, but also the parent-child relationship is deteriorating. Following these perspectives, one can assume that many changes within the Vietnamese family in the Western world are negative.

Integration into the Western way of life with its cultural beliefs and values has been a challenge to many Vietnamese. Role reversal has been documented as one of the most cited problems between husband and wife, between parents and children (Gold, 1992; Kibria, 1993). The traditional hierarchical Confucian family system in which the elderly and the man of the family hold a respected position with power over women and children, has changed under the influences of the struggle for economic survival, and of Western values and ideologies.

An important virtue that is instilled within every Vietnamese is that one should always put family and group interests before one's self-interest. The pursuit of individual goals is not only frowned upon as

selfish, but also seen as an act of disrespect for others. Thus, individuals who exhibit self-negation, self-sacrifice, and modesty are considered to be individuals with good character. These cultural values and expectations have led Vietnamese women to conform to their role as care givers and to view additional responsibilities and hardships as "the way things are" (Maltby, 1998). These women's behaviours are reinforced within the Vietnamese community by the high regard that is given to these women as "good mothers," "good daughters," and "good women." Contrary to Vietnamese culture, values, and expectations, Western society values individual independence, autonomy, and the pursuit of one's own success. Failure to do so is viewed as a personal weakness. The integration of these values has, to a certain degree, created conflict within some Vietnamese families.

In sum, although Vietnamese still retain their cultural values and beliefs, adaptation to the new way of life and integration process into Canadian society have changed their social roles and relationships. Economic adaptation necessitated changes within the family function, leading to changes in the roles of men, women and children. These changes have directly and indirectly influenced how Vietnamese women practice health care. An understanding of Vietnamese cultural beliefs, values, their past and present social, political, economic, and historical processes will assist health care professional in understanding Vietnamese Canadian's adaptation. This understanding will also help in identifying health care strategies that could be applied to the development of an effective and culturally appropriate health promotion and disease prevention program for Vietnamese living in Canada.

3. Health and Health Care Experiences

It is documented that Vietnamese immigrants have suffered from several physical, emotional and psychological problems (Beiser, 1999; Nelson, Bui, & Samet, 1997). Coming from a country where health-related concerns are secondary to fighting for survival, doubled with the very unhygienic conditions in the refugee camps, a large portion of immigrants have contracted or have come into contact with infectious diseases such as cholera, typhoid fever and communicable diseases such as tuberculosis and hepatitis B. A study done in the U.S. which screened 99 recent Vietnamese immigrants who lived in the country for less than six months has shown that 51% of the Vietnamese suffered parasite problems (63% of these people required treatment), 70% tested positive for tuberculin skin tests (39% of them required treatment), 83% had been exposed to hepatitis B, and 17% were depressed (Nelson et al., 1997). However, mental health problems have been identified as the most prevalent among the Vietnamese

immigrants. Studies from the U.S. and Canada revealed that depression and anxiety are the most common mental health problems among immigrants (Beiser, 1988, 1999; Berry & Blondel 1982; Tracy & Mattar, 1999) – especially for Vietnamese whose pre-migration lives and flight were marked with much suffering (Beiser, 1999). It has been reported that as many as 19% of Vietnamese living in Canada suffered a depression disorder (Beiser, 1999).

Beiser (1999), a Canadian psychiatrist, believes that although Indochina immigrants are exceptionally resilient people because they have managed to survive extraordinary adversity in their home countries, the horror of escape, and the crushing environment of the refugee camps, "pre- and post-migration stresses place [immigrants'] mental health and adaptation in jeopardy" (p. 61). Thus, from Beiser's point of view, the host society should concentrate on alleviating stresses that are experienced by the immigrants due to unemployment, underemployment, and discrimination. He also insists that the presence of the family, and the support of both the ethnic community and the host society, influence immigrants' mental health directly and indirectly. Because family provides emotional as well as economic support, immigrants who are married and who live with their family will have better mental health than single immigrants (Beiser, 1999). As such, to facilitate immigrants' well-being and successful adaptation, support for immigrants should be given from the family, the ethnic community, and society at large.

With the migration process, many Vietnamese immigrants came to Canada alone. Their dream is that someday they would be able to sponsor their loved ones to join them in Canada. However, working at low paying jobs has made meeting the government's requirement criteria for sponsorship a difficult task. Thus, many have seen their dreams of family reunion delayed. This has resulted in high incidence of depression among the Vietnamese (Beiser, 1988; Berry & Blondel, 1982).

Many health care providers have recognised that immigrants often encounter difficulties accessing health care services. Barriers to access a health care delivery system include language difficulties, different cultural health beliefs and practices, lack of cultural acceptance and appropriate health care services, and lack of social resources (Anderson, 1998; Hirota, 1999; Stephenson, 1995).

It has been shown that an individual's cultural conceptualisation of health, illness, fate, and acceptable ways to deal with life events affects how one views stress and shapes coping responses and outcomes (Aldwin, 1994; Kleinman, 1980; Lazarus & Folkman, 1984; Slavin, Rainer, McCreary, & Gowda, 1991). For example, many people who live in North America view that health is important and stress causes many illnesses. Thus, how to avoid stress has been a popular topic in both lay and professional

discourses. Individuals are told that they can deal with stress and stay healthy by changing their life style and learning to use methods developed to reduce stress (Donnelly & Long, 2003). Many techniques such as relaxation exercise, meditation therapy, and counseling have been developed to help people deal with daily pressure. Similarly, to many Vietnamese, health is viewed as gold. However, illness is viewed as an inevitable part of life – an event predetermined by destiny (Maltby, 1998; Nguyen, 1985, Donnelly, 2002). Thus, the acceptance of these beliefs has helped the Vietnamese to view changes in life, illness, and sometimes even death not as a source of stress, but as part of the Buddha's teaching: "to be born, grow old, fall ill and die" (Nguyen, 1985, p. 410).

In this context, individuals' cultural backgrounds shape their explanatory models of illness and disease, and their expectations toward treatments, which in turn, determine how they make decisions regarding coping with illness and health care practices (Good, 1994; Kleinman, 1980). Maltby (1998), in a combined qualitative and quantitative study, compared the cultural beliefs and values that underlie the health behaviour of Vietnamese women living in Australia with mainstream cultural groups. Malby's study indicated that Vietnamese women's health care practices reflected their cultural conceptualisation of health and illness.

Although there is little research focused specifically on the health status of Vietnamese immigrant women living in Canada, a few studies from Canada and other countries such as the United States and Australia have revealed that Vietnamese immigrant women suffer from a number of major health problems. Among them, infectious diseases, communicable diseases, and mental illnesses ranked high (Beiser, 1999; Nelson, Bui, & Samet, 1997). Mental illnesses such as depression, anxiety, and somatisation have been identified as the most common psychological problems experienced by Vietnamese women. Recent studies have also revealed that Vietnamese women suffer high mortality rates for cervical cancer and breast cancer due to delays in seeking help for these diseases (Cheek, Fuller, Gilchrist, Maddock, & Ballantyne, 1999; Lesjak, Hua, & Ward, 1999).

D. Breast Cancer and Cervical Cancer

Cervical cancer is among the most common cancers for women in the countries where Papanicolaou smears are not routinely performed (BC Cancer Agency, 2000), and Vietnamese-born women have a significantly higher incidence of cervical cancer (Cheek, Fuller, Gilchrist, Maddock, & Ballantyne, 1999;

Lesjak, Hua, & Ward, 1999). Even though breast cancer is less common among Vietnamese women, they are more likely to be diagnosed at the late stages than women in the general population (Pham & McPhee, 1992). Screening reduces the incidence and mortality of both cervical cancer and breast cancer (BC Cancer Agency, 1999, 2004). However, the data from the U.S. and Australia suggest that Vietnamese women do not fully utilise these cancer screening services (Cheek, Fuller, Gilchrist, Maddock, & Ballantyne, 1999; Jenkins, Le, McPhee, Stewart, & Ha, 1996; Lesjak, Hua, & Ward, 1999; Yi, 1994). Because both breast cancer and cervical cancer involve body sites that are considered very private, and taboo, investigating these two problems together and how Vietnamese women use both breast cancer and cervical cancer screening services will explain why there are differences in mortality and late stages diagnosis for these diseases.

1. Mortality and Incidence Rates

According to the Canadian Cancer Statistics 2003, the Age-Standardised Incidence Rate of breast cancer rose from approximately 88.3/100,000 in 1974 to an estimated rate of 107.3/100,000 in 2003. The breast cancer mortality rate slightly decreased from 31.1/100,000 in 1974 to 25.4/100,000 in 2003. It was estimated that in 2003 approximately 21,100 women would develop breast cancer and 5,300 women would die of this disease (Canadian Cancer Statistics, 2003). Each year, in British Columbia alone, 2,800 women develop breast cancer and about 600 women die of this disease (BC Cancer Agency, 2004).

Although incidences of cervical cancer and mortality rates have decreased greatly in Canada, in 2003 there were approximately 1,400 new cases of cervical cancer, and 420 Canadian women died of this disease (Canadian Cancer Statistics, 2003). As indicated by Lee et al. (1998), immigrant women who are older and/or with a lower socioeconomic status have a higher risk of cervical cancer.

The U.S. data suggest that although the breast cancer incident rate is low for Asian women, their mortality rate is high due to late stage diagnosis of the disease. There is evidence to show that more Asian women (79%) were diagnosed with breast cancer's tumors larger than 1 cm than U.S. white women (70%) (Hedeen, White, & Taylor, 1999), and more Vietnamese-American women were diagnosed at advanced stages of breast cancer than Caucasian women (Pham & McPhee, 1992). Furthermore, the mortality rate for cervical cancer is higher for Asian women than for American women (Perkins, Morris, Wright, 1996 cited in Wismer, 1999). Data from the U.S. National Cancer Institute for the years 1988

through 1992 show that Vietnamese women's average annual age-adjusted breast cancer incidence rate was 37.5/100,000 while white women's breast cancer incidence rate was 111.8/100,000; by contrast the cervical cancer incidence rate for Vietnamese women was 43.0/100,000 as compared to white women's cervical cancer incidence rate of 8.7/100,000. In addition, data from the Northern California Cancer Center in the U.S. revealed that among Vietnamese women, there was an annual age-adjusted incidence rate of 47.7/100.000 for breast cancer and 38.1/100.000 for cervical cancer from 1988 through 1993 (McPhee, Stewart, Brock, Bird, Jenkins, & Pham, 1997). More recent data also revealing that, according to U.S. National Cancer Institute's Surveillance, Epidemiology, and End Result (SEER), Vietnamese women have the highest incidence rate for cervical cancer, which is 43 per 100,000, while White women's cervical cancer incidence rate is only 7.3 per 100,000 (Lawson, Henson, Bobo, & Kaeser, 2000). This high incidence of cervical cancer might be the result of low Pap testing among the Vietnamese women, hence the precursor lesions are not detected and treated before progression to cancer. Furthermore, in Australia, Vietnamese-born women have a significantly higher incidence of cervical cancer as compared to other groups of immigrants and Australian born women (Cheek, Fuller, Gilchrist, Maddock, & Ballantyne, 1999; Lesjak, Hua, & Ward, 1999).

2. Vietnamese Canadian Women's Health Care and Cancer Screening Practices

In relation to health care practices, not only do cultural beliefs, values, and practices influence an individual's appraisal of illness and their coping choices and options, but also their social positions within a particular society. These, in turn, will shape an individual's health care behaviour. Anderson (1991, 1993, 1998), Dyck (1989), Kearns and Dyck (1995), Papps and Ramsden (1996), Stephenson (1995), and Stingl (1996) have examined barriers to access health care by members of different ethno-cultural background groups. They have identified obstacles to accessing health care that are not only related to cultural beliefs and values, but also ethnic inequality, in terms of political power and social economic status. Thus, other determinants of health such as social, political, economic, and historical factors should become important issues of analysis.

A review of the literature reveals that cultural attitude, beliefs about health, and beliefs about the sources of illness influence how the Vietnamese practice health care and that differences in cultural conceptualisations of health and illness can pose barriers to seeking treatment from Western health care (Stephenson, 1995; Uba, 1992). Stephenson's study (1995) revealed that Vietnamese underutilised the

existent health care services, although not specifically related to breast and cervical cancer screening practices, further suggests that Vietnamese Canadian women might be less likely to have cancer screening compared to women in the general Canadian population.

A quantitative survey conducted by a group of health care providers in California showed that although not strongly correlated, Vietnamese's social values contributed to some extent to how Vietnamese women practice breast and cervical cancer screening (McPhee et al., 1997). The results of Yi's (1994) telephone survey of 141 Vietnamese women and McPhee et al.'s telephone survey of 933 Vietnamese women in the U.S. suggested that barriers to Vietnamese women's cancer screening behaviour are low socioeconomic status, lack of health care insurance, low level of education, poverty, and never being married. In addition, while McPhee et al. (1997) found that having a Vietnamese physician contributed to the lower participation rate of these women's cancer screening practices, Lesjak et al. (1999) and Cheek et al. (1999) found the length of residence in the adopted country affects participation in cervix screening with recent immigrants being less likely to be screened.

It has been pointed out that an individual's responses to illness, which differ from the physician's assumed rational point of view, are not just because of lack of information, but rather because they are grounded in a culture and a system of beliefs and practices that might be different from those of biomedicine (Good, 1994, p. 38). Barriers to practice biomedicine by people of different ethnocultural backgrounds may be the result of different understanding of health, illness, and diseases.

While caring for clients of different cultures, different personal beliefs and values might lead to discrepancies in the perception and expectation of care between health care providers and clients. Anderson (1987) pointed out that culturally appropriate care cannot be achieved unless health care professionals recognise and take into account the different cultural perspectives on health and illness held by the clients. They should be able to elicit these discrepancies by negotiation with the clients to come up with a plan of care that is mutually acceptable to both the health care providers and the client. Cecil Helman (1990) concurs with this notion by saying that it is important to maintain open communication between medical professionals and the clients because their views of health, illness, and diseases may be very different. Therefore, "the clinician's diagnosis and treatment must make sense to the patient, in terms of their lay view of ill-health, [clinicians] should acknowledge and respect the patient's experience and interpretation of his or her own condition" (Helman, p. 125).

Working within biomedical model, which has its knowledge and practices closely connected to the biological sphere (Good, 1994), physicians and many other health-care professionals have often viewed disease and illnesses as particular parts of a complicated human body that is malfunctioning, and that these parts can be "fixed" with specific solutions (Capra, 1982; Good & Good, 1993). Health-care critics contend that this perspective neglects the wholeness of the patient and pays inadequate attention to the social and environmental contexts of illness and disease (Capra, 1982; Good, 1994).

As observed by Byron Good (1994), contemporary biomedicine and medical behavioural science do not adequately address social and psychological issues by focusing on the modification of individuals' "irrational" behaviour to reduce risk factors and increasing the compliance with medical regimens. In health care practice, health care professional cannot assume that knowledge will lead to "rational" behaviours, which in turn, leading to appropriate illness preventing and health-seeking behaviours. Not only do individuals often ignore their risks (Gifford, 1986), but health-seeking and/or illness preventing behaviours should be seen as a situated product, largely shaped by the immediate circumstances and affected by contextual factors of the situation (Bloor, Barnard, Finlay, & McKeganey, 1993).

In summary, an overview of the literature reveals that Vietnamese women are at significant risk of having advanced breast cancer and cervical cancer due to their low participation in these cancer screening programs. To date, I have not been able to locate other studies examining how Vietnamese Canadian women participate in breast and cervical cancer screening practices. However, present data indicate that Vietnamese women's health care practices are influenced by their cultural backgrounds, understanding of health and illness, social values, and degree of acculturation. Sparse data from the U.S. and Australia also indicated that Vietnamese women's low participation rate in breast cancer and cervical cancer screening programs is the result of different cultural beliefs and values, low level of education, poverty, never being married, recently migrated, and having a Vietnamese physician. There is very limited information on (a) how Vietnamese Canadian women use the available breast cancer and cervical cancer screening services, the quality, suitability, and accessibility of these services, (b) what leads Vietnamese Canadian women to seek health care, from whom they seek help, and the social support networks that women draw upon to foster their health care practices. Furthermore, there is very little research that analyses the role of cultural conceptualisations, social ideologies, and socioeconomic status, which are shaped by race, gender, and class, as important factors in determining Vietnamese Canadian women's breast cancer and cervical cancer preventive health care practices and health-seeking behaviour.

E. Research Questions

In this study, I address the following research questions from both the Vietnamese women and the health care providers' perspectives:

1) How do Vietnamese-Canadian women participate in breast and cervical cancer screening practices?
2) What is the process by which the decision to engage in regular breast cancer and cervical cancer screening is reached? What are the key factors that influence this decision-making process?
3) How do contextual factors such as social, cultural, political, historical, and economic at the intersection of race, gender, and class affect Vietnamese-Canadian women's breast cancer and cervical cancer screening practices?

Chapter Three: Theoretical Questions

I hold that individuals' health care behaviours are influenced not only by their cultural beliefs, values, and practices, but also by their social positions within a particular society. Race, class, and gender shape individuals' social position. Thus, addressing Vietnamese Canadian women's breast cancer and cervical cancer screening practices should be viewed and assessed using theoretical perspectives that emphasise the effect of culture, race, class, and gender on individuals' social, cultural, historical and economic background.

Social and cultural processes shape the ways in which people think, act, and use health care services (Kleinman, 1980). Examining how culture conceptualisations influence Vietnamese women's view of health, disease, illness, and social relationships will provide insight into the ways in which they make decisions to engage in breast and cervical cancer screening programs. The ways in which people use health care services is influenced by how they conceptualise health and illness. Kleinman (1980) asserts that "[people's] beliefs about sickness... including their treatment expectations .... affect the way individuals think about and react to sickness and choose among and evaluate the effectiveness of the health care practices available to them" (p. 38). Furthermore, "beliefs about symptoms, diseases, and health have a strong influence on how individuals make sense of their vulnerability and respond to illness" (Johnson, Bottorff, Balneaves, Grewal, Bhagat, Hilton, & Clarke, 1999. p. 251). For this study, Kleinman's explanatory model of health and health care has directed me toward the examination of (a) Vietnamese women's conceptualisation of health and illness, and their explanation of what causes breast and cervical cancer; (b) whether or not Vietnamese women's health care behaviour is influenced by their cultural knowledge and values, (c) to what extend cultural knowledge and values influence Vietnamese women's health care decision making and health care relationships; and (d) what elements of culture can be identified as facilitators and/or barriers to health care practice.

I hold that social antagonism and inequalities, the effects of poverty and political domination, which are present in the institutions such as work places, schools systems, government offices, and health care services, influence Vietnamese women's lives and health care. Adopting postcolonialism and Black feminism will help with the investigation of how the micropolitics of power and the macrodynamics

of social and institutional structure (Kirkham & Anderson, 2002) shape individuals' social position within a society, which in turn, influence how they experience reality and practice health care.

Postcolonialism and Black feminism will "shed light on the complex issues at the intersection of gender, race, class relations and culture, and further our understanding of how material existence, shaped by history, influences health and well-being for those who... have 'suffered the sentence of history...[of] diaspora, [and] displacement'" (Anderson, 2002, p. 11). In health care, postcolonialism and Black feminism offer an alternative approach to the examination of issues such as equity in health and accessibility in health care services at the time when global migration and health care reform are happening in many Western countries (Anderson, 2002). Postcolonialism and Black feminism provide a theoretical framework that recognise Vietnamese women's marginalised voices as legitimate, as a direction for health care actions that are responsive to Vietnamese women's specific social locations within Canadian society.

This chapter illuminates how Kleinman's Explanatory Model (1978, 1980), postcolonialism, and feminism —in particular Black feminism— have provided theoretical perspectives and conceptual frameworks that guided the way in which I chose to address Vietnamese Canadian women's breast cancer and cervical cancer screening practices and answered my research questions. In the first section, I present an overview of Kleinman's explanatory model. In the second section, I articulate the theoretical framework that underlies my research – postcolonialism and feminism.

A. Kleinman's Explanatory Model: Medical System as Cultural System

Arthur Kleinman (1980) asserts that health and illness beliefs and behaviour, and health care activities are governed by the same set of socially legitimated rules. The way people think, act, and use health care services shape health care systems. To study changes in health care behaviour, one must also examine changes in the health care system. The medical system is viewed as a cultural system because the health care system's origin, structure, and function, Kleinman theorises, is socially and culturally constructed. Culture, Kleinman (1978) defines, is "a system of symbolic meanings that shapes [individual's] social reality and personal experience" (p. 86). Culture mediates between the 'external' (social, political, economic, historical, epidemiological and technological) and 'internal' (psychological, behavioural and communicative) parameters of medical systems, thus culture is a major determinant of

the medical system content, effect, and functions. How people of a particular society conceptualise health and illness, their cultural beliefs, values, behaviours, and expectations toward treatments shape their health care system. To understand how a particular health care system functions and operates within a given society, we have to analyse it within the social and cultural contexts of that society. Therefore, to understand Vietnamese women's health care behaviour, we need to understand their conceptualisation of health, illness, and disease, and how their cultural knowledge and values shape their expectations toward medical treatment within Canadian context.

According to Kleinman (1980), social reality and clinical reality are two important dimensions of the health care system. Social reality symbolises human interactions which consist of meanings, norms, social structures, and behaviour expected in a society. Kleinman suggests that, "beliefs about sickness, the behaviours exhibited by sick persons, including their treatment expectations, and the ways in which sick persons are responded to by family and practitioners are all aspects of social reality" (p. 38). Thus, the ways in which Vietnamese women think about and make decisions about breast cancer and cervical cancer screening will be affected by their social reality which consists of their beliefs about sickness, their treatment expectations, and the ways in which they are responded to by family and health care practitioners.

Clinical reality is a health-related aspect of social reality. It is defined as " the beliefs, expectations, norms, behaviours, and communicative transactions associated with sickness, health care seeking, practitioner-patient relationships, therapeutic activities, and evaluation of outcomes" (Kleinman, 1980, p. 42). Both social reality and clinical reality are "cultural constructions, shaped distinctly in different societies and in different social structural settings within those societies" (Kleinman, p. 38). Thus, to understand how Vietnamese women think about and attend to their health, we need to have insight not only into their beliefs and expectations, but also into what they consider to be social norms in regard to communication, health care seeking, and their relationship with important others and health care providers.

The inner structure of every health care system, Kleinman (1980) proposes, is composed of three overlapping domains: the popular (e.g., family, community, social network), the professional (e.g., nursing, medicine, and other health care professions), and the folk sector (e.g., non-professional). Although there are some beliefs and values shared by the three domains, each of the three domains has its own distinct explanatory model of health and illness.

1. The Popular Sector of Health Care

According to Kleinman (1980), the popular sector of health care is the largest part of any health care system. It is within this sphere of health care that illness is first defined, treatment initiated, and progress evaluated. Within this sector, the family plays a crucial role in deciding what to do and how to engage in what type of health care activities. These decisions are influenced by the popular culture's beliefs and values about health and illness. For instance, if a Vietnamese child is sick with the flu, it is his parents who first notice that the child is sick. The parents then draw from their past experiences and cultural knowledge about this type of illness, what they believe regarding health (a balance between two basic components: am or breath, and duong or blood) and illness (caused by bad wind, rotten food, or bad spirits). The family will then decide whether to administer herbal therapy or to seek outside help by taking the child to a medical facility, or both.

2. The Professional Sector of Health Care

The professional sector of health care is comprised of the organised healing professions. It is often referred to as modern scientific medicine. In many societies, the modern medical profession has become a source of social power and has successfully dominated the health care system by using legal and political means. The modern medical profession has forced other healing traditions to disperse and to submit to its power (Kleinman, 1980). An increase in professional power creates changes within the system of knowledge, medical technology, and health care institutional structure. In some societies, these changes have resulted in culture-repatterning and Westernisation of the health care systems. Kleinman criticises the ideology held by many modern medical professionals that many health-related activities undertaken as the result of beliefs held by the popular or folk sector are irrational and unscientific. This ideology, he points out, has led to an insensitivity towards patient expectations and beliefs of health, illness, and health care.

Thus, Kleinman (1980) calls for a broader cross-cultural perspective that would include the views of clinical reality held by other healers and by patients themselves. He also instructs health care professionals to be skeptical about the value judgments enforced by the socially constructed biomedical professional ideology. More importantly, health care professionals should be able to elicit and recognise "patients beliefs and values with respect to their illnesses and treatments and to negotiate with (or

translate between) these differing perspectives in the same way an advisor gives expert advice to an advisee, who retains the right to accept, alter, or reject that advice" (Kleinman, 1980. p. 58).

3. The Folk Sector of Health Care

Kleinman (1980) categorises this sector of health care as a mixture of many different components, some related to the professional sector, but most related to the popular sector. There are two distinct sides to this sector of health care, sacred and secular, but they often overlap. Sacred healing usually emerges from studies of folk religion and includes ritual curing. Secular forms of healing comprise "herbalist, traditional surgical and manipulative treatments, special systems of exercise and symbolic non-sacred healing" (Kleinman, 1980. p. 59). Many health care professionals question the efficiency and effectiveness of folk healing medicine because there is no system in place to evaluate the patient's condition before and after treatment. However, there are many forms of folk healing linked to the popular culture and traditional healing in Western societies and in developing countries, indicating the important function of this health care sector.

Kleinman (1980) observes that there are no clear-cut boundaries between these three components of the health care system. All three sectors interact because the patients pass between them. It is important to note that boundary lines only serve as points of entry and exist for patients who follow their health care plan. For example, a Vietnamese woman may enter the professional sector of health care for treatment of a certain illness, but in the process of evaluating the effectiveness of the treatment will also draw from her knowledge acquired from having contact with all three sectors of the health care system.

4. Explanatory Models (EMs)

Individuals' EMs provide explanation for sickness etiology, symptoms, pathology, course of illness, and treatment. EMs derive from individuals' knowledge and values, which are specific to their different social sectors and subsectors of the health care system. Studying and comparing clients, family, and health care practitioners' EMs can contribute to understanding health care relationships. Conflicting EMs coupled with cultural insensitivity will lead to relationship and communication breakdown between client and health care provider. These, in Kleinman's view, are major deterrents of client compliance, satisfaction, and appropriate use of health care services. Client-health care provider communication

problems are often the result of differences between lay (popular culture) EMs that construe sickness as *illness* while professional medical (biomedical) EMs construct sickness as *disease*.

One of Kleinman's important contributions was the distinction between *disease* and *illness*. Disease "denotes a malfunctioning in or maladaptation of biological and or psychological processes .... Disease is most commonly associated with the EMs of professional practitioners (modern or indigenous), where it relates to special theories of disease causation and nosology that are stated in an abstract, highly technical, usually impersonal idiom .... Illness, on the other hand, signifies the *experience* of disease (or perceived disease) and the societal reaction to disease. Illness is the way the sick person, his family, and his social network perceive, label, explain, valuate, and respond to disease" (Kleinman, 1978, p. 88). Illness is often associated with the EMs of the lay (or popular culture) whereas sickness is dealt with in a more personal, less technical manner and where life problems arise as a result of sickness are manifested. The illness EM is directly influenced by the individual's culture, knowledge, values, and experiences.

Kleinman further points out that health care activities mitigate between both the disease and the illness models of sickness. Problems will arise if health care professionals only see and treat sickness as disease whereas clients seek both symptom relief and meaningful explanations to which they could psychologically, socially, and culturally relate. The important point here is that to provide effective health care, and to ensure clients' cooperation, health care professionals need to treat both disease and illness in a way that the client can relate to culturally, socially, and individually. Within these perspectives, Kleinman's approach to patient care is most holistic because it incorporates the social and cultural aspects of the patient's life. Another relevant feature of Klienman's approach is its recognition of the separate conceptualisations of health, illness, and different personal beliefs and values that both health care professionals and clients bring to health care situations (Anderson, 1990).

Kleinman's explanatory model has been examined by many scholars (Anderson, 1985, 1987, 1990, 1993; Dyck, 1989; Good, 1977; Helman, 1990; Lynam, 1992). Although his conceptual framework addresses health care at a professional-client level and not at the structural and health care institutions level, Kleinman's theoretical model of medicine as a cultural system provides a systematic method for the analysis of the impact of culture on individual's sickness and healing.

Kleinman's conceptualisation of the medical system as a cultural system and his explanatory model of health, disease, and illness have also provided me with a framework by which to examine the

interactions between Vietnamese women, their families and health care practitioners, which reveals how cultural knowledge and values influence Vietnamese women's breast cancer and cervical cancer screening behaviour. However, Kleinman's framework does not illuminate how power relations, race, class, and gender influence individuals' health care experiences. Incorporating postcolonialism and Black feminism as theoretical perspectives for this study will enable me to examine how Vietnamese women's health care practice is shaped by other contextual factors, namely, social, political, historical, and economic factors at the intersection of race, gender, and class.

B. Postcolonial-Feminist Scholarship: Its Relevance in Addressing Health Care Issues

Both postcolonialism and feminism provide a theoretical lens through which issues of equity and social justice are examined and incorporated into the analysis of this research. Postcolonialism "provides a theoretical perspective from which to contest the historical construction of the racialised and cultural 'other' through the processes of colonisation" (Anderson, 2002, p. 18). Because Canada is a nation founded on colonisation and immigration, and my research is with Vietnamese women who come from a colonised society, postcolonial perspectives, with its conceptual framework, issues, and debate provide valuable insights that guide the way I address and incorporate the effect of racialisation processes into the analysis of Vietnamese Canadian women's health care experience and practice.

As Anderson (2002) points out, "[f]rom a post-colonial vantage point, we might come to understand that the difficulties people face in accessing and utilising health care may be due not to their 'culture', but instead, to historical processes that have produced systemic inequities and oppression" (p. 15). Postcolonialism can be used to examine social issues in any place that has had an experience of colonialism. In Western societies, many social and cultural issues do bear comparison with situations in postcolonial societies —issues such as the sociocultural conditions that are affecting both majority and minority populations (Quayson, 2000). According to Alto Quayson, "[f]actors like multiculturalism, ethnicity, diaspora and transnationalism as they apply in the West can only be fully understood if seen in tandem with the realities of struggles in real postcolonial societies, precisely because some of these factors are actually the effects of global population and cultural flows after colonialism" (p. 11).

Black feminism provides a conceptual framework from which to examine social phenomena from the women's perspectives. It pushes us to use the everyday experiences of women as the sources for

research. Most importantly, "black feminism pushes [researchers] to analyse gender, 'race' and class relations as simultaneous forces, and to examine knowledge production from different social and political locations" (Anderson, 2002, p. 18).

These above theoretical perspectives have directed me towards the exploration of how the social, cultural, political, historical, and economic, which are shaped by the conceptualisation of race, gender, and class, influence Vietnamese women's breast cancer and cervical cancer screening practices. Moreover, postcolonialism and Black feminism have led me to a research methodology that has the following characteristics: (a) there is a shift in thinking that science is socially constructed; (b) the researcher treats women as subject and not as object of the study; (c) the researcher is committed to fostering social and political equality for women; and (d) the research is used for the promotion of social justice and equality. With postcolonialism and black feminism combined, this research methodology "[lays] the groundwork for the analysis of gender, 'race' and class relations as simultaneous, contextualised and historicised" (Anderson, 2002. p. 19). To illuminate how post colonialism and feminism provide lens through which Vietnamese women health care experiences can be examined, I discuss postcolonialism and Black feminism.

1. Postcolonialism

Quayson (2000) asserts that the term "postcolonialism" often invokes the implicit idea of chronological supersession because of its prefix 'post' —which suggests that the colonial stage has been surpassed. However, the term should be viewed as "a process of coming-into-being and of struggle *against* colonialism and its after-effects" (p. 9). In viewing postcolonialism as process we are avoiding the misleading conception that views postcolonialism merely as a chronological marker, connecting the postcolonial phenomenon with any precise dating.

Anderson (2002), drawing on Quayson, suggests that there is no single definition of postcolonialism. Although the understanding of postcolonial scholarship is diverse, scholars critically address the experience of colonialism whether it is in the past, present, or future and how these experiences have been constructed under the influence of race, racialisation process, and culture within particular historical, colonial, and neo-colonial contexts. In a broad sense,

> [P]ostcolonialism refers to theoretical and empirical work that centralises the issues stemming from colonial relations and their aftermath. Its concern extends to the experiences of people

> descended from the inhabitants of these territories and their experiences within the 'first-world' colonial powers .... Overall, the project of postcolonialism today centers on theorizing the nature of colonised subjectivity and the various forms of cultural and political resistance. (Kirkham & Anderson, 2002, p. 3)

Quayson (2000) conceptualises postcolonialism as a process, an epistemological path which addresses social issues that are related to: (a) the global politics and the formation of a global order after empire; (b) the re-evaluation of the exclusionary forms of Western knowledge and their roles in imperial expansion and the formation of colonialist rules; and (c) the challenges to dominant discourses (Quayson, 2000, p. 3). Moreover, these concerns extend beyond the formerly colonised lands to include the relationship of dependency between the West and its Others. He writes:

> Postcolonialism has to be seen as a viable way not just of interpreting events and phenomena that pertain directly to the 'postcolonial' parts of the world, but, more extensively, as a means by which to understand a world thoroughly shaped at various interconnecting levels by what...we might describe as 'the inheritance of the colonial aftermath'. The process of postcolonializing, then, would mean the critical process by which to relate modern-day phenomena to their explicit, implicit or even potential relations to this fraught heritage. (Quayson, 2000, p. 11)

Postcolonialism allows for a wide rage of applications because it often involves the discussion of various experiences such as migration, suppression, resistance, differences, race, as well as racial discrimination and minority issues in the West. Although postcolonialists address very diversified issues, in Quayson's (2000) view, what has served to unite these different methodologies is the desire to draw on an understanding of the process of colonialism for understanding the formation of the contemporary world with its social, political, and cultural issues. To further my discussion on the possibility and challenges of postcolonialism, I offer background information on the process of colonisation and colonial issues.

2. Understanding Colonisation and Racialisation

The process of colonisation involved the invasion and the acquisition of territories by European nations in the late nineteenth century by means of economic and military forms of power, as well as the desire to protect these territories from other competing nations (Williams & Chrisman, 1994). Colonialism is also viewed by Williams and Chrisman (1994) as "a particular phase in the history of imperialism, it is now manifested as the globalisation of the capitalist mode of production, its penetration of previously non-capitalist regions of the world, and the destruction of its social organisation" (p. 2). In this context, imperialism and colonisation are complex processes. Both are supported and impelled by the ideologies

that certain territories and its people are inferior, subordinate, and dependent; and thus, require authority and domination, and the knowledge that is associated with domination (Fanon, 1994; Said, 1993). Because colonisation aimed to seek new markets, sources of raw material, and labour, its ultimate result was economic exploitation of the indigenous people. Colonisation also involves systematic domination that maintains the dominant group's power relation with others and produces an organisational system with institutions that perpetuate these relationships (Williams & Chrisman, 1994). Aimé Césaire (1994) vividly narrates how colonisation works when he writes,

> Colonisation dehumanised even the most civilised man...I see force, brutality, cruelty, sadism, conflict...There is room for only forced labour, intimidation, pressure... contempt, mistrust.... domination and submission which turn the colonizing man into a classroom monitor, an army sergeant, a prison guard, a slave driver, and the indigenous man into an instrument of human production. (p. 177)

Colonisers brought with them not only a series of assumptions that the indigenous people were interested in the coloniser's social system construction, religious, legal, and health care systems, but also the diseases, conflicts, and technology which seriously altered the indigenous people's lives (Ramsden, 1990). The environment and land were exploited and divided for trading value and commercial use. The destruction of cultural beliefs and values, and the economic and spiritual deprivation have consequences to this day. Alienation, poverty, and a lack of cultural dignity, which result from long-term suppression, lead to grief and anger within indigenous populations (Papps & Ramsden, 1996). This trouble is often manifested in high mortality and morbidity rates, much lower life-expectancy compared to the country's average life-expectancy, high incidence of mental illness, escalating high risk behaviour, and inflated suicide rates (Ramsden, 1990).

Edward Said (1993) examines culture in relation to imperialism and colonisation. He sees imperialism as "the practice, the theory and the attitudes of a dominating metropolitan center ruling a distant territory" (p. 9), and colonialism, a consequence of imperialism, is "the implanting of settlements on distant territory" (p. 9). Imperialism and colonialism, Said theorises, are acts of accumulation and acquisition of certain dominant ideologies within a society. The ideologies in which certain people are deemed "less advanced" or "subordinate" or even "inferior" have allowed the processes of domination to occur, creating tensions, inequalities, injustice, and racism in many societies. Said insists that this process of domination has been extended and embedded in all cultural affairs. Although there now exists a greater awareness of cultural differences, and more effort is being put towards the elimination of racism,

the consequences of these imperial ideologies, the discrimination of one culture by another, the tendency to dominate other cultures, and an inequality of power and wealth still exists in many societies (Said, 1993).

Racism is "a doctrine that unjustifiably asserts the superiority of one group over another on the basis of arbitrarily selected characteristics pertaining to appearance, intelligence, or temperament" (Elliott & Fleras, 1992, p. 52). Connell (1989) has identified three levels of racism: (a) Personal racism occurs when an individual or a group of people see itself as superior and has the power to enforce this superiority upon other groups which it views as inferior. This level of racism is detrimental to people because it destroys their sense of self-worth and denies them access to resources and opportunities in society. (b) Institutional racism occurs when institutions and agencies enforce policies which put certain racial groups at a disadvantage. (c) Cultural racism is less obvious, but it is embedded in people's way of life. The most destructive aspect of cultural racism is, again, the underlying ideology of superiority. Although "it is not openly expressed ... it is constantly implied" (Connell, 1989, p. 17). Furthermore, cultural racism is often associated with the differential access to power in the determination of control over the means of social production and distribution of social resources. Many immigrants suffer all three levels of racism.

Racial oppression implies, "an unequal relationship... [in which] the dominant group has the power to oppress and the subordinate group has fewer resources to resist the oppression" (Bolaria & Li, 1985, p. 22). Racial oppression results in a loss of cultural identity, the destruction of human relationships, inferior education, housing segregation, and poverty. Racial oppression also results in economic exploitation and social system domination, all of which contribute to inequity and injustice within a society (Bolaria & Li, 1985), poor health and other psychological problems (Connell, 1989; Fanon, 1994; Hall,1994; Li, 1988; Papps & Ramsden, 1996; Ramsden, 1990; Said, 1993).

The question put forth is that how do racial discrimination and oppression contribute to immigrants' health care problems? Racial discrimination and class assumptions can affect immigrants at both the individual and institutional level of care. At the individual level, racism refers to the negative attitudes and behaviour exhibited towards clients of different ethno-cultural backgrounds, which can potentially interfere with a health care professional's willingness to care for clients who are perceived to be different (Kearns & Dyck, 1996). The health care provider's negative attitudes and behaviour towards clients can create barriers for immigrants who feel that they are powerless or discriminated against

(Anderson, 1985; Donnelly, 1998; Dyck & Kearns, 1995; Kearns & Dyck, 1996; Lynam, 1992; Papps & Ramsden, 1996; Ramsden, 1990). This situation contributes and reinforces the problems of immigrants' access to equity in health care services.

Thus, at the individual level, health care providers must be aware of their own capacity for racial discrimination, and of their own cultural beliefs, values, and attitudes that they bring to their work. This view is consistent with Kleinman's (1980) assertion of the importance of health care provider-client relationships. However, problems with health care relationships are the result not only of conflicting explanatory models between clients and clinicians, but also of health care providers' negative attitude and behaviour toward clients.

It is important to acknowledge that clients' negative attitude and behaviour toward health care providers will also result in relationship problems. However, in health care relationships, health care providers often hold more power which, when misused, can potentially cause harm to clients. Health care providers have the power in decision-making regarding client care and distribution of health care resources. This is well demonstrated in the way health care providers make care plans and health care policy. It is the health care providers who identify the client's needs, decide on the solutions to meet these needs and decide which health care programs should be funded. Thus, it is essential for health care providers to recognise that "each health care relationship between a professional and a consumer is unique, power-laden and culturally dyadic. From this perspective, whenever two people meet in health care interactions, it inevitably involves the convergence of two cultures. This bicultural component involves not only unequal power and different statuses but often also two cultures with differing colonial histories, ethnicities or levels of material advantage" (Kearns & Dyck, 1996, p. 373).

At the institutional level, unequal access to health care resources and unequal power relations between social groups affect how individuals receive health care and cope with illness. Anderson, Blue, Holbrook, and Ng (1993) found that non-English-speaking immigrant women were unable to obtain health care services that they needed because of the position and condition in which these women worked and lived, and also because the existing health care system is set up to serve mainstream society. Thus, it is imperative to examine the effect of racism at the institutional level because this is where the policies are made and reinforced. It is at this level that the dominant group has the power, and the capacity to excise that power to situate certain racial groups at a disadvantaged social position and to place them in low

socioeconomic status groups. Examining ethnic inequality in relation to social class, education, and economic opportunities, can illuminate immigrants' inequality and their inadequate access to health care.

Examining ethnicity and race as products of unequal relationships which are socially constructed and maintained by differential power relations between a dominant and a subordinate group, Li (1988) found that ethnicity makes a difference in the education and economic opportunities of Canadians. Moreover, ethnic inequality has become a systematic and institutionalised feature of Canadian society. Li (1988) asserts that structured social inequality is responsible for the disadvantaged positions of many ethnic groups. These disadvantages include unequal access to educational opportunities, class positions, and earnings. Barriers within a school system for certain ethnic groups to achieve higher education will affect earning potential. Earning disparity contributes to the unequal distribution of wealth, privileges, and power among classes in Canadian society. These dimensions of inequality combined with low earnings contribute to poor health status of immigrants, poor quality of life, and loss of control over life situations.

Canada's immigration process, its history, law, and policy not only systematically structure and reinforce sexism and racism against women, but also put immigrant women at a disadvantaged status and create barriers that prevent them from accessing certain social supports and resources (Ng, 1988; Thobani, 1999). Historically, Canadian immigration policy has always been racist in the sense that White English-speaking immigrants are preferred over non-white immigrants in the selection process (Ng, 1988). Thobani (1999) has pointed out that at its inception, Canada's nation building process was developed to strictly control and prevent the entry of women from the third world by designating them "non-preferred races." Third world women were viewed as a threat due to their present racial "inferiority" and their potential to produce "non-preferred races" (Thobani, 1999). Although the 1976 Immigration Act had helped to remove racist and sexist discrimination to some extent, women from third world countries still faced discrimination (Thobani, 1999) due to the fact that under this Act, the husband, in most cases, is the one who will be granted the "independent" immigrant status and he is considered to be the head of the family. The wife and the children are considered "family class" immigrants, which means that they are allowed to enter Canada only if a husband or an immediate family member who is either an independent immigrant or a Canadian citizen sponsors them. This process has not only systematically structured gender inequality within a family, but has also made women totally dependent on their sponsors with a series of disadvantageous consequences. For example, family class immigrant women and children are not eligible to obtain family benefits, welfare, employment training, health care programs, and other forms

of provincial assistance during the five-year sponsorship period, unless there is a break in the sponsorship contract (Ng, 1988). Over the years, many new Immigration Laws and Acts have been added and changed, yet immigrant women remain unequally treated and discriminated against. As summarised by the Canadian Research Institute for the Advancement of Women (CRIAW), the timeline between women and immigration has several important features:

> 1976-78: A new *Immigration Act* was passed in 1976. This document governed Canadian immigration for 25 years. More regulations were passed in 1978 dealing with the sponsorship of "dependents". This is the basis for the regulations that still have a negative effect on the lives of immigrant women.
>
> 1981: The Foreign Domestic Movement Program came into effect. It allowed women to immigrate to Canada if they could first find employment as a domestic worker. These women were not granted citizenship and were forced to follow strict rules regarding their living and employment arrangements.
>
> 1992: The Live-In Caregiver Program replaced the Foreign Domestic Movement Program. This increased the training requirements needed to apply, and retained all regulations that had been affecting women negatively since 1981.
>
> 2002: The *Immigration and Refugee Protection Act* was passed. This replaced the *Immigration Act* and governs all immigration to Canada. Unfortunately it was influenced by the fear of terrorism after Sept. 11, 2001. The *Act* makes it harder for immigrant women to gain access to Canada. However, the *Act* requires that a yearly report be presented to Parliament on the gender impact of this law.
>
> (CRIAW, 2004, http://www.criaw-icref.ca/factSheets/Immigrant_fact_sheet_e.htm)

Thus "institutional discrimination against immigrant women is built into the statutory services for immigrants" (Ng, 1988, p. 188).

3. Postcolonial Scholarship

Recognising the complexity of contemporary experiences, postcolonialists, on the one hand, place an emphasis on illuminating how hegemonic discourses construct and define domination and subjugation in social relations in society. On the other hand, they pay close attention to the ways in which material, social, political, and economic factors produce and reproduce any discourses. In other words, "a central underline assumption is that a focus on the discourse and ideology of colonialism is as important as one on the material effects of subjugation under colonialism and after" (Quayson, 2000, p. 2). Thus postcolonialists are critical of colonial discourses, which represent "Others" in ways that re/produce unequal social relations (Bhabha, 1994; Hall, 1997; Mohanty, 1991; Quayson, 2000; Said, 1994; Spivak 1988; Trinh, 1989).

Homi Bhabha (1994) theorised that an important feature of colonial discourse is the ideological construction of racial, cultural, and historical otherness through representation. Conceptualising colonial discourse as "an apparatus of power"(p. 70), as a form of "governmentality" that appropriates, directs, and dominates the colonised society's various spheres of activity, he said:

> [Colonial discourse] is an apparatus that turns on the recognition and disavowal of racial/cultural/historical differences... It seek authorisation for its strategies by the production of knowledges of coloniser and colonised which are stereotypical but antithetically evaluated. The objective of colonial discourse is to construe the colonised as a population of degenerate types on the basis of racial origin, in order to justify conquest and to establish systems of administration and instruction. (Bhabha, 1994, p. 70)

In contrast, "post-colonial discourse [provides] the grounds for interrupting ahistorical, generalising, essentialising, culturalist and racialising discourses, which have categorised people according to racial categories and hierarchies" (Anderson, 2002, p. 13). Thus, researchers who engage in postcolonial scholarship are critical about the language they use in the production of knowledge. They pay attention to the process by which dominant hegemonic discourses and ideologies create a sense of otherness, unequal social relations, imbalance and injustice within society. Following these perspectives, I recognize that dominant social and cultural ideologies and discourses through language and social practices have, to a certain extent, contributed to the racialisation process that place and maintain Vietnamese women within the socially disadvantaged "Others" category, which in turn, impact how health care is provided to these women.

4. What is Postcolonial Research?

According to Quayson (2000), the central tenet of any postcolonialist project is the ability (a) to critically examine the social phenomenon in such a way as to disclose the complex interrelationships between postcolonialism and other domains of contemporary experience, (b) a postcolonial project will address the imbalances and injustices that are present in both East and West societies – whether it is about racism, minority rights, labour division between the sexes, or environmental issues. In other words, the postcolonial project has to do with the correction of imbalances in the society wherever these imbalances and injustices may be found – not merely for the oppressed in and from formerly colonised societies, but also for the "*intersubjective* relations that arise out of responses to crime from both crime fighters and racial minority victims" (p. 12), (c) although far from unified in their views, many postcolonial

projects are concerned with issues pertaining to the social construction of *race* and the process of *racialisation*, as well as the re-conceptualisation of culture as a concept that operates with/in the construction of *race* and carries with it social, political, and historical meanings (Anderson et al., 2003). *Race* is no longer viewed as a biological entity that categorises people according to their physical attributes, but it is viewed as a socially constructed ideology that has often been used to define and organise social relations between society's social groups. Racialisation is "an [ideological] process of delineation of group boundaries and of allocation of persons within those boundaries by primary reference to (supposedly) inherent and/or biological (usually phenotypic) characteristics" (Miles, 1989, p. 74). Thus, the term "racialisation" "draw[s] attention to the social processes whereby groups are singled out for unequal treatments on the basis of real or imagined phenotypical characteristics" (Li, 1990), and (d) the representation of Other which re/produces a sense of otherness.

5. Black Feminism

The central tenet of Black feminism, Anderson (2002) points out, is that it views women's experiences as diverse, historicised, and contextualised. Recognising that women's struggles are the product of historical reasoning, racialising processes, and class relations, the researchers' aim is to expose these sources of oppression. Thus, there is a commitment to listen to and value the voices of marginalised women – voices that come from the margins.

Following these perspectives, I have used Vietnamese women's everyday life situations as resources for investigating their health issues. Because I hold that there are gender differences in the lives of men and women, women's lives are used as sources for defining their social and health problems and to create scientific evidence and knowledge, and women's health research begins in women's everyday lived experiences. Starting from the Vietnamese women's perspectives enables me to understand the processes through which social life and social relations have organised these women's lives and have shaped labour division between the sexes, which in turn, have influenced how they practice health care.

By women's everyday lives is meant "the patterns women create and the meanings women invent each day and over time as results of their labours and in the context of their subordinated status" (Aptheker, 1989. p. 39). Thus, describing every aspect and the activities of women's lives is not as important as knowing the meanings women give to their labours (Aptheker, 1989). If health care

professionals understand how Vietnamese Canadian women create patterns of their daily lives and what this means to them, then they will see women's reality in a different way.

Feminism posits that women's experiences are important resources for the organisation of social structure and social life in general. As such, women should have an equal opportunity (to men) to participate in the design of social and institutional structures, administration, rules, and practices (Harding, 1987). Feminism holds that in many patriarchal societies, women have often been looked upon as subordinate, and their experiences have been considered as insignificant or totally ignored. Thus, feminists believe that women, in general, and to a different degree, have been oppressed and mistreated by socially dominant groups. Oppression, as defined by Patricia Hill Collins (2000), "describes any unjust situation where, systematically and over a long period of time, one group denies another group access to the resources of society. Race, class, gender, sexuality, nation, age, and ethnicity among others constitute major forms of oppression" (p. 4). In a society, dominant groups hold power that can exclude women from actively participating in social relations, production, and reproduction. Insisting that inequality and injustice exist between men and women within society, feminists are committed to the elimination of social inequity and injustice (Borland, 1991; Harding, 1987).

bell hooks (2000) asserts that feminism encompasses the examination of how women's everyday reality is informed and shaped by politics (which include the personal politics, the politics of society, and global revolutionary politics). Feminism can also become a means by which to analyse and illuminate how social ideologies and institutional structures produce and reproduce the experience of discrimination, exploitation, or oppression. To hooks (2000), when feminism is viewed in that way, it "calls attention to the diversity of women's social and political reality, it centralises the experiences of all women, especially the women whose social conditions have been least written about, studied, or changed by political movements" (p. 27). Scholars such as Anderson (2002), Collins (2000), and hooks (2000) assert that marginalised women's social position, which is the result of historical, racialisation, and classification processes, should be an important element in the analysis of women's struggles and experiences.

Regarding Black feminism, it is important to explicate that the term "black" is not used as "a biological category, but as a 'political' category" (Anderson, 2002, p. 15). The term "black" is "used by people of different shades of skin colour in a show of solidarity and coalition to resist labels such as 'visible minority' which, unwittingly, designate people as marginal with minority status and, therefore, inferior" (Anderson, 2002, p. 15).

Black women, in the view of bell hooks (2000), "are in an unusual position in this society, for not only are [they] collectively at the bottom of the occupational ladder, but [their] overall social status is lower than that of any other group. Occupying such a position, [they] bear the brunt of sexist, racist, and classist oppression" (p. 16). Thus, Black feminists have a world view that closely reflects the lived experiences of marginalised women in a patriarchal society. With the understanding of how marginalised women live, Black feminists are in an advantageous position to generate knowledge that fosters women's empowerment and social justice (Collins, 2000; hooks, 2000).

An important question is what would a postcolonial feminist research guided by the above perspectives look like? A postcolonial feminist research exhibits several important characteristics. First, researchers who conduct postcolonial feminist research are critical of traditional social science, its ontological and epistemological underpinnings. They argue against the objectivism and value-free epistemology of traditional scientific inquiry (Gandhi, 1998). Thus knowledge generated in this dissertation is socially constructed. Recognising that the researcher's race, gender, class, and culture shape her/his research process, my positionality as a Vietnamese immigrant woman is acknowledged and incorporated into the research analysis. In this research, the limitation of the biomedical model is recognised and the rhetoric of biomedicine that has produced conventional biomedical knowledge is not taken for granted. It is this awareness that has directed me to choose a qualitative research approach with Kleinman's explanatory model and the postcolonial feminist theoretical perspective as foundations of analysis.

Adopting postcolonial feminist perspective, Vietnamese women's breast cancer and cervical cancer issues can be identified and addressed from the perspective of women's experiences. Because the postcolonial feminist perspective values women's experiences as a significant indicator of women's lives, solutions to women's problems are derived from women's perspectives which provide women with explanations that they can draw upon to understand themselves and the social world. All of the above helps to validate women's sense of agency – the autonomy, the right, and the freedom to address what women themselves define as important issues and problems (Harding, 1987).

Second, a feminist project is a social justice project that places women's experiences and thought at the center of analysis (Anderson, 2002; Collins, 2000). Feminist research is also politically driven in the sense that it challenges the hegemonic forces that shape women's lives and seeks answers to how to neutralise those forces (Harding, 1987). In this study, Vietnamese women's lived experiences were

emphasised as the most important component of analysis. My aim is not only to generate a more accurate account of women's health care activities from their everyday experiences, but also to improve the conditions in which women live and practice health care.

Third, a postcolonial feminist research is committed to the examination of how race, gender, and class relations influence social, cultural, political, and economic factors, which in turn, shape the lives of marginalised women. One of the important functions of postcolonial feminist research is to illuminate the ways in which unequal social power relations contribute to the unequally distributed health care resources and inaccessibility of health care services for the women of marginalised social groups. In this study, I examined how racialisation, gender roles and expectations, and class hierarchical relations shape Vietnamese Canadian women's health care practice. Instead of viewing individual women as being totally responsible for their health care behaviours – behaviours which are dictated by their cultural beliefs – I have also examined how health care institutions and organisations' infrastructure and policy affect these women's health and health care.

Fourth, postcolonial feminist research pays attention to the connection between knowledge and power relations. Discussion of Foucault's work is of benefit here because his theory which underlie the work of many postcolonial feminist scholars, connects the production of knowledge with power relations, and discourse (Anderson, 2002). Foucault (1994) insists that knowledge cannot be simply reduced to language, meaning, or the investigation of whether or not statements and theories are true, because all knowledge is subject to change (and distortions) under the influence of power relations within social institutions and disciplines. To Foucault, knowledge is connected to social and institutional discursive practices. It is also produced in relation to the disciplinary power structure – the power structure that influences meaning statements, regulates discourse, and produces strategic knowledge. Thus, Foucault's theory about discourse places much emphasis on the relationship between power, knowledge, and truth.

One of the most important works of Foucault is his challenge to the many otherwise taken-for-granted assumptions of contemporary health care and medicine (Cheek & Porter, 1997). Through a Foucauldian analysis, health and illness concepts are viewed as not objectively created, but rather produced through the dominant discourse of biomedicine. The dominant discourse of biomedicine has shaped the ways in which disease, illness, and health are conceptualised, which in turn, promotes certain treatments of particular health problems and exclude other conceptualisations of health and disease treatments (Cheek & Porter, 1997). The dominant biomedicine discourses also produce knowledge that

values rationality, and influences the discursive nature of health care towards naturalism, individualism, and objectivism (Donnelly & Long, 2003).

A limitation of discourse analysis, however, is its totalisation of history's imprint that emphasises that the subject's (women) practices and experiences are constructed (or are determined) by societal macro forces, social discourse, and cultural practices. This might compromise women's ability to resist oppression and domination because it undermines women's sense of agency and ability to reflect on the social discourse and challenge its determinations. It erases any room for maneuver by the individual within a social discourse or set of institutions (Alcoff, 1991).

In this study, paying attention to discourse is useful because, "the study of discourse allows an investigation of the social rather than psychic imperatives of behaviour" (Currie, 1999, p. 289). It is important to note that discourse analysis does not simply designate the study of passages of connected writing or speaking through language. It is a study of where meanings come from, and how discourse produces meanings through social and institutional rules and practices that shape and influence social relations, and the production of knowledge in different historical periods (Hall, 1997). The study of health care discourse is then a study about how both popular (or lay) and professional discourses produce and reproduce meanings of health, disease, and illness through social and institutional practices that ultimately shape Vietnamese women's understanding of breast cancer and cervical cancer, and its management.

Because discourse provides a medium through which thought, actions, and communication are expressed, articulated, and controlled, the study of health care discourse should emphasise not only how knowledge of health, illness, and its management are constructed and used in social interactions, but also how knowledge influences our consciousness, social values, and in fact, our practices. Because social consciousness and values are produced by people, and are a social product, the analysis of health care discourse should also focus on "issues concerning stake and accountability, and look at the ways in which people manage pervasive issues of blame and responsibility [and]... the way that descriptions are put together to perform actions and manage accountability" (Potter, 1994, p. 129).

In conclusion, because I hold that individuals' cultural conceptualisation of health, disease and illness, and socially constructed positions within a society influence/shape their health care behaviour, Kleinman's explanatory model, postcolonialism, and feminism provide the theoretical foundation for this research. Kleinman's conceptual framework has helped me to explore how culture exerts its influences on

Vietnamese women's health care behaviour, in particular, breast cancer and cervical cancer screening practices. Postcolonialism and feminism have pushed me to examine critically how individuals' social position which is shaped by race, gender, and class influences Vietnamese women's lives and health care practices. Recognising that cultural and social constraints which are the result of societal inequality and unequal power relationships, effect how immigrant women practice health care, I have drawn on the postcolonial and feminist perspectives to address Vietnamese women's breast cancer and cervical cancer screening issues.

Postcolonial feminist researchers assert that traditional research pays inadequate attention to the historical forces that shape the individual's social position and thus their experiences (Anderson, 2002; Kirkham & Anderson, 2002). Inherent in many postcolonial feminist projects is the discussion of the ways in which dominant ideologies and discourses construct the Other's images as "irrational," "backward," and "uncivilised." Postcolonialists such as Edward Said, Stuart Hall, and Homi Bhabha, to name a few, have illuminated how these discourses have contributed to the racialisation process that secures the "different Other" as "inferior Other." The detrimental effect of such a racialisation process is that it naturalises and legitimatises unequal social relations, and creates an unequal distribution of power and social resources in society. If inequality and injustice are seen as inherently present within a society, one is to accept one's own situation. It destroys individuals' agency and silences their voices.

For this research, postcolonial feminist scholarship has helped me to put Vietnamese women's marginalised experiences at the focal point of analysis. It has also helped me to analyse the effect of historical forces, together with the present social and political processes, which have shaped Vietnamese women's lives, their health care, and contributed to the remaking of social inequity. These analyses have brought out the awareness that to provide appropriate and effective health care to clients of different ethno-cultural backgrounds and to foster their health care practice, changes in both individual behaviour and social and institutional structural conditions and practices are needed.

Drawing on the literature on Vietnamese and women's health care practices, Kleinman's explanatory model, postcolonialism and feminism the following research questions were constructed: (a) How do Vietnamese-Canadian women participate in breast and cervical cancer screening practices? (b) What is the process by which the decision to engage in regular breast cancer and cervical cancer screening is reached? What are the key factors that influence this decision-making process? and, (c) how do contextual factors such as the cultural, social, political, historical, and economic at the intersection of

race, gender, and class affect Vietnamese-Canadian women's breast cancer and cervical cancer screening practices?

Chapter Four: Research Methods

A. Research Participants

In this study, a maximum variation purposive sampling was used. Maximum variation purposive sampling is "the process of deliberately selecting a heterogeneous sample and observing commonalties in their experiences" (Morse, 1994, p. 229). Maximum variation purposive sampling can enable the researcher to capture and describe core experiences from the common pattern or themes that emerge from variation within participants (Patton, 1990). The participants consisted of 15 Vietnamese women and 6 health care providers. Fifteen Vietnamese first generation immigrant women with diverse backgrounds, age 50 and over, who speak Vietnamese, come from both North and South Vietnam, and lived in Canada for more than 3 years participated in the study (see Appendix D, p. 231 for their socio-demographic profiles). Justifications for this selection include: (a) the need for the age group to overlap for both breast and cervical cancer screening; (b) the increased aging population; (c) the increased risk for both cancer sites with older age; and (d) the decreasing rate of usage of screening with older ages.

The health care providers consisted of four physicians and two community health nurses, who provide health care services to Vietnamese women. The physician's years of working in Canada ranged from 7 to 25 years. One community health nurse had been working with Vietnamese women for 4 years, while the other nurse worked with Vietnamese women for more than 15 years. All health care providers except one community health nurse speak Vietnamese fluently.

Table 4.1

Health Care Provider Participants' Profile

Years of practice	Physicians (*N*=4)	Community health nurses (*N*=2)
4		1 (female)
7	1 (male)	
18	1 (male)	1 (female)
21	1 (male)	
25	1 (male)	

Because the cervix and breasts are considered the most private parts of the woman's body, investigating factors that affect how women participate in both cancer screenings would give more information on women's cancer preventive behaviour. Due to the need for the age group to overlap for both breast and cervical cancer screening, women between the age of 18 and 50 were not included. Thus, data on factors that influence Pap testing on Vietnamese women between 18 and 50 years of age are not gathered. The reason for this decision is that younger adults who have been living in Canada since a much younger age, some of them even being born in Canada, are not likely to face the same challenges of accessing Pap testing as older women. Younger Vietnamese adults' cancer screening behaviours might be similar to that of young adults in the general population because they might not have language barriers and the influence of cultural knowledge and values might be minimal. I found that having data on both breast cancer and cervical cancer screening practices does not complicate analysis of the result of this study.

Morse (1994) proposed that in qualitative research, adequacy of research sampling is guided by the expertness of the participants and their ability to articulate their experience. In this study, based on the richness and quality of the data collected, a total of 26 interviews were conducted with 21 participants to meet the project's objectives. Each interview conducted with the Vietnamese women lasted between 3 to 4 hours (with the exception of one interview, which lasted for only 2 hours). Interviews with health care providers lasted between 1/2 to 1 hour. Informed consents in both languages, Vietnamese and English, were provided and was obtained from each participant. Each participant was given an explanation of the study. Participant information was kept confidential in a locked cabinet and password protected computer's files. All identifying information from transcripts was removed to preserve participants' anonymity. Pseudonyms and code numbers were used throughout the research process and this report.

B. Gaining Access and Developing Rapport

Gaining access through Vietnamese community gatekeepers and health care organisations was the main approach of this study. Recruitment of Vietnamese women was made through Vietnamese Community based organisations such as MOSAIC – a multilingual multicultural non-profit organisation, Vietnamese Senior Association, Vietnamese Senior Support Groups, Protestant Church and Women

Support group, and by personal referral from the Vietnamese community workers and the women participants.

Recruitment of health care professionals was done by referral from community workers, community health nurses, and by personal referral from physicians who also participated in this study. Letters specifying the study's purpose, objectives, research questions, and recruitment criteria were provided to community agencies. Moreover, I made several presentations about the research project to community agencies. Participants and personnel from community agencies were asked to contact potential participants who fit the study criteria, to inform them about the study, and to ask their permission for the researcher to contact them. Once I received permission to make contact, I then talked to potential participants via telephone. During the initial telephone conversation, I explained the study to potential participants and answered any questions before scheduling an interview. At the interview session, I read and explained the informed consent to the participants, answered questions, and reassured them that they had the right to withdraw from the study at anytime (see Appendix E, p. 233, and Appendix F, p. 234 for Women's Informed Consent Letter). Enthusiastic support from community agencies was received.

Being a Vietnamese woman who had gone through the experience of being a refugee living in Canada, I have insights into the Vietnamese culture and understanding of Vietnamese women's experiences. I am also aware that the unequal power relation that exists between myself as the researcher and the participants might create discomfort for the participants. Thus, every effort was made to be respectful towards the participants. At the beginning of the interview, often, the participant and I shared our story about our flight to Canada. Many participants have often asked about my own experience in Vietnam and how I got out of the country. My experience of leaving Vietnam by fishing boat via China to Hong Kong helped generate some commonalities between the participants and myself. There were several occasions when knowing that I had grown up in North Vietnam under communism generated discomfort for participants who came from South Vietnam. However, by honestly acknowledging that I was not a communist, and sharing my own family background helped me to create a more comfortable atmosphere and more open communication. There were times when I felt that trust was established between us only after I talked about my family's experiences under communism.

C. Method of Data Collection

To address my research purposes and questions, a qualitative research approach was used because it provides detailed contextual information, and can capture the complexity, and meanings that Vietnamese women and their health care providers attribute to their thoughts, actions, and health-related behaviours (Stephenson, 1995). In a study where different language and cultural perspectives are prevalent, conducting in-depth interview using the participants' language enables the participants to describe their experiences using their own words (Anderson, 1986). Fluency in Vietnamese gave me the ability not only to conduct interviews in Vietnamese, but it has also enabled me to understand and closely attend to the participants' narratives. It allowed me to engage more directly with participants.

The data for this study are constituted of information gathered from in-depth interviews, field notes with Vietnamese immigrant women and health care providers, and direct participation in Vietnamese community events (i.e., Vietnamese women group meetings, church meetings, Vietnamese social gathering events). Demographic data about the women participants were also compiled. In addition, information about the health care structure and policy, social resources, Mammogram Screening programs, and data from BC Cancer Agency and BC Ministry of Health were reviewed and documented. All the above mentioned data were used for data analysis.

In-depth interviews were the main method of data gathering and analysis. In this study, the process of in-depth interviews can be described as open but focused (Schwandt, 1994). The participants were able to describe their experiences as openly as possible while still maintaining a research focus because dialogue between the participant and myself was interactive, reflective, and open. Participants were encouraged, respected, and listened to. Using an explanatory conceptual framework developed by Kleinman, postcolonialism, and feminism as theoretical foundations, a semi-structured questionnaire with open-ended probing questions was developed to encourage the participants to discuss their experiences with breast cancer and cervical cancer screenings.

Ideology and discourse influence the research process – from formulating the research purpose, refining the research question, developing the interview guide, completing the interviews, data analysis, and the representation of results. Interviewing involves direct interaction between the researcher and the research participants. Thus, I am aware of how ideology and discourse influence the ways in which I ask questions, the type of questions that are generated during the in-depth interview, and the power that

exists during our interaction. This awareness provides me with the opportunity to gain a more accurate view of the participants' lives.

D. Research Interviews

In-depth interviewing is "a data gathering technique used in qualitative research when the goal is to collect detailed, richly textured, person-centered information from one or more individuals" (Kaufman, 1994, p. 123). Elliot Mishler (1986) conceptualises interviewing as

> a form of discourse...that it is discourse shaped and organized by asking and answering questions. An interview is a joint product of what interviewees and interviewers talk about together and how they talk with each other. The record of an interview that we researchers make and then use in our work of analysis and interpretation is a representation of that talk. How we make that representation and the analytic procedures we apply to it reveal our theoretical assumptions and presuppositions about relations between discourse and meaning. (Preface)

In conceptualising the interview as a communicative event (i.e., a discourse between speakers), accurate records of the questions asked by the interviewer and the answers given by the interviewee, are necessary. Because interviewing with open-ended questions is often complex in intention and wording, it leaves much room for interpretation by both the interviewer and the participants (Potter, 1994). Ambiguity and complexity are, therefore, present in all interview situations and types of discourse. Shared implicit assumptions and the mutual recognition of contextual factors are important to facilitate mutual understanding of the meaning of the questions asked and the responses given (Mishler, 1986).

If interviewing is a discourse and Foucauldian analysis (Foucault, 1994) contends that power inscribes within discourse, attention to power relations between researchers and their participants is a must. Interviewing involves interactions within an unequal power relationship. I have attempted to minimise this power differential by engaging the participants in a more reciprocal dialectical relationship. Traditionally, researchers often hold more power than their participants and in some situations, "interviewers define the role of interviewees as subordinates; extracting information is more to be valued than yielding it; the convention of interviewer-interviewee hierarchy is a rationalisation of inequality; what is good for interviewers is not necessarily good for interviewees" (Oakley, 1981, p. 40). Furthermore, within the traditional model of sociology, an ideology that validates objectivity and value-free research has made some social researchers view interviews merely as an instrument of data collection (Oakley, 1981).

To facilitate the collection of information, a pseudo-conversation is created in which the interviewer asks questions with warmth and clarity, but does not engage in the exchange of information and does not reveal his/her personal beliefs and values. Behaving otherwise would lead to 'bias' and invalid research would result. Thus to ensure the success of the interview, the interviewer has to achieve a balance "between the warmth required to generate 'rapport' and the detachment necessary to see the interviewee as an object" (Oakley, 1981, p. 33). Many feminist researchers assert that these interviewing techniques are unethical. Successful interviewing, they suggest, is achieved when an equal power relationship exists between the interviewer and the interviewee, and when the interviewers are willing to invest their personal identity in the relationship (Finch, 1993; Oakley, 1981).

In this study, a non-hierarchical research interviewing approach was used. The women participants and I were willing to invest our personal identities in the relationship through sharing our own stories. This approach to qualitative data gathering helped me to generate detailed, richly textured, and person-centered information from the participants. It has helped me to develop and maintain rapport and trusting relationships with my participants. This is an essential element in the research process because many sensitive topics such as social support, discrimination issues, and political perspectives were addressed.

Recognising that political issues exist between the Vietnamese who came from North Vietnam and Vietnamese who came from South Vietnam is an important aspect of this research. Because I came from North Vietnam, which was under control of communism, the participants often want to know about my political perspective, and whether or not I support communism. Thus emphasising that my main purpose for doing this study was to find ways to promote cancer preventive health care practice among Vietnamese Canadian women and that I am a nurse who is mostly interested in health care issues was essential. In addition, by honestly recognising that there is tension between North Vietnamese and South Vietnamese people due to the historical and political nature of our country, I was able to develop trust with my participants. As a result, the participants were quite open in talking about such sensitive topics.

The individual in-depth interviews were conducted in the language that was preferred by the participant. Initially, my plan was to interview each woman participant two times, each time for the length of 1 hour to 11/2 hours, whereas each health care provider would be interviewed one time for 30 minutes (which is the time that many busy physicians could give). However, most of the participants wanted to

talk, and as a result, our conversations lasted much longer than anticipated. With the participants' permission, all the interviews were audiotape recorded.

Interviews with the Vietnamese women yielded information addressing the research objectives: (a) to explore how Vietnamese women participate in breast cancer and cervical screening, what leads Vietnamese women to seek health care and from whom they seek help, and the social support networks that they draw upon to foster their health care practices, (b) to explore whether Vietnamese women find the current preventative cancer services suitable and accessible to them, (c) to explore how social, cultural, political, historical, and economic which are shaped by the conceptualisation of race, gender, and class influence Vietnamese women's breast cancer and cervical cancer screening practices, (d) to explore differences between Vietnamese women's perspectives and those of health care providers, and how the health care providers' perspectives influence the health care experiences of Vietnamese women, (e) to explore how a postcolonial feminist perspective contributes toward the understanding of Vietnamese women's health care experiences and cancer screening practices. However, some of the interviews with health care providers have also provided much insight into the analysis of these issues.

An interview guide with open-ended questions was designed specifically for the study. It was in both the Vietnamese and English languages. The interview guide contains questions regarding Vietnamese-born women's health care knowledge, attitudes, past and current practices about clinical breast examination (CBE), breast self examination (BSE), mammogram, and Pap testing. The questions also inquired into how Vietnamese women practice breast and cervical examination; what prevents or what motivates these women to engage in preventive cancer screening practices; what do they perceive as barriers to accessing health care services and provisions, and who are their health care supporters. In addition, questions assessing socio-demographic information about Vietnamese immigrants gave additional information about Vietnamese women's social support networks (see Appendix G, p. 235 for Initial Interview Questions for Vietnamese Women and Appendix I, p. 239 for the Socio-Demographic Data Form).

To identify if there are differences between Vietnamese women's perspectives and those of health care providers, interviews were conducted with health care professionals who provide health care services to Vietnamese women. Interviews with health care professionals focused on exploring what these professionals believe motivates or prevents Vietnamese-born women from engaging in CBE, BSE, mammogram, and Pap testing practices; what they perceive as barriers for Vietnamese women to access

these services; what information, health care programs, and services would best benefit Vietnamese Canadian immigrant women; and what they perceive as the best possible strategies to promote breast cancer and cervical cancer screening practices among Vietnamese women (see Appendix K, p. 245 for Initial Interview Questions for Health Care Providers).

The data obtained from interviews were transcribed in the primary language of the participants and then back translated into English. Although only sections of interviews that I used to quote were translated into English, a sample of five interviews was randomly selected, translated into English, reviewed, and analysed. The code categories from the English translation were used to compare with the categories from the data in Vietnamese. My coding process was consistent and accurate because the code categories developed in English were similar to the code categories developed in Vietnamese.

E. Data Interpretation, Coding, and Analysis

Data obtained from interviews and field notes were transcribed as soon as possible. All of the interview data were coded and used as examples to be quoted. My approach in working with the transcribed data also included continuous data analysis and interpretation. Data analysis was an ongoing process that involved thorough reading, marking transcript margins, identifying, refining, adding codes, and categorising themes. In addition, data collecting, filing, and organising theme materials were done so that data could be easily retrieved.

The process of data analysis and data collection occurred concurrently. The process of data analysis included specific steps. **Step 1**: As data were obtained, they were transcribed in the language that was used by the participants (which was mostly Vietnamese). To ensure accuracy, the transcripts were rechecked against audiotape tapes, corrected, then a hard copy was obtained for preliminary data analysis. **Step 2**: In the early stages of analysis, transcripts were coded to identify preliminary themes from the data and to formulate a list of code categories for organising incoming data. These code categories were refined as subsequent data were gathered. **Step 3**: Data coded in one category was examined for its relevance to other categories. The final outcome of this analysis is a statement about a set of complicated interrelated concepts and themes. This process of analysis involved a systematic and rigorous development of code categories and subcategories, which were flexible and evolving and used for the coding of subsequent transcripts. During this step, I meet with my supervisors and research

committee members to review, and to share reflections on the process of conducting the interview, personal feelings, and analytic descriptions. **Step 4**: Themes and concepts were used to compare within and across transcripts in the data set and across cases. From this, a higher level of data conceptualisation and broader theoretical formulations were generated. This step also included returning the preliminary results to the participant along with my analytic interpretations in the second interview. Returning the preliminary results to the participants was done with six participants (two Vietnamese women and four health care providers, which included three physicians and a community health nurse). This process enabled me to clarify, expand, and discuss with the participants the emergent themes, ideas, and concepts. It also helped me to develop a deeper understanding of the data and gain more insight into Vietnamese women's breast cancer and cervical cancer screening practices, and the social processes and structures that organise these experiences.

Because categories were developed based partially on the meanings that participants attribute to their experiences (Carspecken, 1996), I paid particular attention to the ways in which meaning is reconstructed. Meaning reconstruction involves the way in which I mentally noted the possible underlying meanings and/or messages that the data conveyed. Meaning was understood and contextualised by reflection into the everyday life of the participant. To begin the initial meaning reconstruction, I read through the interview data and field notes, and mentally noted possible meanings. After several careful readings, I was able to identify common patterns as well as unusual elements or events that may have been important to my analysis. I then performed a line-by-line data analysis and preliminary coding was employed at that point. After reading through the data and beginning the preliminary coding process, segments that seem to be representative of action and thought patterns (regular pattern and/or anomalies in the pattern) were selected. This process was done in order to make explicit the underlying norms and possible meanings of these actions and thoughts, and to make the voices of my participants visible. Selected segments were then read line by line and my comments on discursive articulations of meaning, which I believed may underlie the interaction, were recorded.

As pointed out by Carspecken (1996), the articulation of possible meaning involves researchers' inference of the meanings they think their participants might infer, either overtly or implicitly. Because I could not know for certain that my articulation of the participants' intended meanings is in fact so, I could only specify possibilities of what my participants might mean. Because there is no guarantee that my reconstruction of meaning is, in fact, experienced by the participants, there is always an element of

uncertainty and ambiguity in what I interpret as participant's intended meaning. Thus, it begs the question, how would I validate my reconstruction of meanings?

Carspecken (1996) recommended several ways that researchers can support their articulation of meanings. First, the more familiar researchers are with the culture of their participants, the closer their articulated meanings would be to that of the participants. Having gone through an experience of a Vietnamese refugee helped me to understand some of the issues these Vietnamese women were facing. Furthermore, as a health care provider, I was able to understand the social constrains which the physicians and the community health nurses were coping with. Second, the use of member checks plus dialogical data generation helped refine my articulated meanings.

Member checks were done by sharing the results of my preliminary data analysis with the people who participated in these first interviews. These were participants whom I believed could give me the most feedback based on their level of articulation. In this study, the women and the health care providers agreed with my constructed meanings, themes, and insights. Member checking was also done with my supervisory committee members through meetings that included presentation of what I conceptualised and by individual consultation with each member, especially with my two supervisors.

Another form of member checking was done through the process of generating dialogical data, which is data generated through dialogue between the participants and myself. In this study, an open-ended mode of inquiry helped my interacting with participants and interpretating participants' perspective in a hermeneutic dialectic mode. Guba (1990) emphases that the hermeneutic approach focuses on data interpretation and the refinement of individual constructions; whereas the dialectical focuses on comparing and contrasting dialogue between the researcher and the participants. To bring my interpretations and the participants' interpretations into consensus, active interactions between the participants and myself were employed. During each interview, the participants and I discussed, negotiated, and decided on what I understood as the meanings of the data. On several occasions, further exploration and clarification of my interpretations with the participants lead to greater understanding of participants' experiences. These activities provided ways for further "member checking."

Trustworthiness and validity have been identified as important issues in research. To ensure rigor and credibility of this study, beside "member checks," "critical self-awareness," and "self-decentralizing" (Lather, 1991) were employed in this study by recognizing that my own social position and perspective influenced the research process. Validity, to Carspecken (1996), refers to "the soundness of arguments

rather than to the truth of statements"(p. 55). Validity is, thus, "inhering in the structures of communication...[and] how well it meets validity criteria derived from the communication itself" (Carspecken, 1996, p. 57). In this study, for my claims to be considered as "valid," my interpretation was agreed upon (or achieved consensus) by the women and health care provider participants.

Besides making sense of the data, paying attention to the politics of creating meaning, exercising self-reflexivity and self critique, and ensuring rigor and credibility of the study, there are ethical issues that need to be attended to. Pamela Cotterill (1992) also reminds us that "when the researcher leaves the field and begins to work on the final account, the responsibility for how the data are analysed and interpreted is entirely her own. From now on the [participants] are vulnerable. Their active role in the research process is over and whatever way it is produced is beyond their control" (p. 604). Defining and presenting the participants' realities, in Cotterill's view, is the power that the researchers hold. Sharing the same ethical and moral concerns, Janet Finch (1993) notes that although interviewing is a great technique in creating social knowledge, it also leaves women open to exploitation of various kinds.

F. Representation of The Research Results

In representing the research findings, researchers are "engaging in the act of representing other's needs, goals, situation, and in fact, who they are; presenting them... [and] participating in the construction of their subject-positions" (Alcoff, 1991, p. 9). Researchers who use qualitative methodology are often faced with an enormous amount of data. It is difficult to decide what relevant information to comment on, issues to address, and what to include in the presentation of the result. Research approaches to organising data and to focusing attention on relevant information have been identified as one of the crucial dimensions in the research process. It has also been recognized that ideology and discourse influence researchers' interpretation of the meaning of their research data.

Michael Stubbs (1982) has warned researchers that stereotyped ideology can pose much danger to the way they approach their data. A danger of stereotyped ideology is that "[it] can be a barrier to analysis, and can prevent us from seeing what is really going on" (p. 43). Gubrium and Holstein (1997) emphasise that the interpretation and the presentation of qualitative research should be concerned with not only what research is presented, but also how the research is presented. Cultural sensitivity and

reflexivity to the spoken and written texts and the nature of discourse are important issues in this production and reproduction of social forms. Therefore, in the construction and representation of the participants' lived experiences, I paid close attention to my language of analysis and what it means to represent.

Michel Foucault (1978) poses a question regarding silence in "History of Sexuality" –

> silence itself – the things one declines to say, or is forbidden to name, the discretion that is required between different speakers – is less the absolute limit of discourse....There is no binary division to be made between what one says and what one does not say; we must try to determine the different ways of not saying such things, how those who can and those who cannot speak of them are distributed, which type of discourse is authorised, or which form of discretion is required in either case. There is not one but many silences, and they are an integral part of the strategies that underlie and permeate discourses. (p. 27)

Thus, I paid attention to what was spoken, what was implied, and what was not spoken about. My analysis included those who can and cannot speak and why certain issues are not spoken about. I was also aware that often it is not

> a plain and simple imposition of silence. Rather, it [is] a new regime of discourse. Not any less [is] said about it...But things [are] said in a different way; it [is] different people who say them, from different points of view, and in order to obtain different results" (Foucault, 1978, p. 27).

Foucault (1978) pointed out that there is a whole network of diverse discourses produced by many mechanisms from different institutions that can act as either stimulating or constraining discursive social practices. From these multiple discourses many distinct discursive formations arise from different disciplines such as medicine, psychology, nursing, ethics, and political science. Thus, multiple discourses, which often involve conflicting perspectives, influence interpretation and thus the presentation of data.

Interpretation is a difficult issue in feminist research. As feminist researchers, we are committed to certain ideologies and discourses. Because feminist researchers' goals are to obliterate the oppression and domination of women, and to empower women (Borland, 1991; Farganis, 1986), by providing vehicles that give voice to women who are "socially and politically silent" (Cotterill, 1992), their works might involve contradictions (Borland, 1991). In her own work with oral narrative research, Borland (1991) reminds us that feminist researchers seek to empower the women whom they work with by interpreting the women's perspectives and the ways they live their lives. She cautious us that feminist researchers "hold an explicitly political vision of the structural conditions that lead to a particular social behaviour, a vision that our [participants]... may not recognize as valid" (p. 64). Therefore, conflicting interpretations

can arise between the researchers and the participants who do not share the same political perspectives that shape those interpretations (Borland, 1991; Cotterill, 1992).

Thus, to adequately present the participant's perspectives, while adhering to their research goals, feminist researchers need to be reflective and sensitive, not only to what kind of information they present and how they will present their work, but also to what kind of ideologies and discourses that they and their participants produce and reproduce. Cotterill (1992) concurs with Borland (1991) by saying that she accepts the validity of the participants, while recognising that the responsibility for presenting their realities and the power that goes with it remains that of the researcher. As such, feminist researchers should be as honest as they can and also "not to undercut, discredit or write-off women's consciousness [that are] different from [their] own" (Cotterill, 1992, p. 604). Last but not least, they should try to create "a sociology which articulates women's experiences of their lives – rather than merely creating data for oneself as researcher" (Finch, 1993, p. 178).

From my own involvement with several qualitative research projects, I have found that there are many dominant societal ideologies influencing the stories told to me by participants and that also influence the ways in which they interpret their experiences. As a researcher, my own experiences, cultural background, position as a health care professional, theoretical framework, professional ideologies and discourses, all influence how I interpret the meanings of data. As such, there are instances when my interpretations are not the same as that of the participant. Although it is not possible to always come to a mutual understanding, it took reflexivity and sensitivity from both myself and the participant to understand each other's perspectives. As Bakhtin (1986) explained, to have a special kind of utterance (speech production) is to "enter into a special kind of semantic relationship that we call dialogic" (p. 118). For the researchers to enter this dialogic relationship, elements of language within the language system or within the "text" need to be transformed into a "world view," a "viewpoint, " or a "social voice" that extends beyond the boundaries of linguistics" (Bakhtin, 1986). For me, a dialogic relationship and the extension of voices beyond the boundaries of linguistics include the recognition that my voice and the voices that I seek are only a few among many other voices.

In the writing of this dissertation, I was constantly reminded of a question that Patricia Collins (2000) once asked of herself: "How can I as one person speak for such a large and complex group as African-American women?" Although I am fully aware that as one researcher I cannot and should not speak for others, Linda Alcoff's (1991) criticism of the position that refrains researchers from speaking for

others also comes to mind. Acknowledging that although there are problems involved with issues of speaking for others and about others, Alcoff insists that adopting the position that one can only speak for oneself is sometimes problematic. To Alcoff, "the attempt to avoid the [problem] of speaking for [others] by retreating into an individualist realm is based on an illusion, well-supported in the individualist ideology of the West, that a self is not constituted by multiple intersecting discourses but consists in a unified whole capable of autonomy from others" (p. 21). The question I put forth, then, is how can I as the producer of this dissertation speak and present in such a way that illuminates not one voice but the dialogue between people who have been silenced? Recognising that my social position as a Vietnamese woman, an academic, and a health care provider influence the way I produce this text, I have tried to the best of my ability not to produce and reproduce the unequal social position of my participants.

The "rituals of speaking," a term coined by Foucault, refers to "discursive practices of speaking or writing that involves not only the text or utterance but [people's] positions within a social space, including the persons involved in, acting upon, and/or affected by the words" (Alcoff, 1991, p. 12). In the "rituals of speaking," the position or the location of the speakers is an important element. The position or the location of the speaker affects not only the meaning of spoken words and meanings of the event, but also the value and the significance of any claim made (Alcoff, 1991). In the area of knowledge production, whether the knowledge is taken as "true," valid, and legitimate depends on who says it, which, in turn, affects the style and language in which it is presented. An important analysis arose from the conception of the positionality of the speakers; what is taken as truth and whether claims can be upheld as knowledge depends upon the researchers who speak for and about others. It holds researchers accountable and responsible to the ways in which they interpret and present their data. Thus, sensitivity and reflexivity to the location of oneself and others must be critically and consciously exercised in the representation of the text (Wolf, 1996). As a feminist researcher, Patricia Collins (2000) has found that her social position as an African-American/woman/mother/ working–class person/academic scholar has helped her to speak in a voice that is "both individual and collective, personal and political, one reflecting the intersection of [her] unique biography with the larger meaning of [her] historical times" (p, vi). Similarly to Patricia Collins, my social position as a Vietnamese Canadian/woman/mother/refugee/health care provider has enable me to write this text in a way that is reflective of both the participants' collective and my personal experiences.

Not only do researchers' social positions influence their worldview and their methodological framework, but also political and cultural ideologies, and discourses. Raymond Williams (1981) states that

cultural institutions are essential parts of the general social structure and the basic components of selected tradition and ideologies by the people of the dominant culture. These dominant ideologies and selected traditions are taught in schools, expressed in the media, and are important dimensions of the social, political, and economic organisations. These organisations represent and reflect a society's dominant relations and ideologies, which then become a norm against which other forms of social relations, behaviours, and productions are interpreted and judged. In her discussion throughout "Girl Talk," Dawn Currie (1999) warns researchers that they "can not read 'the social' off cultural artifacts, such as commercial magazines" (p. 308). Not only should these commercial texts be viewed as simply cultural or textual representations, but they should also be viewed as "a textual form of social power that mediates everyday practices of meaning-making and the 'doing' of gender" (p. 308). As researcher, we need to move beyond the immediacy of the text and to consider that presentation of qualitative research findings should be concerned with not only what research is presented, but also how the research is presented. Cultural sensitivity and reflexivity to the spoken and written texts and the nature of discourses are important issues in the production and reproduction of social forms (Gubrium & Holstein, 1997). Therefore, in my construction and representation of the participants' lived experiences, effort was made to pay close and systematic attention to the diverse and complex relations between my language of analysis and what they are meant to represent.

Analysis of the women participants and health care providers' narratives revealed four themes. These four themes include the influence of cultural knowledge and values, gender roles and expectations, the social support networks, and socioeconomic status on the women's health care practice, in particular, breast cancer and cervical cancer screenings. The next four chapters are report of these findings.

Chapter Five: Cultural Influences: Knowledge and Values

Vietnamese's social values are different from the general Western population and this divergence contributed to some extent to how Vietnamese women participate in breast and cervical cancer screening programs (McPhee et al., 1997). However, Jenkins, Le, McPhee, Stewart, and Ha (1996) found that their data do not support the notion that traditional beliefs or cultural practices pose barriers to preventive health care services. In the present study, in-depth interviews with Vietnamese Canadian women and their health care providers revealed that cultural conceptualisations of health and illness, social ideologies and values shaped Vietnamese Canadian women's health care practices and health-seeking behaviour to some extent. Furthermore, the results from my study showed that many of their health care practices and knowledge are, in fact, quite congruent with Westerners health care practices. Thus, it begs the question: Why are Vietnamese women considered a hard to reach population? What other factors prevent these women from seeking help from health care providers? These questions force us to ask how health care providers and policy makers provide health care. Based on the data of my study, this chapter illuminates the process by which cultural knowledge and values about women's bodies, social relationships, and knowledge about health and illness influence Vietnamese women's decision to engage in certain health care practices, in particular breast cancer and cervical cancer screenings.

A. Cultural Knowledge and Values about Women's Bodies

1. The Private Body: Embarrassment, Hesitation, and Sexual Morality Discourses

The women's narratives revealed that conceptualisation of the body as private greatly influences the ways in which they seek and receive health care, especially breast and cervical cancer examination. Because the breast and cervix are considered as the most private body parts of a woman, the women participants' discourse regarding the privacy of the body often link to discourses of embarrassment, hesitation, and sexual morality. For some of these women, Confucianism and Buddhism influence how they view their body which, in turn, influence the ways in which they practice health care and participate in breast and cervical examinations.

Many women participants believe, nobody should touch the woman's body except her husband. These women reflected the Confucianism teaching that "Nam nu tho tho bat than" (a woman and a man should never touch or be close to each other. They have to avoid each other). Women's bodies are for themselves and their husbands only, nobody else. The cultural emphasis on women's body as private makes both women and male physicians uncomfortable with clinical breast examination. One male physician stated that he would verbally teach the women how to do breast-self examination but he thinks that clinical breast examination is not culturally sensitive or appropriate for Vietnamese women.

Women participants' narratives also reflected the Buddhist teaching that avoiding desire (quyen ru) and modesty toward the display of flesh is important. There is a common assumption held by some women that sins are caused by "Ai" which is love and "Duc" which is sex and sexual impulses. Buddhism also teaches that "Ai" and "Duc" will lead a person to darkness (vo minh), doing wrong things, and committing sins. This will, in turn, lead that person to a very unhappy and unfortunate life.

Below are tables that summarized women participants' experience with breast and cervical examinations.

Table 5.1

Papanicolaou Smears: Women Participants' Examination Pattern

Frequency	Women participants (*N*=15)	%	Women who met screening criteria	Women who did not meet screening criteria
Regularly once a year	5	33.3%	4 (26.6%)	1(6.6%)
Had it done once	3	20%	3 (20%)	-
Had it done twice	2	13.3%	2 (13.3%)	-
Never go for Pap test	5	33.3%	2 (13.3%)	3 (20%)

Of the 15 women I interviewd, 11 met both breast and cervical cancer screening criteria at the time of the interview. They reported on both their past and current screening practices. My data show that there are three women who have never gone for Pap testing, did not meet the present screening criteria and one woman who was not eligible for testing at the time of the interview, but had participated in screening. The reason that these three women did not meet the criteria for Pap testing at the time of our interviews was because of their age range (two women 73 year old, one woman 78 year old). However, all three women have been in Canada for many years. During these years of living in Canada, they had met the screening

criteria, yet they had never had Pap smear done. Thus their views on cervical examination remain relevant for this study.

Table 5.2

Mammography: Women Participants' Examination Pattern

Frequency	Women Participants (*N*=15)	%
Regularly every 2 years	7	47%
Had it done once	1	6.6%
Had it done twice	1	6.6%
Never	5	33.3%
Did not mention	1	6.6%

Table 5.3

Clinical Breast Examination: Women participants' Examination Pattern

Frequency	Women Participants (*N*=15)	%
Regularly once a year	3	20%
Never	4	27%
Did not mention	8	53%

Table 5.4

Breast-self Examination: Women participants' Examination Pattern

Frequency	Women participants (*N*=15)	%
Regularly once a month	1	6.6%
Once in a while	1	6.6%
Did not mention	13	86.6%

Most of the women participants say that they are very embarrassed when it comes to having Pap smear or breast examination by either male or female physicians.

> Mrs. Hai: For women, it is very uncomfortable when you let the doctor examine 'it'. Very uncomfortable, very different. It doesn't matter a woman or a man doctor, I don't like it. I don't like any body touch those 'things'...[breast examination] is not as bad as down there. But it is till too uneasy. (Translated and edited from W-Hai-3-A-1)

Many Vietnamese women participants say they are very hesitant to go for any kind of women's health care issues such as birth control, clinical breast examination, or Pap test (especially if their doctors are male doctors). For some women, especially older women, removing their clothes during an examination is an uncomfortable task. Even just talking about it creates embarrassment. For example, a group of women who work at the Vietnamese radio show which airs every Sunday from 8 to 10 AM were talking about breast cancer. They were trying to avoid using the word "vu" which means, "breast" in English. So they were talking about "ung thu nguc" which translated into English would be "cancer of the chest." When

they realised that it was not appropriate to call breast cancer "the cancer of the chest," they then called it "ung thu nhu hoa" which translated into English as "cancer of the two flowers." After much consideration, they finally called the disease "ung thu vu," which is "breast cancer."

Ms. Lyn is 68 years old and has lived in Canada for 13 years. For her, anything to do with "woman's things" is considered private. One should not display those "woman's things" but treat it with discretion.

> I don't know why I feel that way. I live with my grand daughter but I would wait until she gone to work to take my bath. I wash my underwear but I never let anybody see it. When I was young, no one in my house knew that I was having my period, even my family members... I just feel that men should not see these "women activities."
>
> Researcher: What would happen if men see it?
>
> Ms. Lyn: Nothing would happen. It's just that I feel very uncomfortable about it. (Translated and edited from W-Lyn-10-B-1)

Although she had six children, letting the doctor examine her breasts and the cervix when there is "nothing wrong" is very uncomfortable.

> Ms. Lyn: I am very embarrassed about it. Just show my breasts when nothing is wrong. Very embarrass (laugh). I would be very embarrassed. Even though I am old, I am still very embarrassed. (Translated and edited from W-Lyn-10-B-1)

The thought that she has to tell her son or daughter to take her to the doctor for a breast and cervical examination generates as much anxiety as the examination itself. "What would I say to my children? Ah, I need you to take me to the doctor to have my breast and my cervix exam. No, that is very uncomfortable, very embarrass" (W-Lyn-10-B-1). Similarly, Mrs. Mai says:

> It is because of the embarrassment that make a woman not wanting to have these examinations. Pardon me but if you have nothing wrong and yet you take off your pants and lay on the table with the legs up like that ... I think that is very embarrassed. I think that women would not like that. It is not the same as if you get your teeth check. So if you can have a Vietnamese female person to examine you then it would be better. (Translated and edited by W-Mai-9-A-1)

Contrary to other studies (Cheek et al.,1999; Lesjak et al., 1999; Yi, 1994), this study found that the degree of acculturation (good command of English language, more familiar with Western ways of living) and the length of time which Vietnamese women participants live in the host countries do not influence how they participate in breast and cervical cancer screening. The majority of the women participants have been living longer in Canada. For some, it is more than 20 years, and still they are quite uncomfortable with these examinations. For some women,

> Yes, language is very important. But it is not just the language. Our culture doesn't permit us talking, sharing with others about such taboo problems. Talking about the woman's body cannot be publicly. For example, my friends, they know English very well. They studied here for a long time. They told me "I talk to the doctor about the problem and I was so uncomfortable." These women are not comfortable to talk about it. So I think, language limitation may prevent women who just came here. But also these are not easy topics to discuss. (Translated and edited from W-Phi-2-A-1)

Mrs. Phi has been living in Canada for 26 years. Not only does she speak English and French fluently, but she has also been very successfully adapting to the Canadian way of living. This is what she said:

> I am embarrassed even to touch my own breasts, let alone other people. They (health care providers) need to understand that. Talking about the cervical, well, it is even more taboo (tham kin), more embarrassed. So they just don't go, and if they go, they would go to the female doctor. If there is a serious problem, they have to go [to the male doctors]. That's what I mean by understanding Vietnamese culture. Even though we are here, because we were always like that, still, we are remained the same. If there are no female doctors, we would hesitate to go for these kind of check up. (Translated and edited from W-Phi-2-A)

She further explained:

> People here do not live in Vietnam, so they don't know that Vietnamese people, especially, the Vietnamese women, don't like going to the doctors. It is worst if there are no female doctors. Breasts and cervix are places that are most private to the woman. Except the husband, nobody else should touch them. That you must understand. Therefore, when you are trying to motivate them to go to the doctors for these examinations, the first thing they might say is "Oh God, I am too embarrass," some thing like that to see a male doctor ! .... They (health care providers) need to understand this. So that they wouldn't be surprised of the fact that Vietnamese women don't used to the maximum this kind of health care services. The major thing is that they are embarrassed. So you see, also for that reason, they (the women) preferred to go to the traditional healers who would only examine their pulses, tell them whether their blood is good or bad, or cold blood, hot blood, etc. then give them the medication.
>
> Researcher: They do not touch your body.
>
> Mrs. Phi: They do not touch.
> (Translated and edited from W-Phi-2-A-1)

When asked why Vietnamese women feel so embarrassed about breast and cervical examinations, Mrs. Mai attributed it to the ways in which women have been taught from generation to generation. Her narrative also shifted toward what she thinks as sexually appropriate for women and her disapproval of the younger generation's behaviour.

> Vietnamese women are different. Our traditional behaviour is better. Now a day I see young Vietnamese girls here and back in Vietnam too they act very badly. Their dresses are so short, it shows everything. They would sit on the men's laps in public.... Back then we were never like that. We act properly (ne nep). We had to wear long formal dress (ao dai) as soon as we stepped out of the house. Just ask your mother, she'll tell you what it was like...You just would not show your bump like that....Before, when the parents say something, the children would listen, not all mixed up like here... I tell her to wear a longer dress but she like to wear it up to here. (Translated and edited by W-Mai-9-A-1)

Physicians also recognized Vietnamese women's hesitancy to address issue related to breasts or cervix. However, one physician, while fully recognising that women are quite embarrassed and hesitant about letting male physicians examine their breasts, stressed the importance of clinical breast examination.

> Dr. Tien: I think [clinical] breast examination is very important because the patients might not know about the symptoms of breast cancer. It is not simply that they could detect a lump. It's not just that, many times, there is no lump or the lump is just too small to be detected by touching. There are other external symptoms such as changes of the skin, the shape of the breasts, the axillary lumps, indent of the skin, etc. These things, the patients would not know about it. They think that they have cancer only when they have a lump. So clinical breast examination is important. Even though it is not as accurate as mammography or echo-graphy, it is very important. (Translated and edited from H-Tien-17-C-1)

Doctor Dau has been providing health care to the Vietnamese in Canada for more than 18 years. He states that even he, a General Practitioner who also practices as an Obstetrician, meets obstacles when it comes to encouraging women to talk about breast and cervical examinations. In his experience,

> Vietnamese women are very hesitant (ngai ngung) about these things. These are considered very private (tham kin) parts of the women. So they are very hesitated to have these parts examined. That is one of traditional Vietnamese thinking.... Very hesitant. There was a woman who had a lump in her breast and she was still wondering if she should have the doctor examining it or not. When suddenly one day, she told me about it. I was so worried.(Translated and edited from H-Dau-13-C-1)

When asked about how he as a Vietnamese male physician feels about talking to the women about these issues, he does not see talking to the women is a problem. However, in practice, he does take precautions.

> Researcher: When you talk to these women, do you feel uncomfortable?
>
> Dr. Dau: No, I am not uncomfortable. But usually I would have other person with me. Usually the woman would have her husband, mother, or friend with her. I have to avoid the, well, the situation. Actually it is not to avoid. I do talk to them. Often there are lots of opportunities to talk to them about it. It is not too bad. I often tell them to have Pap smear done once a year and tell them that it is to their benefit to have it done. (Translated and edited from H-Dau-13-C-1)

Although physicians have said that they have no problem with telling the women to go for mammograms, they indicated that providing health care and information about these issues is not easy. Discussion about birth control or sexual relationship problems are often very difficult for the women, even for those whom they have been providing health care for quite some time. There were patients who have sexual relationship problems but did not seek help from physicians until four or five years later because they were too embarrassed to talk about these problems. This might be one of the reasons why some women participants in the present study did not know that they should have breast and cervical examinations regularly. Acknowledging that women's hesitation does pose a barrier to the women's

participation in breast examination and Pap smear, physicians, however, think that it could be overcome if health care providers provide adequate information to women.

> Dr. Dau: But I do think that we can help them to understand. I don't think that it is too difficult. There are many women who have made an effort to get these things done.... Yes, it is important. But this problem could be overcome if we explain these things to the women. However, the problem, as I see it, is that not many people would sit down to explain to them, to encourage them. (Translated and edited from H-Dau-13-C-1)

Another Vietnamese speaking male physician, Dr. Thinh, agrees that the Vietnamese traditional view towards the female body as private might influence Vietnamese women's participation in breast and cervical examinations. However, he thinks that it was more of a barrier 10 to 20 years ago, but is no longer an issue. He says:

> Dr. Thinh: Definitely, it is because of the Vietnamese traditional thinking which emphasise female body as private (kind dao, te nhi) that made women hesitant (ngan ngai). That is our custom. But that was only 10 or 20 years ago. Now a day, it is not an issue anymore. Women are used to it now. They know about it. Now they would go for these checkup and not thinking about being embarrassment anymore. Furthermore, there are female doctors. People who are embarrassed can just go to see the female doctors.... For women who do not want to be examine by a male then I would refer them to other female doctors. (Translated and edited from H-Thinh-16-C-1)

Doctor Tien, who trained in a Canadian medical school, asserts that Vietnamese women and Asian women in general do not pay adequate attention to breast and cervical health. He thinks there is a lack of information reaching Vietnamese women, as well as a "cultural mentality" which makes them hesitate (ngai) to discuss these issues. Clearly expressing his disappointment, he talked about the difficulties he encounters in his practice:

> Dr. Tien: Number one is that there is a lack of information from the government organisations and the physicians. Secondly, it is because of the mentality of Vietnamese women. They don't want doctors examining their breasts and cervixes. The majority of these women are very embarrassed about these things. The majority of the Vietnamese women are feeling that way.
>
> Researcher: Do you see that very clearly?
>
> Dr. Tien: Oh yes, very clearly, very clearly. That is why I am quite disappointed sometime, very disappointed indeed. When I was in the medical school, they taught us to take care of the women. At a certain age, we should advise them to do this and that. But when I talk to the women about breast examination, although I have all the drawing and the instruction about it, I feel that Vietnamese women, from young to old, are not interested (phot qua) in these issues. They would say something like, "oh, it's no problem".... The mentality of the Vietnamese women is that. They don't even want to have these kinds of examinations with the Vietnamese female physician ... They don't want to be touched or to have these parts examined.
>
> Researcher: So. You know that they are quite hesitant, do you still ask them to have these examinations done or are you hesitant yourself?
>
> Dr. Tien: I still explain everything, like the risk factors, the consequences, everything. But I think that although they listened to me, sometime, they even agreed to make an appointment for breast examination, they just didn't show up for it. So what can I do? However, as the physician, I still have the responsibility to talk to them about it. I do know that the women don't like to talk about it,

but because of my responsibility, I still talk to them. I have to record on my file when they don't show up for these checkups. (Translated and edited from H-Tien-17-C-1)

2. The Body Is an Experiencing Agent: The Embodiment Experience

For many people, bodily sensation governs many of their life's activities. Human beings often act and think through their bodies. Thus, human bodies are considered the subject of life's actions (Schutz, 1970). In the present study, women participants often put emphasis on their embodiment experience as the direction for their health care. The body is not treated as separate entity, but as an essential part of the self. How their bodies feel or react to illness and treatment determine their health care actions. How illness is experienced determine from whom they seek help and when they seek help. Several participants do not think they have a problem unless they are experiencing discomfort.

Furthermore, the effectiveness of either Easter or Western treatments is evaluated according to the ways in which the body responds to the treatment. Treatments that do not alleviate symptoms would be considered ineffective, and alternative treatment would then be considered.

For Mrs. Mai seeking treatment for her arthritis is a process of trying out several treatment modalities. Although she preferred traditional Chinese treatments such as acupuncture, she evaluates the effectiveness of the treatment based on her embodiment experience. After several acupuncture sessions, still having pain in her legs and arms, Mrs. Mai started to use Western medication because she found that it had helped to reduce the pain.

> Mrs. Mai: For a while, every day my husband took me to the place just few blocks from here for acupuncture. I had it all over my two arms, but it did not work. It did not cure me at all...So I went back to my family doctor. He gave me this medicine. I took this medicine and within two days I felt better. Only two days and I felt better. (Translated and edited from W-Mai-9-A-1)

On the contrary, Ms. Lyn has been having problems with her stomach and had been taking Zantac as prescribed by her family doctor for few years. However, in the past few months, she changed the management of her problem based on what her body was telling her. Instead of taking the medication, Ms. Lyn pays very close attention to how her stomach responds to food. Noticing that the pain would subside if she eats small meals every four hours, Ms. Lyn is making sure that she eats before her body has the chance to react.

> Ms. Lyn: According to my experience, if I eat right away when I feel that the pain is coming, then the pain would stop. So now I am not taking the medication. The medication would just do the same thing. For example, when I have pain, I take the medication, the pain would go away. But then when I am hungry, I would have pain a gain. If I have pain, I eat and I can feel the pain stops. So you see, I just give myself treatment that way and I do not have to go to the doctor for two months now. It is because they [the doctors] gave me Zantac. A dollar for one tablet and

> when I take it, it has the same effect. If I stop taking the medication, I would have pain just the same. (Translated and edited from W-Lyn-10-B-1)

In addition, she has been doing a lot of walking because going for a walk every morning has made her feel healthy and energetic. For Ms. Lyn, motivation for keeping her active life style comes from her body's positive response. Health promotion, disease prevention, and the implementation of a healthier life style are not based on the advice of Ms. Lyn's physician, but are directly related to the ways in which her body is experiencing and responding to her actions.

To several participants, the embodiment of health is defined at least in part as the absence of diseases and illnesses. One is having good health if one feels healthy enough to work and if there is no physical symptoms that indicate the presence of diseases.

> Mrs. Phan: We are healthy if we can go to work as normal. We would go to the doctor only when we have diseases or some evidences to show that we are sick ... Normally, we know that we are healthy if we can work. If we feel that we are sick, have something wrong, or tired and pain then we go to the doctor. That's it. (Translated and edited from W-Phan-11-A-1)

Mrs. Chau works every day making Vietnamese sweets to sell to local Vietnamese stores. Her daily routine is to get up in the morning at 6 or 7 o'clock and she works until 8 or 9 o'clock at night. Although Mrs. Chau has been diagnosed as having heart enlargement, hypertension, and has had a stroke in the past, she considers herself very healthy because not only does she have no symptoms, but also she is still able to work every day.

> Mrs. Chau: I have seen several old women. Every one of them has some health problems. But me, I only go to the doctor twice a year. I seldom go to the doctor .... If I were not healthy, I would die long ago. I would not live this long with those diseases.... So you see, I am very healthy. I work very hard. Even young women would not be able to work like I do. (Translated and edited from W-Chau-7-B-1)

B. Cultural Conceptualisation of Health and Illness

As Kleinman had suggested, Vietnamese women participants' social reality which includes their beliefs about health and sickness, their expectations toward Western and Eastern treatments influenced how women react to sickness and choose among health care options. But more importantly, women participants in this study placed great emphasis on what health and illness mean to both themselves and their families when they thought about and participated in health care activities such as breast and cervical cancer screenings.

1. "Health is Gold" (Suc khoe la vang)

Vietnamese's proverb "health is gold" (suc khoe la vang) is emphasised by participants. Women participants explicitly stated that they consider health as the most important thing.

> Mrs. Mai: Health is a number one important. For example, I'll alway ask you "how are you?" I would never phone you and ask, "How much money do you have?"... When we see each other, the first thing we ask is "How are you?" (Chi co khoe khong?). And I would be very glad if you say that you are fine. But if you say that you are sick with this and that then I would be very sad for you ... Very soon few of my friends will call and they would ask me "How are you in the last few days?"...they would not ask "How many thousands dollars do you have?" or "How much money do you have now?" Nobody is going to ask you that. (Translated and edited from W-Mai-9-A-1)

Being healthy is important to Vietnamese women because without health one cannot accomplish much, nor could one take care of one's family. Mrs. Ha insists that "health is gold" because a woman needs to be healthy to take care of her children.

> Mrs. Ha: If she is not healthy then she cannot work. If she is not healthy then even if she wants to, she cannot do anything. How would she be able to take care of her children if she can't get out of bed. If I want to take care of my children then I have to be healthy. If I want to go somewhere, if I want to ask for help from someone, I would have to go to that person or be able to talk to that person. So you see, health is gold (Translated and edited from W-Ha-12-A-1).

For others such as Mrs. Mai, having good health is important because financial stability and family welfare depend upon it.

> Mrs. Mai: We have to be healthy so that we can go to work to make money because if we don't then how are we going to pay rent and all the other bills....You see, we have to be healthy so that we can handle all those things. Take care of our family, go to work to make money. We have to have money to pay for our bills. We would be very stuck if we don't have money.... If we are not healthy, we would not be able to do our best, to take care of our children. (Translated and edited from W-Mai-9-A-1)

This view is shared by one of the physicians, however, what he sees is that although Vietnamese value health as gold, metaphorically speaking, this kind of gold is not properly invested. In his words:

> Dr. Dau: They [the Vietnamese women] still value it [health]. There is gold that is for keeping in the locked cupboards [laughing]. They still value this gold. You see, in Vietnam, there was much gold that were saved. Not in the bank, but in the houses' locked cupboards...It's just that they don't know how to invest, to use it, to use what they have. (Translated and edited from H-Dau-13-C-1)

Because health is viewed as important and health care activities are considered a necessity of life, several participants, even though they do not think that having breast examinations and Pap smears are important for themselves, think that younger Vietnamese women would benefit from having these examinations done. Mrs. Chau, a 73-year-old woman who has never had any kind of breast examination or Pap smear since she came to Canada in 1979 thinks that encouraging women to go for these tests is a good thing, especially when going for these tests does not cost any money.

> Mrs. Chau: It is very good if you can encourage the women to go for these examinations. No harm done. Don't have to pay. Here they let us go to the doctor. We need to go for these checkups. I see some younger women, husbands and wives have diseases. Younger women need to go...they are ones who have serious diseases. If they leave it for too long, it cannot be cured....These examinations are good for them. (Translated and edited from W-Chau-7-B-1)

Vietnamese women's conceptualisation of health also reflects the ideology of the body and mind connection. Absence of physical symptoms might not mean that one is totally healthy. To some women, feeling healthy is performing one's roles and duties well. Thus health is not seen as something that is only connected to the individual's body, but rather, it is being seen as an important dimension of women's daily lives (Aptheker, 1989). That is, health is viewed within the context of the women's daily life, interconnected with other factors. In particular, health is closely connected to women's ability to look after children, to perform family activities, and to survive economically. Thus, health is not seen as a major dimension in and of itself. It is seen in relation to all other life activities. This conceptualisation of health is in contrast to Western culture-bound notion which emphasise the individuation of self. In the present study, understanding of self and health is connected to social relations within the particular culture context.

For some Vietnamese, a person is understood as acting agent within the context of a family relationship. Confucianism, Taoism, and Buddhism are internalised within many of the Vietnamese. None of these traditions encourages the development of a highly individualised self. The development of self is closely connected with family kinship networks, social position, social obligations, and through the responses of others. An act that denies self's interest is not considered a sign of personal weakness but rather as inner strength.

For Dr. Dau, a Vietnamese speaking physician who has worked with the community for more than 18 years, seeing the women's life within their social and family context is not an option but a must. Family problems affect individual's health profoundly.

> Dr. Dau: if they [the women] are able to help their families back home, they are happier, and as the result, they are healthier. Those things influence their health directly. Imaging, each night or each month they get phone calls telling them that people at home need this and that, their mother, their children, their brother and sister were sick and all that. If they cannot help their loved ones back home, they would go crazy themselves (Dien nguoi len). That would affect their health. So, health means everything. You have to look at everything. You just can't look at medication only. Health is not just that ... Asian's view is very good. That is the physical body and the mind is one. If the physical body or the mind is not good, it affects the whole body's health. In health care, we have to recognize that many things affect health. We have to understand that getting mammogram done or having Pap test done, or having checkup is not enough. Getting these things done is only partially adequate. (Translated and edited from H-Dau-13-C-1)

The ways in which Vietnamese women practice health care and keep themselves healthy depends upon how important health is to them. To many women participants, health is considered very important and keeping themselves healthy is the number one priority. The difference, however, is that to some women, health is important in and of itself, while others talk about the importance of having good health within the broader social context of their lives.

Good health is seen as the absence of not only physical symptoms, but also psychological symptoms. Most of the participants verbalised that going for checkups, mammograms, and Pap smears are important health care activities for keeping oneself healthy. For example, Mrs. An, a 70-year-old woman, recognises that breast cancer and cervical cancer are diseases that can be present in the body without any symptoms. She stresses the psychological impact of having mammography.

> Mrs. An: I think it [mammography] is good because, firstly, we could be feeling fine, but inside, we don't know. Secondly, we have to trust the modern machine here. It is better that we know. If we know about it then we would be able to do something about it. If we know about it, we would not be too worry. When we listen to this person and that person talks about it [breast and cervical cancer] we tend to get worry. So if we had the machine check it out for us then we would not worry anymore.... It is necessary and it makes us feel more at peace. (Translated and edited from W-An-14-A-1)

2. Vietnamese Women's Conceptualisation of the Causes of Disease and Illness

Reflected in the Vietnamese women's narratives of what cause disease and illness are three major concepts: (a) Disease and illness are caused by an imbalance of the body; (b) Disease and illness are caused by the invasion of bacteria; and (c) Disease and illness are predetermined by a higher power.

An ideology of intact harmonious mind-body is often underlined in the ways in which the women participants' conceptualised what makes a healthy body and what causes disease and illness. Because a healthy body is achieved through balancing several forces such as Am (yin) and Duong (yang), or Dark and Light, or Female and Male and the equilibrium of "hot" and "cold," disease and illness will result if there is something that throws the whole body out of balance. Diet, activity, emotion, and environmental conditions are common factors that can cause imbalance of the body.

The women's narratives about what cause disease and illness, more specifically, what cause cervical cancer also refers to bacteria's invasion, a belief more in line with contemporary biomedicine. The most frequently mentioned factors are individual hygienic health care practices and environmental conditions. More culturally specific to the women's thinking of what causes ill health is that disease and illness are predetermined by a higher power.

Disease and Illness are Caused by the Imbalance of The Body

The conception of a healthy body as a body that functions in harmony and balance is pervasive within the Vietnamese participants' discourse. Disease and illness will result if there is abuse or violation, which pushes one's body out of balance. It is interesting to note that Western biomedicine ideologies weave like a thread throughout the women's narratives. Although diet, activity level, emotional state, and unfavourable weather are factors that women think push the body off balance and cause ill health, how one should cope with these is reflective of Western cultural assumptions of a healthy life style.

Several women participants talked about how paying inadequate attention to one's diet can cause disease and illness. To them, a diet that causes health problems is a diet that is inadequate in either the quality and/or the quantity of food that is eaten.

> Mrs. Chi: We get sick and diseases because of the ways in which we eat, because of our diet. First, not eating right. May be because we eat something that is difficult to digest. Second, we get sick because we don't exercise. Third, because we don't eat enough fruit. Fruit is very important. It helps your bowel move regularly. For example, if you don't eat fruit, you'll be constipated. Especially, when you are old. Constipation will lead to many problems. So if you eat about 3 to 4 fruit a day, you will have no health problem. Eat a lot of fruit and swimming a lot.... don't eat fat, eat only lean meat. Buy fresh fruit and vegetable. (Translated and edited from W-Chi-4-A-1)

Many women's narratives reflect western medicine's strictures on reducing the intake of fat and maintaining a healthy body weight. The women, like many Canadians, pay a great deal of attention to what they must do to control their weight and cholesterol level. At the age of 72, after having lived in Canada for more than 10 years, Mrs. Mai recognises that life in Canada is different than life back in Vietnam, thus she needs to change the ways in which she eats in order to stay healthy.

> Mrs. Mai: To keep ourselves healthy, we need to eat properly...don't eat too much or too little. Here, we are worried about fat in the blood. So don't eat too much fat.... Here, fat is the worst. It makes the belly very fat then it needs surgery to get the fat out...Here is different. Back in Vietnam the more food we ate the better for us, but here it is not good to eat too much. Food is plenty here but I would not eat a lot. Only eat moderately. Control your eating. (Translated and edited from W-Mai-9-A-1)

Although the women's dietary practices have been influenced by Westerner's ways of viewing diet, Vietnamese women's understanding of food and eating habits is something that is also quite culturally specific. These practices are often passed down from mother to daughter, and sometimes, from generation to generation. Mrs. Le talks at length about how she learned to look after her children from her mother.

> Mrs. Le: In my family, eating is very important. For example, I would not feed my children fish sauce until they are two years old. Under two years old, I didn't give them because it would make a very bad odor. Fish sauce would goes through the body into the sweat. Fish sauce is very good. It has a lot of protein but I think that it is too strong for a young child. Usually I used salt and soya sauce and I always made sure that there was enough nutritious food .... My mother raised us the same way. (Translated and edited from W-Le-8-A-1)

For other Vietnamese participants, eating foods that are considered "doc" (poison) can cause health problems.

> Ms. Ngoc: We have to be careful with what we eat. I used to eat lots of dry bambo shoots (mang kho). But then people told me that bambo shoots are poisonous (doc). When I was eating it a lot, I had so much pain in my bone and my knees. So I think that they are right, bambo shoots are poisonous. It is not good to eat it. (Translated and edited from W-Ngoc-19-A-1)

Similarly, other women also believe that certain foods can hinder the body's healing process.

> Mrs. Phi: Diet is directly connected to medication. For example, if you take cough medication, you should not eat chicken. If you had an operation, you should not eat beef. It is quite true. If you don't follow that, your disease will take longer to cure. I do belief those things. If you have an operation and you are eating just anything and not abstain from these foods, then your wound will take longer to heal ... you'll have a big scar (theo lon). Here, they would explain that the reason for a big scar is because the doctors sew it too tight. But I think that it is partially due to what we eat. (Translated and edited from W-Phi-2-A-1)

The women's discourse about what causes disease and illness parallels contemporary biomedical discourse. Because disease and sickness can happen if one does not eat well, sleep well and exercise regularly, to keep oneself healthy, one needs to eat wisely and moderately, exercise, get enough sleep, and keep clean.

> Mrs. Mai: To avoid being sick, I think we need to eat properly. Get enough sleep and exercise regularly. Exercise for half an hour or one hour every morning. Control your eating, don't eat too much or too little. Here, many people have fat in the blood so don't eat too much fat....For women, keep the "women part" clean so it doesn't get infection. In general, that is one should do. (Translated and edited from W-Mai-9-A-1)

Mrs. Lyn had a very difficult life when she lived in North Vietnam. In order to make money to look after her family, she had to knit sweaters for an exporting company. She often stayed up and worked until 1 or 2 o'clock in the morning. Mrs. Lyn associates her liver problem to her lack of sleep.

> Mrs. Lyn: They said that you would have problem with your liver if you lack sleeping. It is because sleeping affects the liver. When you are sleeping, your liver sleeps too. So if you stay up too much, your liver would not be able to sleep either. After a while, it becomes sick. It is just like if you don't go to sleep for a long time, you would get headache. The liver is the same way. They said sleeping is in the liver. So if you stay awake for too long a time, the liver will get sick. (Translated and edited from W-Lyn-10-B-1)

Some women participants attribute the cause of cancer to one's life style. For example, Mrs. Chi attributed the cause for her friend's cancer of the liver to that woman's inactive life style, which she see as

directly related to the fact that "she just sit and play mahjong all day." Therefore, to keep herself healthy, this is what she does:

> Here, we eat too well; the body gets fat very easy. Because we get fat so easy, we need to go for walk or swim or exercise at the centers where there are organised classes. I have to do all those things because here I gain weight... I feel very heavy. So I go for walk, swim, and sometime I go on treadmill. I also try to eat less. When I was in Vietnam, I ate meat, I ate the fat too. I didn't said, "oh this has more fat I should eat less of it," but now I have to be careful. I eat very little fat. I eat more fruit and vegetable. In general that's what I do. (Translated and edited from W-Chi-4-A-1)

Some women's conceptualisation of what causes cancer is directly related to the imbalance of ones' emotional psychological state, thus reflecting the body – emotion control model. Mrs. Chau has been living in Canada for 21 years. When asked what she thinks cause breast cancer, she says:

> People get cancer because they are worried and angry too much.... I think there are hereditary diseases, but people who would get the disease if they angry too much. About that disease (breast cancer), I don't think that disease is hereditary. (Translated and edited from W-Chau-7-B-1)

Prevention and treatment for cancer, then, is directly related to what she thinks are its causes.

> Mrs. Chau: Don't get angry, worry or feeling bitter then you will feel much healthier. Number one is to try not to get angry. If you are angry, don't keep it all inside. In the past, I would get angry, but not now. If I were angry with someone, I would forgive him or her. I would not keep it inside so that I would hate that person or think about revenge.... I heard the doctors say that we get diseases because we get angry and bitter too much. (Translated and edited from W-Chau-7-B-1)

Disease prevention, for Mrs. Chau has everything to do with psychological health. Thus, to prevent breast cancer and cervical cancer, one should take care of one's psychology and social relationships, especially, emotional control which is seen as an important determining factor. Similarly, Mrs. Phi states:

> If we were not strong psychologically, we would get sicker. If you are sick but you think the doctors and the nurses are very good. You would then feel that your sickness is not as bad. But if you keep worry about your pain and that nobody around you, your condition will get worst. And it will be difficult to treat you, especially with cancer. I think that if you are strong, and if you are brave, then you might overcome the disease. I read books that tell the story of women who don't pay attention to their sickness. For these women, it was easier to treat the disease. If you just sit there, being depressed and grief over your life, then your disease will get worst. (Translated and edited from W-Phi-2-A-1)

Disease and Illness are Caused by the Invasion of Bacteria

The women participants' explanations for the cause of diseases, especially, cervical cancer are directly connected to the bacterial invasion theory of contemporary biomedicine. From the women's perspective, bacterial invasion of the body is through either individual hygienic health care practice and/or environmental conditions. Thus, to keep oneself healthy, one needs to pay attention to one's hygiene and the environmental conditions in which one lives. Here we see the integration of all three sectors of health care. These sectors, as Kleinman identified are the popular sector, the professional sector, and the folk

sector of health care. Women participants beliefs and values about disease and illness in each sector, although has its own distinct explanatory model, are often overlaping.

Mrs. Minh is 61 years old. Before coming to Canada, she lived in North Vietnam with 6 children. To keep herself and her children healthy, she has always paid attention to bodily hygiene.

> Mrs. Minh: In Vietnam, we have many children, so we didn't pay a lot of attention to the food we ate and the clothes we wore. For us, keeping ourselves clean was very important. For example, Vietnam's weather was very warm, and the land was very dirty. So for my family, we kept ourselves clean every day. Many people I knew, for many years they don't even know what soap is. But us, we bathed and cleaned our clothes with soap. Even in the winter when it was very cold, my children still bath two, three times a week. That is how we kept ourselves clean every day. We washed ourselves before going to bed and in the morning. It was necessary for our body. Our health is depended upon our hygiene. (Translated and edited from W-Minh-5-B-1)

Mrs. An is 70 years old and used to live in South Vietnam. As a mother of 5 children, she talked of how she always put great effort into making sure the food is handled and cooked properly. To her, one has to pay attention not only to the kind of food one eats, but how the food is prepared. Hygiene is a factor of utmost importance. Her eating practices go back to her life in Vietnam. To ensure that her children stayed healthy and did not get sick by eating contaminated food, she did not allow her children to buy food on the street at the open stalls, but fed them at home instead. Drawing from her own experiences of seeing many people around her suffering with gastrointestinal problems, Mrs. An was very mindful of proper food handling.

> Mrs. An: I think that the ways we handle the food we eat is very important. We have to have clean hands. That is very important to keeping ourselves healthy. Number one is that we have to be choosing about the food we eat. Number two is to keep our hands clean. We use our hand to put food in our mouth. (Translated and edited from W-An-14-A-1)

Bacterial invasion which cause cervical cancer, to some women participants, is also linked to the environment they live in. Exposure to public sources of contamination is another way for bacteria to enter the body.

> Mrs. An: The third reason is that the women go to public swim. Although there is chemical to clean the water, I don't know how well. There are people who have the disease who going there but we don't know. So we would be with them. Disease such as AIDS, that disease is obvious. (Translated and edited from W-An-14-A-1)

Among the women participants, another very common belief regarding the cause of cervical cancer is that a woman would often get the disease via their relationship with their partners. The women's explanation for the cause of cervical cancer is the invasion of bacteria into the woman's body if they are not clean "down there" or by having sexual intercourse with an "unclean man."

> Mrs. An: I think women get cervical cancer because they are not clean. You grow up with your cervix inside you, nothing would happen to it. You get the disease when the bacteria from the out side get inside you.... For example, women can get the bacteria from their unclean husbands. There are men who are dirty. They don't pay attention to their hygiene and then they sleep with their wives. Those wives would then get the bacteria into their cervix.... Another way a woman would get the disease is if she is not clean when she has her period.... Bacteria would also go inside you if your own hands were not clean. (Translated and edited from W-An-14-A-1)

Because bacteria is viewed as the main cause for cervical problems and is thought to be the result of poor hygiene or a sexual relationship with a partner who has poor hygiene, prevention is focused on cleanliness. Thus,

> Mrs. Chi: Yes, hygiene is important. Also when they are having sex (an o voi chong) with their husbands too. After having sex, they should clean themselves. That thing [the vagina] should be kept cleaner than the mouth even. You clean your mouth how many times a day, you clean that "thing" just as many times. You should never ignore its hygiene. If you don't clean that "thing." It will get diseases.... Also, you have to keep an eye on your husband. Don't let him do wrong thing. If he does the wrong thing, it doesn't mater how clean you are, you'll get the disease. (Translated and quoted from W-Chi-4-A-1)

Women's discourse around the cause of cervical cancer and other sexually transmitted diseases, especially AIDS is often alluded to sexual relationship. The new Vietnamese policy that encourages people who have left Vietnam to come back to the country for visits has created a trend of Vietnamese Canadian making trips back to Vietnam. Many men had gone back to seek wives and some have gone back just for a visit. Several women participants have expressed concern saying that many men who had been back to Vietnam got the "disease."

> Researcher: What do you mean by doing the "wrong thing"?
>
> Mrs. Chi: Well doing the "wrong thing" means, I don't know about the Caucasian men, but Vietnamese men, especially the younger ones, when they come back to Vietnam, all of them have got the disease. (Translated and edited from W-Chi-4-A-1)

Because cervical cancer is viewed as the diseases of "young people," who are sexually active, older women think that they are not at risk for getting these diseases. Mrs. Chau does not see that it could happen to her. "These cancers, it is not going to happen to me. I am too old for that" (W-Chau-7-B-1). One of the reasons Mrs. Chau has never gone for a breast examination or Pap smear is her perception that an old woman is not at risk for getting these diseases. She thinks only younger women who are sexually active are at risk for getting the disease.

As I have shown, Vietnamese women's conceptualisation about what cause diseases and cancer is quite diverse. Although many women express their firm belief in modern medical technology, some women remain skeptical about its ability to diagnose and treat contemporary diseases. For Mrs. An, cancer is a name that is given to diseases that cannot be cured by biomedicine.

> Mrs. An: I think that whatever the diseases that they cannot cure, they called it cancer. If they try many different treatments but they can't cure that disease then they call it cancer....I think that diseases which they cannot cure, they call it cancer and diseases that take too long to treat they call it allergy. That is what I think. About cancer that is inside the body, I don't know. It just stays inside, when it becomes noticeable, it cannot be cured, then it is a cancer....They don't know what it is so they call it cancer. (Translated and edited from W-An- 14-A-1)

This belief might be one of the reasons why some women would not seek help or treatment for cancer. To these women, if cancer cannot be cured then seeking treatment for it may be seen as a waste of time and family resources.

Disease and Illness are Predetermined by a Higher Power

Several women participants have very strong beliefs in their religious teaching, whether it is Buddhism or Christianity. According to Buddhism, everything that happens is under the influence of "nhan duyen" and "dinh menh" (destiny). Under this universal law, a person does not have much control over his/her life, and what ever is destined to happen, will happen. It is up to God (mac troi). Because of that belief, a woman may not seek treatment, believing that a cure is up to God. Sickness, we cannot do anything about it, what ever happen, will happen. Mrs. An, a 70-year-old woman illuminates how this belief influenced her daughter's decision on how to deal with breast cancer.

> Mrs. An: She told me, "Mom, I am not going to the doctor." I don't exactly know what she thinks but she decided not to go to the doctor. The doctor tried to talk to her many times. He told her "you are still very young. I don't want to see you died." She said, "doctor, I have God. My destiny is in God's hand. I do not want to have the operation." (Translated and edited from W-An-14-A-1)

Mrs. An's daughter, who was only 40 years old, discovered a small lump under her arm while watching TV with her sister. Despite the doctor's entreaties, she refused a mastectomy and lived for seven years without treatment of any kind. Only in her final stage, in the hospital bed, did she consent to chemotherapy treatment. According to Mrs. An, one of the reasons her daughter refused to have the operation is her faith in God. Although Mrs. An acknowledged that she is sad that her daughter is gone, she firmly believes they will be united again. Born and raised in a strong Protestant family, Mrs. An and her husband, who is a Pastor, are among the most active members of their Church. Their lives are organised around Church activities and their trust in God is unshakable. Mrs. An thinks that her daughter's seven years of living with breast cancer without pain was a miracle, a gift from God.

Women who are members of a particular religion often talked about their firm belief and trust in God to cure their diseases. Mrs. Ly is 78 years old. She contributes her ability to walk again to God's doing,

> Mrs Ly: I am very grateful to God. God must of see that I am a good person because what ever I pray God for, God gives me. I am so grateful to God. When I was sick. I had pain in my legs. I had to use a cane for walking.... I couldn't even move my legs ... because I kept praying to God a lot, I now could walk without the cane ... God told me not to use the cane. So I didn't use the cane. Do you know what? When I first came to live here (Vancouver), in 1994 or 1995, I have been living here for several years now. In the morning, I could not get up. I had to work at it, sometime, not until 12 o'clock when I could get up to eat lunch. Can you imagine that? I could not move both of my legs. But God makes my legs strong now. That is miracle. (Translated and edited from W-Ly-6-B-1)

Similarly, Mrs. Chau talked about her miracle recovery from what she called "a big heart disease." For her, the reason that she is alive today is because of God's help.

> Mrs. Chau: I had a big heart disease. A very serious one. I saw many doctors in Sai Gon, Hong Duong. They told me just go home to eat and die....That day, I thought I was going to die. The Pastor came to pray for me. I couldn't even lay still. I had pain in every joints of my body. I couldn't breath...That night I thought I was going to die. The doctor left and the Pastor came. He prayed for me. About five minutes after he prayed for me I felt much better. I was able to lay still and go to sleep. I hadn't slept for several days. I couldn't even recognise my children. But after he prayed for me, I went to sleep.... I was well from then on...I didn't even have to go to the doctor for checkup. Even though the doctor told me that my heart is still as big as the two men's heart, I didn't have to go to the doctor. I am not sick anymore. Praying to God had cured me...God gave me my health. (Translated and edited from W-Chau-7-B-1)

However, one should not assume that all women who go to the church or temple attribute their good health to God's doing or illness and death as something that is predetermined, as their destiny. Mrs. Mai, a 73-years-old woman who recognises herself as a Buddhist and goes to the temple quite regularly, has this to say:

> Mrs. Mai: Me! I don't believe in destiny. If we keep ourselves healthy then we will be healthy. God would not be able to help. We will be healthy if we take care of ourselves. If you say that it is your destiny and you would not look out for oncoming cars and you died, would you say that is your destiny? You have your eyes, you have to watch out for those cars. If no cars are coming then you can cross the road. If you don't watch out and you died, you cannot say that God plans all that, that it is your destiny. No, it is not your destiny. It is your eyes. You have to look. (Translated and edited from W-Mai-9-A-1)

C. Beliefs and Values about Health Care Provider and Patient Relationship

The health care provider and client relationship which is an aspect of clinical reality, according to Kleinman, has been identified as an important component in health care practice. Thus how Vietnamese women use and make used of breast and cervical cancer screenings are affected by how they view health care provider-patient relationship. To many Vietnamese women, physicians have great authority. Physicians hold a very high social status in Vietnam, just as they do in Canada. Because physicians are in the business of saving lives and relieving suffering, they are regarded as people who have great character. The Vietnamese saying "bac si nhu tu mau" (doctors are gentle mothers) parallels the care of a

physician with the care of a mother. "Doctor should act like a gentle mother. Even if the doctor is young, he needs to be friendly, calm, and show respect to others. He should talk to his patients in such way that they feel they could come and talk to him." (Translated and edited from W-Chi-4-A-1)

The relationship between patient and physician is a hierarchical relationship, with the doctor holding considerable power. Some women are quite intimidated by their physicians and asking them for information is not the norm, especially when doctors are very busy. As observed by a community health nurse, who had been providing services to the Vietnamese community for many years:

> Mrs. McDonald: What [the women] grows up with and what they know traditionally is this huge hierarchy and that whatever the information the doctor give you then that is the information you get. And that you are questioning his authority if you ask question...So I think for sure that those are barriers for the women. (Edited from H-McDonald-20-C-1)

From the physician's perspective, although communication with Vietnamese women is viewed as a challenging issue, some do not see it as a problem of power relations but as the effect of "culture."

> Dr. Dau: With Vietnamese women, because of the influence of culture (van hoa), the ways they think are different with other [Caucasian] women. They don't tell you about what they want. They talk about their concerns in a very ambiguous way and very indirectly. So it is very difficult. There are problems that they don't even want to talk to you about. I have to encourage them to talk to me. There are cases that are necessary for them to take action, and yet, they don't want to do anything about it. So I have to find ways to encourage them to talk, to take action. (Translated and edited from H-Dau-13-C-1)

Ms. McDonald works with Vietnamese clients for many years. Because she speaks Vietnamese fluently, she has been doing a lot of teaching with Vietnamese women. In talking about how Vietnamese women participate in breast cancer and cervical cancer screening, she sees that lack of information is one of the many barriers to the women in seeking health care. Yet many women have difficulty asking their doctors for information.

> Although they (the Vietnamese women) have male family physicians who were Vietnamese speaking, one of the things they talked about is that they want to get information but it was difficult to ask the doctor. They felt awkward asking their doctor. And it was the kind of thing that unless the doctor offer the screening, they wouldn't going to say "I need to have my breast screen" or "I need to have the Pap." They were waiting for the doctor to take the initiative of that. (Edited from H-McDonal-20-C-1)

Although acknowledging that traditional thinking plays a big role on women's uneasiness with these examinations, several participants, feel that women's embarrassment can be overcome if family doctors take initiative to encourage the women to have breasts and cervical examinations. Thus, one could hypothesise that doctors might be experiencing cultural constraint as well.

> Mrs. McDonald: I wonder how much the doctor was constrained with the cultural aspect that they wouldn't offer this. But then I don't know even for mainstream doctors. It seems as that, I think a lot of time doctor waits for the woman to phone up and say "I am ready, I am due for my Pap, I

am going to come in. I don't know how many family practices have a system where they call the women and say, "you know, it's that time of the year again. You need to come in for your Pap." So you know it might not just be a cultural thing or it might be just a doctor thing." (Edited from H-McDonal-20-C-1)

Several male physicians acknowledged that sensitivity to cultural beliefs and values has affected how they offer clinical breast examinations and Pap smears to Vietnamese women.

Researcher: Do you think that Vietnamese family physicians are also hesitant to offer clinical breast examination and Pap smear to the Vietnamese women?

Dr. Thinh: That is true. It is because Vietnamese doctors know about Vietnamese custom. We came from the same culture. Way back when a doctor examined a woman, he had to cover his eyes and took her pulse through a handkerchief on her wrist. That was way back then, now we have come a long way. In this society, we do examine the women. However, it is still uncomfortable... So it is true, I, myself, am quite hesitant. (Translated and edited from H-Thinh-16-C-2)

Here, doctors being more culturally aware might have created a negative effect on how Vietnamese women participate in breast and cervical examinations. It is also for this reason that some Vietnamese women, when they cannot find female physicians, might prefer to go to Caucasian male doctors. For some Vietnamese women, it creates less anxiety if their doctors do not share the same cultural knowledge.

Barriers for physicians to offer breast and cervical examinations are not limited to the fact that they are more culturally aware of what creates anxiety for the women. Clinical breast examination and Pap smear, to a certain extent, are not comfortable procedures even for mainstream health care providers. Dr. Huy who has been a General Practitioner in Canada for 19 years talked at length about the difficulty that he and other physicians encounter in clinical practice.

Dr. Huy: In 1991, 92, there was a study from the US which shows that 10% of physicians had sexually abused their patients. This result was taken by several feminist groups as evidence to show that many doctors are abusive. Because of that, many doctors are not keen on doing clinical breast examination....I have been doing breast examination for the women for many years. If we are to discover a 1 cm tumor in clinical breast examination, we have to examine very carefully and we have to examine both side. Well, after the release of that study, many women would only let me examine the breast which they think might have tumor. It was that bad. Many of them were very afraid that their physicians might take advantage of them. (Translated and edited from H-Huy-21-C-1)

Clearly expressing his disappointment of how the issue has been handled and popularised, Dr. Huy thinks that it had, in fact, been very harmful to women. According to him, the mortality rate for breast cancer increased significantly after the study was published. Not only that, it has affected how he gives breast and cervical cancer screening to Vietnamese women.

Dr. Huy: After the publication of that study, the majority of male physicians' opinion was that: why should I go out of my way to do these examinations. It costs more of my time. Not only that it

> takes away my time from other patients, but if patients misunderstood my action and press charge then my practice would be destroyed. So you see, they would then just send the patients to gynecologist. Me, I also told my patients to go to Dr. L (a female Vietnamese doctor). I would only examine patients who had asked me many many times; they have to ask me at least three times before I agree to do the examination. I would never examine them before being asked. (Translated and edited from H-Huy-21-C-1)

Doctors being sensitive and cautious about giving breast and cervical examinations to women might have influenced access to these examinations. Unlike mammograms where either the women themselves or the doctor's secretary can arrange for the test, clinical breast examination and Pap smears are more doctor-dependant. Hesitation by the doctors might have contributed to the low participation rates for these cancer screening programs among the Vietnamese women.

Confidentiality is also a big concern within the Vietnamese community. For some women, the thought of other people knowing about their problem might be viewed as a bigger risk than the disease itself. For some Vietnamese, having a disease could mean disgrace to the family and the danger of loosing face within the community.

> Mrs. Chi: I, myself, don't want to see Dr. L [Dr. L is a Vietnamese woman doctor]. I went to the Chinese woman doctor. The Chinese doctor doesn't know who I am... if I went to Dr. L, a few days later I see her at the party, I would be so embarrass [laughing]. I would feel that she knows everything of me. I would feel that she knows all of me, I can't hide anything. But the Chinese woman, if I see her, she wouldn't know who I am and I don't know who she is. And the whole thing is over. And if anything happened to me it is okay. But with Dr. L., if I have the disease, she might accidentally talk to someone about me having this and that. Even if she only accidentally tell one person, the whole Vancouver will know what I have. That is the true. (Translated and edited from W-Chi-4-A-1)

Recognising confidentiality is an issue for the women, and that trust must be developed between a physician and a patient, Dr. Dau has taken precaution with how he relates to his patients.

> Dr. Dau: I do not carry my work outside of my office. Everything about my work stays in the office. I always practice that way. Words come into one ear, go out the other ear. My behaviour is very clear and my patients know that... My life outside of the office is separated from my practice.... Yes, it is a sensitive subject. You should never let it to be known outside of the office.... Trust is very important. Even between the husband and wife, they have different stories and I don't even let them know about each other's story without their permissions. Vietnamese need to know that other people's issues belong to themselves. I would not hesitate at all to refuse discussing other people's stories. I would only discuss with a couple about their issues if both of them give me their permissions to do so. I don't even discuss with the husband the result of his wife's Pap smear or mammography. (Translated and edited from H-Dau-13-C-1)

D. Conclusion

It is quite clear that Vietnamese women participants' explanatory models of disease and illness influence the ways in which they participate in preventative cancer programs. Although some of the traditional

beliefs and values of the Vietnamese women are very different from that of the general Western population, many of their conceptualisations of health, disease, and illness are quite congruent with contemporary biomedicine perspectives. Findings in this study also confirm Kleinman's assertion that the popular sector of health care is the important part of health care system. How Vietnamese women participants define illness, initiated and evaluated treatments is decided within this sphere. Here we have also seen that the family plays a very crucial role in how women engaged in breast and cervical cancer screenings. It is less clear, however, as to what extent these traditional beliefs and values pose as barriers for Vietnamese women to seek regular breast examinations and Pap smears.

These Vietnamese women's beliefs and values about women's bodies as private, which leads to a pervasive feeling of embarrassment, is a barrier for women seeking breast and cervical cancer screening. It is important to acknowledge that not only the women, but also the Vietnamese physicians are uncomfortable with these examinations. Thus, in certain situations, being culturally aware might restrain health care providers from taking an active role in reminding women to have clinical breast examinations and Pap smears.

Although the women's emphasis on their embodiment experience as the basis for their health care practice has benefited them in many ways, in the promotion of breast and cervical cancer screening, it is a potential barrier to active participation. Because breast cancer and cervical cancer are non-symptomatic in the early stages, it is difficult for the women to conceptualise that they might be at risk for having these diseases, and this, in turn, affects their willingness to overcome other barriers to seek health care.

The woman – physician hierarchical relationship is a barrier to seeking help for these Vietnamese women. Refraining from asking for more information limits their knowledge about the disease processes, which determines whether they even consider having breasts and cervical examinations.

Because these women view cervical cancer as the disease of younger women who are sexually active, the older Vietnamese women did not think that it is necessary for them to have a Pap smear. Furthermore, having cervical cancer might mean that one is promiscuous, or one's husband is promiscuous. This perspective could be a deterrent for the women to have a Pap test done regularly.

The belief that disease and illness are predetermined by a higher power might pose a barrier for these Vietnamese women to seek cancer screening. If one's destiny is already predetermined, one is not

going to have control over one's health. Passive behaviour toward health care might be the consequence of this belief.

It has been recognised that a mismatch between the different ethno-cultural clients' views of health and Western health care concepts result in barriers to health care services and ultimately lead to poor health status of clients (Kearns, 1997; Kearns & Dyck, 1996). Because clients avoid health care services that are incongruous with their health care values and beliefs, health care providers are encouraged to recognise that there are different ways of viewing health and practicing health care. In the present study, Vietnamese women's conceptualisation of disease and illnesses is, to a certain extent, culturally specific, however, how women keep themselves healthy reflect Western biomedicine's health care discourse and practices.

Many Vietnamese women believe that "phong benh con hon chua benh" (it is better to prevent the disease than to cure it). This belief reflects Western health promotion and disease prevention principles. It is also the message that is being put forth by breast cancer and cervical cancer screening programs. Furthermore, it is also evident that not all of the women's beliefs and values are barriers to their seeking Western health care. The Vietnamese women's perspective of "health is gold" is actually a motivational factor for the women to engage in cancer screening practice.

Jenkins et al. (1996) set out to examine if Vietnamese American's cultural beliefs and practices act as barriers to accessing health care and utilisation of Western health care services. Their results indicate that although many Vietnamese do have an explanatory model of disease, and their traditional beliefs and practices are different than that of the general U.S. population, such disease conceptualisations, beliefs, and practices do not pose barriers to accessing Western medical care or to the utilisation of preventive services (Jenkins et al., 1996). Eventhough the Canadian health care system is different compared to the U.S. health care system, the data from my interviews with Vietnamese women and health care providers revealed an important point: we cannot attribute cultural traditional beliefs, values, and practices as the main or the only barrier to the Vietnamese women's health seeking behaviour, specifically, breast cancer and cervical cancer screening practices. Thus, barriers to the utilisation of preventive medicine might not be due solely to traditional beliefs, values, and practices.

Chapter Six: Gendered Roles and Expectations

Similar to many women who live in the Western world, gender roles and expectations shape the ways in which Vietnamese women live their lives, practice health care, and participate in breast cancer and cervical cancer screening programs. Because a large part of providing health care is about human beings caring for each other, an understanding of gendered human relations will illuminate not only what motivates or prevents Vietnamese women's participation in health care practice (in particular, in cancer screening programs), but also the meaning that underlies their actions. Insight to their gendered roles and expectations will assist health care professionals with providing culturally appropriate and acceptable health care to the Vietnamese. In the previous chapter, I demonstrated how Vietnamese women's values and beliefs influence the ways they live their lives and practice health care. In this chapter, I explore how certain human relationship principles and gendered conceptualisations have shaped and/or constructed Vietnamese women's health care experiences. It is important to note that, although relationships with others in a society have been shaped for many decades, the present society's social and political natures play an important role in constructing the ways in which Vietnamese women live and treat others. For the Vietnamese, social relationships, as well as gendered roles and expectations have been integrated into many aspects of life with the most important being the educational system, family practices, and the changing status of the women throughout several colonial societies.

A. Vietnamese Social Relationships

Under traditional Confucian educational system, only men were allowed to enter the educational system. Women were excluded from education and administrative positions (Nguyen Khac Vien, 1974). Although many changes occurred throughout the years, women's education is still very often regarded as secondary to that of men's education. Some older women participants, who did not have educational opportunities when they were young, are experiencing more difficulty in Canada as a direct result of their lack of education. Coming to a new country and adjusting to new ways of living is hard enough; mastering a new language is even harder for them. Several women participants speak of this difficulty.

> Mrs. Mai: I don't understand what they say at all. It they ask me "how are you?" I say "thank you." If they ask me another question, I cannot say thank you then I would say "so so." Just that, only a few sentences. I cannot learn any English. It doesn't go into my head. My tongue cannot say the words. It is very frustrating. (Translated and edited from W-Mai-9-A-1)

Although she has lived in Canada for more than 10 years, Mrs. Mai cannot speak English. She thinks she cannot learn English because she had very little education as a child.

> Mrs. Mai: I did not go to English classes. Only my husband went. He understands more. My tongue would not speak ... Because I have a very low education, I was afraid that I could not learn what they wanted me to learn. I only have grade three education. What can I do with grade three education? ... Back then, my husband had time and his family gave him opportunity to study. (Translated and edited from W-Mai-9-A-1)

Ms. Lyn has lived in Canada for 14 years. She was one of the most articulate of the women participants. I gained many insights from her wisdom and experience. My 4 hours of interviewing her was filled with emotion and information. Not only is Ms. Lyn a very intelligent woman, a very dignified individual who has much love for others, but she is also a woman with many beautiful qualities. Listening to her life story has made me realise that women have enormous strengths and how they cope with life's adversities deserve recognition. Yet, Ms. Lyn feels that she does not have the capacity to learn English because of her lack of education.

> It is very difficult for me to learn English because I don't have the necessary education. Even in Vietnam, my education was very low... I was not allowed to learn much. My parents told me that girls should only need to learn how to read and write. Too much education would make them bad because they would just use it to write letter to boys. They did not let me go to school. That was why I don't know much. I only know how to read and write in Vietnamese ... So you see, because my education is very low, I cannot learn English. I cannot remember. (Translated and edited from W-Lyn-10-B-1)

Although the practice of polygamy has been abandoned for many years, some men choose to continue this practice by having mistresses or simply by being promiscuous. The interesting thing is that when this happens, a wife is often the one who feels more shame. Instead of being critical of the men's behaviour, the wife might get blamed. The husband's misconduct is often looked upon as the wife's weakness. She is to blame for her inability to make her husband happy, thus she must not be a good wife or a desirable woman. She is also a woman who is "vo phuoc" (a woman who does not inherit any good luck from her ancestors' good deeds; a very unlucky woman).

> Mrs. Le: For Vietnamese women, we have learned to accept since we were born. Everything was our doing. If our husbands are unfaithful, we say it is our destiny to have such husbands and because it is our destiny, we just accept it.... There are many women who would not say anything about their husbands because if they do, it is like you are talking bad about your husband, you are 'vo phuoc' to have such husband....So it is more embarrassing for a woman to admit that her husband is not good to her. Everything has to be covered. (Translated and edited from W-Le-8-A-1)

Coupled with language barriers, this traditional ideology and discourse of keeping face for one's husband thus oneself have a direct influence on how Vietnamese women think of and participate in Pap smears. Because having problem "down there" is often associated with husband's unfaithfulness, social stigma and lost of face may pose barriers for some women to engage in frequent Pap testing.

> Mrs. Phi: The language is a barrier, because each time they go, they have to find a translator. And they just can't find a translator anytime they want. Finding a translator is difficult. They are not even comfortable with the translator. If I have a headache or a runny nose then it's okay, translate for me, but [voice lower] if I have white discharge, or if I have got an infection from someone, I would not dare saying anything about it. If you have STD, of course you don't want any body to know. It's embarrassed because they will question why you have that disease. Is it because of her husband is running around? For a woman to say that her husband is running around, it is a big embarrassment. Beside that, if the woman is single, oh, she must have many partners, etc. So, I think all that prevent Vietnamese women from going to the doctor for this kind of things. For Asian women, this kind of things is difficult to talk about. They might not even talk to their own husband that they have pain there, let alone talking to another man about it. (Translated and edited from W-Phi-1-A-1)

Eventhough there are studies which show Vietnamese who live in contemporary Vietnamese society might not necessarily follow traditional family practices and expectations (Luong, 1984; Hirschman & Loi, 1996), in traditional Vietnamese culture, women are expected not only to take care of their children and spouse, but also members of the extended family (Maltby, 1998; Waxler-Morrison, Anderson, & Richardson, 1990). In Canada, the Vietnamese family structure, relationships, and roles have changed dramatically. It has been argued that the migration process has led to social disruption. Western ideologies and values and the effect of urbanisation have changed the nature of the Vietnamese family structure (Coughlin, Walsh, & Cook, 1996). It has been observed that the traditional Vietnamese family – an intact, harmonious and extended patriarchal family does not necessary exist in the Western world (Coughlin, Walsh, & Cook, 1996). Coughlin et al. put forth that Vietnamese families are now largely comprised of a two-generation nuclear-family which consists of parents and children, and that the number of single-Vietnamese parents is increasing. Not only is the traditional close relationship with the extended family becoming more distant, but also the parent-child relationship is deteriorating.

Role reversal has been documented as one of the most common problems between husband and wife, and between parents and children (Gold, 1992; Kibria, 1993). The traditional hierarchical Confucian family system in which the elderly and the man of the family hold a respected position with power over the young and the women, has changed under the influence of the struggle for economic survival, and Western values and ideologies. Integration to the Western way of life with its cultural beliefs and values has been a challenge for many Vietnamese women.

> Mrs. Le: Vietnamese women are under lots of stress. I think it is because this culture is very different from our culture. For example, a woman often sees that Caucasian man helps his wife a lot and he treats his wife nicely, whereas her Asian husband does not do that. She then compares and feels very unhappy ... In reality, although Caucasian men might appear as very nice compared to Asian men, many of them abuse their wives. Many of them beat up their wives. The thing is that psychologically, when we go to a new and different place, we tend to see everything else is better than what we have. We might see that men here help and being fair with their wives. They help with cooking. They cook while their wives clean up. But our husbands are not the same. They might not help us....And then we have to go to work. We have our jobs too. (Translated and edited from W-Le-8-A-1)

Although many Vietnamese still retain many of their values and beliefs, adaptation to this new way of life and integration into Canadian society have changed their social roles and relationships. Economic adaptation has also necessitated role changes for men and women within the family structure. As with many Western families, to make ends meet, both husband and wife need to enter the labour force. In the traditional Vietnamese family, it is expected that the husband is the main breadwinner, whereas the woman's economic contribution is viewed as secondary to that of the husband (although, as previously discussed, in reality women often end up being the breadwinner of the family).

> Mrs. Minh: For Vietnamese, the husband might be the main breadwinner. But the wife is the one who looks after the spending and family financial situation. She also looks after meals and family activities. The wife has all that responsibilities .... The Vietnamese women have more responsibilities. We took it upon ourselves. Nobody say that we have to do that. But we want to do that for our family. It is depend upon how a woman runs the family that result in a "bad" or a "good" family. (Translated and edited from W-Minh-5-B-1)

Back in Vietnam, submerged in the social ideology and culture conceptualisation that supports the domination of men over women, Vietnamese women's status remains one that is conformist to the authority of their husbands and their parents. However, the employment situation coupled with the influence of Western values and ideologies caused Vietnamese women's role as the breadwinner to take on a different meaning in Western society. With greater earning power have come a change in status and an increase in power for women.

This role reversal and changing status have created hostility between husband and wife for some Vietnamese families. Marital conflict, emotional and psychosomatic problems for both men and women have resulted, especially for men, who find it difficult to relinquish their dominant roles (Gold, 1992). As observed by one of the Vietnamese physicians: "Here, family is not an issue. Women do not think much about their husband. It is not a barrier for the Vietnamese women. They are not dependent upon their husband" (H-Thinh-16-C-1).

An important virtue that is instilled within every Vietnamese is that one should always put the family and group interests before one's self-interest. The pursuit of individual goals is not only frowned

upon as selfishness, but also seen as an act of disrespect for others. Thus, putting oneself as second to family and husband has been looked on as a great virtue of Vietnamese women by some Vietnamese women participants.

> Mrs. Minh: For us, as a family, the first priority is our children. The children should have enough, then we are second. Go to school or eating, they – the children should come first. For Vietnamese, the parent's needs are second. Children come first. For the woman, not only the children, but also the husband come first and she is second. That's Vietnamese way .... Yes, it is a Vietnamese thinking. We always want a perfect family. So we always worry about the family. Family comes first, and we come after. You see, that is how Asian people think. We don't think about equality. Vietnamese women think about their children and their families before themselves .... We brought all that with us here. We still think the same way. (Translated and edited from W-Minh-5-B-1)

Thus individuals who exhibit self-negation, self-sacrifice, and modesty are considered to be individuals with good character. These values are reinforced and supported within the Vietnamese community by the high regard that is given to these women as "good mothers," "good daughters," and "good women." Contrary to Vietnamese culture, values, and expectations, Western society values individual independence, autonomy, and the pursuit of one's own success. Failure to do so is viewed as a personal weakness. The integration of these values has, to a certain degree, created conflict within the Vietnamese family.

Many women participants verbalise that the children and their family are most important to them. When asked what concerns them the most, many women would cite their children and family. For these women, their children's success and happiness are what make them well. Therefore, taking care of one's own health might have totally different meaning, thus the saying "I am happy when my children are happy; I am healthy when my children are healthy."

> Mrs. Minh: Here, in this country, women are considered themselves as important. But us, we want our family and our children happy. So we put ourselves behind all those things. We give things to our children first. We take great responsibility to our families welfare. In contrast, the women here [Canadian women] are not worried. They just let the children do what they want. But Vietnamese women, we are not like that.... For us, if the children are good (dang hoang), we like that. That is the result of our good work ... It makes us happy. (Translated and edited from W-Minh-5-B-1)

Mrs. Hai came to Canada 20 years ago with her husband and two young children. With hard work and persistent saving, they now have a total of four houses. Although quite financially stable, with both of her children having graduated from university and working, she still says that she is most concerned about her children.

> Mrs. Hai: I am most concerned about my children.... For example, I was very sick but I still went to work. But when I heard that my daughter and her fiancé have problem, I phone my work place asking for the day off immediately. I wanted to take care of my daughter and talk to her. But for

> me, I was sick and I still went to work. That's just the way it is. I am concerned about my children. I worry that if anything happen to my daughter, her future will be affected, etc. So I would take a day off. It was not because of the money. If I just concern about the money, then I wouldn't be concerned with my daughter. I would just let her do whatever. But I cannot do that. I would take a day off so that I can help them, talk to them. (Translated and edited from W-Hai-3-A-1)

Based on the data obtained from a study which spanned two decades, Coughlin et al. (1996), asserts that the general assumption of the Vietnamese family in which the elderly are well respected and children are well behaved and studious is a misconception. For many Vietnamese, the children are expected to look after their parents when they are old. In Vietnam, the elderly do not live in a Senior's or Nursing Home. Instead they often live with either their son (often the first son) or daughter's family. The parents often help with daily activities such as cooking and looking after grandchildren. In return, the sons and daughters are expected to take care of the parent when they fall ill. Children who do not fulfil their duty are considered "con bat hieu" (bad children). There is a common belief that if one does not treat one's parents well, one will have bad luck and will suffer in the next life. These cultural beliefs and practices continue in Canada. When someone is sick, the family members are expected to be with that person at all times.

> Mrs. Phi: For the majority of Asian people, even though they don't have to translate, or help taking their mother to the washroom, or help her with walking or eating, they feel that it is their duty. When the parents are sick, the children have to be around all the time. Or when children are sick, the parents have to be around all the time. That is the Vietnamese way. So if we can do that we'll feel good. Even though we don't do anything but we feel that our family care for us. We feel better and not guilty. We were not considered as "bad children" (con khong co hieu) – those children who are not around the parents when their parents are sick. So in reality, it is more for psychological reason. (Translated and edited from W-Phi-2-A-1)

In Canada, many Vietnamese women find that it is difficult to meet these expectations. Added on to the pressure of performing traditional roles and expectations is the difficulty of adjusting to the new life, different living arrangements, busy working schedule, and daily demands from their own children.

> At home, the parents don't need their children as much because they have friends. Here, in Canada, many parents feel insecure because they can not speak English. So they have to rely on their children more. Having their children with them make them feel more secure. So, here, performing the children's role is much more difficult. They have to take care of their husbands, their children, and also their parents. So the main person is a woman. (Translated and edited from W-Phi-2-A-1)

Aside from working and looking after their own children, many Vietnamese women are expected to take care of their parents as well.

> Mrs. Phi: I see many elderly complain that here, in Canada, "my children don't care about me. Anything happen to me they took me to the hospital and left me there for others to take care of me." They [the elderly] don't know that if we come to the hospital, we only sit with them, talk to them, and that our present will only make them feel less lonely... The nurses and the doctors do everything here... [but] the majority of the parents are expected that their children should be

around them. So, in Canada, fulfilling the children's role is more difficult than compared to back home. Here, the children have to work, and also take care of the parents. They have to do more things for the parents here. (Translated and edited from W-Phi-2-A-1)

Parental expectations coupled with increased dependence create conflict and feelings of guilt for women because they are the ones who look after the parents.

> Mrs. Phi: At home, they have many duties too, but their parents had others who they could count on. So the parents don't notice their children's absence as much. But here, if the parent notice of their children absence, it's very sad for the parents. It is better if the parents understand their children's circumstances. Some elders do understand, like my mother and father. They really understand how difficult our lives here. They never demand anything. So we don't feel guilty if we were not able to visit them.... On the one hand, we can't say that we are too busy. On the other hand, if we don't tell them, they would think that we don't care. So the children's duties here are heavy (nang). (Translated and edited from W-Phi-2-A-1)

Many immigrant women have experienced difficulty in managing illnesses and accessing health care services because of life circumstances (Anderson, Blue, Holbrook & Ng, 1993). When asked about how Vietnamese women's gendered roles and expectations affected the ways they think and take care of themselves, a 50-year-old woman who has lived in Canada for 23 years said:

> Mrs. Le: Because the family is considered as most important. They tend to forget about themselves. They worry about their families too much. Vietnamese women think about their families too much so they don't think about themselves... Because we are women, we are bounded to our duties. (Translated and edited from W-Le-8-A-1)

Women who fulfilled these roles are valued as "good women." These cultural values and expectations have led some Vietnamese women to conform to their role as caregivers and to view additional responsibilities and hardship as "the way things are" (Maltby, 1998). When asked if she ever thinks about herself, Mrs. Hai responses:

> Mrs. Hai: Yes I do. But when I think about myself, I think that I have to stay healthy so that I can look after my family. Yes. I do.... I do think about myself but I don't consider that as important... If I think about myself, I just think about going to work. Even when I am sick, I go to work instead of staying at home or going to the doctor.... That is just the way it is. (Translated and edited from W-Hai-3-A-1)

Mrs. May is an English speaking community health nurse who has been working very closely with Vietnamese women for the past 4 years. Together with a Vietnamese community worker, Mrs. May had conducted many women's support group sessions. In her opinion:

> Mrs. May: The women whom I come in contact ... think their husbands wouldn't want them to, they think that it wouldn't be a good thing for them. So we try to talk to them that, you need to take care of yourselves...One topic we talked about was taking care and looking after yourself... Even though you are looking after 6 children, and how do you try to look after yourself. We talked about little things that you can do for yourself. And many of the women felt very passion about the topic and that they didn't feel they have the right to look after themselves. They really saw that they didn't feel right to pamper themselves and to take that time for themselves. And that they are there to look after every body. And that is their roles and that is their jobs... They didn't really feel they have the right, and that was what comes out of that group. And I felt very discouraged and

> upset by that. But then I came back and I thought, but they are looking after themselves. They are coming to this group. And that is something that they are doing for themselves. They may not identify that, but they are coming here to support each other. They are coming to this group, and that's something that they do for themselves. (Edited from H-May-18-C-1)

B. Ms. Lyn's Story

Living in Canada for the past 13 years, Ms. Lyn is now 68 years old. She came to Canada from North Vietnam. She lives by herself in a basement apartment, which she recently started to share with one of her granddaughters. As with many other Vietnamese, Ms. Lyn lives on the east side of Vancouver, an area that is affordable for low income people. Crime rate is often high with drug trafficking and thefts, thus it is not the safest place to live for elderly women who are living alone. It was in this neighbourhood that my car was broken into while I attended an evening of fund raising for the Vietnamese Women Association. Yet, the majority of the women participants in my study live in the east side of Vancouver. Several women live in small basement apartments, which typically get little sunlight. Because rent is low and many Vietnamese stores and markets are located within walking distance, many have chosen to live in this area.

Although I have informed Ms. Lyn about the purpose of my study and the length of our interview, Ms. Lyn talked to me for four hours. For slightly more than two hours of this, she told me her life story. Sitting in a very simple living room furnished with secondhand furniture, with tears in both of our eyes at times, Ms. Lyn talked non-stop.

After she married, Ms. Lyn left her parents and followed her husband to live in one of North Vietnam's harbour cities. To look after the family, she worked as a merchant selling things such as dry shrimp and fish at a local market during the day, and knitted sweaters for an export company at night. Her husband, who worked at several jobs, did not give her any support. Instead, he used the money he made to support his gambling habit. As if the event is still fresh in her mind, Ms. Lyn recalled the time when she had just delivered her sixth child. As with the delivery of all the other children, Ms. Lyn was expected to get back to her duties which consisted of washing clothes by hand, cooking all the meals, and carrying water from a distant community's water source back home. That time, after coming back from the hospital, she was too weak to get up to work. Her husband, using the foulest language, told her to get up to look after the children and to cook for him. Ms. Lyn had attempted to leave her marriage, but could not. She said:

> Ms. Lyn: Divorce was very rare. Vietnamese women when they get married, they have to tolerate hardship for the rest of their lives. Not many women can get divorce. Very very rare. Only second or third wife. For example, a man would just leave the first wife at the village and gets another wife in the city. The wife at the village would just had to stay there. The man would come back once in a while. Because the village is his root, he came back once in a while. There is no such thing as divorce. My time, divorce was still very rare. That was why I had to suffer all my life (crying). (Translated and edited from W-Lyn-10-B-1)

Although desperately wanting to change her life, Ms. Lyn could not. The children's welfare was her reason for staying in the marriage.

> Ms. Lyn: Divorce from the husband is possible but the children will suffer. A man cannot look after the children as good as a woman. You see, the elders often say "sanh cha thi an com voi ca. Sanh me thi liem la dau duong" (lost your father, you will eat rice and fish. Lost your mother, you will leak leaves on the street). I have seen many situations where the children have the mother but no father or father but no mother. These children suffered so much. First of all, I have too many kids and all of them are boys. They would become bad very easily if they don't have me around. Their father only concerned with gambling, not the children. He could not look after the children. That is why I sacrificed all my life until my youngest boy got married...then I thought, now my children have all grown up, I should free myself. I don't know how many more years I'll be able to live since I was already sixty some years old, but I should try to free myself.... I have already scarified my whole life for my children. (Translated and edited from W-Lyn-10-B-1)

Despite her difficult situation, Ms. Lyn kept having children. She talked of the reason she had six children.

> Ms. Lyn: When he comes to me, he is a man, I am a woman. I am his wife, how can I stop him from doing it. That was why I keep having babies ... I didn't want to but he kept coming to me. What can I do? I could not do anything because I am his wife. I could not just scream for help. So you see, there are many ways of suffering. Back then there was no birth control available. (Translated and edited from W-Lyn-10-B-1)

Living in Canada is the best thing that happened to her. She is very grateful and thinks that Canadians are very humane and kind to people like herself, who cannot work. Her life is much less difficult now. Now she does not have to work day and night to support her husband and her children. However, her husband continues to mistreat her in many other ways. Because Mr. Lyn was listed as the head of the family, all government paperwork came to him. He hid the paperwork that indicated how much money the family was entitled to receive from social assistance and kept almost all the money. He only gave Ms. Lyn $200 per month to buy food for the family. To supplement their income, Ms. Lyn baby-sits small children for other Vietnamese. Not knowing any English, Ms. Lyn had no way of knowing what her husband was doing. It was not until 12 years later that by chance, she discovered Mr. Lyn had been keeping several hundred dollars every month for himself. Not only that he had been hiding the money from Ms. Lyn, but he had also prevented her from going to Vietnam for her son's wedding by hiding her passport application.

Although she suffered a great deal in her marital relationship, Ms. Lyn was still willing to forgive and to help her husband when he had difficulty. After several trips back to Vietnam, Mr. Lyn came back

with no money and his mistress had also left him. Although Ms. Lyn had been living with her children for a while, to help, she told her husband that he would only need to give her $200 per month and he could keep the rest which amounted to $1200 per month. Mr. Lyn did not agree. Instead, he said that he would not give her any money at all. That was the last straw for her. By the time I interviewed her, it has been more than a year that Ms. Lyn has been getting her own money from old age pension. For the first time in her life, she was able to get a basement apartment for herself.

Recognising that her situation does not apply to all Vietnamese women, Ms. Lyn insists that people's circumstances are different.

> Ms. Lyn: It really is depend upon the situation and the individual. There are many men who are good husbands, not all of them are like my husband. Otherwise no one would want to get married. People are different. There are men who treat their wives and their children very well. There are also bad men. In reality, there are more good men than bad men around. If more bad men then everyone would be too scare to get married, right? So you see, it is depend upon the individual's circumstances. (Translated and edited from W-Lyn-10-B-1)

This view is shared by Mrs. Minh who thinks that some 'modern' Vietnamese men have changed a lot and many of the husbands and wives are having good relationships, often working together to raise their families these days.

> Mrs. Minh: I think Vietnamese family is quite equal. Now, there are more equality between men and women. In the last 50 years, modernisation (tan tien) made husband and wife relationship better than in the feudal society. In the feudal society, it was different. There were many rules and family's traditions that constrain the women. But now, there is more loving relationship between men and women. For example, when the husbands see their wives work too hard, they often help. Of course there are exceptions, some husbands do not help, but there are not too many of them around. The husbands often worry about making money. They have to find out more about their jobs in order to work well. The wives are not only working, but also take care of the family. Husbands now these days are not like before. They are not that ignorance and let their wives do everything. I have seen many of them, together with their wives, taking care of the family. They are not just fooling around and left everything to their wives. This day and age, it is better .... Our thinking (nhan thuc) is better than before. (Translated and edited by W-Minh-5-B-1)

Despite all the difficulties, Mrs. Lyn has always tried to live and act in such a way that she would leave some "phuoc" (luck) for her children. To her, leaving money and material wealth to the children might not be as important as leaving her "phuoc." This is how she has conducted her life.

> If one sees a poor person, one should try to help. Do not do anything that is harmful to others. I try to live in such a way that I don't loose my dignity. If I known something I will show others.... When I see beggars on the street, if I could not give them a dollar or two I feel very uncomfortable. My children told me that those people are drug addict and I should not give them any money. Many times I try to walk away but after a block or two I just could not stand it, so I turned around and give them something. Only then that I can walk away.... We are not rich but many people are still very poor. So if we can give something then we should ... The elders often say "phuc duc tai mau ba oi" (blessed or not is depend upon the mother). I need to do all those things so that my children don't suffer. (Translated and edited from W-Lyn-10-B-1)

C. Conclusion

Gendered roles and expectations influence the ways in which Vietnamese women manage their health and participate in health care practice. Although traditional ideologies have had many negative effects on the lives of Vietnamese women, history has proved that even though Vietnamese women have suffered extreme hardship, they are capable of living against all odds. For some Vietnamese women, the eradication of traditional custom, which is the product of ages-old ideology and their persistent struggle against oppression, are not easy. Although equality between men and women has been better compared to the past, some men have been slow to change their ideas about Vietnamese women's place, resisting women's struggle toward social and political equality.

Allen (1996) and Roseberry (1989) have observed that culture represents certain societal political groups because politics are generated around particular social and cultural positions that create a group or community. They involve images and movements in the society that are products of and responses to particular forces, structures, and events within that society. In many cultures, gender roles and expectations are often manifestations of unequal power relations between the sexes. Examining culture in relation to gender and power, Franco (1988) revealed that male domination and power have been associated with mobility and the public sphere. Although women have been associated with immobility and private, these gendered ideologies have created many disadvantages for women within society.

Living in Canada, some Vietnamese women are still living under the ideology and institutional practices that deny them independence and value their roles as family care takers which, in turn, manifests itself as a barrier that prevents Vietnamese women from seeking health care. For example, in the immigrant selection process, Canada prefers to admit Vietnamese refugees who were young, healthy, and who have attained a certain level of education or trade skill into the country. Meanwhile, the elderly and women were not favoured, unless other family members (usually male) accompanied them (Beiser, 1999). Therefore, there are Vietnamese women, especially women with small children, who have experienced difficulty in gaining independence in Canada. These institutional practices coupled with traditional ideology that one should honor, obey, and be loyal to those who are in a higher status have made voicing their dissatisfaction about health care services a difficult task for some Vietnamese women. As a result, they may choose to remain silent, and the government may thus overlook their health care needs.

Vietnamese women, however, cannot to be restricted to a role of passive victims of traditional ideology and discourse. Rather, they have human agency. They are not just conforming to the dominant forces (Donnelly, 2002). Women like Mrs. Hai, on the one hand insisted who she is – a Vietnamese woman who follows the call of motherhood's "duty," yet also echoing in her voice is a desire to resist dominant forces that are imposed upon her.

> Mrs. Hai: I think may be Vietnamese women are going to the extreme. We forget about ourselves. Maybe we should think about ourselves a bit more... I saw my mother-in-law; she is doing the same thing. It's too extreme. We are here. We don't need that. We have money, not like when we were in Vietnam. (Translated and edited quote from W-Hai-3-A-1)

Many women in the present study have made many attempts to reconstruct their own identity and re-present themselves through active participation in representational discourse that disrupts and challenges taken-for-granted dominant hegemonic discourse. Many women have not only carefully evaluated their health care options, but they have also chosen to act in ways that are most appropriate for their circumstances. Although some health care decisions might be seen as "irrational" from the Western health care providers' perspectives, these decisions have been carefully evaluated according to their specific circumstances by the women.

Because putting the family before one's self-interest is still considered an important virtue by many Vietnamese women and the pursuit of individual goals is frowned upon as being selfish, there are women who will face adverse conditions with patience, silent suffering, and perseverance. Health care providers need to recognise that this behaviour is related not only to a long history of struggle against a harsh nature, feudal systems, and colonial regimes, but also to the fact that patience, courage, and maturity are required in order to achieve personal success. Western health care professionals with their values of independence and autonomy might feel that a Vietnamese woman who devotes her time and effort to looking after the family is neglecting her own health. However, it is imperative for health care providers to understand that for some women, their children's happiness and family success might mean that these women have successfully accomplished the most difficult task of their lives and with it, a sense of pride, self-respect, and the respect of others from their community. To some Vietnamese immigrant women, devoting time and effort raising their children means ensuring the children will have a better socioeconomic future than themselves.

Although domestic violence and oppression do happen to Vietnamese women, and many are still struggling to overcome age-old traditional ideologies and practices, to many others, family offers

opportunities for advancement that are denied in major societal institutions. Contrary to some feminist approaches, which consider that the family with its obligations is another place where women experience oppression, for some Vietnamese women this assumption is not entirely accurate. It has been pointed out that in societies where greater degree of social discrimination is experienced, the family is the least oppressive institution (Stasiulis, 1990). Family can also function as a site where socially disadvantaged women and men unite in their resistance to oppression by the dominant forces.

Given that many Vietnamese women have considered family and children as most important, health promotion and disease prevention strategies should address issues within the family's context. Health promotion discourse that capitalises on individual interest, on doing good for oneself, might not be an effective message because it conveys the Western value of individualism. Focusing on both individual's and family's interests might be a more culturally sensitive and effective way of promoting health care among immigrant women. Because an individual's health care practice is often a family's practice, promoting breast and cervical cancer screening programs should consider all family members as its target population. Information on breast cancer and cervical cancer should be made accessible to all family members, which include elderly, women, men, and children.

It is important to note that changing family structure and women's status has also had some positive effect on family dynamics. Some Vietnamese men have become quite supportive of their wives. As observed by one physician,

> Dr. Thinh: I have seen many couples in which husbands encourage their wives to go for check up. I do not think that men would ever prevent their wives to go for these kinds of examinations. On the contrary, they encourage their wives. (Translated and edited from H-Thinh-16-C-1)

Health care professionals need to be conscious of the fact that by focusing and praising the women's gendered roles and expectations, we might, in fact, participate in the reproduction of the unequal social relations between men and women. It is important for health care providers to recognise that although superficially the Vietnamese appear to have some commonality, there is also diversity among Vietnamese Canadian women. They come from different backgrounds, have different experiences, and encounter different obstacles. Thus, although some women take pride in how they put their families and children before themselves, others might despise the fact that they are forced to consider themselves as second to everyone else.

Following this perspective, health care providers cannot generalise or assume that all or most of Vietnamese women have the same characteristics or act in a unified pattern. It is important to elicit the

meaning that underlies our clients' thoughts and actions. Furthermore, on investigating how immigrant women participate in health care practice, health care providers need to take into consideration what one of the physicians has said:

> Dr. Dau: There are other issues. Their jobs and other things, so even they (Vietnamese women) see that health care is important. Other daily things take priority. Not only that they are struggling (doi dau) with their own lives, but they are also thinking about their families back in Vietnam. This new society has too many issues that they have to deal with. Many issues that are important to the Western women, are not necessarily important issues for these Vietnamese refugee women. It is not that they don't know about it (breast and cervical cancer screening programs), but there are just too many other things that they have to deal with. (Translated and edited from H-Dau-13-C-1)

Chapter Seven: Social Support Networks

Individuals' health and health care practices are greatly influenced by their social support networks. Individuals' social support networks are comprised of both formal and informal spheres. In this dissertation, formal social support networks include organised social institutions and/or organisations that support the individuals' health and health care practice (such as social development Canada and health care institutions). Health care providers who have formal training at health care institutions who provide care to individuals are also included in this category. Because my conceptualisation of health and health care is not only limited to health care services, social organisations related to public services such as financial and legal institutions that have both direct and indirect influences on individuals' health and health care are part of the women's formal social support networks. An individual's informal social support network consists of both the immediate and extended family members and friends. The Vietnamese women's informal social support networks also include people from the Vietnamese community and the community in which they live.

Family network is not only a source of social and emotional support, but also economic support to the Vietnamese. In addition, the supports of family members and friends reduce the stress of being unemployed (Johnson, 1988). Thus, many Vietnamese who came to Canada without family members were keen to establish a social support network through developing a close relationship with other Vietnamese in the community.

In this chapter, I explore how social support networks whether they are formal or informal influence Vietnamese women's participation in preventive cancer screening programs. I also show how social discrimination that exists in cross-ethnic groups and within Vietnamese community impact Vietnamese women's health and health care practice. The first part of this chapter explores Vietnamese women's formal social support network. The second part discusses Vietnamese women's informal social support networks. The third section discusses Vietnamese women's experience with social discrimination.

A. Formal Social Support Networks

1. General Social Institutional Support

In general, the women participants have a positive view of the Canadian social support system. Several women spoke gratefully of the support that they received. Social assistance and old age pensions are the most appreciated forms of institutional support, according to the older women participants. Mrs. Mai is 73 year old. She said:

> Mrs. Mai: Here we have it so good. We could afford certain things. For younger people like my sons then yes, they have to work very hard.... People at my age in Vietnam, even if they have pension, it would only be enough for them to have food on the table for 20 days of the month. So they would have to spend their money very carefully, some day they would just eat fish sauce and salt (an mam, an muoi). So whatever they give to us here, it is enough. We eat well and we live in a place that has everything. I think Canadians are very kind because they look after old people like me who cannot work to make a contribution to the society. Vietnamese saying "An qua nho ke trong cay" (when you eat the fruits, remember the person who plants the tree). I am very grateful to the Canadians and I thank Buddha for getting me here. (Translated and edited from W-Mai-9-A-1)

Ms. Lyn is 68 year old. She shares this view:

> I have suffered all my life. That is why I always think that I am so lucky to be here. I am old and cannot work, yet the government looks after me. From now until I die, I am not going to suffer. The government gives me some money and as you know that us –Vietnamese, we spend money very carefully, so it is enough. So you see, I am not suffering because I don't have to worry about that....People in Canada are very humane that is why non-working person still have food to eat – people like me, old and cannot work. (Translated and edited from W-Lyn-10-B-1)

Immigrants who came from North Vietnam often lived under difficult economic situations. Under communism, not only was the government salary not enough to buy sufficient food for the family, but having money did not guarantee that one could buy food. It is not surprising that these immigrants express gratitude towards the host country, the government, and private sponsors. Although immigrants from South Vietnam who had previously enjoyed a prosperous life in Saigon found their economic status and political power decreased, they have also expressed their gratitude towards their host country (Beiser, 1999; Freeman, 1989).

Mrs. Phi has been living in Canada for close to 25 years. From the beginning, she has been a very active community worker. Both her and her husband have helped many Vietnamese newcomers settle in their new lives. This is what she said:

> Talking about social support (dich vu xa hoi), I think that Canada is a rich country. So if you compare the social support with back home, back home was not even close. So I feel that social support here is much more than adequate (qua day du), or even wasteful. Here, people don't

> value the social support because they got use to be treated too well. For people who came from a developing country, we see the different, so we valued these social supports much more. (Translated and edited from W-Phi-2-A-1)

Although Mrs. Phi sees and appreciates the social support that is given to the Vietnamese living in Canada, she, nevertheless, talks of the need for more family support and understanding of cultural differences. It has been pointed out by others that misunderstandings because of lack of cultural knowledge, different values and different ways of life have led to barriers for seeking help for family problems among the Vietnamese. Sometimes, serious accusations such as child abuse and neglect have occurred due to these misunderstandings.

> Mrs. Phi: But talking about social support for family, I think there is a need for more improvement. They (the Canadians) need to understand the traditional knowledge and customs of the 'developing country' so that they could combine these two kinds of knowledge without experiencing conflict. I have seen many families complaining. Not only the Vietnamese families in general, but also families that have their children taken away from them. They (the Canadians) don't understand how other people take care of or teach their children. So I think that there is a need for more understanding. (Translated and edited from W-Phi-2-A-1)

Institutional support, however, is limited for the Vietnamese women who do not speak English or who are isolated at home. For these women, institutional support is "out of reach." Unfamiliarity with the society's organisational structure and services coupled with the inability to speak the host language have made it very difficult for them to access the available health care services and organisational support networks. Not only it is "out of their reach," but they do not even know where to start. Mrs. Hai who has been living in Canada for 22 years, describes how she accidentally found out about certain services:

> I still don't know much about the health care system. I just go to the doctor, but other than that. Some time, we only go to the hospital if it is emergency.... I only know about the doctor. I don't know about other things. Also, any social resource or support, social organisations, I don't know. The other day, my sister's boyfriend (pause) two policemen came. They tell her that if she needs anything to phone them, they will help. She was so surprised that such things exist. We didn't know that there are organisations that could help. For example, if you are sad or depressed, you can call for help. But I didn't know. (Translated and edited from W-Hai-3-A-1)

All the research participants expressed that limited language skills are one of the major barriers to accessing the available health care services. It is due to this fact that much information about the kind of services that are available does not reach the women. Many health care providers have identified this as a barrier, yet, the problem still exists and funding for translation services remains very limited. Institutional support for health care again is limited because of funding.

> Mrs. May: Language is a big one...I wonder if some Vietnamese women, do they want to learn? They probably want to learn English but they might not feel that they are able to learn English. I always think that, there is a need for more interpreters' services available to women. But this is all, short of dollars, you know, money, when it comes down to money, it's so difficult. (Edited from H-May-18-C-1)

Furthermore, women who are isolated at home and women who are too busy working to get involved with community activities would not know about other existing services. Mrs. Thanh is 71 years old. She has lived in Canada for 28 years. In her view, institutional support is very limited.

> Mrs. Thanh: No, no one helped me with anything. I only know that living in Canada, my life would be better. Since I came here, I just worked. Only now that I am older, I get the support from the government. For many years I just work. I had been working for a long time.... I have never investigated for other supports. I did not know. Well, if nobody tell you, how would you know about any other things.... If there are so many help out there, they need to let the people know about it. Otherwise, we would not know. I don't know about any organisations or what they can help. (Translated and edited from W-Thanh-15-B-1)

Although older women participants felt financial support is adequate, for younger women who want to explore other opportunities in the labour market it is limited. Mrs. Ling came to Canada in 1981. A lawyer in Vietnam, she was very motivated to acquire more language training and the education necessary for her to make a new life. However, Mrs. Ling's dream was shattered. She immigrated to Quebec to live with her husband and small child, like many other Vietnamese. However, she found that her French was not adequate to seek employment compatible with her qualifications. Realising that finding a good job was impossible without the proficiency in the host country's language, Mrs. Ling kept on going to classes to learn French in addition to her full time work and family responsibilities. She was eventually promoted to a machine operator position. Ten years later, when her husband died, Mrs. Ling and her daughter moved to British Columbia (an English speaking province). Again, she was faced with language difficulty. Despite her motivation to acquire English, there was no institutional financial support for her to go to language classes.

> Mrs. Ling: If 10 years ago they (the governments) let me learn more English and if they give me some supports then I would not have to go to work, I would be able to continue studying... If they only give me enough money to pay for school tuition, I would have used my own saving to buy food to eat. But I didn't even have the money to pay tuition. There were no free programs. I ask you, where would I get the money to pay the tuition and to buy food. Because of all these reasons, I have failed (that bai hoan toan). (Translated and edited from W-Ling-1-A-1).

For some Vietnamese women participants who participate in the labour force, institutional support with health care is also limited. Mrs. Phan spoke of this:

> Mrs. Phan: No, no help from any organisation. It is this, if I am sick only my family helps me. Because I am working, I am not on welfare, only my family supports me. I would be able to get help from others only if I am on welfare. But when you are working, you have to take care of yourself, nobody helps except your family. Brothers, parents, husbands, wives, and children, have to take care of each other... No help from any institutions because once you are working, you have some income, you would not get help from any organisation. Only people, who are on welfare, they get help from institution. Me, I am working. I am not qualified to get any help. (Translated and edited from W-Phan-11-A-1)

Ironically, the welfare policies that only give support to women who are in its system make it difficult to leave the system. Because only women who receive social assistance would qualify for other social and health care services, women, who are "out of the system," yet still needed help due to their low level of income would not get any support. Thus, the very structure of this social support compromises women's health care.

Limited institutional support contributes to low socioeconomic status, which, in turn influences Vietnamese women's participation in health promotion and disease prevention programs. This is because Vietnamese women who have to struggle to make a living are not likely to consider going for breast and cervical examination as one of their priorities, but family economic situation is. For the same reason, limited support from government and corporate institutions with employment opportunity will therefore, negatively affect how Vietnamese women practice health care.

Limited language skills and non-transferable professional training have made the idea of self-employment desirable for the Vietnamese living in Canada (Johnson, 2000). Not only is self-employment desirable for immigrants because it provides income as well as employment in a tough labour market, but self-employment also helps immigrants achieve a sense of independence and autonomy (Gold, 1992). A Canadian 10 year longitudinal study of Vietnamese adaptation revealed that the majority of Vietnamese respondents considered self-employment a favourable mode of employment to provide for the family's and individual's economic needs (Johnson, 2000). The study shows that although self-employment was one of many avenues taken by the Vietnamese to provide income for the family, and that it was highly valued, "self-employment has not become the major source of employment income for this particular group" (Johnson, 2000, p. 9).

Despite the fact that self-employment is desirable for many Vietnamese, the Government of Canada's profile indicates that Vietnamese immigrants were less likely than Canadian and other immigrant populations to be self-employed. By 1991, only 6% of employed Vietnamese immigrant men (compared with 12% of Canadian-born men) and 5% of employed Vietnamese immigrant women (compared with 6% of Canadian-born women) were self-employed. The more recent data in 2001 show that Vietnamese's self-employment rate for both men and women has increased slightly since 1991.

Table 7.1

2001 Vietnamese's Self-Employment Data

Vietnamese	Male	Female
Population in Canada	74,720	76,485
Employed	38,080 (100%)	32,045 (100%)
Self-employed (incorporated)	1,255 (3.3%)	755 (2.4%)
Self-employed (unincorporated)	2,560 (6.7%)	1,995 (6.2%)
Total number of self-employed Vietnamese	3,815 (10%)	2,750 (8.6%)
Employed in other occupations	34,265 (90%)	29,295 (91.4%)

Source: Statistics Canada (2001). Ethnocultural Portrait of Canada: Topic Based Tabulations http://www12.statcan.ca/english/census01/Products/standard/themes/DataProducts.cfm?S=1&T=44&ALEVEL=2&FREE=0

To be self-employed, one needs the resources in terms of capital to start a business and manpower to operate that business. The majority of Vietnamese came to Canada empty-handed. Once they arrived in Canada, being employed in a low paying job without security meant that it would take much longer for them to save enough capital to start a small business. Lacking both capital and credentials, support from institutions such as banks was also difficult to obtain. In addition, having lived in Vietnam where social and political struggle during the war destroyed the individual's sense of security and trust, Vietnamese often count on family members and relatives. They often prefer family businesses with several family members and relatives working together. For some Vietnamese, successful economic adaptation comes with hard work and support from many family members. The problem is that most of them came to Canada without any extended family members – who, from the Vietnamese economical perspective, would form a solid family labour force.

Many Vietnamese desire to sponsor other family members to come to Canada. However, according to the previous Canada Immigration Act, which was approved in 1976, to be eligible to sponsor a family member(s), sponsors must show that they are able to support their sponsored family members or relatives for 10 years after they immigrate to Canada. This means that sponsors have to have good incomes, stable jobs, and be financially solvent. As mentioned in the previous chapter, many Vietnamese work in lower echelons of the labour force. Thus many might not be able to sponsor their family members to Canada. It also means that many Vietnamese women are without the support of their own family for a very long time. As observed by a 68-year-old woman:

> Ms. Lyn: Many Vietnamese women have a very difficult life because they don't have anyone to give them support. Not only that they have to look after their children, they have to make a living as well. They have to work very hard. It is very difficult. (Translated and edited quote from W-Lyn-10-B-1)

Thus, the previous government's immigration policy that placed more responsibility on the sponsors created barriers for family reunification which, in turn, decreased family support for the women. Limited support from family members coupled with working conditions and family responsibility, in the view of women participants, are indirect barriers for women to go to a doctor for cancer screening.

2. Formal Health Care Support Networks

For some women participants, formal health care supports come mostly from their family physicians. Other health care professionals in the community such as public health nurses are either unknown to them or not sought out.

> Researcher: If you were sick, what organisations and/or persons do you seek help from?
>
> Mrs. Ling: Actually, for over 10 years, I have never been sick to the point that I can't get up, just flu and cold. When I was worried about my mother, I had problem with keeping my food down. I though I had problem with my stomach. So I just contacted my GP (General Practitioner).
>
> Researcher: Beside the GP, do you need support from anyone else. Here they have, for example, community health nurse.
>
> Mrs. Ling: No, I have never got in touch with them. Maybe because I have never been in a situation where I needed them. My GP, when she is on vacation, she is only off for one or two weeks. And there is always someone else replacing her. But I didn't even have to see the substitute GP. (Translated and edited from W-Ling-1-A-1)

Many Vietnamese women participants in this study also expressed that health care support in Canada is much better than the health care support in Vietnam. The fact that they do not have to pay for doctor's visits, tests, and treatments is extraordinary to them. Furthermore, their perceived view that the Western health care system is much more advanced than that which they had in Vietnam has made them feel very positive and confident about the kind of health care that is available in Canada.

> Mrs. Phi: Lets just compare then you'll see why I have confidence. If I was in Vietnam, either before or after 1975, it's all the same. Before 1975, the health care system might be a bit better. After 1975, it was worst. Now it is better. However, it was still not even a fraction compared to the health care system here. Well at home, people still live. It's not that people are not living. So we have to think. Here, with a much better, much more adequate health care system, we should have more confidence. If we want to have a better care, well people always want to have more, but it should be a balance. (Translated and edited from W-Phi-2-A-1)

Mrs. An had extensive experience with the Canadian health care system due to her daughter's breast cancer. The last few years of her daughter's life were filled with trips for treatments and periods of hospitalisation. In her view:

> Mrs. An: From my own experience, support from the Canadian government is very good. They (the health care providers) are very caring. Doctors are very kind and conscientious. They were

> very humane and they looked after us so well. Her doctor visited very frequently and did everything he could, order blood, this and that. The government also helped us by letting nurses to come to help us at home. Things we needed for dressing such as gauge and cleaning solution were given to us. They even gave my daughter the milk that helps to get her strength. They were so good to us. They have supported us both physically and psychologically. (Translated and edited from W-An-14-A-1)

Limitations, however, exist. Limited formal health care support for women lies mainly in inaccessibility of available health care services. Although inaccessibility to many social and health care support network is due mainly to the women's inability to speak the host language and the unfamiliarity of the social structure and programs, these barriers can be overcome if the women know about the existing health care services. Some other women participants such as Mrs. Phi, although very confident in the present health care and appreciative of the care that is being provided to the people, see the problem as being related to inaccessibility of the information that reach the Vietnamese.

> Mrs. Phi: For health care, I don't have any complain. With health care, I think that it is much more than adequate. The nurses working on women's health issues at the health care clinics, they work very hard and they have many programs that are good for Vietnamese women. I know that because I have the opportunity to work with them in several projects for the Lac-Viet radio. I see programs that are very effective. So I hope that in the future, we would have some funding for health care programs which provide health care information to the Vietnamese here. At present, we all work as volunteers. Nobody gets pay. So of course, it's not the same. If we get some funding from the government, there would be health care professional that will help to develop programs. But now, all of us are volunteers except the public health nurses who give us information for programs. They are paid salary by the government. (Translated and edited from W-Phi-2-A-1)

Health care provider participants often talked about formal health care support networks for the women. Their concerns are quite often directly linked to the very structure of the existing health care system. From their perspective, health care supports for Vietnamese women are not adequate. Limitations of the health care that is being provided to the Vietnamese, in their view, are due mainly to limited manpower and funding resources to distribute health care information among the Vietnamese.

The community health nurse agreed with the women's perspective in citing that limited language proficiency is one of the major barriers for women to accessing health care. She identified the need for more interpreter services and translations of information into Vietnamese but found that shortage of funding is a big problem. In her experience:

> It is the funding... it's really frustrating because I may have a piece of written material that I could have the interpreter sit down to translate it or write it out. But through our organisation, we are not allowed to do that now. It all has to go to a very structured process to have material translated. And so sometime professional, nurses, you know are just like, oh it's just so much work to have to go through that process. And then there is no funding. And so I think that its not as easy as once was .... That is a big, big problem. (Edited from H-May-18-C-1)

Dr. Tien has been practicing as a general practitioner for 7 years. Acknowledging that language is obviously a barrier to the women's health care practice; a bigger barrier, from his perspective, is the lack of government funding for the promotion of breast and cervical cancer screening among the Vietnamese women.

> Dr. Tien: Yes, language barrier is a big factor. But there is another bigger barrier.... I just came back from California. In California, there are books and magazines in Vietnamese about health. The doctors there are responsible for these things. These books and magazines talk about diseases, including women diseases and breasts cancer. They also have conferences, teleconferences every week on TV. They organise these things for the Vietnamese. (pause) Here, we don't have those things.
>
> Researcher: Why do you think that kind of activities are not happening here?
>
> Dr. Tien: If we want to organise that kind of activity, we need support from certain organisations. We need their financial support. I cannot organise a conference for 200-300 people by myself. I could not pay for rental of a hall, refreshment, and security. If we get the government's financial supports, we can work together with social workers, health department workers, other doctors, and people who have experience with breast cancer. That would be very helpful. We must do it. The past 4 years of my practicing here, I had a total of 4 cases of breast cancer, despite the fact that I can only examine a small number of women because of the embarrassment issue. But even with this small number of women, 4 of them have breast cancer. With all of these 4 women, I was able to discover their cancer early. So they are still alive. (Translated and edited from H-Tien-17-C-1)

B. Informal Social Support Networks

In the present study, although family structure is slightly different between those participants who live in urban and in rural areas, their family networks are often comprised of both nuclear family members (father, mother and children) and extended family members (grand parents, aunts, uncles, etc.,). Family members often live in the same household, or within the same geographical regions. Supporting each other in child rearing, work, money, and problem solving is not only considered a norm, but is expected of the family members. Because parents usually live with the son's family, Vietnamese women's social support system often includes the in-laws. A woman who has parent-in-laws who are sympathetic and helpful would have a lot of support. Mrs. Ly remembers fondly her mother-in-law.

> Mrs. Ly: I have 11 children but I don't know what is a labour pain. I was not like other people, after a week, they return to work at the store or what not. Me, even after the 4th day. I just rest in bed. I had it good. My mother-in-law liked me a lot. After the delivery, 12 days later, I would "Xong" (steam bath with boiled leaves) then I take a bath. My mother-in-law took care of me as if I am her daughter. But it was also because I know how to behave. My sister –in-law too. I have two of them and I like them very much. It is because I am a girl, I got married and live with my husband's family. I was not at home to take care of my mother. So if I am nice to my sister-in-law, they will help take care of my mother better. I know how to treat them. (Translated and edited from W-Ly-6-B-1)

Individual social support is understood as mutual agreement between family members. Vietnamese children are considered to be the main supporters of their parents. They are expected to look after the parents economically, psychologically, and emotionally. Thus, women who are without their children often experience difficulty with both daily and health care activities. Mrs. Ly came to Canada in 1992. Although she has 9 living children, there are only two sons who live in the same city as her. One of her sons has a wife and two children who live close by. Mrs. Ly lives with the other son who is not yet married. Because her son works full time, Mrs. Ly who is 78, is often by herself. Without any English or transportation, she can only go for doctor's appointment on the day that one of her sons is not working or else she would have to call upon the Pastor of her church to take her to the doctor's office – something she would rather not do. Although there are friends at the Church who are willing to help, Mrs. Ly would still rather not bother them.

Difficulties arise not only with finding ways to get to the doctor's office, but also with the management of health care at home. For Mrs. Ly, the management of her medications has been a challenging task. Having several kinds of medications, some labeled in Vietnamese, others in English, Mrs. Ly takes her medication according to what she remembers of her doctor's instructions. Because there are several kind of medications, she often forgets when and how much to take. For example, instead of taking an antibiotic according to the instruction "take three tablets per day: one in the morning, one in the afternoon, and one at bedtime," Mrs. Ly took one tablet every couple of days. Her sleeping pill was prescribed "half tablet at bedtime," and she took one tablet. Identification of the medication is also a problem. Mrs. Ly relies on the shape, size, and color of the pills to distinguish which medication is for her aches and pains, which is for sleeping, and which is for flu. Many of these medications have been put together in one container. At the interview, we spend a fair amount of time trying to sort out her medications. Thus, limited family support and ability to manage medical regimens present a potential health problem for the Vietnamese elderly.

Women, who have more family members living close to them get more support. Mrs. Chau lives with her husband and her daughter's family. She also has other children living in the same city. Mrs. Chau's husband is the one who makes sure that she takes her medication. Every morning Mr. Chau gives his wife her medication for high blood pressure. He also reminds her not to eat too much salt. Besides the support from her husband, Mrs. Chau has her daughter and son-in-law to take her to see the doctor. For

28 years, Mrs. Chau has never gone anywhere by herself. Mrs. Chau feels she is a very lucky woman who has a good family.

> Mrs. Chau: when I was sick in the hospital, my children went with me. They were with me all the times. They even slept at the hospital so that they could look after me... Thanks to God that if I am sick my children will look after me appropriately. They would not abandon me. My children are very good children. Every one of them would take care of me. If I were in the hospital, they would come and sleep there too. They don't just leave me there by myself. (Translated and edited from W-Chau-7-B-1)

Women who belong to a religious community often had more support from the group members.

> Mrs. Chau: I have been going to the Church for a long time. Brothers and sisters members of the Church, love each other. If some one is sick or having problems, many people would come to visit ... That time when I was sick, three, four, five Churches hold prayer sessions for me. Any person who hears that Mrs. Chau is sick would say prayer for me. Many people care about me. That time, this person phone, that person phone. (Translated and edited from W-Chau-7-B-1)

There is a popular assumption that an Asian person gets lots of support from family members and that in general the children look after their parents. This is thought to be part of their culture. However, because of different living arrangements in Canada, older Vietnamese might have difficulty with getting support from their family. Back in Vietnam, if the parents did not live with their children's family, they would live in the same city and a short distant from each other. But life in Canada is different and many Vietnamese found that it is difficult to get the support they needed from their family members.

> Mrs. Ling: Life is more difficult, not like in Vietnam. As you know, back in Vietnam, we have our family members lived nearby. Here, I have a sister who lives in Port Coquitlam. If I call her to come down to help me with certain things, for example, if I have a fight with my husband and I phone her, still she cannot be with me. Only if she hears gun shots or screaming etc, a real emergency, then she would drive all the way from Port Coquitlam to be with me. If you have family members who live in Seattle, they cannot come to your rescue. You know that brothers and sisters, where they live these days depend upon where they could find jobs. They cannot try to live close to you because, as I have mentioned to you before, financial concern is number one on their list of priorities. If you have no job, the bank will take your house because you don't have money to pay the mortgage. That is why many Vietnamese don't have relatives around to help with emergency situations. In contrast, back in Vietnam, we just ran back and forth between each other's houses... So the support for each other is less here. (Translated and edited from W-Ling-1-A-1)

For many elderly Vietnamese, it is not that their children are overlooking or do not care about their parents, but that difficulties arise as the result of other contextual constraints. Mrs. Minh has seven children and even though both her and her husband live with one of their children's families, she found that it is still difficult to get support from the children.

> Mrs. Minh: They all have to work. They would just phone or come to see us in the evening. They would stay for a little while then they go to their own homes.
>
> Researcher: You mentioned that when someone is sick, everyone in the family is influenced. I have talked to some women. They mentioned that, here, their children are very busy.

> Mrs. Minh: It is true. My children live in different places. They could only visit me in the evening. It also depends upon each family. Some families, they don't care much. Some families, the children try to visit, to see how their mothers are doing. So they would come in the evening. If things were not serious, they would just come to see me on Saturday or Sunday. If there were something wrong, they would have to come to the hospital to see me. They might not have to help us financially, but they would have to provide psychological (tu tuong) support. The psychological (tu tuong) support is very important. (Translated and edited from W-Minh-5-B-1)

Several women participants said that they try not to bother their children too much because their children have to work. Many times when they needed help their children could not be there for them. To give you an example, I got a call from a husband of a 73-year-old woman participant. He asked if I could help read a letter that was sent to them saying that they owed some money. Both he and his wife were very worried because they are on a fixed income. It took me half an hour to drive to their place. It turned out that the letter was a letter asking for a donation. Yet the woman told me that she was so worried she could not sleep the night before. She tried to call her daughter who lives near by with her husband and children, but they could not come.

In Canada, two social programs that give economic support to its low-income senior citizen are Old Age Security Income Supplement (which is a federal program) and Social Assistance (which is a provincial program). Immigrants who are 65 year old and over, who live in Canada for more than 10 years are qualified to receive Old Age Security Income Supplement, whereas immigrants who do not qualify to receive Old Age Security Income Supplement will get their income through Social Assistance program. These two programs, although different in categories, provide a very limited income to the elderly. For some Vietnamese elderly, support from Social Assistance and Old Age Security Income Supplement have helped them, on the one hand, adjust to their new life, avoid hardship, and live independently from their adult children. On the other hand, ability to live independently has also distanced them from their family, which in turn created a sense of loneliness, isolation, and loss.

For older Vietnamese women, their health care links to the fact that they have to depend upon other family members, usually a husband and/or grown up children, to take them to the doctor's office or screening centres. Women who do not speak English well need others to translate and to drive them. Several older participants told me that they could not go to the doctor unless they are with someone. Other women said that they have to arrange their working schedule in order to take their mothers to the doctor. Several of these women expressed concerns that grown up children here are very busy with their own lives, many often work long hours in a labour job. Drawing from her mother's experience, Mrs. Hai told me: "The older women who just came here from Vietnam, they don't know their way around. They

don't speak English. And their children are too busy working, so they can't take the parents to places" (Translated and edited from W-Hai-3-A-1).

Transportation has been cited as a barrier for many newcomers (Wong, 2000). Restricted mobility impairs women's ability to seek the available health care services, especially for older women. Coming from an environment where health care facilities were often within walking distance, the use of cars and buses instead of walking and bicycling is a new skill that women have to acquire. Older women who do not speak English found it is not an easy task. Although many Vietnamese speaking doctors' offices and screening centres are located close to where the Vietnamese live, these places are not within walking distance to the majority of women. Thus, the location of health care facilities, coupled with lack of access to transportation, is a barrier to women seeking health care.

Mrs. Lyn has lived in Canada for 13 years. Since separating from her husband, she lives by herself in an apartment. Public buses are her main mode of transportation because of its low cost. At the time of our interview, there was a city wide bus strike lasting a few months that disrupted the ability of many elderly people to travel. At that time, lack of public transportation confined several Vietnamese women participants to their homes. Mrs. Lyn describes her experience in coping with the transportation issue:

> Because there has been no buses for several months, I could not go anywhere. Even if I want to walk to places, I don't know the roads. Not too long ago, there was an announcement in a Vietnamese paper about a big ceremony at a Buddist temple so I tried to find the way there. Well, the roads are like many flowers; I did not know which one to choose. I was lost. The roads here are wide and so long. Finally I had to ask for taxi.... When it was time for me to go home, I did not know which way I should go, whether to go up or down the street. So I kept walking up the street, when I didn't see anything familiar, I walked back. I walked up then down and up again then down again for a long time. Finally, I saw a white man reading a newspaper, I shown him my address and he showed me the way.... My first time taking the bus, I was lost for 3 hours, from this bus to that bus. Then I had to call for taxi, I gave him the paper with my address on it and he took me home. It costs me $9. (Translated and edited from W-Lyn-10-B-1)

When asked why she did not call her children if she could not find her way home, this is what she said:

> If I phone my children, I would have to tell them where I am so that they could come to pick me up. I would have to tell them the name of the street, the corner where I am. But I could not say the name of the street so even if I call my children, they would not know where to find me. If I could not tell them the name of the street then they would not know where I am anyway. That is why I just don't call. I often try to find my way around. If I am really stuck then I ask for taxi. (Translated and edited from W-Lyn-10-B-1)

For some Vietnamese women, health care support came from friends. Ms. Ling lived in Canada for many years, yet did not know about Pap test until a friend told her.

> Researcher: How did you know about the test? Did the doctor talk to you about the Pap test?

> Mrs. Ling: Just by coincidence. I had a friend, she asked me if I had a general checkup that year. I asked her "what general checkup?" She said, "what, you don't go for checkup every year?" I said, "I don't." I lived for 10 years back there (Montreal), every year, my GP would call to tell me that she had the medication to prevent the flu. Then I would go to see her. So I saw my GP once a year. She gave me the flu vaccine. If she didn't call me, I would forget about that too. (Translated and edited from W-Ling-1-A-1)

Women participants feel that having good friends is very important for socialisation. But in the situation when one is sick, many think that they would not want to impose on their friends for assistance.

> Mrs. Phi: Well, friends, we have to understand that our friends are not free either. They work too. We shouldn't expect them to visit you daily. Yes, they are good friends, but they might only be able to come to visit you once a week. It is still appreciated even if they come to visit just once for the whole time we were in the hospital. Many of them would only telephone. It is difficult for them to come to see or to help you too. We had to have certain knowledge so that we can be more understanding towards our friends. Especially, when we are sick, we should not expect too much. We should only count on the care provided by the nurses in the hospital. (Translated and edited from W-Phi-2-A-1)

Mrs. Phan has many Vietnamese friends. They often get together for meals during holidays and for each other's birthdays. However, when asked whom she would call on for help in case of sickness, this is what she said:

> To be honest with you, not my friends, it is my family. My friends, they all have to work. We would only ask for help from them if they were free. But here, they are very busy. We would only count on family for help, husband, wife, children and then brothers and sisters. If you ask friends for help, they would have to have time to help you... So it is limited because everyone is busy working.... Back in Vietnam, people who work at the same place were very good friends. We care more about each other. Our friendships were at a deeper level. When I was sick, my friends who work with me would take time off from work to take me to the doctor. They would help me with this and that. But things like that doesn't happen here. There is more sentiment between friends in Vietnam. In Vietnam, people care more for each other.... But here, to be honest, there is no sentimentality. (Translated and edited from W-Phan-11-A-1)

When asked why she thinks that there is no sentiment among the people in Canada, she said:

> Mrs. Phan: It is because everyone has to work. We are just too busy. It is also because life here is different. Back in Vietnam, neighbours visit each other often. Here, there is no such thing. You can be neighbours for more than ten years and still not know each other. The most we do is saying "hi" when we see each other on the street. We may talk for a couple of minutes, but never go to each other's house. Back in Vietnam, when I was sick, my next door neighbour helped me to cook or to take me to the doctor. Here, no way. Here, people only care for themselves.... Many of my friends say that in this land there is no sentiment, no caring (khong co tinh nguoi, khong co tinh cam). (Translated and edited from W-Phan-11-A-1)

The reason for diminished social contact and caring between people, in the view of Mrs. Phan, is cultural differences and life style. Differences, however, exist not only between Euro-Canadian and Vietnamese, but also between Vietnamese living in the same community.

> Mrs. Phan: Living across from me is a Vietnamese family. But I think because of the different style of living, we are not friends... Here, we are only associated with certain groups. For example, Mrs. P, and I, during holidays, we visit each other. So you see, there are groups of Vietnamese.... I think us – the Vietnamese do not totally care for each other (khong hoan toan

> thuong yeu nhau). I don't exactly know what it is, but Vietnamese who came here long before us, have everything. So they associate with each other. People who came later, who don't have everything, associate with each other. (Translated and edited from W-Phan-11-A-1)

Having everything here does not refer to material means but rather differences in ways of living, group's interests, and perhaps political ideology among the Vietnamese.

> Mrs. Phan: It is not because of the money. Here, everyone has to work. It is not because of different class (giai cap) either. It is difficult to explain. I think it is because of the commonality between some people that they belong to certain groups. Here, little social support exists between people, even between close friends, not like in Vietnam. In Vietnam, helping is more genuine and without motive (vo tu). I think, here, people are just too busy. They have to work so hard that they don't have time to help others.... People like me, after working hard all day, I come home exhausted, I don't want to go anywhere, just want to lie down to rest. We work so hard. In the weekend, I only want to rest at home. (Translated and edited from W-Phan-11-A-1)

C. Social Discrimination

1. Cross-Ethnic Group Discrimination Experiences

Living in a country that is united and without war has been a dream of many Vietnamese. An expression "you don't know how lucky you are living in this country" – which they often say to their Canadian friends, refers to their past experiences of living in a country which for decades has been ravaged by war and poverty. Many Vietnamese immigrants often expressed their gratitude to the host society by showing that they can be economically self-sufficient. Gratitude was also shown in the form of filial obligation to the host country – one is to keep good "face," good name, and good praise for the people who come to your rescue. As noted by Johnson (1999), "filial obligation was more prominent among more recent immigrants" (p. 54). As such, despite the fact that during the first couple of years in Canada, many Vietnamese felt helpless, vulnerable, and hopeless because they could not find work for which they were trained, they tried not to blame society, but instead saw their failure to enter the labour market as their own weakness. For many Vietnamese, being undemanding, making the most out of a bad situation, and focusing on the idea that their situation was only temporary helped them to have hope and gave them determination to endure and to solve economic problems (Deschamps, 1987).

From the Western psychological perspective, in coping with economic distress, recent Vietnamese immigrants seem to use "emotion-focused" coping, which according to Lazarus (1993), often predominates when stressful encounters are appraised as out of one's control. Emotion-focused coping is used to change "the relational meaning of what is happening, which mitigates the stress even though the actual conditions of the [stressful] relationship have not changed" (p. 238). However, immigrants who

have lived in Canada longer have often stated that discrimination accounted for their failure to enter the competitive labour market and their ability to find suitable work (Deschamps, 1987). There is evidence to show that ethnic inequality in relation to social class, education, and economic opportunities have had an impact on immigrants' experiences (Li, 1990).

Peter Li (1988), a Canadian Sociologist, asserts that ethnicity makes a difference to the education and economic opportunities of Canadians. His analysis shows that despite a widely shared ideology of equality, ethnic inequality does exist in Canadian society. Ethnic inequality, which is socially constructed and maintained by differential power relations between a dominant and a subordinate group, creates barriers within the labour market for certain ethnic groups to achieve higher earning potential. According to Li, the myth of the open capitalist society is that individuals and groups have an equal opportunity to compete in the labour market. Thus immigrants' failure to obtain employment is a reflection of the personal weakness of people who fail to make the most of opportunities. This ideology serves as a justification for the system of social inequality, because it denies inequality and blames immigrants for their failures (Li, 1988).

Immigrants' barriers to entering the labour market lead to high unemployment rates and dependence on the welfare system. According to the Vietnamese Canadian's government profile (1996), there is a high rate of Vietnamese women's unemployment. Some of these women are forced to enter the welfare system and as a result have experienced social discrimination. One Sunday morning on the Lac-Viet radio, during an aired session on social support information, a Vietnamese woman phoned in. She talked about the reason why she is forced to stay on welfare and cried when she asked people to please not think that persons like herself are lazy individuals who only want to take advantage of the system. Ms. Ling who has been voluntarily helping many Vietnamese with translation services, spoke on this topic.

> Ms. Ling: Those small things I can help with... Go to welfare asking for this and that is easy. But I don't want to do a lot of that because I don't want to show up in those offices.... The people misunderstood me. It is okay if I take them (the Vietnamese) to the doctor. To fill out application for UIC etc., is ok. But welfare, I only helped people who had helped me a lot.
>
> Researcher: Why don't you like to go to welfare offices?
>
> Mrs. Ling: It is because, the truth is that welfare social workers treat people who are on welfare very badly. Unlike doctors, they don't welcome people. They work for welfare, but they don't respect people who are on welfare. I do recognise that there are people, not only the Vietnamese, who have abused the welfare system. That is why there is a bad reputation. So when you go to these offices asking for things, they automatically assumed that we are using or abusing the system. Well in 10 cases, there might be 3, 4 cases, where people are abusing the system. But they don't know which cases or who and so they just treat everyone the same. They look at you

very strange (ki cuc) or they ask you very strange questions. And I am not used to answering these kinds of questions. (Translated and edited from W-Ling-1-A-1)

Contrary to the belief that Southeast Asian refugees are a burden to Canadian society and that they are not interested in giving something back to Canada, the result of the Refugee Resettlement Project conducted by Beiser and Johnson (1999) showed that these refugees felt good pay, steady work, and being useful to Canada were important sources of job satisfaction. Some of the women in this study have participated in many voluntary works. To them, helping others has not only increased their sense of citizenship, a form of contributing to the host society, but it is also a way of showing they value their independence. Independence, viewed in their social context, is to break free from being dependent on the mercy of others, from always being on the receiving end of a helping relationship. Mrs. Chi is 56 years old. She and her husband have been living in Canada for 20 years. Remembering very clearly how kindly Canada treated her family when she first came, she now works as a volunteer to return the favour. Mrs. Chi participates in many activities while her husband also works as a volunteer for the Lac-Viet radio that broadcasts news in Vietnamese.

Mrs. Chi: I work as a volunteer at the hospital. I feed the patients. I sell the lotto for them. The money is used to help low income seniors. I also volunteer as the receptionist at the neighbourhood house. I work as volunteer a lot. I also work as volunteer at the library. I organize books. Saturday and Sunday, on my days off, I work as volunteer. I participate in social work. I try to help as much as I can. In the hospital, the nurses have to feed many patients. For many elderly, the food doesn't go down easily ... I help feeding these people... You see, when we first came here, they helped us. Now, we are not rich, but we have enough. Our children have grown up and successful. I have time now, so I try to help as much as I can. So I am out all the time [chuckle] I am rarely home.... I am happy when I help people. I can't just sit. If I do that, I feel useless. So if I cannot work at the difficult things, I can try to help as much as I can. I am happier and I feel useful when I can help. (Translated and edited from W-Chi-4-A-1)

After 10 years of living in Canada, Mrs. Ling is very motivated to help other Vietnamese whom she feels are less fortunate than she is. Seeing adequate command of English as a way of helping others, at the age of 50, Mrs. Ling is taking whatever English classes provided to her free of charge.

I try to learn because in my head I am always reminded of the difficulty that many Vietnamese people are facing here.... Now I have enough. I have enough to eat. My life is okay. But if I want to help people, I had to have the language. To live here we had to have the knowledge. But I do not have the support so that I can go back to school. So I just study on my own a lot. Self-learning is good for certain things, but English, I do not think that I could learn by myself. For example, when I listen to TV, I knew that I was wrong with certain words so I try to fix it myself. I would look at the dictionary and try to fix it myself but many times it was still not correct. I need someone to help me. (Translated and edited from W-Ling-1-A-1)

For many Vietnamese, inability to speak the host country's language leads to an inability to voice one's concern regarding exploitation at the work place and inability to get help.

> Mrs. Ling: Here, many people can not speak the truth because they can't speak the language. For example, at work, they are afraid to say that they are being exploited (boc lot) because they are afraid to lose their jobs. They don't know any community resources, any offices that could protect them. If they want to contact offices that could help them, they would have to be able to speak English. (Translated and edited from W-Ling-1-A-1)

Some Vietnamese, because of their limitation in language skills have to endure not only less than desirable working condition, but also the inequity of treatment in the work place.

> Mrs. Ling: In many situations, they would just ignore it (an phan thoi). People who have the ability (phuong tien) might get mad and quit their job.
>
> Researcher: I see, can they talk to anyone?
>
> Mrs. Ling: They can't talk to anybody. What would you say? If you want to talk or to complain to someone, you have to be able to speak the language. If you cannot speak the language, how can you talk to them? What would you say? You might only say, "You are not fair with me." They, in turn, talk back to you a whole bunch, and you don't even understand what they are talking about. There are Vietnamese who told me that they could only say "I upset." When being asked "Why are you upset?", these Vietnamese could not explain why they are upset. So you see, it's no way out (ket lam). That is the story of the Vietnamese. (Translated and edited from W-Ling-1-A-1)

In her opinion, although the conditions are better now, lack of proficiency in English or French leads to an inability to advocate for others.

> Mrs. Ling: I have a lot of ideas which I have discussed with you. But I don't have enough language so I could not say it. I was able to talk about that in the school because I think that the people there were about my level or below my level. If I go to places that have all those MLAs, tell me to speak, I would not dare to speak. You see. In a meeting that has only Canadians who speak English fluently and professors at the university, even if they are Vietnamese, and people like yourself, for example, of course I would be too scared to speak. I would be too hesitant, too ashamed. I would not dare to speak. (Translated and edited from W-Ling-1-A-1)

These experiences echo what a Vietnamese elder who lives in the United State described:

> English is a sign of knowledge. They [the Vietnamese] have no English. Employment is a sign of independence. They have no job. In the eyes of their children, their image is diminished. Your children look at you in a different way; your wife. Society here is very materialistic. Here children respect money. They do not respect their father. We are old already. We look at those who came in 1975 and so many are successful. But those who stayed and paid the full price of staying, we feel we have lost twice. We were cast aside by the new society in Vietnam and we have no place in the new Vietnamese society in America. (Robinson, 1998, p. 197)

In regard to the issue of over-used and abused health care services, the study by Beiser and Johnson (1999) revealed that frequency in visiting doctors for most of the Southeast Asian refugees is the same as the national average, about two to three times per year. Similarly, the majority of women in this study said that they only go to the doctor when it is absolutely necessary, some only visiting their doctors once or twice a year.

It is clear that public ideology and discourse of immigrant-related issues – whether it is within the Vietnamese community or in the larger host society – affect these immigrants' lives. Media organisations

such as the press, publishing companies, television, and the film industry are important dimensions of the social, political, and economic organisation. Not only do these organisations represent and reflect a society's dominant ideologies which then become a standard against which forms of social relations and behaviour are interpreted and judged (Williams, 1981), but it has often been used to manipulate the public's attitude. As such the media portrayals of Vietnamese that focus on the bad rather than the good has initiated a growing negative attitude towards the Vietnamese. It has done much damage to the Vietnamese's reputation as hard workers and loyal citizens, contributed to the re/construction of their social position as the subordinated Others, thus, making the adaptation and integration process into mainstream society even more difficult for them.

2. Within Ethnic Group Discrimination Experiences

Vietnam's history and political climate have shaped its people's attitude towards each other in a negative ways. It has been pointed out that division between the Vietnamese northerners and southerners creates many stereotypical assumptions. There is a general assumption that the northerners are hard workers, have more discipline, are more careful of their money, and more studious than the southerners. They have more tightly knit family units and relationships, and are more aware of their position and duty within society. They are also inclined to community action, and tend to submit to authority (FitzGerald, 1972). The southerners would criticise the northerners as "miserly...they consider money as a big wheel. They are cowards like land crabs... they are servile flatterers, always nodding to show their submission and never conceiving any idea of fighting for their rights" (FitzGerald, 1972, p. 48). Meanwhile, the northerners would consider the southerners as people who "never [are] satisfied with anything... fighting among themselves all the time... only know how to have fun [and] their fighting standpoint is weak" (FitzGerald, 1972, p. 48). Whether it is different personal characteristics and/or political aims that separate the northerner and the southerner, the present study found that conflict and uneasiness do exist between participants and that there is an obvious division between Vietnamese immigrants who came from the North and those who came from the South.

Differences exist within the Vietnamese community. The complexity of the social and political nature of Vietnam has created many issues within the community and its people. Differences between individuals who belong to different socio-political groups have created certain stereotypical assumptions. Differences in past experiences in economic situations and political climate have also shaped Vietnamese

immigrants' political attitude towards each other. It is not only that historically, under the influence of Confucianism, Vietnamese society was a very hierarchical society, but also more than three decades of war between North and South have produced many ideologies and discourses that have divided its people. Division and discrimination between some Vietnamese living in Canada has often reflected the fight between capitalism and communism, and the division between classes within a society.

The majority of Vietnamese refugees who came to Canada between 1978 and 1980 were from South Vietnam. Most of them were from middle-class families who either owned their own businesses or worked for the South Vietnamese government and/or military. Due to their affiliation with America, they were exposed to Western ideas to a certain degree. The downfall of Thieu's regime which led to the fleeing of thousands of people as political refugees created much bitterness towards communism among this group of refugees (Freeman, 1989). Vietnamese magazines from the West often published stories that criticised communism and aimed to expose the social and political issues of Vietnam. There were autobiographical books published that told the stories of South Vietnamese personnel after the North Vietnamese military took over the South, of how people were forced to enter the "re-education" or "hard labour" camps. Highlighted among them is *The will of heaven: A story of one Vietnamese and the end of his world* by Nguyen Ngoc Ngan (1982).

Vietnamese living in both Canada and the United States are very anti communist. Because there are Vietnamese refugees who came from communist North Vietnam, distrust exists within the Vietnamese community. Not only does this distrust divide the community into two different groups – that of the South and that of the North – but it has also created other emotional and readjustment problems. As narrated by one of the elderly who came from the North of Vietnam,

> because I came from the North, people believe I sympathise with the communists. This makes it difficult to live, and now I'm very cautious. I'm old now; I don't want to have trouble, just want to live in peace...I don't want to do anything to affect my life. I just want to live a few more years. (Freeman's (1989), *Heart of Sorrow: Vietnamese-American lives*, p. 413)

This division has also been expressed as a very sensitive topic among the Vietnamese living in British Columbia, Canada – disunity and distrust have not only cut to the heart of Vietnam, but has also managed to find its place in Canadian soil. As expressed by one Vietnamese who came from South Vietnam, "there are two distinct groups...We don't think in terms of boat people and economic immigrants; the split is North and South." Controversial overtones and stereotypical assumptions took place: "It's easy to tell who's making most of the trouble here. There's no question about that.

Unfortunately they give the rest of us a bad name....In Vietnam a prejudice has always existed that people from the North are more corrupt" (Hulsman, 1998).

There is a stereotypical assumption among several participants that North Vietnamese are often involved with drug dealing. A woman was very careful when she talked about this problem within the Vietnamese community. She feels even the police are aware of this phenomenon, to the point that when they meet someone they will ask what part of Vietnam he or she came from – North or South. The reason why so many North Vietnamese are involved with drug dealing, as she puts it:

> I think that the children are the victims because their parents came from North Vietnam. Their parents are about my age. If Ho Chi Minh came to South Vietnam, I would then have to live under the communist control, I would suffer. But because he came to the North Vietnam, the people of North Vietnam had to suffer. Because the people from North Vietnam used to live under a very poor condition, when they came here, they only think about making money. Making money is their priority. They don't care about anything else. Their lives, they threw it away. They just want to make a lot of money so that they could send it back to their families in Vietnam. Their children, they did not pay attention, so these children grow up follow what their parents did. It is a pity. Those people, at first, my thinking about them was different, but now, I feel sorry for them.

Not only does this woman feel sorry for these children, but also she is sad and ashamed of their action. In her struggle to make sense of the situation she redirects her explanation and attributes its cause to the individual's past experience. What is interesting, though, is that she was able to move beyond blaming the individual to blaming the system (in this case, the communist system) for shaping the individual's actions. Thus changed her hostile feelings to feelings of being sorry for the youth.

There are women who, despite differences, want to help other Vietnamese. However, they found that limitation of language skills is a barrier for giving support to others.

> Mrs. Ling: Yes, I calculate very carefully about finances, and about health. That is why I go to classes. If there is an opportunity for me to learn, I would try to learn as much as I can. Right now, I still go to school. I go to free classes. These language classes are provided through the community. It doesn't cost any money.... It is for improving my English. What ever is good for me, I try to learn. I am doing this because in my head, I am always reminded of the difficulty that many Vietnamese people are facing here. I want to help but I cannot. My daughter, she can help but she could not work for free. Me, I can work for free but I don't have the [language] ability to do so. (Translated and edited from W-Ling-1-A-1)

Caring for others is not limited to just relative and family members. It is extended to include those who are less fortunate, those who suffer historical and political sentences. This is the voice of a 73-year-old woman who, up until 11 years ago lived a difficult life.

> Mrs. Mai: I don't mean to speak ill of our country. It is still a place where I was born and raised. Because our country is poor, we suffer. Other people who have fortunate destiny (cai so cua nguoi ta may man), live in a rich country. Because our destiny is such, we have to endure difficulty. Other people are blessed so they live in a country like this. So we should not complain too much. *Ong troi* (Buddha) intended it that way. I am very lucky now that I am here. But I feel (thuong) for the Vietnamese. I am sad and feel for the Vietnamese who are suffering poverty, who

> don't have enough food to eat. I have lots of sympathy for them. It is not that now I am here I forget everything. I still remember and I still feel for my people, not just my children or my sisters and brothers, but my neighbours and everyone else. When we have good fortune, we should remember others who are suffering. We should remember the poor. (Translated and edited from W-Mai-9-A-1)

It has been recognised that health care providers' attitude toward clients, if negative, can create barriers for the client to seek help (Anderson, 1985; Dyck & Kearns, 1995; Papps & Ramsden, 1996). Because the majority of Vietnamese physicians came from South Vietnam, social ideologies and discourses about North Vietnamese people who had lived under communist regime might have an influence on what they think about and how they care for their North Vietnamese clients. There is a popular belief among the Vietnamese physicians that people who lived under communism for 50 years have limited knowledge about health and health care. Not only that, they care more about making money than their health.

> Dr. Thinh: People who lived under communism are behind civilisation. And that is what has affected those people. They would only pay attention to something that is of benefit to them. They don't pay attention to their health. They don't go to the doctor for check up. So I think that those people's health is affected by that.
>
> Researcher: What make you think they are that way?
>
> Dr. Thinh: It is because these people were brainwashed by the communists for 50 years. They don't know anything else. They don't understand anything else. They would only come if they see that there is something for them. Just as if they lived under the communist regime....They struggle to live. In North Vietnam, people had to fight with each other to survive. So they are used to that kind of living. (Translated and edited from H-Thinh-16-C-1)

Although quite frank about how he feels toward communists, Dr. Thinh insists that his personal feelings do not interfere with how he provides health care to clients. To him, recognising the effect of communism would help physicians understand how people live their lives and take care of their health. Admitting that discrimination exists, however, he naturalises discrimination as some thing that is innate to human beings. A doctor, just like everyone else might not be able to avoid certain discriminatory feelings towards patients. However, to provide good health care, doctors need to act according to their professional ethical and moral obligations.

> Dr. Thinh: Naturally, discrimination is in our head and our heart....The tendency to discriminate is in you since you were born. You are born with it. It is a human instinct. That is why a doctor might not be able to avoid discrimination toward a patient. We are born with it...That is why as doctors we have to rely upon our responsibility, ethical, and moral conduct to treat everyone fairly.... We have to acknowledge that we have those feelings but as doctors we cannot just say "Oh I like this person, therefore I would only treat this person." We cannot do that. Our conscientious does not allow us to act that way.... But discrimination exists. I guaranty that 100 persons, 100 persons would have that feeling. The thing is that they don't want to talk about it. (Translated and edited from H-Thinh-16-C-1)

Similarly, Dr. Dau said:

> It is difficult to define what is discrimination. Either we discriminate a lot or little, everyone of us has some kind of discrimination. For example, even in the family, pardon me but do you have a family?
>
> Researcher: Yes, I have three children.
>
> Dr. Dau: Do you treat all three children equally? I think that there might be some discrimination... So you see. Sometime it is not our intention to do that. But we do discriminate. Actually, to call it "discrimination" is not correct. It is the different ways in which we treat people. So, for example, a Vietnamese come to the office. The person's language and knowledge are both limited. Other doctors, they don't have the time to sit and explain everything. Even if they want to explain, they just couldn't. So the doctor would just write whether or not this person has agreed to do this or that in the file. If a person don't want to do certain things, it is that person's right. There are many things. But that is also a kind of discrimination.... Doctors who are conscientious would take time to listen, but some would not. (Translated and edited from W-Dau-13-C-1)

Here, naturalisation of discrimination has, in effect, legitimised feelings toward others who are different from oneself. Because discrimination is seen as something that is unavoidable, one is able to get on with daily activities without feeling bad about oneself. It is also important to note that health care providers often rely on professionalism and ethical and moral codes of conduct as guidelines and principles upon which to act.

D. Conclusion

This chapter explored the impact of social support on Vietnamese women's health care practice. Both formal and informal social support networks influence and shape the ways in which women access and receive health care. In looking at the women's formal social support experiences, it seems that the amount of support that women receive is also influenced by their age. The majority of older women participants in this study have a positive view on the general social support that is given to them by the government of Canada. Coming from the country where there is almost no formal social support system, older Vietnamese women have been very appreciative of the support that is given to them by the governments of Canada. From their perspective, older people like themselves who cannot work, do not contribute much to the society. Thus, to have a life that is free of worry about where the money for food will come from for next month is, to some of them, a blessing.

Whereas, younger women who are participating in the labour market found that they have received little support with language and occupational training, which in turn limited their employment opportunities and mobility in the work force. Lacking proficiency in the host country's language,

occupational skills, and limited financial support from institutions confine these women to the lower echelon of the labour force. Several women participants in the study found that difficult working conditions; diminished support from family members, friends and neighbours, and difficulty in communicating are barriers for them to form a solid informal social support network.

It is important to note that the general assumption that Vietnamese's informal social support networks are adequate due to the nature of their culture, is not always accurate. Women in this study found that support from family members and friends are not readily available when needed. Diminished informal social support, however, is not due to the lack of willingness to help by others, but it is often related to occupational and economic demands.

Because family is not only a source of social and emotional support, but also economic support to the Vietnamese, there is an overwhelming wish for unification with the family members among the Vietnamese immigrants (Beiser, 1999; Chan & Indra, 1987). Older women participants who live with their children's family, who have more family members living nearby, and who belong to religious groups often get more support. It has been found that immigrants who are married and who live with their family have better mental health than single immigrants (Beiser, 1999). Furthermore, the presence of the family, and the support of both the ethnic community and the host society, have been shown to influence directly and indirectly immigrants' health status. Thus, to facilitate women's well-being, successful adaptation, and health care practices, support for immigrants should also be given to their family and their ethnic community.

Limited funding for the distribution of health care information and social resources to the Vietnamese has been identified as the most significant barrier for women to access the available health care services by the majority of health care provider participants. Several health care providers felt that in order to provide adequate health care to Vietnamese women, more funding is needed.

Social discrimination affects women's well being and the ways in which they practice health care. It is also a significant barrier for women to seek support from both formal and informal sources, which will influence women's accessibility to health care services. Several women participants have experienced both cross-ethnic and within-ethnic group discrimination when entering the social support system and the workforce. Vietnam's past political climate, the division between North and South, and the fight between capitalism and communism, have created certain assumptions between some Vietnamese physicians and the women. Although some of these physicians acknowledged that they have assumptions, the

extent to which these assumptions affect how women receive health care is difficult to assess. It is also important to note that the physicians interviewed expressed the opinion that their personal professional code of conduct was their guide in how they treated their patients, whether these patients were from North or South Vietnam.

The women participants have frequently expressed their interest in contributing to Canadian society. Several women talked about their desire to not "take advantage" of taxpayers. This shows that contrary to some stereotypical opinions, Vietnamese immigrants are very willing to work hard and to make contributions to the society in which they live. They desire to be contributing citizens of their new countries. Older women like Mrs. Chi and Ms. Ling work as volunteers in many activities in order to contribute. Women such as Mrs. Thanh and Mrs. Hai are working hard to be financially independent. These women are proud to be able to make it on their own instead of being dependent upon social assistance. Thus, as Beiser (1999) states, the host society should concentrate on alleviating stresses that are experienced by the immigrants due to unemployment, underemployment, and social discrimination.

Chapter Eight: Socioeconomic Influence

Socio-economic status affects how one lives and practices health care. Factors such as occupation and socio-economic status affect health, quality of life, and access to health care services. Evidence shows that people with better incomes and higher socio-economic status are healthier and have lower mortality rates than people with lower incomes and lower socio-economic status (BC Provincial Health Officer's Annual Report, 1996; BC Ministry of Health, 1997). Although many Vietnamese immigrants have achieved economic success, many of them are still located within the lower socio-economic groups. A significant number of unskilled immigrant women are either forced into low paying, unskilled jobs, with little or no opportunity for advancement in the workforce (Anderson, 1998; Anderson et al., 1993; Ng, 1988), or are unemployed. They experience difficulty achieving optimum health and accessing health care services. Under the Canadian Medicare system, an inability to pay does not prevent immigrants from accessing health care services. However, an immigrant who lives below the Statistics Canada Low-income Cut-off line or who works two, sometimes three jobs to make enough money to live will experience low income and poverty as indirect barriers to health care practice. In this chapter, I explore the ways in which low socioeconomic status affect Vietnamese women's life, impact their health care practices, breast cancer and cervical cancer screenings. In the first part of this chapter, I discuss the economic profiles of the Vietnamese women participants. In the second part, I reveal the perspectives of the women participants and of their health care providers. Finally, I discuss the influences of socioeconomic status on Vietnamese women's health and health care behaviour.

A. The Vietnamese Women's Economic Profiles

The age of the 15 Vietnamese women I interviewed ranged from 46 to 78 with the average age being 58. All of these women have been living in Canada for quite a number of years, the shortest length being 9 years and the longest being 26 years. The average number of years of residence in Canada for the women participants in this study is 22.7 years. Fifty percent of women participants reported having family income below $20,000 per year – $20,000 being the lowest category given by the researcher. Six of these women are either widowed or divorced and their reported English skills ranged from none to little.

Twenty percent of women participants reported an income between $30,000 to $39,000, and another 20% reported an income between $40,000 to $49,000. Only one woman (0.6%) said her family income is between $70,000 to $79,000. Of all the women participants, only four women (26%) said they worked fulltime, other participants reported their occupation as housewife. Of the four women who are working fulltime, only one holds a professional job with the other three women working as a waitress, a sewing factory worker, and a store customer services employee. Most of the women who identified themselves as housewives often work as baby-sitters or by selling Vietnamese sweets and sausages to supplement their Old Age Pension income and welfare payments. (See Appendix D, p. 231 for women participants' socio-demographic data)

B. Women Participants' and Health Care Providers' Perspectives

Despite economic difficulty as the consequence of fixed income and low paying jobs, some women participants, although admitted that their life is hard in Canada, maintained that compared to life back in Vietnam, "Canada is a haven." Some women participants are very glad to be living in a Western society that gives them a level of material comfort they did not have in Vietnam. When asked about what people in Canada did for them that they most remembered and appreciated since living in Canada, several women talked about how well they were treated when they first set foot in this land. For example,

> Mrs. Ling: What I always remember about this nation for the past more than 20 years was that in general, Canada is like a haven because of so many systems and favours that it gives to its citizens. But then later on, they (the government) lost its popularity because people abused the system. Because some people abused the system, others who saw that and did not agree, they then protest it. So the government has to reduce its support for the people. For example, now if you go to welfare, it is not easy. They would ask you this question, that question. They ask for many papers. It's not like 20 years ago. You just go there and they would give it to you. Right away, they gave you the money for food for that day. So because of the support the government gives to people, I really like Canada. (Translated and edited from W-Ling-1-A-1)

Vietnamese women who cannot enter the labour force because of their limited English language skills, unmarketable training, and family commitments are forced to enter the social welfare support system. The discourse which criticises these women as individuals who take advantage of the system further creates feelings of being alienated and marginalised, which might reinforce their helplessness and passive behaviour towards health care. Health care providers who have worked closely with these women and have seen how they live within their social context have developed an understanding of their

circumstances. Mrs. May's narrative about what she sees in her care for the Vietnamese women reveals that some health care providers have been struggling to understand the reason why some women collect social assistance and question the ethics of this practice.

> Mrs. May: I try to understand where they are coming from ... I think that because they come from a place of war and to be able to get, whatever they can to survive. It's something I am trying to understand ... you feel angry and frustrated ... you feel like, you know, you pay taxes and you. Quite often you go into some homes and they have these incredible entertainment like huge TV with screen and stereo system, and these things. You see, and you can made judgment and think. Well that's where you spend your money. But at the same time, I try to step back and to try to understand where these people are coming from. What their experience has been. I don't think they are bad people ... I also think that maybe people who are on social assistance, they don't do the type of thing that I do for entertainment, like go to movies, go for nice dinners, go away for the weekend, those short of things ... This is their entertainment, their source of entertainment, their source of enjoyment. And so what, what is wrong with that then?... but anyway, it does make you sort of think. (Edited from H-May-18-C-1)

Narratives of the women participants also revealed their conflicted feelings about their new home. Although several women were very glad to be in Canada and had expressed their gratitude to Canadians, they also said that living in Canada is not easy. Mrs. Phan came to Canada in 1990 with her husband and two children. With hard working and persistent saving, they now own their own home. There are two things about Canada that she will always remember.

> Number one is that the Canadian government helped us to come here. They let us study English. And they had also helped us with housing. We lived in the co-op housing for several years. Yes, we will always remember those things that were done for our family.
> (Translated and edited from W-Phan-11-A-1)

Grateful to be living in Canada – a much richer country than Vietnam and acknowledging that as its citizen, she is given the high standard of living and the human rights she enjoys, Mrs. Phan remains skeptical in commenting whether or not her life in Canada is better than when she was back in Vietnam.

> Researcher: In your opinion, is life in Canada better than in Vietnam?
>
> Mrs. Phan: It is difficult to answer. Of course, the living standard and the economic condition here is much better than in Vietnam. You work hard but you can make more money and you can live a better life. Back in Vietnam, we did not work as hard but we did not have anything either. Here you work very hard but in return you can have many things. In Vietnam you work little and you have nothing. So you see, it is difficult to compare. Now all I know is that I am here. In this society, we have more human rights. In talking about human rights, although I do not want to talk bad about our country, I must admit that here we are given more human rights than in Vietnam.
> (Translated and edited from W-Phan-11-A-1)

Women like Mrs. Phan who are younger and able to participate in the labour market, after a few years of living in Canada, may find they enjoy a relatively high standard of living. However, a significant number of older Vietnamese women who are dependent on government support, live on fixed incomes that are below Statistics Canada Low-income Cut-offs. Although some women participants reported their

income as below $20,000 (which is the lowest socio-demographic income level asked in the questionnaire), the actual income of some women is between $8,000 to $10,000 per year. These women found that even though they have everything that they need such as sufficient food and clothing, still they have to budget carefully due to low income level.

Mrs Mai is 73 years old. She came to Canada with her husband in 1992. She and her husband live in a basement apartment in the East Side of Vancouver where rent is cheaper than other parts of the city. Although both Mr. and Mrs. Mai are over 70, they do not qualify for Old Age Pension income supplement because they have not been living in Canada long enough to qualify for such assistance, instead, they are on Social Assistance. Still haunted with many pre-migration memories of a difficult life and the experience of coping with illness, she said:

> Mrs. Mai: It was so difficult. Back then, my life was so difficult. I did not make much money working as a blue color worker. Furthermore, as you know, living under communism we had nothing. We were lucky if we had enough food to eat. I worked hard to keep myself healthy waiting for the day that I could come here. Now that I am here, good or bad, haven is this place. I am being treated as a Canadian. I am grateful to my children. They sponsored me here so that I now could live like this. Just eating and sitting around. If I were back in Vietnam, I would not be this healthy, especially me – a person over 70 years old with a surgery like that. (Translated and edited from W-Mai-9-A-1)

As grateful and as glad as she is to be living in Canada, Mrs. Mai and her husband live on a restricted income and have to watch their spending very carefully. Even with something as necessary as her hearing aid is rationed. Mrs. Mai would only use it on special occasions because the battery, although only costing a few dollars, is still expensive to her.

> Mrs. Mai: [The batteries] are very expensive, 7, 8 dollars.... I try to save it by not using it too much. I wait until I get there [the temple]. I would only turn it on when the ceremony begins and turn it off when the ceremony finishes. (Translated and edited from W-Mai-9-A-1)

Although 73 years old and suffering from the pain of arthritis in her legs and arms, up until a couple of years ago Mrs. Mai baby-sat several children to generate some extra income. When she was not looking after other children, she looked after her grandchildren so her daughter could go to work. For Mrs. Mai to go to the doctor, she has to plan around her schedule and her daughter's schedule as well because her daughter can only take her to see the doctor on her day off from work. Thus, health care practice for the Vietnamese elderly is related to both the individual and the family members. Going to the doctor for a checkup is not just an individual's appointment, but other family members' event as well. Therefore, for older Vietnamese women, health care practice involves not only an individual's financial condition, but also their children's family's economic status as well. Life circumstances influence how

elderly Vietnamese women participate in breast and cervical cancer screening programs. As observed by one health care provider:

> Mrs. McDonald: When we talk about the cultural barriers, it is a huge issue as you get into the senior population. All those feelings that if there is no sign of illness there is no need to do anything about it and the concern about who is going to examine my body... Also often the seniors are doing child care so that both parents can be working. So there is the whole economic aspect of that senior being in the home. It's very costly to the family to take grandma off to get screening when she seems to be just fine. If mom or dad would have to stay home from work, and there is no one to look after the kids. So I think those are the big barriers.
>
> ... My guess is that if the socioeconomic situation is better for the family and the status of living is higher then there is not as many constraints on that family, more educational level and more awareness of prevention in health care. All of that would enable that senior to get care more than if both adult children are working 7 days a week at a low paying job and grandma is providing the care of the children at home. Two parents who are working 7 days a week, the last thing they would think about is the preventative care for the senior while they are trying to survive. So that has a huge impact. (Edited from H-McDonald-20-C-1)

C. Socioeconomic Status Influences on Health and Health Care Behaviour

Socio-economic status affects health and quality of life. Evidence shows that "there are successive increases in health status from lower to higher socioeconomic levels in society. This effect has been found in all wealthy societies, and it is found regardless of whether income, education, occupation or a combination of these measures is used to define socioeconomic status" (Hertzman, 2001, p. 542). Vietnamese women's participation in breast cancer and cervical cancer screening is influenced by their socioeconomic condition, occupation, and income. "Data clearly indicate that people's health and well-being suffer the most when they are unable to secure appropriate employment and can no longer access adequate 'social safety nets' and supportive services" (Gottschalk & Baker, 2000, p. 7). More importantly, "income inequality appears to affect health by undermining civil society, eroding social cohesion and political participation" (Hertzman, 2001, p. 542).

As indicated in chapter two – my review of the literature, in Canada, the ability to find employment in the occupation for which the immigrants have been trained and the proficiency of either English or French are two important factors leading to successful economic adaptation. Many Vietnamese immigrants have problems with both of these elements (Samuel, 1987). Downward occupational mobility is common among the Vietnamese (Beiser, 1999; Chan & Indra, 1987; Gold, 1992; Johnson, 1988, Kibria, 1993; Samuel, 1987) and regardless of the immigrants' educational background and previous occupations held in Vietnam, the majority of respondents were employed in lower echelon jobs at a

minimum wage (Chan & Indra, 1987). Many of them were often employed as garment factory workers, janitors, dishwashers, and factory labourers (Chan & Indra, 1987; Johnson, 1988).

Mrs. Hai was a teacher back in Vietnam. However, she could not practice her profession in Canada. Arriving in Canada as a refugee, she went through only five months of English training. Then, like many other Vietnamese refugees, Mrs. Hai had to find work. Part of the Canadian Immigration Policy was that refugees and immigrants who came to Canada were entitled to five months training of English. After this time, they were encouraged to find jobs because financially independent immigrants mean less pressure on government's or sponsor agencies to provide financial support. Thus, Mrs. Hai's decision to find work after just few months of language training was due to her desire: (a) to take care of the children; (b) to make enough money to sponsor her family to Canada; and (c) to comply with the government's interest of having new immigrants entering the work force as soon as possible. The problem with this policy is that immigrants who were able to find jobs at that early stage would not have the opportunity to develop their English/French skills to the level which would enable them to enter professional training/jobs. This policy, coupled with the anticipation that families back in Vietnam are waiting for assistance made many Vietnamese immigrants eager to enter the workforce as soon as they could. Sadly, Mrs. Hai reflected on her situation.

> When I first came here. The government sponsored us. We were refugees. They let us study English for 5 months. Then my friend, a classmate found us a job washing dishes at the restaurant and help in the kitchen at night. So we worked to get money to send back to our family. Whatever I made, I sent back to my family. I made few hundred dollars, I sent few hundred dollars back. Since then, I have kept on working. I didn't investigate anything, any other benefits... If I have a better job, if I have time to study, or train on different skills, then I would be better off. But I just keep on working the same job. (Translated and edited from W-Hai-3-A-1)

Even though by 1991, the majority of Vietnamese immigrants could speak at least one official language, with 85% conducting a conversation in either English and/or French (Government of Canada, Statistics Canada, 1996), their language proficiency was not necessarily adequate for them to enter professional training and better paying jobs. Thus, limited proficiency in one of Canada's official languages is a barrier affecting the Indochinese immigrants' employment opportunities (Samuel, 1987). Furthermore, English insufficiency has also resulted in lower paying wages, long hours of work, and no opportunity for advancement (Johnson, 1988).

The short time for language training did not give women like Mrs. Hai the English proficiency level to find jobs that might give her the opportunity for mobility in the work force. After a few months of working

as a dishwasher at the restaurant, she started working at a department store, and there she remained for 20 years. This is what she said:

> Mrs. Hai: When I first came here, I worked for a restaurant for 4 or 6 months. But then I didn't like working at night, so I went and applied for this job. They gave me the job and I work at the same job until now. So it is about 20 years.
>
> Researcher: Do you like your job?
>
> Mrs. Hai: With this work, I don't like it, but I don't hate it either. So I just keep on working. I didn't look around. I just keep on working. Now, I work at the Customer Service Counter. I don't like the job. Hate, well sometime it makes me angry.... The salary that they pay me is very low. Also many customers are very rude. That area has a lot of criminals, thefts, and drug addicts.... I work there for 20 years, yet my salary is only a bit higher than the new worker. (Translated and edited from W-Hai-3-A-1)

Despite low salary and worse than unfavourable working conditions, Mrs. Hai remains working at the same place. One of her reasons for doing so is:

> Mrs. Hai: One time, I was trained to work at the bank. Well, I should of work at that earlier. But when I came here, my English was a barrier. My English was limited. Back then we had to sponsor our family. So we had to work to make money. We had to take care of our children and sponsor our family. So I had to withstand all the difficulty to be able to work. But when I feel that I need to find another job, it's too late. I went to the bank. Before, it was quite easy [to get full-time job]. But when I came, I can only work part-time or part-time on call. And I need a full-time job. I don't want just to work part-time here and there and staying home waiting for phone call. To work at some kind of professional job, I don't have the ability. I have never learned professional trade. So I have to cope with it (phai chui thoi). Now, I am too old. Where would I go. Anywhere I go, it would only be part-time job. I don't want to work part-time or call today, but not the next day, or get laid off at any time. (Translated and edited from W-Hai-3-A-1)

As previously discussed, economic independence brings self-respect and autonomy. As such, in the beginning many Vietnamese would take English classes or other training courses during the day and work as cleaners or dishwashers at night. It is not unusual to see a Vietnamese immigrant working two, even three jobs at one time. However, working too much has also interfered with their language training. Ms. Thanh came to Canada when she was 45 years old. She started to work from the beginning, first at a pizza place, then at various restaurants including one she co-owned with friends. Now, at the age of 71, she still finds her limited language skills a barrier to many of her daily functions and health care practices.

> Ms. Thanh: Because I did not learn any English, it is very difficult for me... When I first came here, I went to work right away. I did not ask the government for help. I did not ask for any English training. I just work right away. But that is only one thing. Another thing is that no one told me or showed me what to do. Back then there were not many Vietnamese around to help... I did not know what to do because no one told me. I just worked day and night for many years instead of studying English. I worked until I fell and broke my arm. (Translated and edited from W-Thanh-15-B-1)

Low socioeconomic status has negatively affected some Vietnamese women's quality of life, but for many others, it is also a source of motivation. Coming from a living condition that was filled with

difficulty – arriving empty handed but with plenty of determination, the majority of Vietnamese were filled with the anticipation that with hard work and thrift, they would be able to rebuild their lives and to establish a good life not only for themselves and their family members who accompanied them, but also for those they left behind. Once landed on Canadian soil, many Vietnamese were eager to find work and to save money. Many have successfully achieved economic independence. Women like Mrs. Hai did not let hardship and difficulty destroy their dreams.

> Mrs. Hai: I think that made you more determined. If we have difficulty, we would try harder. We will go up as the result. But if you keep being dependent upon others, not trying to be independent, but waiting for others to help you, then your life will not go up.... We work so much and so hard. In general, yes, we have come a long way. From not knowing any English. At the beginning, they asked, "are you married?" I didn't even understand what they said. (Translated and edited from W-Hai-3-A-1)

1. Low Socioeconomic Status and Health

Low socioeconomic status affects health, and poverty causes health-related problems. In general, the more wealthy and affluent the individual, the healthier they are (Evans, Barer, & Marmor, 1994; Shah, 1998). Evidence shows that people with better incomes and higher socio-economic status are healthier and have lower mortality rates than people with less incomes and lower socio-economic status (BC Provincial Health Officer's Annual Report, 1996; BC Ministry of Health, 1997). Low socioeconomic status results not only in disparity in health but also poor housing, which in turn, affects health and quality of life.

Mrs. May is a community health nurse. Many of her clients are immigrant women. From her experience, low socioeconomic status leading to poor housing affect women and children's health.

> Mrs. May: I think, socioeconomic issues, not having enough money.... some of the women are living in basement suites that are damp and moist. And concern about allergy related to that for themselves and their children. I think probably accessing affordable housing is an issue, not just with the Vietnamese population but with other immigrant's families.... Because most of the women that I see in this area are on social assistance and many of them are single mothers. They are probably having difficulty finding housing. When they are single mothers with three children or four children and on welfare, it's the question of the landlord and who would rent to them. So I think that is another issue. (Edited from H-May-18-C-1)

Dr. Dau had also encountered poverty-related issues in housing. According to him, many Vietnamese women would have a Pap smear done only once, some women might have it done once in 7 years, and some women go for Pap smears every year or every two years. One strategy, which he thinks might increase women's participation in cancer preventive screening, is that physicians can use telephone calls to remind women that it is time for their test. However, the obstacle he encounters in his practice is that it is not easy to contact some Vietnamese women. Because there are Vietnamese who do

not stay permanently in one place or have permanent telephone numbers and many move often in order to find a place with cheaper rent, it is difficult to reach them.

> Dr. Dau: Reminding them through telephone call is difficult because their telephone numbers change quite often. Housing for the Vietnamese people is different with that of Canadians. The Canadians, they live in one place, have permanent mailing address. For the Vietnamese, they sometime use others' telephones so the telephone numbers changed often, and so do their addresses... There are cases when this problem is quite severe. For example, there was a person who had TB and I could not get hold of that person. I could not find the person. I had to go to that person's friend's house to look and to ask how I could get in touch with that person. I had to drive to their house. There are times, to inform the person of the Pap smear's result, I would have to know who her friends are. Who came with her to the office. I have to remember all that. Sometime I don't remember the name of the friends, but there are times I would find out and I had to go to them asking for their help in contacting the patient. There was a case, where I had to phone Calgary because I just could not find any contact persons here. Then I had to phone other places asking for the address. These problems, a regular doctor would not understand. It is difficult, not at all simple. (Translated and edited from H-Dau-13-C-1)

Low socioeconomic status creates mental health problems, which affect women's ability to work and to be financially independent. It has been documented that Vietnamese immigrants have suffered from a number of emotional and psychological problems (Beiser, 1988, 1999; Berry & Blondel, 1982; Nelson, Bui, & Samet, 1997). Among them, depression has been identified as the most prevalent illness. As I have mentioned in chapter 2, literature review, it is estimated that 19% of Vietnamese living in Canada suffer from a depressive disorder (Beiser, 1999).

Many Vietnamese immigrants came to Canada with the hope that someday they would be able to sponsor their loved one. However, to be able to do so, they would have to achieve economic independence and meet the government criteria. As already pointed out, Vietnamese often work in lower wage jobs, thus, many have found that their dream of family reunion is delayed due to financial constraints. This is one of the causes for Vietnamese immigrants' high incidence of depression. Results from a study conducted in Canada by Berry and Blondel (1982) revealed that Vietnamese refugees exhibit high levels of psychological dysfunction.

It has been found that mental health problems were more prevalent among the refugees who had poor English skills, low financial status, a more traditional Vietnamese point of view, and a higher level of education (Starr & Roberts, 1978 cited in Berry & Blondel, 1982). Contrary to what one might expect, some refugees with a higher level of education had more problems with personal adjustment. This experience can be explained by the downward employment phenomenon, which is very prevalent among refugees. Although my study did not aim to investigate mental health problems with the participants, some psychological issues came up during several interviews. Several participants talked about how

limited English skills, coping with financial constraints, and underemployment affected their lives. It was apparent in this study that women who had higher levels of education and professional training pre-migration are experiencing more disappointment with their present employment status. For example, back in Vietnam, Mrs. Hai was a teacher, Mrs. Minh was a university professor, and Mrs. Ling was a lawyer. In Canada, these women could not utilise these skills for which they had trained. Thus, dissatisfaction with employment, the pressure of coping with life changes, and limited language proficiency might result in low self-esteem and high stress level. In a study by Berry and Blondel (1982), in which 72 Vietnamese persons living in Kingston, Ontario were interviewed, the Vietnamese refugees who have already settled in a Canadian city exhibited psychological dysfunction, were experiencing more stress and had substantially poorer mental health than Canadians in general.

Low socioeconomic status is an obstacle for Vietnamese women to seek certain health care services. Many women have also used Chinese and Vietnamese traditional medicine, and the fact that many of these treatment modalities are not covered by the Canadian publicly funded health insurance has made it very difficult for women to seek health care services that might improve their health status. Many elderly who are on fixed incomes have to pay for Chinese or Vietnamese medicine. Women who work in low paying jobs also found that they could not obtain other forms of health care such as acupuncture or other alternative medical treatments.

Mrs. Phan found that although acupuncture is the most effective treatment for her Sciatic nerve problem, this type of traditional medicine, which is viewed as alternative medicine, is not covered by the universal health care system. Working in a local restaurant with no extra health care coverage, she could not seek this type of treatment due to financial constraints.

> Mrs. Phan: Acupuncture works very well, but it is very expensive. One session costs $30 to $40. I would not dare to go for it.... That much of money, me, with my salary working in that type of job, how can I afford it... If you have the treatment, you need at least three times a week. People like myself, how would they be able to afford. The governments do not pay for that kind of treatment. (Translated and edited from W-Phan-11-A-1).

2. Low Socioeconomic Status and Health Care Behaviour

For some health care provider participants, health care should not only be concerned with the examination and the treatment of diseases, but also with how clients live their lives. Economic condition is just one of many factors.

> Dr. Dau: We have to look at everything that influences the people's lives. For example, their jobs, if they have enough food to eat, that is health. If they don't have to struggle a lot to survive, if their

> relatives are taken care of, all those things influence health. These things are even more important for the Vietnamese women.... If you can go around to see. I had an opportunity to observe. In a basement apartment, I saw 7 or 8 people sleeping on the floor... They cannot rent a whole house. A house, after 7 or 8 years on welfare, they cannot afford that. Sometime, even if they can afford a better place, they rather save the money for something else. (Translated and edited from H-Dau-13-C-1)

Obtaining health care costs money. Women who are working in the lower echelon of the labour force often get paid hourly wages. For these women, taking time off from work means they would loose money. Thus, for some Vietnamese women, going to the doctor for a checkup, in fact, does cost money. They may not have to pay from their own pocket but the cost of these services is manifested in terms of loosing time from work. Women who are not entering the "formal" workforce often work "informally" at home to make some extra money or to help out their own children. Some women also work as babysitters, looking after two or three children at home. Some make Vietnamese sweets to sell to the stores, while others sew at home for companies. For these women taking the time to go to the doctor is difficult and costly. Many would rather stay at home to work than to spend several hours waiting at the doctor's office. This makes low socioeconomic status a barrier to breast and cervical cancer screening. This is what one GP observes:

> There are people who know about it [prevention of diseases], but they too, forget about it. It is because they have to struggle with many difficulties in their lives. Especially, here, not many people are their own boss. Most of them work for other people. They are employees. They cannot just take time off from work any time. If they take one day off, they lose $100. One hundred dollars might not be important to you but that $100 is important to them. A Vietnamese person's monthly salary is $200, $300. They have to send $100 to their families. So you see, there are many other issues. (Translated and edited from H- Dau-13-C-1)

Women participants such as Ms. Ling share this view point.

> You see, the people have to have a place to live. If they raise the rent and you don't have the money to pay rent, then you have to move. If they are living in an apartment but the land lord told them that beginning next month the rent will be increased to $800, $100 more a month. If their budget is $700 a month for rent, where would they get an extra $100. So they try to work overtime. So you see, all that influences their health. They don't have time to think about health care. They don't think about prevention, only when they are very sick, then they pay attention to their health. (Translated and edited from W-Ling-1-A-1)

This view, however, is not shared by all of the health care providers. From Dr. Thinh's perspective, health care cost related to time constraints is not an important barrier because many Vietnamese women are unemployed.

> Dr. Thinh: That would only affect a very small number of women. The majority of women are not working. They are housewives. Also, women who are on social assistance, they have plenty of time. Women who are working then may be, but there are only about 20% of them working... Not many of my patients are working. Many of them are at home. Even if they work at something else, they have time to go to the doctor. So that is not a barrier. The main barrier is their limited knowledge. (Translated and edited from H-Thinh-16-C-1)

For some health care provider participants, the effect of an individual's socioeconomic status is seen mainly in its effects on an individual's knowledge about health and health care. Because educational level and knowledge about health and health care is seen as the most important indicator of whether or not an individual will participate in breast and cervical cancer screening, poverty is seen as mainly affecting the woman's behaviour.

> Dr. Thinh: If the people are poor, they are not as hygienic, so the cervical cancer incidence might be high. Because unhygienic condition and multiple partners cause cervical cancer, people who are not educated or who are poor are more likely to get the disease.... Poverty affects cervical cancer, but not with breast cancer.... In term of its screening, people who are poor are disadvantaged because they don't have the knowledge. (Translated and edited from H-Thinh-16-C-2)

Some health care providers do not think that low socioeconomic status and poverty have a direct influence on an individual woman's health care behaviour. They think the woman's educational background has more influence on how she understands health issues and practices health care. The general assumption is that Vietnamese women in general have little education, thus they might not have the necessary background to understand health information.

> Dr. Huy: It is not necessarily because of poverty. It is their educational background. They don't have the general knowledge. That is the most important factor. It is this, many Vietnamese do not have high school education. Many of them all though not illiterate, only have elementary education. Because they do not read or understand much, they tend to believe more in rumor than their doctors. I have patients who would not take the medication I prescribed to them. When I asked them why, they said that because they heard some people said this and that. So you see, that is a barrier. Barrier is not related to poverty, but it is the educational background, the understanding of the problem. They do not understand. (Translated and edited from H-Huy-21-C-1)

Client's compliance with medical regimens is seen as an important dimension of the health care relationship. Successful treatment depends upon the willingness of the individual to follow his/her doctor's advice. Some Vietnamese might not always follow doctors' recommendations because of their financial and work situations. Mrs. Lyn did not take the doctor's prescribed medication for her stomach problem partly because each pill costs her one dollar. Mrs. Phan's husband could not follow the doctor's advice to exercise to lower his cholesterol level because after each day of work he is too tired. "His doctor kept telling him that he needs to exercise more. My husband, after the whole day of working so hard, he could not do that. After working over 10 hours (muoi may tieng) a day, he is too tired and have no time for exercise" (Translated and edited from W-Phan-11-A-1).

D. Conclusion

Poverty affects health and health care and having financial stress/constraints is a barrier for Vietnamese women to participate in cancer screening programs. As previously discussed, Vietnamese women participants often consider having a stable financial status and looking after their children and families as their most important concerns. Therefore, low income, insecure employment, and uncertain finances directly reduce the frequency of women's participation in breast and cervical cancer screening programs.

For some Vietnamese women participants, finding ways to improve family financial status such as working extra jobs, working overtime, or finding jobs have become their top priority. Although the Statistics Canada census shows that Vietnamese women's employment rate is lower than the general population, it does not necessarily mean that the majority of these women are not working. In this study, all of the women who consider themselves housewives engaged in some type of work to generate extra income. For these women, the cost of health care services is directly related to the cost of time spent away from revenue generating work. Thus, low socioeconomic status greatly affects how women participate in cancer screening.

Drawing from Trinh's (1999) experience as a Vietnamese woman who came to the U.S. to pursue her career as a writer, a Vietnamese woman's hesitation in taking time off from work for medical checkups can also be understood in light of class. A Vietnamese woman may experience guilt when she takes time away from work or from taking care of others. Because she comes from a family, a social context in which commitment to others is emphasised and time is valuable and at the cost of someone else's comfort, taking time for oneself could mean having less money to take care of the family, the children's education, or having less money to send back to Vietnam. What we see here is "the complex positioning of the subaltern and the postcolonial subjects in relation to [the] notion of commitment ....Class is dealt with not as an issue in itself but as part of the issues of gender and race" (Trinh, 1999, p. 64).

Some health care providers such as physicians might not see the impact of low socioeconomic status on women's health care behaviour, specifically, breast and cervical cancer screening, because the clients might not talk about these issues to their family doctors. First, when they see the doctor, there is not even enough time to talk about health concern(s), let alone about financial problems and their impact on health. Second, discussing one's financial status and problems is not easy, especially if the clients do not know their doctors well. Because doctors are considered to be of high social position within the

Vietnamese community, women might feel quite uncomfortable talking about their financial difficulties. However, health care providers who work closely with the women or who have the opportunity to see the social and environmental context in which these women live are more likely to be aware of the impact of poverty on their health care behaviour. A physician who did some house-calls, community health nurses, and a Vietnamese social worker have all acknowledged that low socioeconomic status affects women's health care behaviour and pose a barrier to women's participation in cancer preventative screening programs.

Despite the fact that many Vietnamese women have adjusted very well to their new lives in Canada, many are still living below Statistics Canada Low-Income-Cuts-offs, in particular older women. Several older women participants in this study are either on Old-Age-Income-Security Supplement or Social Assistance. It is important to note that, although these women are living with a very restricted income and encountering many difficulties because of language and culture differences, they are very glad to be living in Canada. These women often compare their present living condition with life prior to migration and what they imagine their life would be if they were living in Vietnam. This tends to relieve the emotional burden of their socioeconomic constraints.

Limited language skills are the most cited problem linked to poverty. For younger women, "knowing the language of the host country is an important criterion of labour market entry, an important factor in earnings" (Boyd, 1997, p. 155), and accessing health care services. In Canada, not knowing English or French has not only limited the degree to which individuals can utilise health care services, but has also limited their ability to use previous education and work experience in a broad array of jobs (Boyd, 1997). Studies find that immigrants who do not know English or French have average annual earnings below those of immigrants who can speak one or both of the two official languages (Boyd, 1997).

A very important point I want to make here is that poverty and inability to find good jobs should not be construed as due solely to limited language skills. It is true that knowing the language and familiarity with Canadian culture and societal infrastructure are definitely an advantage. However, Miles (1982) points out that racial group limited opportunities to obtain employment, is not due solely to the "race" (or culture) itself. In other words, race or culture by itself does not (or should not) pose a barrier for immigrants to enter the workforce, but rather it is the socially constructed notion of race and culture by the dominant group that affects people's attitude toward others whom they perceive as different (or even

inferior) to themselves. Furthermore, racialised assumptions lead to unequal social relations when the dominant group has the power to decide and implement social and institutional policy. Some women participants found that certain immigration policies and language training programs for immigrants lend little support to women's efforts in learning new skills.

In Canada, immigrants are expected to be responsible for obtaining needed skills. There is an assumption that they would learn the language when it pays to do so in terms of getting a job or in obtaining higher earnings. There are several language training programs initiated by the federal government in 1991 under the Immigrant Language Training Policy such as the Language Instruction for Newcomers to Canada (LINC) for adult newcomers; and the Labour Market Language Training (LMLT) designed for immigrants destined for the labour force. However, these programs are constrained by limited funding and rules of eligibility, and thus remain inaccessible to many immigrant women (Boyd, 1997). According to Boyd (1997), one important reason for the reduced participation of women in these language training programs is that under these new programs, training allowances are not available to anyone. This means that no income will be generated during the training period. Because Vietnamese men are often destined to enter the labour force, it is more likely that men would take the training program while the woman work in the type of jobs that do not require extensive language skill (i.e., in manufacturing).

Inaccessibility to the new federal funded language training program by immigrant women also links to the acquisition of legal citizenship rights (Boyd, 1997). Because the program has its focus on the newcomer, immigrant women who have received Canadian citizenship are not eligible to enter the program. The rationale for this provision is that the person who has obtained legal citizenship has already acquired enough language skill to understand the new society and to participate in the labour force. Participating in another language training program would make it redundant (Boyd, 1997). Thus inabilities to obtain more language training by women who are already in the labour force reinforce their location in the lower echelon of the occupational structure.

The economic adaptation of immigrants has been considered an important indicator of how well the immigrant has adjusted to their new lives (Deschamps, 1987). Therefore, the immigrants' ability to enter the work force and to generate income are viewed as the best indicators for the success or failure of the integration process (Deschamps, 1987). However, limited language skills, lower level of education,

and unmarketable previous professional training hinder many Vietnamese women's ability to generate higher incomes in Canada.

From these perspectives, it seems that to foster Vietnamese economic adaptation by way of increasing their income and employment rate (thus, increasing contribution to the host society and decreasing tax payers' burden), more attention should be paid towards developing strategies that would help Vietnamese immigrants overcome these difficulties. As suggested by Bieser (1999), to improve the health status of immigrants, the host society should concentrate on alleviating stresses that are experienced by the immigrants due to unemployment and underemployment.

Although there are barriers for Vietnamese immigrants to achieve economic success, in general, Vietnamese economic adaptation is adequate with some extraordinary successes. There are several reasons for the successful economic adaptation of Vietnamese immigrants, with one being Canada's immigration selection process (Deschamps, 1987). It has been pointed out that, although Canada accepts Vietnamese immigrants for humanitarian reasons, another reason, is to benefit the country – to meet the country's economic and population demands (Beiser, 1999; Deschamps, 1987). This view is manifested by government efforts to match the occupation, education, and training experiences of the immigrants to the needs of the country (Deschamps, 1987).

The positive effect of the selection process, however, as described by Deschamps (1987), is that once admitted to the country, these immigrants would have a greater chance of economic success. Since the nature of their work experience meets the manpower demands of the host society, they are likely to enter the labour force without much difficulty.

However, immigrants who have lived in Canada longer have often stated that discrimination accounted for their failure to succeed in a competitive labour market and their ability to find suitable work (Deschamps, 1987). Thus, ethnic inequality in relation to social class, education, and economic opportunities had an impact on Vietnamese experiences.

According to Li (1988), despite a widely shared ideology of equality, ethnic inequality exists in Canadian society. Ethnic inequality which is socially constructed and maintained by differential power relations between a dominant and a subordinate group creates barriers within the labour market for certain ethnic groups to achieve higher earning potential.

Earning disparity, according to Li (1988), is one of many dimensions of social inequality, which contributes to the unequal distribution of wealth, privileges, and power among classes in Canadian

society. These dimensions of inequality affect other aspects of life. For example, poverty leads to poor quality of life and loss of control over life situations; when combined with inferior positions, poverty and powerlessness will generate low self-esteem and other psychological problems. Thus, unequal distribution of wealth, privilege, and power combines with low earnings and limited language skills to negatively affect the economic experiences of Vietnamese immigrants. As a result, although hard working and determined to be economically self-sufficient, the majority of Vietnamese immigrants' income remains an average of $17,600 per year – which is below Statistics Canada Low-income Cut-offs (Government of Canada, Statistics Canada, 1996).

In summary, Vietnamese immigrants living in Canada are experiencing both positive and negative impacts of the changes in their economic status. In general, Vietnamese are adjusting fairly well economically and many are enjoying the high living standard of Western society. A large portion of them still have incomes below Statistics Canada Low-income Cut-offs and Vietnamese immigrants' income level is lower than people who are born in Canada and other immigrant populations (Government of Canada, 1996: Profiles Vietnam; Statistics Canada, 2001). It is important to keep in mind that in the analysis of the Vietnamese immigrants' economic adaptation, contextual factors affecting their economic condition must be taken into account. It is not only personal background, experiences, and skills that affect how Vietnamese adjust to their new economic situation, but also other social issues such as institutional policy, social structure, and relations as well.

One of the misconceptions that health care professionals might have is that immigrants should be able to access health care services if they know about it, that they know the importance of having these checkup done, and that they have knowledge about diseases and their risks. It is not that simple, having knowledge and awareness of certain diseases and the available health care services might help, but keep in mind that for immigrants there are many barriers to accessing these services, some of which have already been mentioned (i.e, limited language skills, limited health care providers, and limited health care resources). To many immigrants, struggling with economic survival takes priority. It is not that taking care of their health is not important. To many immigrants, health is very important, and while "health is gold," making sure that their bills are paid and their children and families are well provided for is a necessary part of their health care.

To provide quality and equitable health care to Vietnamese women – clients of different ethno-cultural backgrounds, in particular immigrants, an alternative approach is needed that is not only culturally

sensitive, but also considers the many factors that affect their lives. If health care professionals are to advocate for holistic health care, then health care services ought to move beyond the treatment of diseases. It must examine how social, political, economic, and historical relations at the intersection of race, gender, and class, shape an individual's multiple social positions and create unequal social relations, which, in turn, affect health and health care.

Chapter Nine: Health Care Responsibility and Accessibility

The ways in which individuals, health care professionals, and health care policy makers view health care responsibility determines how health care services are delivered. Perspectives on health care responsibility not only determines who does what and who is responsible, but also who is to blame (Cheek, 1997). At present, the discourse on who is responsible for health and health care tends to focus on individuals despite the Canadian ideology of health care as the joint effort of both the individual and their society. In the prevention of breast cancer and cervical cancer, the message put forth by the dominant discourse is one that emphasises the important role which women play in its early detection. Women are told that breast cancer can be prevented if they take the responsibility to engage in preventative measures (Lupton, 1994). This message has not only placed blame and responsibility mostly (if not all) on the women, but it has also overlooked other contextual factors such as socioeconomic status, gendered roles and expectations, and social support networks that influence women's health care behaviour. Furthermore, it has ignored the impact of race, gender, and class issues in shaping health care that is provided to marginalised women. Through examining the associations between women's characteristics with getting or not getting a Pap test, Lee et al. (1998) state:

> Non-compliance does not imply personal responsibility. Women may or may not get a Pap test for a variety of reasons, including awareness, belief in its effectiveness, promotion by health care providers, and access to programs and services. (p. 12)

At present, popular discourses on the prevention of breast cancer and cervical cancer are based on an empiricist paradigm and a biomedical framework that reflect Western ideologies that value individualism, rationalism, and objectivity. Not only do these contemporary discourses influence the subjective experience of both the lay public and health care professional, but it also shapes the ways in which women are expected to practice health care. Often, individuals are told they can prevent illness by appropriately managing their life – by delegating, prioritising, and learning to use Western biomedicine developed methods to reduce health risks (such as exercise, diet, relaxation, therapy, counseling, etc.). These discourses, which reflect dominant social and cultural ideologies about the distribution of responsibility and role expectations between individuals and institutions, have been popularised and incorporated into an individual's understanding of health and illness.

The ideology that keeping healthy is the individual's responsibility has been popularised in the media (television, magazines, popular self-help books) and frequently expressed in professional health-care discourses. These ideologies and discourses have influenced the direction of health care practice, and the ways in which people manage pervasive issues of blame and accountability. Although many health care professionals are committed to providing holistic health care, which pays attention to one's specific circumstances and other determinants of health that affect an individual's life, many are still influenced by dominant discourses that place health care responsibility on the individual. The danger of such discourses and practices is that it might encourage people to self blame and to accept their losses and silence their complaints.

In this chapter, I illuminate how the women participants and their health care providers view health care responsibility. I show how being different affects health care services provided to immigrant women. My hope is that an awareness of how the Vietnamese women's lived experiences are influenced by their situated social position might lead to change in health care practice and policy. In the first part of this chapter, I explore some of the current health care issues, which have direct impact on the ways in which Vietnamese women practice health care. In the second part, I discuss how Vietnamese women and their health care providers view health care responsibility. Finally, I discuss the inaccessibility of health care services to immigrant women.

A. The Canadian Health Care System

1. Foundational Values Underlying the Canadian Health Care System

Liberal egalitarianism provides fundamental social values that underlie the Canadian health care system. As Stingl (1996) points out, in principle, liberal egalitarianism values the coexistence of the individual and the society at large. Individuals and others in the society are engaging in a joint partnership, a cooperative and participatory relationship. Under liberal egalitarianism, individual can excise his/her liberty such as freedom of speech, association, conscience, and the ability to pursue one's own personal good, however, an individual's liberty is also limited to ensure the good of others. The value of individual liberty, according to Stingl, is that individuals have the ability to think about and make decisions on the ways in which they conduct their lives. They are free to choose the result towards which they will act to achieve personal goods such as material wealth, knowledge, love, and social power and

prestige. In other words, the individual is granted the ability to make choices and the right to have options available to them. The implicit ideology imbued within the value of individual liberty is that the individual is responsible for the outcome of their actions and life structure. How the individual's life turns out depends upon the individual's actions.

Although individualism holds its place as the most fundamentally important value, in principle, liberal egalitarianism views societal collectivism as no less important. That is, liberal egalitarianism "values individual choice... it [also] gives independent value to the ongoing social relationships that link the choices of one person to those of the next. It recognises that although each of us may choose the course of our own life, none of us chooses the background of ongoing social cooperation that makes such a choice possible...[it] sees society as having an independent existence and value of its own" (Stingl, 1996, p. 9).

Based on liberal egalitarian values of a society, the existing Canadian health care system is a federal-provincial system of public reimbursement for the costs of hospital and medical care. Medicare – the Canadian health care insurance system – is a federal-provincial joint partnership enterprise. At present, both private medical practitioners and not-for-profit hospitals provide health care services. To ensure that Canadians would have and continue to have a high quality, efficient, and fair public funded health care system, the 1984 Canada Health Act reaffirmed five principles.

1) Public administration – The province has to ensure the public participation, authority, and responsibility to the provincial government's administration and operation.
2) Comprehensiveness – The provincial health insurance plan should cover all the essential medical services provided by health care practitioner.
3) Universality – The health care insurance plan must insure all people living in the province.
4) Portability – Health care benefits must be portable from province to province.
5) Accessibility – The province has to ensure that all people have equal access to health care services that are available (Canada Health Act, 1984).

2. Restructuring of The Canadian Health Care System

The Canadian health care system is undergoing changes as the result of the perceived escalating health care costs and decreasing federal funding for provincial health care. It is estimated that nearly 70% of all health care expenditures are paid by provincial governments (BC Royal Commission on Health Care

and Cost, 1991, p. A-11). In 1990/1991, BC health care expenditures were $15.3 billion, about one fifth of the $81.1 billion Gross Provincial Domestic Product. The government is saying that it may not be able to maintain the publicly funded health care system unless more revenue can be generated and health care expenditures can be lowered. It anticipates that better utilising of health care services and fostering individuals' health care responsibility will increase the efficiency of health care services and decrease the health care bill (BC Ministry of Health, 1993; BC Royal Commission on Health Care and Costs, 1991). Financial pressure also leads to the questioning of the efficiency and effectiveness of the existing universal health care programs with more health care policy makers calling for increased individual responsibility in controlling the funding and to shift costs from the public sector to the private sector (Vail, 1996). As the result of these changes, the BC health care spending has dropped to around $10.7 billion in 2003/04 on health care (BC Health care, 2004). However, many concerns have been raised over the results that such health care reforms might produce (Anderson, 1991, 1998; Rachlis & Kushner, 1995; Stingl, 1996; Storch, 1996; Swartz, 1993).

"Self-care" is currently emphasised by policy makers and health care professionals as one of the important aspects of restructuring the current health care system. Self-care refers to "the decisions taken and the practices adopted by an individual specifically for the preservation of his or her health" (Epp, 1986, p. 7). This focus upon "self care" may create further problems for the immigrant patient seeking health care services (Stingl, 1996). Shortened hospital stays, for example, cost the hospital and hence the government less but result in additional costs for the consumer for home care and lead to higher demands on the time and energy of family members.

Because immigrants are among the most economically disadvantaged individuals, this situation adds another burden to their already tenuous economic and family situations, and fosters further social inequality. As argued by Anderson (1991), self-management can give people a great deal of control over their lives. However, it has become evident from her study of immigrant women that health care providers often do not adequately prepare people to take on the responsibility for self care. Anderson also stresses that "these (self-reliant) expectations shape the patient-practitioner interactions in ways that make it difficult for patients to get the help they need to manage their care" (Anderson, 1991, p. 715).

Furthermore, as Anderson (1996) points out, the potential pit fall of this ideology and discourse is that "we risk glossing over the institutionalised practices that perpetuate inequity and that are barriers to health and well being" (p. 699). By focusing solely on empowering the individual to take responsibility for

his/her own health, we risk overlooking "how class and power differentials will be addressed," also it is not clear "how people who live in poverty, or have the marginal existence that a job in the lower echelons of the workforce provides, will acquire the resources to become empowered to assume greater responsibility for their health and health care" (Anderson, 1996, p. 699).

Debates about who should bear more responsibility for health care often links to who pays and how much. The rising discourse about increasing health care costs, which leads to the question of whether or not the Canadian publicly funded health care systems can be sustained has not been supported by the recent Romanow's health care report (Romanow, 2002). It has been pointed out that "health spending in Canada is on par with most countries in the Western world...and that we devote a smaller portion of our Gross Domestic Product (GDP) to health care today than we did a decade ago" (Romanow, 2002, p. xvi). Furthermore, making the individual more responsible for health care and shifting costs to individuals might not control health costs or improve appropriateness of health care, but rather, might have a devastating impact on the health of poor people. It has been pointed out that the impact on the poor is considerably greater than the reduction of services experienced by the entire population (Evans, Barer, & Stoddart, 1993; Moorhouse, 1993; Vail, 1996). Furthermore, shifting the cost of medical care could mean that a two-tiered health care system might develop with a private sector for the rich and a public sector for the poor. The potential pitfall is that once wealthy people cease using the public services, they would no longer be willing to contribute their tax money to services they do not use, they may not care about or even know how these public services are working, and they would stop advocating for good public services. It would then be up to the poor —often marginalised, less powerful people— to fight for good public health care services. The burning question is whether these people can fight for themselves (N. Waxler-Morrison, personal communication, March 19, 2004).

These are more than just fundamental ethical problems. There are moral and value conflicts as well. Various provincial commissions reviewing health care in Canada over the past decade reveal that equity is the most important value held by Canadians with regard to health and health care. Canadians should have equal opportunity to achieve health and wellbeing, and equal opportunity to receive health services according to their need, not their ability to pay (B.C. Royal Commission Report on Health Care and Cost, 1991; Rachlis & Kushner, 1995; Romanow, 2002).

As such the rhetoric about health care restructuring should not put emphasis on how to cut health care spending but rather how and where to distribute its health care dollars to meet people's needs in the

most effective and equitable way. It is clear that putting more responsibility on the individual to cope with health related-problems is not only ineffective, but also an unjust way of providing health care to immigrants.

The current emphasis on the restructuring of the health care system with its focus on the efficiency and the effectiveness of health care services might have further placed health care responsibility on the individual. Although recent discourses about health and health care have paid more attention to the interrelationship between individuals and the social context in which they live, failure to stay healthy and to take action to prevent illnesses are still often being seen as individual's lack of effort. Although, on the surface, the emphasis on efficiency and effectiveness might have helped the government to reduce some of the health care costs, it has created more barriers for people with different ethno-cultural backgrounds, who are already suffering from the migration processes, to obtain equitable health care services. Furthermore, the health care systems' emphasis on self-care might further compromise the fundamental societal value that we should care for each other – the value that bond human beings to each other. And with that, the institution's responsibility for its members' well being might be overlooked. Deborah Lupton (1994) insists that the dominant biomedicine perspectives, which she found not only hegemonic but also patriarchal in its direction, in that it excludes women's needs, wants, and feelings, have shaped cancer prevention rhetoric. It is, therefore, imperative for health care providers to gain insight from the women's perspective of not only who they think is responsible for health care, but also why that is the case. It is also important to illuminate the ideological differences that exist between those who provide and those who receive health care services. For increased participation in health care practice can only come about when there is a true sense of understanding and cooperation.

B. Shared Responsibility

Both the women and the health care provider participants talk about health care responsibility. Women's narratives reflect their ideology of a shared responsibility by placing emphasis on both themselves as responsible for their health and responsible for seeking health care, and others when they stress that the doctors are also responsible for giving advice and encouragement for women to seek health care. Similarly, most of the health care provider participants place the responsibility for seeking health care and for having breast and cervical examinations upon the women and themselves as physicians. However,

physicians often emphasise that failure to have regular checkup is often the result of the women's unwillingness to having these tests done. Although the physicians are quite ready to acknowledge that they are responsible for giving good health care to patients, they do not see that the women's low participation in breast cancer and cervical cancer screening might be related to the physician's hesitation to discuss and/or to perform breast and cervical cancer examinations.

1. Health Care Responsibility: The Women's Perspectives

Several women participants emphasised that the individual woman is responsible for her health care. Many see that going for a checkup or taking care of one's health is the responsibility of the individual woman. Discourse around the health care system by women reveals that many Vietnamese women are very grateful for their present health care. A comparison is often made between the existing Canadian health care system with the Vietnamese health care system. The advancement of medical technology and the ability to get medical care without paying from one's own pocket were often cited as the most important factors to consider in asking what good health care means to them.

With the assumption that the Canadian health care system is better than Vietnam's and the fact that one does not have to pay to go to the doctor, most women feel that going for mammogram and Pap smear test is the women's responsibility.

> Mrs. Chi: Yes, I think that, here, the doctors are very good. If you have the disease, they would know. Except that if you are lazy, you don't go to see them, so you are late, that's your fault. When you go to see the doctors, it didn't cost you anything. So if you have time, you should see them. (Translated and edited from W-Chi-4-A-1)

Not only is the individual responsible for seeking health care but she is also responsible for monitoring her own health and to work with the physician to keep herself healthy.

> Mrs. Phi: We have the responsibility to keep an eye on our own conditions. If any changes, we notified the doctor so that he could adjust the medication. If the medication doesn't work, the doctor would change the medication. It was pretty much like here. (Translated and edited from W-Phi-2-A-1)

Failure to follow the doctor's advice, to go for the tests and checkups are seen by some participants as an individual's lack of effort to take care of her own health, thus, it is the patient's loss.

> Mrs. Minh: It is up to the patient to avoid all those things (breast cancer and cervical cancer). Whether or not the disease is reduced, it is partly depended upon the patients. The doctor is one thing. But if we have the disease, it is depended upon whether or not we follow the doctor's advise. It depends upon the patients. If the patients don't follow doctor's advise, then the disease might not reduced. If they tell you not to eat sugar or this and that, but you keep eating all those things then the doctor cannot do anything about it. So the major thing... for the diseases that can be cured by avoiding this and that, then it is the patients' decisions. If they are not doing it, then

> nothing can be done... we have to listen to the doctors. If we don't follow what they say, we would not be cured... That would be their loss. That is the patient's loss. (Translated and edited from W-Minh-5-B-1)

Although Mrs. Hai lived in Canada for 20 years, she rarely goes to the doctor for checkups. When asked about what she sees as barriers for Vietnamese women to go to the doctor, she says:

> Mrs. Hai: I think it is because we didn't want to go for these checkups. It is not because of other difficulty. If it is our day off, we make an appointment then we go. But if we don't want to go then it is up to us. We don't go for these tests because we are not motivated enough to go. There is no difficulty. (Translated and edited from W-Hai-3- A-1)

Similarly, Mrs. An who has a Caucasian family doctor and several encounters with the Canadian health care system that included treatment of her daughter's breast cancer, praises doctors and nurses. She also feels that the individual is responsible for herself.

> Mrs. An: We have to look after ourselves first because it is our body... Our body, we have to look after it. Doctors are very good here. They are more than willing to look after us, but if we do not look after ourselves then the doctors cannot do anything. We need to look after ourselves first. Sometime we have difficulty it is because we left it too long. (Translated and edited from W-An-14-A-1)

Although many women stress individual responsibility by emphasising that women themselves are responsible for going to the doctor for checkups, mammograms and Pap smears, they also feel that doctors have the responsibility to remind them and to talk to them about these tests. Mrs. Ha, a 70-year-old woman who has been living in Canada for 26 years attributes her regular mammogram and Pap smears to her Caucasian family doctor.

> Ms. Ha: Yes, it is up to us, but the family doctor is responsible too. The family doctors have to pay attention to their patients and send them to these examinations. They have to tell the patients what to do. Like me, it is because I have a Caucasian family doctor. I didn't know about these things. My family doctor sent me, otherwise how would I know about these things? So Vietnamese family doctors should do the same thing... If the doctors don't pay attention and don't tell the women then the women wouldn't know.... It is very important to encourage the Vietnamese doctors to talk to their patients and to tell them [the women] what to do.... If the doctor is a man then he needs to tell his patients to go to doctor Y [a female doctor] or any other female doctors. (Translated and edited from W-Ha-12-A-1)

Some Vietnamese male doctors are also influenced by the "culture." As a result, they might not want to talk about or perform breast and cervical examinations on the women. Recognising that these male doctors are also uncomfortable with talking about and performing these examinations, she says:

> Ms. Ha: The truth is that Vietnamese women are very hesitant to go for these kinds of examinations. If the doctors don't insist to have it done, they would not have it done. Vietnamese male doctors, they are too under the influence of Vietnamese culture. This woman, too much trouble, don't bother, talking to her about it she would then hesitate this and that... so the truth is with these kind of examinations, the doctors need to encourage the women and tell them what to do. The doctors have to tell the women about it because many women, like me would not know where to go for mammogram or who to talk to. So we need doctors' help. (Translated and edited from W-Ha-12-A-1)

Self determination has been mentioned by several women as one of the important components to not only dealing with life adversity, but also, coping with illness.

> Mrs. Phi: We have to be able to accept certain difficulties. Nobody is going to be healthy 100%. So if we got a disease, we should accept it and treat it yourself (tu tri) [tell yourself that you will overcome the problem]. That will be a benefit for you. Beside the care by the doctors in the hospital, we have to know how to take care of our selves. Then we'll be able to overcome our problem. For example, if you are sick but if you just sit and feeling sorry for yourself, then a simple problem becomes a big problem. So I think that if you believe and have confidence in the health care that are being provided here, then, a serious problem will become a simple one. We have to have trust and confidence. (Translated and edited from W-Phi-2-A-1)

Similar to other women participants, Mrs. Minh sees the individual's determination to fight off the diseases is important, but also sees the doctor as having an important role in motivating the patients to take care of their health. For her, motivating an individual to take care of his/her own health is a shared responsibility of both the patient and the health care provider – a collaborative process that would only work if both patients and doctors are willing to take part.

> Researcher: In your opinion what can we do to get the patients to follow the doctor's advise? What can we do to motivate the patient to do what the doctor said?
>
> Mrs. Minh: First of all, the patients had to have the determination to fight their diseases. Second, the doctors, ... they should talk to the patients about the importance of their health. For example, they might say, "if you don't follow my advise, your disease might not be cured or you might not get better" If the doctors only say, your blood sugar is high; you should only eat this and that, and avoid sugar, for example, then the patients might not take it as seriously. When you have the disease, you cannot be the same as when you were... That is the patients should try to take care of themselves. The doctors, they can only give you treatment. It is up to the patients... I have a friend, her mother is a diabetic. Here, the children are working. So the mother could not avoid eating. This woman lives in the U.S. Later, she had to have her legs amputated. that is what happen because the patient didn't follow the doctor's advise. On the other hand, the doctor should gently tell the patients the importance, the consequences if they don't follow the doctor's advice and prescriptions. They need to tell the patients that their diseases will not be cured. That's all you can do. You cannot do anymore than that. (Translated and edited from W-Minh-5-B-1)

Other women, such as Mrs. An, thinks that getting support from Canadians is not difficult. In her opinion, people of the host society are very humane and they are very willing to help. The problem, as she sees it, lies mainly with the individual Vietnamese.

> Mrs. An: In my opinion, whether or not support is available to us depends upon ourselves. People are very willing to help if we are honest. I think that getting help from others when we really needed it then we don't feel guilty. But if we are not honest, if we just want to take advantage of others then we will be bothered by our conscience. I think that even though we are refugees, we need to up hold our dignity. Even if some one wants to do a bad thing, they need to think about the dignity of their family and their Vietnamese culture. If every one of us thinks about that, then the support is easy to find. We should not make it difficult for others (the Canadians) and ourselves. Now there are some problems with seeking help, but it is our fault. Some of us did wrong things and now they are being more cautious about helping us. The ways in which people help us is important. It is different when they are willingly to help instead of being forced or tricked

into helping us. It is depend upon us whether or not support is easy to find. If it is difficult to get help, it is partly our fault. (Translated and edited from W-An-14-A-1)

Women's narratives about who is responsible for health care and how they consider both themselves and their physicians as responsible for the promotion of breast cancer and cervical cancer screenings reflect their "in-betweeness." Living and practicing health care in in-between space is a notion that appeared in many women participants' narratives. Here, women often take the position of in-betweeness when engaging in the Eastern and Western ways of doing and thinking. For some women participants, embracing aspects of both cultures, has, in fact, strengthened their sense of self and relations with others. For example, speaking from a position of in-between, Ms. Ngoc considers herself to have benefited from both Eastern and Western thinking.

> I am not in conflict with Western thinking. It actually helped me. It is an addition to my traditional way of thinking. I used to be so concerned about and go through great pain to make other people understand me...now, I don't think about it too much anymore. As long as I act correctly, I am satisfied...What I have learned from the Western ways of living and thinking is to look within myself, value myself, and care for myself. (Translated and edited from W-Ngoc-19-A-1)

In-betweenness is also manifested by the fact that several Vietnamese women participants recognise differences between traditional Chinese medicine and Western biomedicine, and use both types of medicine. For them, health care practice cannot be reduced to either Eastern or Western modalities, but rather, it is based upon what they see as appropriate treatments for particular diseases.

> I use both traditional Chinese medicine and Western medicine. For diseases, which affect the nerves, traditional Chinese medicine is better. But Western medicine is better at treating other diseases such as women's infection problems and general infections. With these diseases, we need antibiotic to kill the bacteria. We cannot use traditional Chinese medicine to treat these diseases because its effect is much slower.... So I use traditional Chinese medicine for the diseases that can be treated by these medicine, and Western medicine for infectious diseases that need antibiotics. (Translated and edited from W-Phan-11-A-1)

2. Health Care Responsibility: The Health Care Providers' Perspectives

Some physician participants thought that Vietnamese women know about Pap smears and mammograms – as high as 9 out of 10 women, in their estimation. They feel the main reason for low participation in breast and cervical cancer is due to the individual woman's personal choice.

> Dr. Thinh: The best thing is to talk to the women, to advertise in the newspaper, or to organise meetings. If we talk to them, they will understand. But I think that nowadays these issues [breast and cervical examination] are quite normal. Just put it in the newspaper several times and everyone would know about it. However, it is up to the women, whether or not they would go for these checkups voluntary. Now, you ask any women about Pap smear or mammogram, all of them would know what it is. You ask 10 persons, 9 of them know what it is all about. They just don't want to go for these checkups. (Translated and edited from H-Thinh-16-C-1)

Other doctors, however, see the health care providers' role and responsibility as much more involved. Health care providers' responsibilities, according to them, consist of educating women about health care and finding ways to help them seek health care. To Dr. Dau, ways that health care providers could help Vietnamese women seek health care include: health care clinics having more flexible hours of operation; physicians reminding women of their checkups; and more accessible materials for women. Material should be written in Vietnamese, simple and to the point with clear explanation of the dangers of these diseases. Educational material should also include not only information about the cancer testing, but also about breast cancer and cervical cancer itself, its specific stages, its treatments, and the success rate of these treatments.

> Dr. Dau: Educational issue. For example, with breast cancer, 30% of the women have breast cancer. With breast cancer, there are different stages, from 0 to 1,2,3. The success of the treatment depends upon which stage the cancer is discovered. Sometime the success rate is over 90%, but at some stages, it is only 2 to 4%. So we should educate the women with that kind of information. We should also make it easier for them. Not only do we have to educate the women; we have to make it easier for them to seek health care. Especially, health care providers should make it easier for them to seek health care (tao dieu kien cho ho).
>
> Researcher: In your opinion, how should health care providers make it easier for the women to seek health care?
>
> Dr. Dau: For example, in all places that do mammography, the hours of operation should be more flexible because present office's hours are not easy for these women. The women can only come at 3, 4 o'clock in the afternoon. The reason being is that because of the language problem, they have to depend upon their husbands. Also, if the husband is working, they cannot leave their children at home alone. So transportation is a problem. Second, they also forget about these things and have to be reminded. If we remind them, they would go. There are workers who could come and explain to these women. Before, I wrote a fair amount about these things in the Vietnamese newspapers. I wrote about the importance of the annual checkup, mammography, and Pap smears. It helps a little. But still, at the clinic, I bet still not many Asian women have Pap smears done. (Translated and edited from H-Dau-13-C-1)

Another doctor, Dr. Tien, who has been providing health care to Vietnamese women for more than 7 years indicated that although he has made an effort in promoting breast and cervical examinations to Vietnamese women, it is not enough. He attributes women's low participation in preventative cancer screening to their lack of awareness and health care institutional support.

> Dr. Tien: When you walk into my office, you see that I have a poster right on the counter. This poster says that the BC Health Department recommends that women should go for breast and cervical examination regularly. The reason that I have the poster there is that Vietnamese women, actually Asian women in general, don't pay attention (rat la tho o) to breast and cervical cancer. Only when they have the disease, then they worry about it. Otherwise, they just don't want to talk about it. It might be that that is their mentality or it might be because they are hesitant (ngai), or even distrustful, or afraid of the results after examination. I think that it [breast cancer and cervical cancer screening program] is a good thing. I also think that health departments and health care providers should push more. They should have a stronger program – a better advertisement program that promotes the need for Vietnamese women to go for these tests. It should tell them the importance and dangers of breast cancer. We should have a more active,

> stronger program. Right now, I think we are not doing enough.... I have written a lot of information in Vietnamese. I had prepared lots of information but I don't have the time and the support. The government health care organisations could support us by helping with the rental of a hall, and other funding, etc., or support from breast cancer foundation. You can invite physicians and others workers to participate. (Translated and edited from H-Tien-17-C-1)

The majority of health care provider participants are aware that Vietnamese women are very hesitant and embarrassed when it comes to breast and cervical examination. However, they all say that they have the responsibility to remind them and to talk to the women about these tests.

> Dr. Tien: The mentality of the Vietnamese women is that. They don't like touching. They don't even want to have these kinds of examinations with the Vietnamese female physician....I still explain everything, like the risk factors, the consequences, everything. But I think that although they listen to me, sometimes, they even agreed to make an appointment for breast examination, they just didn't show up for it. So what can I do? That is why I am quite disappointed sometimes. However, even though I know that is what's going on, as the physician, I still have the responsibility to talk to them about it. I do know that the women don't like to talk about it, but because of my responsibility, I still talk to them. I have to record on my file when they don't show up for these checkups. (Translated and edited from H-Tien-17-C-1)

As I have discussed, both the women and their physicians verbalised that they are willing to take responsibility for the promotion of women's health. They have also verbalised that they are willing to be accountable for their health care activities. This, coupled with their acknowledge that breast cancer and cervical cancer screening is necessary, should foster women's participation in these cancer preventive programs. It begs the question why, then, do these Vietnamese women feel reluctant to participate in cancer preventive programs? It follows that there must be other constraints that affect these women's health care behaviour.

With the above question in mind, I critically examinined how other contextual factors at the intersection of race, gender, and class manifested in the care given to Vietnamese women. I suggest that Vietnamese women's social position has negatively affected how they participate in these cancer screening programs. The ways in which immigrants are portrayed and conceptualised in society have positioned Vietnamese women who come from a third world country to a subordinate position, a marginalised group. In this historical moment, when the discourse of limited social and health care resources is so pervasive, providing health care to immigrant women might not be viewed as a priority. This has called into question whether or not immigrant women are seen as meriting services in the eyes of some health care policy makers. Health care funding cut backs are a wide spread phenomenon within Canadian society, and services for immigrants have often been the first to be eliminated. It is evidence by the fact that in the BC budget for 2003-2004, the biggest area of reduction was Multiculturalism and Immigration Services. This services' budget was reduced by 37%. In the same budget's year, Women's

Services, which provide grants to private and non-profit agencies for the provision of counseling programs and women's centre services, suffered a reduction of 5.7% (BC Health care, 2004).

Several health care provider participants have acknowledged that social and health care resources are limited for immigrants. Constraints of social and health care resources have led to the inaccessibility of health care services for these women. In the next section, I argue that Vietnamese women's socially situated positions affect the ways in which they make the decision to engage in health promotion and disease prevention, and furthermore, these socially situated positions affect the care that they received in ways that hinder the accessibility of health care services.

3. Inaccessibility of Health Care Services to Immigrant Women

Canadians claim that they value and respect their egalitarian way of thinking about society and that everyone who lives in Canada should have equal access to health care and an equal chance to pursue his/her life dreams (Stingl & Wilson, 1996). However, not only are we living in a gendered society, but also a society where inequality and injustice exist (Li, 1988; Ng, 1993). Within the Canadian society, race, class, and gender discriminations create inequities. In health care, social inequities affect the accessibility of health care services to immigrant women.

As I have previously discussed, it is believed that better utilisation of health care services will lead to greater efficiency of health care services, thus cut down in health care costs. There is evidence to show that too much emphasis on efficiency might lead to problems with responding equally to the health needs of all Canadians (Stingl, 1996). Appropriate utilisation of health care services, as defined by Rachlis and Kushner, is "the right services, at the right time, delivered by the right person, in the right place" (1995, p. 96). This definition implies that tests, treatments, and services provided to immigrants should be founded on the best scientific evidence indicating that services would be of benefit to them and that there is evidence to show that in fact services are needed. However, this emphasis on evidence-based practice and consumer demand may indirectly create unequal access to health care for immigrants. For Vietnamese immigrants, this direction means that unless Vietnamese immigrants (or any other groups of immigrants) are visible enough in the Canadian society, unless their concerns are heard, there will be no particular health care services or institutional government support for them. Not only is it difficult for immigrants to voice their concerns, but their concerns have often not been heard. Lack of appropriate health care services and institutional support create inaccessibility and inadequate health

care services for immigrants. Study from the U.S. shows that accessibility to health care services is the strongest predictor of whether or not an individual will received cancer preventive health care among Vietnamese women (Jenkins et al.,1996). Although the U.S health care system and the Canadian health care system are different, thus how immigrants access health care services in the U.S. is different to Canada, inaccessibility of health care services is a major deterent for immigrant women to get health care. Reduction in funding of community-based health and social services has broad effects on the health of immigrants. A recent study in Canada revealed that policy changes that resulted in health care and social service losses for immigrants created increased barriers to access, increased provider stress and housing problems for immigrants (Steel, Lemieux-Chales, Clark, & Glazier, 2002).

Inaccessible and inadequate health care services are the direct result of limited health care providers and high patient/physician ratio. Because of their limited language skills, many immigrants select their doctors based on their ability to communicate with them. Therefore, many immigrants who do not speak English well would choose to seek help from physicians who can speak their language. Mrs. Phi spoke to this effect.

> Mrs. Phi: Because of the English language limitation, it is difficult for them to describe their problem. For example, if you have pain, you should be able to describe it. To be honest, when I first came here, everything was "it hurts me here, it hurts me there." I didn't know how to tell them (the doctors) this and that. So, language limitation may prevent us from going to the doctors. If the doctors are Vietnamese, now there are Vietnamese doctors here, but before, there were rarely any Vietnamese doctors around. When I first came here, there was only one Vietnamese doctor, and I did go to him because I wanted to talk and explain to the doctor about my problems. I didn't want to just tell the doctor that I had a pain. I want to be able to describe the pain was shaft like this and that, you see, in our language, each word is different. So it's different, it's not just pain.... If you can't even describe your pain, then you can't help the doctor. It's not that you would be able to describe the exact problem, but these symptoms might lead to other diseases. So I think that language is very important. If the doctor has a translator, it'll help. But if the doctor doesn't have a translator, we would go to the Vietnamese doctor. (Translated and edited from W-Phi-2-A-1)

A limited number of Vietnamese speaking physicians has resulted in a high patient/physician ratio. According to 2001 Canada Census, there are 22140 Vietnamese living in Vancouver. There are about 10 Vietnamese speaking GPs in Vancouver of which only about half of these physicians are working full-time, the rest are either working part-time or are semi-retired. Furthermore, there are only two Vietnamese female physicians. According to Canada Ministry of Supply and Services the physician/patients ratio is 1 for every 464 Canadian for the general population (Shah, 1998). For the Vietnamese, although there is no specific data on how many Vietnamese seek help from Vietnamese speaking physicians, in the present study, 53% of women participants go to Vietnamese physicians. Let

us assume, then, 50% of the 22,140 Vietnamese living in Vancouver are seeking help from 10 Vietnamese speaking physicians, the physician/patient ratio for the Vietnamese would be one physician for every 1,107 Vietnamese.

Vietnamese General Practitioner (GP) participants indicated that they have a very heavy workload, especially doctors who are well know within the community. As Lesjak, Hua, and Ward (1999) found out from their study, general practitioners are the main health care providers who perform Pap smears for Vietnamese women. Interviews with Vietnamese doctors and Vietnamese women suggest that the physician's heavy workloads and the limited number of Vietnamese physicians (especially female doctors) have created many problems with providing health care services for this population. The fact that Vietnamese physicians have less time to spend explaining, talking, and listening to patients due to their heavy workload creates much dissatisfaction with the care these physicians are able to provide to patients. This, in effect, creates inaccessibility to health care services for the Vietnamese women.

Mrs. Hai talked of her experience:

> I think we should go to the doctors who are not as busy, who have more time for us. I think the doctor should have more time to talk to you. If he is too busy, I don't feel that there is time for me to talk to him. I go to see him but I don't think he has time to talk to me. There is no time to talk about what I need to know or time for me to ask questions .... They have no time. They are very busy. They have many patients. When I see him, I waited and waited. It doesn't matter what day or what time I went there, I have to wait. (Translated and edited from W-Hai-3-A-1)

Dissatisfaction with the health care provided has led to doctor-patient relationship problems, which in turn affects the willingness of women to seek help, especially when it is for something that is viewed as very personal such as breast and cervical examination. Another 60-year-old Vietnamese woman, Mrs. Chi said:

> You know, the patients are quite difficult, especially Vietnamese. You would only need to ask: How are you? How are you getting along these days? But he doesn't even say anything. When he saw you, he asked: What is the matter with you? I said: I have a cough. He said: How do you cough? I got frustrated. You know, doctor should act like a gentle mother. Even if the doctor is young, he needs to be friendly, calm, and show respect to others. He should talk to his patients in such away that they feel they could come and talk to him. (Translated and edited from W-Chi-4-A-1)

This problem is also acknowledged by one of the physicians:

> The sad thing is that I have too many patients. They come to me because of their language problem. They could not communicate with other doctors. So they come to me. After they have talked to me about their problem, they don't have (pause). I am a GP. But the GP is so busy. (Translated and edited from H-Dau-13-C-1)

Thus, limited health care providers, and high patient/physician ratio creates inaccessibility to health care services for the Vietnamese immigrants. In addition, there is evidence to show that inability to communicate in English has also created a negative attitude toward the Vietnamese among some health care providers. Recalling her experiences with nurses, Mrs. Phi said:

> Because I know a bit of English, the behaviour of the nurses is different. The nurses' behaviour towards a person who knows English and a person who doesn't know English is different.... Because they could not understand why that woman waited until it is too late or why she didn't follow the doctor's advice. They don't understand. Well, they don't show it in an obvious way that I could see it, but I know. I would act the same way if I have to talk to someone 5 or 7 times but she still doesn't respond to what I ask her to do. I would feel frustrated too. So you see, that is nobody's fault. It is because of the lack of communication and lack of awareness. (Translated and edited from W-Phi-2-A-1)

Most of the information on breast cancer, cervical cancer, and their screening programs is written in English, which many Vietnamese women cannot understand. Thus, limited language skills coupled with low funding for translator services is a direct barrier to accessing health care services, in particular breast and cervical cancer screening programs for these immigrant women.

> Mrs. Ling: They [the Vietnamese] don't know any community resources, any offices that could protect them. If they want to contact offices that could protect their benefits, they would have to speak English. If they don't speak English well, they have to ask for help and depend upon others. It is very difficult for them. Here, there are people who ask me "Mrs. Ling, please call for me. I have two teeth that are loose. The dentist told me that I don't have any insurance to fix the teeth. He told me to fill out these forms to see if they [the welfare] approve." The people ask me to help them. I telephoned for them. You know that it is not easy to contact the social worker. I left a message, when they call back, I might not be there. If I left the phone number of the person who I helped for the social worker, when they call, that person cannot speak English. Once they got an appointment to see the social worker, if they want to see the social worker quickly, they would have to have someone to translate for them. If they don't have anyone to help translate, they have to ask for help from MOSAIC. But then they have to wait. It is not that you call and they would have a translator ready for you anytime... If many people have problem then the waiting list is very long .... So you see, it is very difficult for us. (Translated and edited from W-Ling-1-A-1)

Lacking General Practitioners who can speak Vietnamese coupled with limited language skills lead to other problems such as finding a translator. Not only is it difficult to find a translator, but such services raise privacy issues.

> The language is a barrier, because each time they go, they have to find a translator. And they just can't find a translator anytime they want. Finding a translator is difficult. They are not even comfortable with the translator. If I have a headache or a runny nose then it's okay, translate for me, but [voice lower] if I have white discharge, or if I have got an infection from someone, I would not dare say anything about it. If you have STD, of course you don't want any body to know. It is embarrassing because they will question why you have that disease. Is it because of my husband running around? For a woman to say that her husband is running around, it is a big embarrassment. Besides that, if the woman is single, Oh, she must have many partners, etc. So, I think all that prevent Vietnamese women from going to the doctor for this kind of things. For Asian women, this kind of things is difficult to talk about. They might not even talk to their own husband that they have pain there, let alone talking to another man about it.
> (Translated and edited from W-Phi-2-A-1)

Inadequacy and inaccessibility of health care services due to "invisibility" and "inaudibility" are also related to limited funding of programs that provide health care services specifically to Vietnamese. For more than eight years, a group of Vietnamese women and men have been working together as volunteers for the establishment and broadcasting of a Vietnamese radio station in the city. The radio, named Lac-Viet, broadcasts in Vietnamese every Sunday morning for two hours. As the Vietnamese population grows, founders of the radio station recognised that there is a need to bring information and communication to Vietnamese whose English is limited, and started the program with a small group of volunteers. Women participants of this research indicated that they often listen to the Lac Viet program. For many older women, Lac Viet is the main, and sometimes, the only source of connection to the world outside their homes. Many women I talked to would make a point of getting up early on the weekend to listen to Lac Viet. According to Mrs. Phi, one of the station's founders, it is difficult for Vietnamese women to access health care information and giving information via radio is effective because of its easier access.

> Mrs. Phi: The majority of the information that reaches Vietnamese women is not adequate. It is because the majority of women don't read English. They don't understand English and the information in Vietnamese is very limited. So information does not reach Vietnamese women. These women don't know where to get the information. There is a lot of information in the library, but they don't have it in Vietnamese. Some information put out by the health unit in the East Side was translated into Vietnamese in small pamphlets. But only people who go to these places know about them. People who stay home would not have this information.... If you put the information at the library, not only do many libraries not carry Vietnamese books, but people who go to the library are often men more than women..... That also goes with putting the information in the Vietnamese newspaper. Not everybody has a Vietnamese newspaper to read. Although the newspapers are free, only people who work in offices or go to the restaurants can get these newspapers. So for women who stay home, who do not go out to eat, they don't have these papers, they can't read these papers. (Translated and edited from W-Phi-2-A-1)

According to Mrs. Phi, many Vietnamese are listening to the radio programs because with each talk show, the phone would ring and many people would give opinions on topics of discussion. The problem, however, is that there is not enough time to address topics such as health and health care in great detail. Because of the large amount of information and issues that are needed to be addressed, each month there is only 15 minutes of airtime slotted for health care topics. That, Mrs. Phi recognised, is not enough time to cover all topics, however, with only two hours a week, that is the best that they can do. Finding enough money to run the program is a constant struggle for this group of volunteer women. It costs $400 per week or $2,000 per month to have the radio program running for two hours a week. The lack of a constant source of funding has made continuing the show very difficult for these women. In her words,

> Mrs. Phi: The program does not receive any funding. We have to fund raise to run the program, except that there were a few law projects that we were able to ask for some small funding. For example, I did 6 topics, I ask social services for some money, but then I put it towards the radio's fund. All of these services are voluntary. None of us get paid, not even a dollar. We have about 14, 15 volunteers, with that many people working, how would we be able to pay? So everyone say that airtime has to be pay to the mainstream. So we pay airtime, $200 for one hour plus tax. For two hours, we pay more than $400. So we need two thousand dollars a month to pay for the airtime. To get this two thousand dollars, we have to do fund raising. We have to do several small projects in order to apply for some small funding. They don't give us any big funding. They don't have any money. So, when one project is nearly finished, we would have to do another application for another project. We, several women have to get together to do this in order to have money to pay for the airtime. It is very difficult. (Translated and edited from W-Phi-2-A-1)

When asked if they have approached the government for funding support, Mrs. Phi revealed sadly:

> They [the governments] don't support us with any funding. Yes, we did approach them... So we have to seek small projects to make money to pay for airtime.... For example, we do project about law, law information or legal services. If they see that the project is useful, then they'll give some funding. They might give twenty thousand dollars. This twenty thousand dollars can not all be put towards paying for airtime because I have to hire a coordinator who coordinates all that. I don't have law background so I can't do that. Also, we have to find guest speakers... The pay is not at all adequate; our women are mainly volunteering. You know, it involves so many things. When you are doing these programs, you have to contact people and you have to pay for people who do not work as volunteer. So the main force that keeps this radio program functioning is voluntary work [from the women in the Vietnamese community]. (Translated and edited from W-Phi-2-A-1)

When she first started the program, many Vietnamese were quite skeptical, saying that it might not work. Now, in its seventh year of operation, Mrs. Phi is hoping that someday the Lac Viet radio will get some continuous funding from the government to pay for the airtime and for many people who have worked as volunteer for the past seven years. Thus, as pointed out by Anderson (1998),

> The very structure of the health care system compromises the care a woman receives, and health care professionals are sometimes caught in a moral dilemma as they try to provide a service to women without the adequate resources to do so. This calls into question how resources are allocated within different institutions, what is seen as a priority, and what groups are seen as meriting services. (p. 203)

Chapter Ten: Discussions, Recommendations, and Conclusion

> The role of the intellectual is not to tell others what they have to do...The work of an intellectual is not to shape others' political will; it is, through the analysis that he carries out in his field, to question over and over again what is postulated as self evident, to disturb people's mental habits; the way they do and think things, to dissipate what is familiar and accepted, to reexam rules and institutions and on the basis of this re-problematisation (in which he carries out his specific task as an intellectual) to participate in the formation of a political will (in which he has his role as citizen to play). –M. Foucault, 1988

In this final chapter I focus the discussion on issues related to my research questions: 1) How do Vietnamese-Canadian women participate in breast and cervical cancer screening practices? 2) What is the process by which the decision to engage in regular breast cancer and cervical cancer screening is reached? What are the key factors that influence this decision-making process? 3) How do contextual factors such as social, cultural, political, historical, and economic at the intersection of race, gender, and class affect Vietnamese-Canadian women's breast cancer and cervical cancer screening practices?

I address these questions ethnographically. I discuss the contextual factors influencing Vietnamese Canadian women's health care decision making, in particular, breast and cervical cancer screening. Returning to the data discussed in the previous chapters, I emphasise that although cultural knowledge and values influence Vietnamese women's health care decision making, hence practice to some extent, gendered roles and expectations, low socioeconomic status and limited social support networks, all of which under the influence of race, gender and class, shape how they make decisions to participate in health care programs. In doing so, my aims are to illuminate clearly the key factors that promote and/or reduce Vietnamese women's decisions to engage in breast cancer and cervical cancer screening programs and to make clear where the problems lie. To support the women's health care practice and participation in cancer preventative programs, I recommend strategies to remove those identified barriers. Finally I discuss implications for practice and research.

At the analytic level, based on the obtained data, I discuss the process by which Vietnamese Canadian women make the decision to engage in regular cancer preventative programs. I point out that women's conceptualisation of health and explanatory models of illness that derive from the individual's cultural knowledge, values, and experiences, gendered roles and expectations, social support networks, and socioeconomic status —all of which are under the influence of their socially constructed positions and the inequity that exists within the society— shape women's health care decision making process and behaviour.

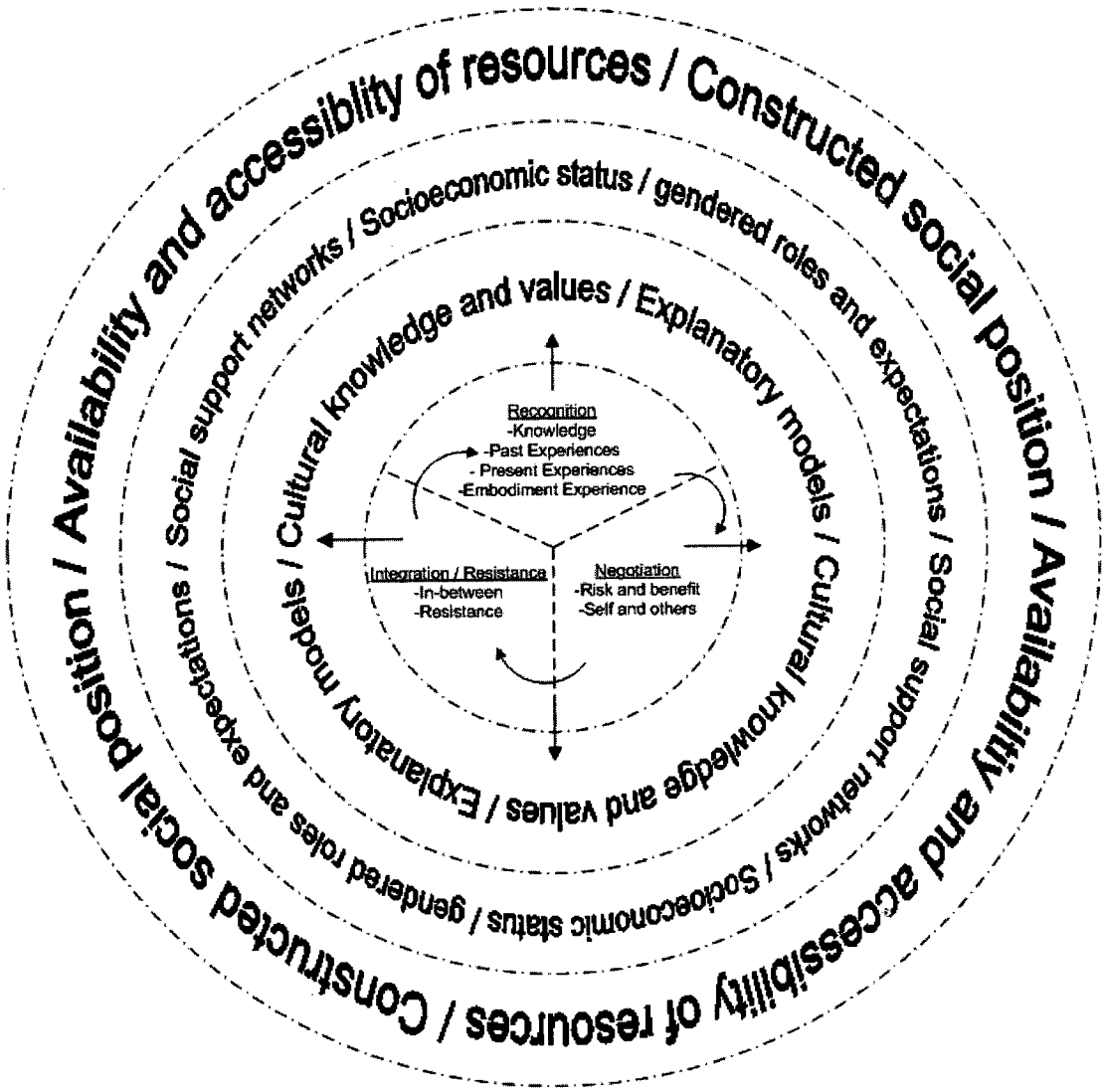
A. Vietnamese Canadian Women: Health Care Decision Making Process

Based on the findings of this research, I conceptualise Vietnamese women participants' health care decision making as a dynamic non-linear process that varies under different circumstances. This process involves three interrelated stages: the recognition stage, the negotiation stage, and the integration/resistance stage. It appears that in deciding to engage in preventive cancer programs, a woman might go through these stages. Here I emphasise that there are no clear-cut boundaries between these three stages because at any point a woman may pass between them, enter them or exist in them. In other words, these three stages of decision making are not a hierarchical, step by step process, but a dynamic non-linear and interrelated process. For example, a woman recognises that breast and cervical examination is necessary for the prevention of breast cancer and cervical cancer, she may then perform breast-self examination, have clinical breast examination and mammogram regularly. However, in the process of evaluating the effectiveness of these examinations, their benefit and risk to both herself and her family, she will draw from her personal and situational knowledge and experiences. She then negotiates/renegotiates her decision as to whether or not she will continue to participate in breast and cervical cancer screening programs.

All three stages of the woman's decision-making process are influenced by her conceptualisation of health and her explanatory models of illness, which in turn, are directly influenced by her cultural knowledge and values. However, other factors such as gendered roles and expectations, social support networks, and socioeconomic status affect how Vietnamese women participants make health care decisions. Structural constraints such as low income and socioeconomic status, and limited social support and resources determine how they practice health care.

Following is a diagram that shows how I conceptualise the decision making process of the Vietnamese women participants of my study.

Figure 10.1: Vietnamese Women's Health Care Decision Making Process



1. Recognition Stage

The first stage of decision making is a stage of recognition where the woman understands that there is a threat to her health and well being. This recognition stage is the earliest and probably the most important stage that triggers a chain of reactions. Recognition of a health threat often involves the experience of one's own body, which includes psychological, emotional, or physical experiences. In other words, a woman perceives that there is a health concern or problem if her body has signs and/or

symptoms, which indicate the presence of a disease or illness. For a Vietnamese woman, the "not normal" bodily experience has to be present with enough severity to cause concern. Recognising that there is a concern with one's present health, the woman then evaluates the degree of threat not to only herself, but also to others of importance to her. Thus the perceived threat is influenced both by the person's subjective knowledge and the knowledge of others (family members, friends, health care professionals, and/ or literature). During this stage, individuals will seek information about the disease which includes what it is, its etiology, what it does to the body (both psychological and physiological), its signs and symptoms. Individual's past and present experience with health problem(s), its treatment, and the degree to which she is familiar with the disease play an important role in the evaluation of the seriousness of the potential health problem(s).

In practice there are no physical symptoms of breast and cervical cancer in their early stages. Because there is no abnormal bodily sensation, a woman may not recognise that there is a potential health problem. Her perception of potential health threat is very low, therefore she is not motivated to opt for these examinations. Here the more a woman is familiar with Western biomedicines, with the diseases, and the practice of breast and cervical cancer screening, the more likely she is to engage in breast and cervical cancer screening regularly. Thus providing information about breast and cervical cancer and its prevention would impact women's recognition of these potential health threats by increasing their awareness, which in turn, might increase their willingness to opt for breast and cervical examinations.

2. Negotiation Stage

A woman enters the negotiation stage upon the recognition that there is a potential health threat. In this stage she negotiates and renegotiates between risk and benefit to both herself and others. The emphasis is also shifted from the individual's embodiment experience toward a consideration of social relationships with important others. Vietnamese women participants' negotiation process often involves the evaluation of what decisions are most appropriate (or beneficial) to important others as well as to themselves. In this process of negotiation, the risks and benefits of available options and their potential consequences are evaluated within the women's specific family context and social relationships. Of special importance is that although the evaluation of risk and benefit is carried out in consideration of both the individual and important others, for some women the benefit of loved ones may be considered more important than their own.

The ways in which Vietnamese women participate in breast cancer and cervical cancer screening practices are also influenced by the perceived risk of having those diseases. A health care action might occur (i.e., going for screening) if a woman recognises that she is at risk of contracting these diseases. A potential barrier to screening is that some women participants think that these diseases are common diseases of Caucasian women and that Vietnamese women do not get these diseases very often. There are several reasons why these "women's diseases" (benh phu nu), especially breast cancer (benh ung thu vu) are considered as not common among the Vietnamese.

First, talking about breast and cervix is considered taboo, thus both men and women (even health care professionals) do not want to talk about these topics in a public sphere. As mentioned earlier, talking about these topics generates uneasiness. For instance, when asked about what they think and know, and their experiences with breast and cervical cancer, women participants responded using general terms such as disease and cancer instead of using specific terms "ung thu vu" (breast cancer) and "ung thu co tu cung" (cervical cancer). Women participants also acknowledged that it is difficult for Vietnamese health care providers who are male to talk about these issues to female patients. Even though male physicians might not like to admit that they are uncomfortable addressing these issues, in practice they might only remind the women about mammography or send them to other female physicians (normally non-Vietnamese speaking) for Pap smears, without explaining to the women in detail how important it is to have these tests performed. Thirty three percent of the Vietnamese women had a Pap smear done once a year (in 1999, the provincial participation rate for women age 20-69 was 75%), and another 33.3% had a Pap smear done at least once in their lives. Physicians might also be hesitant to offer clinical breast examination. The availability of mammography screening in separate clinics where services are generally provided by female health professionals (e.g. x-ray technicians) may provide insight into why approximately 60% of the women participants in this study have undergone mammography at least once. In 1999, the provincial participation rate for women age 50-74 was 48%. Only 20% of the Vietnamese women in this study reported having had a yearly clinical breast examination, 12% having performed breast self-examination. Although in this study, the women's participation rate in Pap testing is not accurately reflected in the result due to the participants' age which ranged from 50 to 78 (women over 69 are not eligible for regular Pap smears), these figures suggest that the context in which service is provided and the gender of the health care provider may affect screening practices.

Second, admitting to having breast or cervical cancer might have serious social consequences not only for the Vietnamese woman but also for her family. Therefore, information about these diseases is not widely distributed within the Vietnamese population. Thus to promote the practice of breast and cervical examination, not only should information be widely distributed but the actual practice of these examinations needs to be present and visible as well.

In the process of negotiation, Vietnamese women often evaluate the meaning of risks and benefits of taking preventive action. The action that a woman is likely to take is one that is most meaningful to her in relation to her specific situation at that point in time. Here the narratives of the Vietnamese women participants often alluded to the process by which they negotiate the differences between Western (Tay phuong) and Eastern (Dong phuong) living and between Western and Eastern health care practices. In the process of negotiating these differences, there are no binary divisions that one can delineate, nor can one reduce the women's lived experiences and health care practice into any fixed category.

3. Integration/Resistance Stage

With the recognition that there are potential health problems, upon negotiating and considering the risks and benefits in relation to themselves and others, women participants then decide whether or not they will take action. They would either integrate the recommended health care action into their daily activities or resist taking such action. It appears that the women participants often consider what they need to do to achieve the in-between state —a state where self-interest is balanced against others' interests and whereby they might act in a way that is beneficial to both themselves and others.

Women's low rate of breast and cervical cancer screenings may be understood as their resistance to the dominant Others "taking control" of their bodies. Living in-between cultures as immigrants, women are often encouraged to live their lives and practice health care according to what has been set forth for them and expected of them. Women who do not conform to the dominant cultural values and health care practices might be labeled as "difficult, non-compliant patients" who belong to an "at risk population." Recommendations of breast and cervical cancer screening, their goals and standards are set by middle-class professionals who value self-control, autonomy and rationality. Thus to some women, acknowledging that they are different and not submitting their bodies to Western biomedicine's control and power may be intended as a form of resistance.

Acknowledging that Vietnamese women are different from Canadian women, some women participants embrace this difference and consider it a strength. This is also a way of resisting dominant forces. Living in an intercultural environment, living with/in "a hybrid place" (Trinh, 1992), Vietnamese immigrant women constantly negotiate differences between the so-called Canadian culture and Vietnamese culture. In this process of intercultural negotiation, they retain their values and beliefs, all the while incorporating some of the Western values into their ways of life.

To some women difference does not equate with separateness nor it is viewed as a precursor to conflict (Trinh, 1991). Difference does not create conflict; rather its negotiation replaces the latter. Some women participants, by adopting Western ideology and value, have in fact strengthened their sense of self and relation with others.

Some women participants embrace aspects of both cultures – of Vietnam and of Canada. In the process of adaptation to the new life, Vietnamese immigrants do not renounce their ethnic origin and cultural values in order to assimilate into the new society, but rather retain aspects of their cultural values and beliefs; at the same time they interact with and adopt certain aspects of mainstream society. Some women found that integrating the Western value of individualism and the Eastern value of collectivism has in fact benefited them. For example, Ms. Ngoc responded that a balance between these values has made her feel more calm and relaxed. It has helped her resolve some conflicts within herself. Under the influence of traditional Vietnamese culture, Ms. Ngoc was taught by her parents always to sacrifice her own happiness for others, for her husband, for her children, and for the husband's family, which she had always willingly accepted and acted upon. Indeed seeing others happy continues to represent happiness for her. The difference, she now feels, is that making others happy is a desire that comes from within. She continues to make others happy, but it is because she values it herself. She still makes many sacrifices, but she does so out of her own will, not because she is conforming to the dominant forces. At the very least she now has a choice without feeling guilty.

In this instance Ms. Ngoc has disrupted the boundary that separates "the critical continental theories with traditional Asian philosophies" (Trinh, 1999, p. 63). Trinh (1999) has said: "what interests me is not a return to the roots nor an assimilation of French theory but rather how I can use all the tools that I have in their radical resistance to one another; how I can read Zen Buddhism and Taoism in light of contemporary critical continental philosophy. The process of cultural and theoretical hybridity gives rise to an 'elsewhere within here' - a space that is not easy to recognise, hence to classify" (p. 63). Similarly, Ms.

Ngoc insisted not only that she need not abandon her beliefs and values but also that she can see some of Confucius' teachings within contemporary Western thinking. To Ms. Ngoc the boundary that divides Eastern and Western modes of thinking is permeable.

> No, no, I keep everything that is mine. If it is good, I keep it. For example, the old verse that tells us how to treat others: "Nhan, Nghia, Le, Chi, Tin." Nhan means kindness; Nghia means justice; Le means respect; Chi means wisdom; and Tin means trustworthy. But you see, Westerners have these principles also. So if you take this Confucius' concept and compare it with the teaching here, you can see that people here have been taught all that as well. (Translated and edited from W-Ngoc-19-A-1)

Here in-betweenness and resistance to the division between East and West, between Self and Other, echoes what is said by a Vietnamese woman: "Our history is always on the borderline of this North and South, but I speak from somewhere in both places, in between, and I will not accept this division, and I will not think truth divides itself in that way" (Trinh, 1999, p. 22).

In their resistance to the division, to the conceptualisation of us/them, some women participants see that health care is a shared arena where both themselves and their health care providers are held responsible and accountable. It is interesting to note that their view reflect what many Canadians also value. Their perspectives often reflect liberal egalitarianism, which values both individual liberty and the interrelationship between individual and society.

Here Vietnamese women's decision making process does not necessarily follow the general assumption which holds that individuals make health care decisions based on their ability to appraise symptoms, review available resources, then make voluntary, autonomous choices in regard to their health care. In this research Vietnamese women appraise symptoms based on their bodily experience and they make choices on what they evaluate as the best action to deal with what they are experiencing. However, there are two problems associated with this process. First, Vietnamese women often cannot accurately review the available resources. Many Vietnamese immigrant women might experience difficulty in reviewing resources that are available to them because of language barriers, inaccessible health care information, unfamiliarity with the health care system, and societal structures, such that they would not know what kind of services are available for them to access. Second, Vietnamese women's health care choices are not voluntary nor are they autonomous. They cannot freely decide on their health care actions because immigrant women are among those who have the least control over their lives. Many structural constraints exist, such as low income and socioeconomic status, and limited social support networks. Thus, by not examining the structural conditions which constrain their health care seeking, we

would be ignoring much of what happens during their lives and why they choose not to participate in certain health care programs. As Good (1994) points out, if we are relying only on the individual beliefs and values as indicators for an explanation of how individuals practice health care, we are reinforcing assumptions that individuals who get sick are weak, submissive, or irresponsible.

4. What Leads Women to Seek Health Care

The women participants in this study will seek Western biomedicine treatments if they experience serious illness. Simple health care problems such as the common cold or flu would be more likely to be treated at home using traditional Vietnamese or Chinese medicine such as ointment, "xong," "cao gio" (coin rubbing), etc. There is an assumption that traditional medicine has long-term effectiveness, that it works slowly, whereas Western medicine has immediate effect. Breast cancer and cervical cancer are viewed as more serious problems that would be best treated using Western biomedicine.

Women participants would seek help if there were symptoms which indicated that they have contracted the diseases. Cervical cancer is often associated with having discharge and breast cancer is often associated with a lump in the breast. Thus breast cancer and cervical cancer screening is a challenge because there are no symptoms at the early stages of the disease. Women would go for a breast examination and Pap smear if they know about these diseases, their seriousness, and the importance of obtaining treatment for them. They would also have these examinations if the family physicians reminded them to have these tests done. However, reminding the women by having the responsible agency sending letters to each household is seen as an ineffective method because many older women cannot read English and they may not even be able to read in Vietnamese.

Women participants would be more likely to undergo a breast examination and Pap smear if they knew that someone in the community has contracted the disease. Thus knowing someone who has the disease brings awareness. In this case, increased knowledge of breast and cervical cancer is not achieved by reading pamphlets or books, but by concrete experiences.

Vietnamese women's decision to seek or not seek health care also depends on how they conceptualised health and illness. Health means many things. Keeping healthy ranges from making sure that food is clean, getting good sleep, not worrying about relatives back in Vietnam, to making sure that their children's present and future are taken care of. There is an adoption of Western health care practice among Vietnamese women. To some women, diet and exercise play an important role. Thus ways in

which women participants keep themselves healthy include trying to eat more fresh fruit and vegetables and less fat, paying attention to one's cholesterol level, jogging, swimming, and walking.

The majority of women participants attribute many illnesses to being overweight, inactive, hereditary, and personal hygiene. Cervical cancer is seen as related to not keeping oneself clean, or contracting an infectious disease such as a sexually transmitted disease (STD) or AIDS from a husband's infidelity. So, for these women, keeping clean by washing and bathing, and keeping control of the husband sexual behaviours are ways to avoid cervical cancer. That is also the reason why some women participants think that unless they are having discharge or their husbands have an STD or AIDS, they are "normal," they do not have the disease. Thus they see no need to go to doctors for a check up. Most of the women participants do not know what a Pap test is, what it is for, and only two women have had regular Pap smears. Most of the women said they had a Pap test done once or twice.

5. Why Women Cannot Seek Health Care

The majority of women indicated that they would not seek health care unless there are symptoms indicating the presence of diseases. This makes encouraging women to go for breast and cervical examinations a challenging issue. To many of them, if there is no soreness of breast, if there are no lumps, no unusual discharge, no pain, etc., then there is no disease.

It is not likely that women participants would seek health care if the cost outweighs the benefit. For some women, seeking health care costs money by losing time from work since going for a checkup often takes several hours. Undergoing these tests would also cost their family members. Some women (especially those over 60 years old) have very limited language skills, are not familiar with the city structure and transportation system, and as such must rely on family members for assistance. Many women participants explained that they do not want to bother their children who, in their opinion, have very busy lives and schedules.

Both women participants and health care providers insist that a dearth of health care providers, especially female health care providers, is a major deterrent to Vietnamese women seeking health care and having breast and cervical examinations. Limited health care providers have also led to long waiting periods. The women participants have identified that long waiting at the doctor's office has negatively influenced their willingness to go for an annual check up. However, some physicians do not support this assertion. They report that time is not a major barrier for women. One physician estimated that only 20%

of his patients are working, and the rest, he said, have plenty of time to go for a checkup. However, of the 15 women I interviewed, four women work fulltime, another four women work as babysitters or as seamstresses at home. The rest of these women are either looking after grandchildren or other family members. Thus it is reasonable to say that although some women may not hold official job titles, time remains an important factor in their daily lives.

The majority of women participants indicated that they did not seek health care because they did not know about the available health care services. As I have mentioned, inaccessibility of health care services is also the result of limited amount of information that reaches Vietnamese women. This is one of the reasons why women do not seek health care that is supposedly available to them. The point here is that although there are health care programs available, these programs do not provide services in such a way that can be easily accessed by Vietnamese women.

Invasion of the personal privacy is another major deterrent in breast and cervical examination. Discourses around these issues often reflect Confucian views of modesty, men-women relationship, concealment, and femininity. Women participants revealed that they are very hesitant to seek health care if there is a great invasion of personal privacy. Breast and cervix are body parts that are very private to women. Examination performed by male (sometime, even female) health care professional is viewed as a great invasion of personal privacy by some women. Because there is social stigma associated with cervical cancer, STD and AIDS, some women verbalised that having those diseases brings disgrace to themselves and their families. Confidentiality is a key concern and seeking help for these diseases is often done in secrecy. Thus there is a real danger that individuals who are suffering from these diseases do not get the kind of help they need. It is interesting to note that breast and cervical examinations when subjectified as something very personal, elicit great resistance from women. By contrast, less resistance to these examinations is elicited when they are objectified as professional tasks or as jobs that must be done.

The perspectives of health care providers are quite similar to those of the women participants. All health care providers of the participants recognised that breast examinations and Pap smears are uncomfortable procedures for Vietnamese women. All four Vietnamese male physician participants said that they would refer women who are not comfortable with these tests to a female physician. One physician said that clinical breast examination is not appropriate for Vietnamese women.

6. From Whom Do They Seek Help?

The majority of Vietnamese women participants seek help from all three sectors of health care arenas, the popular sector, the professional, and the folk sector (Kleinman, 1980). The decision as to whom they should seek health care from depends very much upon what the women perceive as the nature of the health problem, its etiology, its seriousness, and who they think would be able to treat the problem. If the problem is evaluated as not serious, like a common cold, general ache or pain, the popular sector of health care such as self-treatment is the preferred strategy. On the other hand, if the problem is perceived as more serious, such as persistent pains or infection, then help from the professional sector is sought. Women would then seek help from their Western trained physicians. However, women participants also seek help from the folk sector of health care such as acupuncture, especially if Western medicine fails to alleviate symptoms. There is a popular assumption that Western biomedicine is better at treating acute illnesses, but traditional medicine is better at treating chronic illnesses.

For several women participants, the help seeking process is often initiated from a variety of available resources within the popular sector. This finding is in agreement with the result of a Longitudinal Survey of Immigrants to Canada (LSIC) released in 2003 (Citizenship and Immigration Canada, 2003). The survey revealed that relatives (38%) and friends (37%) provided the most support to the new immigrants in obtaining health-care services. Furthermore, the study showed that family class immigrants (women often are admitted to Canada under this category) relied much more heavily on family members (79%) for their assistance.

Family members and friends are often consulted. In seeking health care information, many value the experience of someone they know who had coped with the same illnesses. Therefore, knowing the actual health care experience of someone whom the women can relate to might send a more convincing message. Dr. Dau noticed that when someone in the community was sick with a disease, there was an increase in the number of patients who came to him for a check up. Thus, as health care providers, we should not underestimate the power of informal, oral lay communication and its role in increasing people's health care awareness.

The participants' discourses regarding strategies to promote breast cancer and cervical cancer screening among Vietnamese women often revolve around who they think should take responsibility for breast and cervical cancer screening. Women participants' discourses often reflect egalitarian ideology which stresses both individual and societal responsibility towards health care. Women's narratives about

others' responsibility reflect two different levels, the individual and the institutional level. At the individual level, women participants emphasised that both themselves and their doctors have the responsibility to promote and practice breast cancer and cervical cancer screening. The women participants also want doctors to be more active in the promotion of these practices. They want doctors not simply to tell them to go for these tests, but to explain more what breast and cervical cancer are, and why it is important to participate in screening. The women participants' discourse on doctors' responsibility also called for a better doctor-patient relationship, more effective communication, and improved accessibility to doctors' care.

In general, the women participants have a positive view of Canadian institutions and the services they provide. The majority of women participants expressed their gratitude to the host society and felt that institutions and governments in Canada have lived up to their expectations, although they would like to see more support for language training. This positive view is mainly due to the fact that Vietnamese women often contrast the life that they now have with life back in Vietnam. It is interesting to note that they do not compare their life with the life of women in the general population. By not comparing themselves with the Canadian-born women, Vietnamese women are in fact more content with their own situation.

Health care provider's perspectives on health care responsibility take a slightly different turn. They emphasised that women should take more responsibility for their own health. Health care providers have also said that institutional and social constraints have negative effect on Vietnamese women's breast and cervical cancer screening practices. They therefore call for more redistribution of health care funding and resources for immigrant women. Some male physician participants do not acknowledge that women's low participation in breast and cervical cancer screening programs might be due to the physician uneasiness and avoidance to explain these examinations in detail to women. All physicians said that they talk to women about these tests, however interviews with women revealed that they do not remember their doctors' discussions. This calls into question the effectiveness of doctor-patient communication. Thus health care providers need to pay attention to how, what, where and when breast and cervical cancer and its screening information is provided to the women. As McKellin (1995) has pointed out, clients' understanding of health problems and the decisions that they make to engage in available programs are shaped by the clients' interaction with health care professionals and "[their] perceptions of services and the importance that [they] place on the long term impact of their decisions" (p. 1479).

7. Women Participant's Experience on Breast Cancer And Cervical Screening

Interviews with women participants revealed that mammography is an uncomfortable test not only because women are hesitant, but also because it is quite painful. However, most women participants said that they would go back for these tests. The women revealed that having female technicians perform the mammogram helped to reduce their uneasiness. The younger women participants tended to have mammography done; however only a few said that they have it done every two years. Regarding breast self-examination, only two women mentioned they know and practice it. All the other women participants did not mention or avoided discussion of the issue. With clinical breast examination, most women said that they would not have it done by Vietnamese male physicians, but they would have it done by either Vietnamese or non-Vietnamese speaking female physicians. With regard to Pap smears, the majority of women (including women who have them done regularly) said that this test is very uncomfortable. For many women, it was critical that a female physician do the test. Thus, having only two female Vietnamese speaking physicians in Vancouver might contribute to the low rate of Pap smears among Vietnamese women.

Women have also described limited information on breast and cervical cancer in the Vietnamese language as the direct cause of the inaccessibility of these cancer preventive screening programs. Other indirect causes, as I have previously mentioned, are limited Vietnamese speaking physicians, especially female physicians, and the cost that women endure by taking time away from working and taking care of their families.

Women's participation in breast and cervical cancer screening programs is also influenced by the kind of social support that they get, which includes both formal and informal support networks. Interviewing the women revealed that diminished support from both sectors contributed to the low participation in cancer preventive programs. With the understanding of factors that influence Vietnamese women's participation in breast and cervical cancer screening, in the next section I suggest promotional strategies that might increase women's participation in these programs.

B. Promotion Strategies for Breast and Cervical Cancer Screening

At the theoretical level, I propose that health care professionals should (a) recognise that women of different ethno-cultural background are active participants of health care, (b) put less emphasis on rationality and more on recognising that women's health care decision making is a dynamic process that varies under specific circumstances, and (c) recognise that individual's health care behaviour is influenced not only by their cultural knowledge and values, but also by their socially constructed position, race, gender and class.

At the practical level, I propose (a) that collaborative working relationship with physicians and improving physician-patients relationship is essential for successful promotional strategies for Vietnamese women, and (b) that a health education strategy must incorporate Vietnamese women's different ways of knowing. At the institutional level, increasing accessibility to these cancer preventive programs demands that health care policy makers increase institutional funding to support programs that provide services to immigrant women. Finally, I discuss implications for future research.

1. Women Are Active Participants Of Health Care

It is important for health care providers to acknowledge that even though we might not see Vietnamese women seeking help from professional health care providers, it should not be misinterpreted that these women are not interested in looking after their health or are irresponsible toward health care. In fact, these women are active participants in health care. There are many health care activities that exist between family members and community members.

Health care providers need to recognise that Vietnamese women's low participation in breast and cervical cancer screening program is not due solely to their cultural knowledge and value, nor should it be viewed as their unwillingness to prevent these diseases. Their low socioeconomic status, gendered roles and expectations, and diminished social support networks, which is the result of societal inequity, influence women's health care behaviours. Furthermore, health care providers should pay attention to how health care responsibility is conceptualised and how their conceptualisation of responsibility influence health care practices. In the prevention of breast cancer and cervical cancer, Vietnamese women should not be blamed for their "non-compliance" to engage in preventative measures, but rather the impact of race, gender, and class in shaping health care should be critically examined.

It is equally important for health care providers to recognise that unequal power relationships will lead to resistance and ineffectiveness in health care. Women are active agents and their resistance to the dominant forces has taken many forms (Aptheker, 1989). Although we may not see many of these resistance activities as revolutionary or as taking the form of political activities, there are many kinds of women's resistance that go unnoticed by the public. These include the ways in which women struggle to improve the quality of life for themselves, for their children, and for other women (Aptheker, 1989).

2. Give Less Emphasis on Western Rationality

In the field of health promotion and disease prevention, the Health Belief Model (HBM) has been used to investigate public beliefs and risky health behaviours. In the HBM, "belief" is viewed as "those beliefs and practices relating to disease which are the products of indigenous cultural development" (Hughes, 1968, cited in Good, 1994, p. 39). Within this model, the underlying assumption is that if people know about the risks associated with the development of a certain illness, they will take actions to reduce their risk (Gifford, 1986). However, there is overwhelming evidence to show that people generally do not make strictly rational decisions when assessing risks and other issues of uncertainty (Gifford, 1986) and that "risk behaviour should be seen as a situated product, emergent from the immediate situation" (Bloor, Barnard, Finlay, & McKeganey, 1993). The problem with the model's underlying assumption also arises when one tries to apply the HBM to cross-cultural studies. As I have discussed earlier, Vietnamese women do believe that breast examination and Pap smears are beneficial to their health. These beliefs, however, do not play a major role in their willingness to engage in these examinations. Furthermore, as discussed by Aldwin (1994), Lazarus (1993), and Parkes (1994), an emphasis on the investigation of the public "right" and "correct" health behaviour might cause not only over-generalisations of certain behavioural conducts, but also a tendency to group these conducts into a single continuum or category. As such, human behavioural researchers often dichotomise public health risk behaviours into either "correct" or "incorrect." To evaluate whether certain behaviours are correct or incorrect, objective universal criteria for making these judgments must exist. Many attempts have been made to develop descriptive criteria for analyzing "correct" or "effective" behaviour that would capture a diversity of individuals' action responses. For example, following the HBM and Preventive Health Behaviour, Rosenstock (1974) and other researchers studied why people use or fail to use certain services. Their studies have included demographic variations, illness behaviour and health beliefs, perceived

susceptibility, perceived severity, perceived benefits and cost, etc. (Becker; 1974; Rosenstock, 1974). Although these descriptive criteria cover a wide range of human responses, reaching a general agreement on such universal criteria remains problematic (Ridder, 1997). This example of HBM, while thorough in some categories, does not accurately reflect health behaviours of other cultures (Aldwin, 1994).

For many people, not only is the conceptualisation of risk not objective or quantifiable, but the decision to engage in certain health care practices to reduce risk is influenced by their own terms of reference, which they define differently to that of epidemiologists and clinicians (Gifford, 1986). Daniel Ellsberg (2001) studies patterns of choice behaviour in individual decision-making. He asserts that often, so-called "irrational" behaviour is not accidental, but deliberate, in situations where the considered outcome is ambiguous or is indeterminate. Moreover, this kind of behaviour is often not easy to modify even after much consideration by the individual. As such, Ellsberg puts forth that irrationality should not be considered anarchistic but as a distinguishable pattern of decision making that should not be taken for granted.

For many decades, the rhetoric of decision making has paid much attention to the effect of being rational. It is assumed that rational decision makers would have considered the choices and its possible outcome before making their decision (Ellsberg, 2001). Thus the Vietnamese women should or would have had considered the cancer preventative probabilities and their outcomes when they make the decision whether or not to engage in the practice of cancer screening. Because of the explicit assumptions that having these tests done would bring the best result which might be the early discovery of the cancer (versus late discovery of the cancer which would cause much suffering or possibly death), the expected best decision – the rational decision would be to engage in these practices. Individuals who do not engage in the practice might be considered as individuals who do not have the ability or the intelligence to make such rational decisions.

This logic of rational decision-making, values only rationality and what is considered as the best-expected outcome, would have to be based on a "rational" criterion (which often is a given standard by the dominant "Others"). This approach is challenged by the work of Gifford and others mentioned previously. Vietnamese women, operating in a particular social context, use different contextually relevant assessments of self and other assumptions in rational decision-making.

As Ellsberg (2001) points out, "to act reasonably one must judge actions by their consequences. But what if their consequences are uncertain? One must still, no doubt, act reasonably; the problem is to decide what this may mean" (p. 1). Thus, in the promotion of breast and cervical cancer screenings, the consequences of having breast and cervical cancer screening done would have to be beneficial to the women in order for them to engage in that kind of practice. However, the ways in which Vietnamese women judge the consequences of these actions is different from those of the general Canadian population. Because of their life circumstances with many competing life priorities some Vietnamese women might consider going for these tests is not only without benefit to them, but it might also have negative (even harmful) consequences. Going for these tests might mean that they had to wait at the doctor's office for several hours while the children are left unattended. It might mean that they have missed the chance to work overtime to make some extra money to pay bills. For many older Vietnamese women, going for these tests additionally means that they have to make several arrangements for both transportation and translation services. For many of them, it also means that they have placed an extra burden on their children, who already have very busy and stressful lives. As such, a reasonable decision for many Vietnamese women is not going for these tests.

So what does this all mean for health care providers and health care policy makers? How might this analysis impact health promotion and disease prevention for immigrants? Health promotion and disease prevention programs need to take into account not only the very different world-views of the people whom they aim to serve, but also their lived actualities. We need to recognise that what is considered as a reasonable act by immigrants might be contrary to what is expected by the health care providers. By saying all of the above, I do not mean that we should accept Vietnamese women's low participation in the cancer screening programs as only the result of their personal choice. The point I want to make is that these contradictions should serve as indicators for further investigation into the reason(s) why there is such discrepancy and whether or not our expectations are realistic. We should recognise that appraisal of the action's potential consequences is a complex process that is directly influenced by the individual's lived circumstances and context at a particular time, in a particular place. Frank (1995) reminds us that "[the present] disease-specific policy responses-through health care, public health programs, or otherwise-may be ineffective because they do not address the underlying causes of the social gradient in health status...a [more] understanding of the relationship between social position,

related stress, coping skills, and subsequent healthy outcomes requires investigation at a more general level than the etiology of specific diseases" (p. 236).

3. Socially Constructed Position, Race, Gender, and Class Affect Health Care Behaviour

Providing health care to immigrant women, we need to change our way of viewing health care responsibility. Responsibility for health and health care should lie both with the individual and with society. Because there are many external factors affecting how individuals live their lives and practice health care, individuals should not be blamed for their noncompliance with medical regimes. Vietnamese women's barriers to participating in breast and cervical cancer screening should not be assumed to be due mainly to their cultural knowledge and values. Investigation of barriers to health care practice should encompass many contextual factors, namely, social, political, historical, and economic factors that affect their lives and health.

Health care professionals need to consider the individual's socially constructed position and recognise the impact of race, gender and class. The individualistic approach encouraged in current illness interventions and operating under many 'taken-for-granted' assumptions, may have helped individuals prevent disease and illnesses to a certain extent, but are likely to overlook the social relations that contribute to and define illness. Health promotion and disease prevention should not only be concerned with the promotion of what one should do to stay healthy, but also with the ways in which social relations create "healthy" versus "at risk" subjects, which contributes to our sense of self and how we live our lives and practice health care. Thus, it is necessary to challenge the individualistic, rationalistic, and objectivist discourses by re-examining philosophical and theoretical perspectives and rethinking the power/knowledge connection that shape health care theory and practice (Newton, 1995). Furthermore, health care professionals need to recognise the ways in which the dominant discourse creates the meaning of "at risk" individuals, and how these meanings shape the client's subordinated social position, their coping strategies, and available social resources to deal with illness. This shift in perspective would encourage health care providers to pay more attention to the macro-social factors that shape the ways in which clients experience and manage health risk. It might change the emphasis from considering what the individual should do to the ways in which unequal social relations shape how health care is being provided. With this shift in perspective, health promotion and disease prevention approaches might pay more attention to reducing harmful external factors, fostering social equity and justice, and increasing

accessibility to health and health care for the marginalised population. The question of who is to blame and who is responsible might then be answered from a different perspective that disrupts and challenges the dominant discourse of "keeping healthy." As Thomas (1997) has pointed out, socially constitutive human relations and gendered role expectations can further create distress. Therefore, health care providers need to assess how these perceived social relations and expectations impact an individual's health and health care. Because health care requires an emphasis on individuals and their interrelationships within society, health care professionals should develop a discursive approach that emphasises the roles of social, cultural, political, and economic factors at the intersection of race, gender, and class in framing our social organisations, human relations, thus, health care practice.

C. Implications for Practice

1. Developing Collaborative Working Relationships

Most of the women participants state that they seek help from their family physicians. This emphasises the important role of these doctors in the promotion of breast and cervical cancer screenings. It is important to recognise that although the majority of the women participants talked about their embarrassment and hesitation at having breast examinations and Pap smears, some have said that if their doctors gave them information and remind them of these tests, they would have it done regularly. Thus, the promotion of breast and cervical cancer screening should focus its effort on both the Vietnamese population and their doctors whether they are Vietnamese speaking or English speaking family physicians. However, because many Vietnamese women seek health care from Vietnamese speaking physicians, collaborative effort with these physicians is a very important strategy.

To develop collaborative relationships with physicians, it is imperative for health care policy makers to recognise that Vietnamese speaking family physicians are practicing in a very unique setting. They are practicing medicine in an in-between space – a space where the practice of Western biomedicine model, Western knowledge and values intersect with Eastern medicine, knowledge, and values. Negotiation between differences within that space requires much more effort and sensitivity, and so support should be given to these health care practitioners. As mentioned in the previous chapter, most of the Vietnamese speaking physicians are experiencing high patient volumes. High patient volume may not necessarily be viewed as a negative factor by some physicians because more visits from patients

translates to more money, but Vietnamese women may view a very busy practice as a negative because the doctor cannot take sufficient time for them. Thus insufficient time to spend with patients is a deterrent factor for immigrant women in accessing health care services.

2. Considering Women's Different Ways Of Knowing

To increase community awareness about the diseases, both formal (i.e., workshops, teaching sessions, distribution of pamphlets, and books) and informal (i.e., word of mouth, discussions among friends) routes should be taken. Traditionally, Vietnamese health care practices often involves oral teaching where one learns how to take care of one's health by listening to the elders. Grandmother, mother, and aunts are instrumental in relaying health care information to the younger generations. With the influence of biomedicine health care and education, younger generations have now acquired health care knowledge through the formal school system. However, the practice of oral tradition still exists and remains an important way of distributing health care information, especially among the elderly. As such promoting breast cancer and cervical cancer screening should target not only the women, but also family members and community members as well.

The women participants also indicated that if encouraged by physicians, if breast and cervical examination would benefit both themselves and their families, if going for these examinations does not create difficulty for themselves and for other family members, and if they evaluate seeking help as a priority, then they would go for these tests despite the feeling of embarrassment. Delay in seeking health services might be the result of competing priorities. For some Vietnamese women, others priorities such as the family's financial situation, seeking employment, and children's education, might be viewed as more important. Thus health promotion and disease prevention strategies should place emphasis on finding ways to promote looking after one's health as important not only for oneself, but also for their important others. As suggested by Mrs. Le:

> You have to say why it is important to prevent the disease. You have to explain to them that even though looking after husbands and children is important, keeping themselves healthy is also important. It is this, if you are sick then you stand to lose everything. What ever you invested in you lose. You have to say that if they are sick then all their hard work, their savings will be gone. They work so hard for their children, but if they fall ill, all will be gone. So if they could just take one day a year to go for these examinations, they would be able to enjoy the fruit of their hard work for the rest of their lives. You need to explain why going for these tests is good in that way. Saying that these tests will help them live longer is not going to work. They do not care about that. (Translated and edited from W-Le-8-A-1)

To have a person who has a disease share her experience with other members of the community is a powerful strategy. However, finding a suitable volunteer might be very difficult because of the privacy issue, the social stigma, and the moral assumptions that are associated with breast and cervical cancer. Some Vietnamese still believe that one suffers from serious diseases because one did not live a moral and ethical life or that his/her ancestors were immoral and unethical. Thus, having these diseases might bring disgrace to the entire family, not just oneself. Although in Canada, this belief has dissipated in recent years, the older population still talk about it.

One of the risk factors of having breast cancer is hereditary. Although only 8% of all cases of breast cancer are hereditary (Apantaku, 2000), knowledge of the hereditary component might prevent a woman who has breast cancer from publicly talking about her experience because of the fear that it will affect her children, especially her daughters, and prevent them from finding a good suitor for marriage (similar to the social stigma attached to having someone in the family with a mental health problem). Furthermore, because cervical cancer has been associated with the infection of human papilloma virus (HPV), a history of sexually transmitted diseases, multiple male sex partners, and early age of first intercourse, for a Vietnamese woman to admit that she has cervical cancer is equivalent to admitting that she might have one or all of the above mentioned risk factors. It might mean that she is not a "good" woman or that she is "vo phuoc" (unlucky) to have a husband who "runs around" and gave her the disease. This will prevent women from talking about the problem, and might even prevent them from going for Pap smear due to the "fear of knowing."

The high rate of cervical cancer among Vietnamese immigrant women revealed by the U.S. National Cancer Institute should not be construed as the result of the women's sexual practices because the majority of Vietnamese women value and practice monogamy. Many of them have placed great emphasis on virginity before marriage. Therefore, more research is needed to investigate what causes Vietnamese women's high incidence rate of cervical cancer. Because other risk factors for having cervical cancer are low socioeconomic status and nutritional deficiencies, the racial/ethnic differences in cervical cancer rates might be due to the adverse effect of socioeconomic status and access to health care (Lawson et al., 2000). Thus, information that is being provided to the Vietnamese women regarding the etiology of cervical cancer should emphasise this fact.

Health care providers should recognise that there is a problem with the imposing of culture. Beverley Bailey (2000) talks about the problem of imposing a White mainstream system of doing things

and a White notion of what "should be" on a group of people who live in a different reality and have different ways of seeing their social world. From her experience, the Canadian institutions, in particular educational institutions, do little to recognise and honour other ways of knowing. As a White, middle-class teacher/educator, she came to the realisation that for people to learn, "[they] must be able to ground themselves in their own knowledge of self, and much of that knowledge has to do with a people's unique history and embedded way of learning – that education grows out of culture and is part of it" (p. 133). To echo her comments, we bring people into our country and find pride in the fact that we are creating a safe place for them to live, and a better health care system for them to take care of their health. We are supportive and helpful as we mold them into our way of living and practicing health care. On the other hand, by our discursive and institutional practices, we make sure that they are remain who they are – the different "Other."

In providing health care services for people of different ethno-cultural background, we need to realise that there is a potential clash of cultural values. For some groups of people, the purpose for learning about health care is to help one another, to be useful, to take care of their loved ones. Its purpose might not be for individual health but for family health – the health of others. Bailey (2000) points out that the purpose of education for Aboriginal people is "to serve the people. Its purpose is not individual advancement or status" (p. 133), which she found quite contrary to the Western mainstream individualism. Thus, integrating this way of seeing and valuing into health promotion and disease prevention programs requires thoughtful reflection and careful planning.

Furthermore, the ways in which we deliver/teach health education requires special scrutiny. We need to understand that for many groups of people, learning is often conducted in informal, relaxed situations. It is also often in the form of oral tradition, focusing on the sharing of skills and knowledge between friends, neighbour, and family members. Thus, the formal class room type of learning, although it might appeal to the younger generation, is not the most effective environment for the older generations. As a result, formal seminar and workshop organisers might have a very difficult time in motivating people to attend. Creativity is required. As suggested by several participants, the location for workshops should be close to where people live and informal discussions with a group of women in their home might be more desirable.

3. Increase Funding To Support Programs That Provide Services To Immigrant Women

It has been expressed by health care provider participants (physicians and community health nurses) that institutional funding support is very limited for promoting health care among the Vietnamese. Restructuring of the health care system with budget cut back of health care programs has made limited funding to health care services for immigrants even more noticeable. Thus, the government's policy makers need to recognise that promoting health for immigrants is a priority and that immigrant women truly merit equitable high quality health care.

Furthermore, health care policy makers need to emphasise that (a) sensitivity to and respect for ethnic diversity are important dimensions in planning health care services (Anderson, 1990; Dyck, 1989). (b) It is an ethical and legal mandate for health care professionals to address the cultural needs of individuals, families, and communities (Kulig, 1995). And (c) to ensure that all citizens have equal access to health care services, health care institutions are obliged to consider ethnic diversity in planning resource allocation and in decision-making processes (Donnelly, 1998).

Even though Canada has one of the best health care systems in the world and the Canadian health care system has changed its services to some extent to accommodate the health care needs of clients with different ethno-cultural backgrounds, many immigrants living in Canada are experiencing difficulties accessing current health care services. Based on ethnographic data obtained from immigrant women living with diabetes, Anderson and her colleagues (1993) argued that a significant number of her informants had difficulty in their encounters with health care professionals. The women, especially non-English speakers, were unable to obtain the services they needed because health care professionals often failed to understand the conditions in which the women worked and lived could be a major barrier to the appropriate management of illness. As a result, the current health care system, which is based on the Western ideology of health and illness, remains inadequate to meet the health care needs of clients from different ethno-cultural backgrounds (Anderson, 1991).

Given that there is a large number of South East Asian-born people – the so-called Oriental – entering Canada each year, government policy makers and health care professionals need to recognise that immigrants have special mental, physical, and cultural health needs, and that these needs arise as the result of the impact of the migration process and the very different environments and circumstances from which immigrants come (Donnelly, 2002). It is evident in the present study that Vietnamese women have many difficulties accessing health care services This finding is paralleled by the result from a recent

survey among immigrants. Although long waiting list and a shortage of health care providers are also issues faced by the Canadian general population, 75% of immigrants who sought health-care services experienced these problems (Citizenship and Immigration Canada, 2003). Furthermore, almost one in four new immigrants had difficulties accessing health-care services and 45% of these said the inability to find a doctor who would accept new patients as their most serious problems (Citizenship and Immigration Canada, 2003).

Social and economic inequality has also created unequal access to health care services for the immigrants. Factors such as occupation and socio-economic status have a direct influence on health and quality of life. New data clearly indicate that "people's health and well-being suffer the most when they are unable to secure appropriate employment and can no longer access adequate 'social safety nets' and supportive services" (Gottschalk & Baker, 2000, p. 7). People with higher incomes and socio-economic status are healthier and have lower mortality rate than people with lower incomes and lower socio-economic status (BC Provincial Health Officer's Annual Report, 1996; BC Ministry of Health, 1997). Many immigrant women and children are located within the lower socio-economic groups, and many unskilled immigrant women are working at low paying, unskilled jobs (Anderson, 1998; Anderson et al., 1993; Ng, 1988).

Thus having financial stress/constraints and/or living in poverty are barriers for Vietnamese women to access cancer screening services. As previously demonstrated, many Vietnamese women stated that financial stability and having enough money to pay bills and to look after the children are their greatest concerns. Therefore, low income or loss of employment or unemployment will have a direct effect on how these women participate in breast cancer and cervical screening programs. According to the 1996 Vietnamese immigrants' profile, many Vietnamese women are living on a very low income. For these women, then, finding ways to improve family financial status, to work overtime, or to find a job has become their priority. Going to the doctor to get their breasts checked and to have a Pap smear when there is no physical symptom or discomfort might be the last thing on their minds. Therefore, Vietnamese women's low socio-economic status or poverty is a barrier to these women's participation in breast cancer and cervical screening programs.

The issue here is the limitation of both health care access and availability of health care resources to Vietnamese women. Barriers include: (a) the present health care system is set up to serve mainstream society (Anderson, 1985, 1993; BC Royal Commission on Health Care and Costs, 1991). Not

only are trained health care providers for the Vietnamese limited, when they are available they might not be effective helpers because they have to function within the organisation's policies, objectives, and procedures. Often, these procedures and objectives are set up to meet the standard of middle class "White" Canadians. (b) Immigrants' lives are often difficult. The process of adaptation to the host society, to the new ways of living is often a long and painful process with many struggles both within the "inner family life" and the "outside community life." For Vietnamese women, coping with inner family life, include issues such as changing roles and relationships, and added responsibility, all of which might lead to changing expectations and conflicts. In coping with outside community life, there are several issues: struggle for job opportunities; struggles with the limitation in language; struggles with new ways of conducting businesses; and last but not least, struggles with discrimination from both within and between cultural groups. Awareness of how immigrant women cope with life circumstances might decrease health care providers' perception of immigrant women as "non-compliance clients. " Health promotion programs might then include strategies which address what women themselves identify as barriers to their health care.

Health care professionals should also be aware that there are different priorities. In working with Aboriginal students, Bailey (2000) found that not only do her students lead highly complicated lives, but also that their priorities are quite different. To many of her students, the child, the extended family, and those in the community who are in need are priorities. Similarly, for the Vietnamese women, family members, husbands, children, and the extended family's needs are considered important, deserving of their attention. It is important for health care providers to recognise that this practice should not be viewed as the women's lack of interest or sense of self, but rather "such an approach may be strengthening and may be a strong foundation from which to approach a somewhat hostile world. By insisting that our requirements be met, we may be weakening some of the essential health giving ingredients of the cultural group" (Bailey, 2000, p. 131).

As bell hooks (2000) suggests:

> Feminist activists need to affirm the importance of family as a kinship structure that can sustain and nourish people; to graphically address links between sexist oppression and family disintegration; and to give examples, both actual and visionary, of the way family life is and can be when unjust authoritarian rule is replaced with an ethic of communalism, shared responsibility, and mutuality. The movement to end sexist oppression is the only social-change movement that will strengthen and sustain family life in all households. (p. 40)

Changes need to take place at both individual and institutional levels. At the individual level, health care professionals need to be not only aware that there are cultural differences, but they also need to educate themselves as to what these differences are. Although it is not an easy task to learn about all our clients' cultural differences, understanding the core knowledge and values of others may change the ways in which we provide health care. In the words of Beverly Bailey (2000):

> I come to know, through reading, taking, experiencing, many aspects of a different culture. I can begin to understand the different terms, the different views of the world. Through opening myself to the experience of becoming truly knowledgeable about another culture, I come to have new knowledge and increased respect. I can no longer function from a place of superficial knowledge and ignorance. (p. 136)

However, that is not sufficient. Although "we [need to] consciously work to unearth our own prejudices, biases, and racist notions" (Bailey, 2002, p. 136), in the view of bell hooks (2000), working for change should not focus solely on changing individual attitudes, but rather on addressing racism in a historical and political context. We must explore not only the impact of racism, classism, sexism, educational elitism, but also how these stereotypical assumptions remain intact in our societies. For until we know its structure, how it was built and maintained, we would not know how to dismantle it in the most effective way.

Racial discrimination, class assumptions, and sexism, are responsible for many negative consequences in providing health care to clients of different ethnocultural backgrounds and providers' negative attitudes and behaviour towards the clients of health care (Papps & Ramsden, 1996; Ramsden, 1990). Health care providers need to realise that in health care, racism refers to negative attitudes and behaviours exhibited towards clients, and that discrimination can potentially interfere with a health care professional's willingness to care for clients who are perceived to be different. It is imperative for health care professionals to recognise that helping immigrant women requires not only an understanding of these individuals' problems and solutions, but also an awareness that social, cultural, political, historical, and economic forces affect and determine how they cope with life events and practice health care by situating them in a certain position within society.

In giving health care to immigrants, we need to recognise that many of them are historically, culturally, socially, and economically disadvantaged within our society. A combination of the attitudes of health professionals, poverty, and different understanding of health between biomedical oriented health care professionals and immigrants can lead to misunderstanding and avoidance of seeking health care

services. Stereotypical attitudes and assumptions can place the patient's health at risk, and can even do harm. Health care professionals need to recognise and respect those characteristics that make people different from one another. In order to give effective care to any clients from different ethno-cultural backgrounds, they should be encouraged to be open-minded and to understand how health problems are created within historical, political, and social processes (Kearns, 1997; Papps & Ramsden, 1996).

Health care issues should address the historical impacts of colonialism and post-colonial effects on people within health care settings. Racial discrimination, unequal power relations, oppression, and class assumptions should be recognised as factors that affect not only people's quality of life, but also their health status. Health care education should "reorient the training of health professionals towards a more critical understanding of colonial structures and their impacts on contemporary [health care issues]" (Dyck & Kearns, 1995, p. 141). Health education requires more than just familiarity with customs or differences, but demands that health care professionals examine their own cultural beliefs, values, and the attitudes they bring to their practices (Kearns & Dyck, 1996). They should acknowledge that there are different ways of viewing health and practicing health care. The mismatch between the different ethno-cultural clients' views of health and Western health care concepts will result in barriers to health care services and ultimately lead to poor health status in clients (Kearns & Dyck, 1996; Kearns, 1997).

In an analysis of the power relations between health care provider and client, we must take into account the historical and social contexts of the persons involved. It is necessary that health care providers have an understanding of: (a) poverty and its impact on people's lives, (b) history, demography, social, political, and spiritual factors and their effect on the individual, family, and community must be understood in order to plan for appropriate health care services for different ethno-cultural clients, (c) the tendency of clients to avoid health care services that are incongruous with their health care values and beliefs, and (d) social inequity and unequal power relations that are the result of racialisation, classism, and sexism impacted people's lives and health.

Government, policy makers, and health care providers should recognise that factors that have contributed to the poor health status of the marginalised population are not only health care, but also poverty, housing, education, employment, and unequal distribution of health care resources (Keene, 1989). Unequal distribution of wealth and an imbalance of power relations are inevitable components of colonial societies and are embedded within the colonial societal structure. In health care, it is manifested in the inequity in health service delivery and inaccessibility to health care services. It is within the context

of this power relationship that health care professionals are encouraged to analyze health care problems and approaches to the solutions that would enhance equality and the quality of health care for immigrants.

Health is not merely the absence of diseases. Contemporary health care is concerned not only with health care services, but also with other determinants of health (Lalonde, 1974). Therefore, it would be inadequate to examine the immigrants' inequality and the inaccessibility of health care services without looking at how other social, economic conditions and institutional structures contribute to these problems. Future health care research should focus on the examination of "structural inequities that have a profound influence on the ways in which people are able to gain control over their own lives and manage [illness]" (Anderson, 1996, p. 699), especially for those who are most disadvantaged such as immigrant women and children. Health care researchers should address the need for health care and how to remove identified barriers from the women's perspectives. They should adopt a theoretical foundation that examines both individual and societal issues, and their analysis should include the micropolitic and macrosocial structures of race, gender, and class that shape individuals' health care decision making process and options available to them to deal with illness.

D. Recommendations for Future Research

Health promotion and disease prevention strategies should focus on how to remove structural barriers that affect immigrant women's health care practice. In the letter addressed to Canadians, Mr. Romanow (2002) informs us that governments are willing to make changes in "how and where to invest" and that, "better management practices, more agile and collaborative institutions and a stronger focus on prevention" would be the government's objectives. Although, Mr. Romanow's comments are encouraging, the challenge, is to put those ideas into practice. The call for a stronger focus on the prevention of diseases and the promotion of health has existed for almost three decades since the release of the Lalonde Report, "A new perspective on the health of Canadians: A working document" in 1974 and later on reinforced by then Minister of Health Jake Epp (1986), *Achieving health for all: A framework for health promotion*. However, the process of change remains slow. In his report, Mr. Romanow has made it very clear that whatever recommendations one is to make, must be evidence-based. Evidence-based decision making means that changes can only be implemented or even suggested if there is evidence to show that

changes are needed and that there is a good chance that these changes will result in more effective and better quality health care. In the case of immigrants, this expectation might be yet another obstacle to improving their health care, because in certain immigrant populations, there is not much evidence to show that the present health care system is inadequate or inaccessible to them because little research has been done. Thus more research with immigrants focusing on identifying barriers to accessing health care is needed.

Although my research has identified factors that influence Vietnamese women's breast cancer and cervical cancer screening practices and barriers to accessing cancer preventive screening programs among Vietnamese immigrant women, its result cannot be generalized to the general Vietnamese population. Firstly, because participants of the study are 50 years old and over, insights gained from this study applied mostly to Vietnamese women of this age group. Women between the age of 18 and 40 might not necessarily experience the same obstacles in accessing health care services. Those who were born and raised in Canada, in particular, may find their experiences to be similar to Canadian-born women. Secondly, the results of this qualitative study do not confirm the extent at which Vietnamese women participate in breast cancer and cervical cancer screening programs. Thus, my recommendations for future research include: (a) a population-based survey to assess the current status of Vietnamese Canadian women's breast and cervical cancer screening practices, and to investigate the relationship between identified factors and Vietnamese women's cancer screening practices; (b) the development and implementation of a health promotion and disease prevention program that incorporates the findings of this study into its promotional strategies; and (c) a quasi-experimental study to evaluate the effectiveness of the newly developed promotional strategies on breast and cervical cancer screening among Vietnamese Canadian women.

E. Conclusion

Providing effective high quality health care that is culturally appropriate and acceptable to immigrant women, and understanding their lived experiences, are essential to foster women's participation in cancer preventive screening programs. The purpose of this research was (a) to explore how Vietnamese women participate in breast cancer and cervical screening, what leads Vietnamese women to seek health care and from whom they seek help, and the social support

networks that they draw upon to foster their health care practices, (b) to explore whether Vietnamese women find the current preventative cancer services suitable and accessible to them, (c) to explore how Vietnamese women's breast cancer and cervical cancer screening practices are influenced by social, cultural, political, historical, and economic factors which are shaped by the conceptualisation of race, gender, and class, and (d) to explore how differences between Vietnamese women's perspectives and those of health care providers influence women's health care experiences. To obtain these goals, I addressed the following research questions:

1) How do Vietnamese-Canadian women participate in breast and cervical cancer screening practices?
2) What is the process by which the decision to engage in regular breast cancer and cervical cancer screening is reached? What are the key factors that influence this decision-making process?
3) How do contextual factors such as social, cultural, political, historical, and economic at the intersection of race, gender, and class affect Vietnamese-Canadian women's breast cancer and cervical cancer screening practices?

Using Kleinman's cultural explanatory model, postcolonialism and feminism as theoretical frameworks, this qualitative study's main method of investigation was individual in-depth interviews. Fifteen Vietnamese women living in British Columbia, four Vietnamese speaking physicians, and two Caucasian English speaking community health nurses (one of them speaks Vietnamese fluently) participated in the study. The women participants were asked questions regarding their experiences with breast and cervical cancer screenings, health care in Canada, and in Vietnam. The women participants' sociodemographic data was also obtained. The health care providers' participants were asked questions regarding their experiences in working with Vietnamese women and their issues and concerns with women's breast and cervical cancer screenings.

The study reveals that cultural knowledge and values about the woman's body, their conceptualisation of health and illness, beliefs and values about health care relationships, and their gendered roles and expectations influence how Vietnamese women participate in breast and cervical cancer screening programs. It was found that in keeping themselves healthy, Vietnamese women actively seek help from all three sectors of health care (the popular, the professional, and the folk sectors), and they drawn on both formal and informal social networks for support. This study also confirms that Vietnamese women's low socioeconomic status and limited social and health care resources are major

deterrents to the ways in which they access breast and cervical cancer screening services and contributed to the Vietnamese women participants view of breast and cervical examination as inappropriate procedures. It is found that in many areas, health care provider participants' perspectives are paralleled by the women's perspectives.

The promotion of breast cancer and cervical cancer screening among Vietnamese Canadian women should be aimed at several levels of intervention. I make the following recommendations:

1- At the theoretical level, I propose that health care professionals should (a) recognise that women of different ethno-cultural background are active participants of health care, (b) put less emphasis on rationality and more on recognising that women's health care decision making is a dynamic process that varies under specific circumstances, and (c) recognise that individual's health care behaviour is influenced not only by their cultural knowledge and values, but also by their socially constructed position, race, gender and class.

2- At the practical level, I propose (a) that collaborative working relationships with physicians and the improvement of physician-patient relationships are essential to successful promotional strategies for Vietnamese women, and (b) that a health education strategy must incorporate Vietnamese women's different ways of knowing.

3- At the institutional level, increasing accessibility to these cancer preventive programs demands that health care policy makers increase institutional funding to support programs that provide services to immigrant women.

4- Recommendations for future research include: (a) a descriptive survey and a correlational study to assess the current status of Vietnamese Canadian women's breast and cervical cancer screening practices, and to investigate the relationship between identified factors and Vietnamese women's cancer screening practices, (b) the development and implementation of a health promotion and disease prevention program that incorporates the findings of this study into its promotional strategies, and (c) a quasi-experimental design study to evaluate the effectiveness of the newly developed promotional programs on breast and cervical cancer screening among Vietnamese Canadian women.

Canada's multicultural society is made up of people from many different ethno-cultural backgrounds. How can we live together as people of one nation in harmony despite our differences? This is to me the most fundamental question. With the recognition that each and every one of us will always be different from one another, our task should not be to eliminate the differences so that everyone can be the

same, but rather to change our ways of thinking about difference. "Difference" should not create conflict nor should it be used as a tool of division to conquer. Difference should be used to create strength. We should produce knowledge and create discourses that celebrate and appreciate difference as a "thing" that brings colour and fragrance to life, instead of something which is awkward, uncivilised, or inferior.

Although differences create many difficulties, dissociations, losses, and grief, they also create strength and resilience. Embedded and interwoven in immigrant clients' narratives are many strengths and knowledge from which health care providers can gain insight. Adjusting to and living a new life are very difficult and there are many sad stories. These stories illuminate how these women, in spite of the extreme difficulties confronting them, have maintained their dignity, self respect, and caring for one another.

It is imperative for health care providers to recognise that clients from different cultural backgrounds live their lives and practice health care in "in-between" spaces, spaces that belong neither to East nor to West, and that "[their] ability to shift and to remain multiple defies all reductive attempts at fixing and classifying" (Trinh, 1999, p. 62). Aside from the fact "such understanding... would enhance trust and therapeutic alliance and thereby provide clinicians with the opportunity to intervene when necessary" (Lin & Cheung, 1999, p. 777), quality health care services and meaningful health care relationships can only come about when there is a mutual respect between health care providers and clients. Helping can only be accepted when a genuine sense of caring is felt by the clients – a sense of caring that is borne not out of pity but out of true understanding, respect, and compassion.

In health care, where the landscape of biomedicine remains pervasive, we are still functioning with/in its boundary. Health care providers' goals remain that of diagnosing, curing, and preventing disease and illness. Yet, with the changing demographics and the increase in chronic illness and disability, caring, which has always been a critical element of the health care relationship, takes on a different meaning. Caring no longer means curing. Caring goes beyond this, encompassing the understanding of our clients as whole human beings who have lives, and live life outside of illness.

In order to help our fellow human beings, health care providers must learn to listen to those silent voices of our clients – those voices that are hesitant to reveal themselves, and conceal themselves (Aoki, 1992). Metaphorically speaking, to make the clients' presence visible, health care providers and health care policy makers need to enter into an in-between place, which, Aoki (1992) so eloquently alluded to, the place "into which earth, sky, mortals, and divinities are admitted ... a dwelling place for humans who,

in their longing to be together, belong together" (p. 28); a place where the silent voices dwell and reveal. Only then are we able to understand what it is like to live with illness in the midst of linguistic and cultural differences, only then are we able to shed some light on David Jardine's (1992) question of "how life together can go on in such a way [that even in difficulty] new life is possible" (p. 118), only then are we able to provide health care that is truly humane.

To bring this dissertation to its conclusion, I leave you with a poem, which I dedicated to all my friends who have made this work possible.

Shall We Dance?

By: Tam Truong Donnelly

Can you hear my silent voice?
Can you see my absent presence?
Can you feel my pain?
Can you touch my soul?
Can you taste my bitterness?

Who am I?
Asked – a floating shadow
Invisible to naked eyes.
You
Over there
in the center
fully clothed
Me
Over here
walking around your circle
naked, from the margin.

Acknowledge me,
know me through my white masks.
The color of white – the color of invisibility.
To survive, I wear white masks,
scream with my silent voice,
taste my own bitterness,
feel my own pain,
swallow my ego,
climb mountains.

You asked me
How is life at the margin?

Listen to me!
If you want to hear me,
cover your ears.

My true voice can only be heard
with your heart
your mind
your conscience

Open your eyes if you want to feel my smiles.

Recognition / negotiation / compromise
Come!
to the interspace
the in-between
the third space
the hybrid place.

Shall we dance?

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Appendices

Appendix A. Breast Cancer Screening Procedures For Women Over 40 Years of Age

High Risk Groups in Women Under Age Forty

A woman with two or more first-degree relatives with premenopausal or bilateral breast cancer is at particularly high risk and should be referred for genetic counseling and assessment for hereditary cancer. The Hereditary Cancer Program is a joint activity of the B.C. Cancer Agency and the Medical Genetics, UBC. Some families, accounting for perhaps up to 10% of breast cancers, may be carriers of specific genetic mutations. Testing is available for families at risk of mutations in BRCA1 or BRCA2. These women are candidates for programs of special surveillance. Women at high risk should be referred to the Hereditary Cancer Program.

A woman with a sister or mother with bilateral breast cancer would be at four fold risk of breast cancer if the case were postmenopausal or nine fold if the case were premenopausal. This person would be at even higher risk if in addition to the family history she met any of the following criteria:

1. There was also a family history of ovarian cancer or male breast cancer.
2. Ashkenazi Jewish heritage.

3.1 Breast Self-examination

Women may be encouraged to do regular breast self-examination (BSE). For premenopausal women this is best done in the week following the menstrual period. For postmenopausal women a specific day of the month should be chosen. The examination should include inspection of the breast and palpation of the breast and axilla. To perform adequate BSE the patient needs instruction in the technique and the manner in which she is carrying this out. This should be checked at subsequent examinations by her family physician.

3.2 Family Physician

The combination of physical examination by a physician and mammographic screening has been shown to reduce mortality from breast cancer. The relative importance of the physical examination vis-a-vis the mammogram remains controversial. It is recommended that all women over the age of 20 years receive an annual physical examination of the breasts by their family physician both as a screening procedure and as an opportunity to teach breast self-examination. Ten percent of breast cancers will not show up on a mammogram in older women, but as many as25-30% of breast cancers are not seen on screening mammograms in women age 40 to 49.

3.3 Screening Mammography

Screening Mammography Program of B.C. (SMPBC) Recruitment & Recall Policies Basic Eligibility Criteria:

- 40-79 years of age
- resident of B.C.
- no breast problems
- no mammogram in last 12 months
- has a family doctor
- no previous history of breast cancer
- no breast implants
- not pregnant or breast feeding

SMPBC Recommendations:

AGE	SELF-REFERRAL	SMPBC WILL SEND YOU A RECALL LETTER
40-49	yes	annually
50-74	yes	every 2 years*
75-79	yes	every 2 years*
75+	no	will accept with family physician referral

*a reminder letter will be sent if no visit/appointment is made 4-6 weeks after the recall letter is sent.

Age<40

Family physicians may wish to refer women age <40 with a strong family history of breast cancer (*i.e. two or more family members*), to be screened at the SMPBC. These women may also benefit from discussion of breast cancer risks including genetic counseling and testing. Screening mammography is only one component of care for these higher risk families. The SMPBC asks that **each** screening exam for women age <40 be arranged by family physicians with a radiologist at the SMPBC centre of choice.

Age 40-49

Women age 40-49 need to consider the potential benefits and disadvantages of screening mammography before seeking the service. The SMPBC's pamphlet entitled **'Information About Screening Mammography for Women Age 40 to 49'**, can assist women in their decision making. Family physicians are encouraged to discuss information provided in this pamphlet with women in this age group.

For women in the 40-49 age group who decide to have regular screening, the ***sojourn*** time *(the time during which a breast cancer is potentially detectable),* is significantly shorter and scientific data suggests this age group should attend annually. Annual recall will be provided.

Age 50-74

Research studies show that 25-30% fewer breast cancer deaths can be expected in women if they have **regular** screening mammograms between ages 50 and 69. To achieve this, at least 70% of eligible women in this age group must have **regular** screening mammography. The SMPBC recommends that women age 50-74 have a screening mammogram at least every 24 months and will actively re-invite women to attend.

Age 75-79

Both the risk of developing breast cancer and cancer detection rates with screening increase with age. The SMPBC will offer screening mammography every 2 years to women in their 70's if they are in good general health. Recall letters will be sent every 24 months.

Age 80+

Family physicians may wish to refer women age 80+ in good general health for screening at the SMPBC. The possible benefits of screening mammography in light of other potential health concerns at this age should be discussed with the women. Therefore, the SMPBC asks that **each** screening exam for women age 80+ be referred by family physicians to the SMPBC centre of choice.

3.4 Other Methods

There has been considerable interest in methods of detection of non-palpable abnormalities in the breast that do not use ionizing radiation. Such methods include thermography, ultrasound and diaphanography but in the screening of asymptomatic women none of these techniques approach the sensitivity or the specificity of mammography and cannot be recommended at the present time as the sole screening method. Ultrasound may be very useful in conjunction with mammogram to assess lesions. MRI (magnetic resonance imaging) is being studied in high-risk women with identified genetic mutations to see if it can add to their screening.

Source: BC Cancer Agency (2004). Breast - 3. Screening/Early Detection.
http://www.bccancer.bc.ca/HPI/CancerManagementGuidelines/Breast/ScreeningEarlyDetection.htm

Appendix C. Coding System

Participant / Interview Coding

Plan: Code all participants who participate in the study, differentiating which ones health care provider, use screening services etc.

Codes

*** First character**

Identifying if the participant is Vietnamese woman or health care provider
W: Vietnamese woman
H: Health care provider

*** Second character**

Participant's coded name: i.e., Hoa

*** Third character**

Number representing count of participants in study: i.e., 1 or 2

*** Fourth character**

A: Representing woman who access/use preventative cancer screening services Woman who has pap test or clinical breast examination or breast self examination, or Mammography.
B: Representing woman who do not access/use preventative cancer screening services.
C: Representing health care provider who provides care to Vietnamese Women

*** Fifth character**

Representing which of the two interviews
1: Interview # 1
2: Interview # 2

Example of a code

W-Hoa-1-A-1

W (Vietnamese woman) - Hoa (Coded name) - 1 (Participant number one in the study) - A (woman who accessing services) - 1 (This is the interview # 1)

H-Thu-15-C-1

H (Health care provider) - Thu (Coded name) - 15 (Participant number 15 in the study) - C (Provide care) - 1 (This is interview # 1)

Appendix D. Women Participants' Socio-demographic Data

		Vietnamese women participants (*N*=15)	%
Age	40 - 49	1	6%
	50 – 59	5	33%
	60 – 69	3	20%
	70 – 79	6	40%
Marital Status	Married	9	60%
	Widowed	4	27%
	Separated/divorce	2	13%
	Never married	–	–
Children	1	2	13%
	2 – 3	5	33%
	4 – 5	2	13%
	6 – 7	4	27%
	8 – 9	1	6%
Number of years living in Canada	5 – 9 years	1	6%
	10 - 14	3	20%
	15 - 19	1	6%
	20 - 24	5	33%
	25 - 30	5	33%
Religion	Buddist	9	60%
	Taoist	–	
	Confucianist	–	
	Catholic	–	
	Protestant	5	33%
	Cao dai	–	
	Hoa Hao	–	
	Others: Not decide	1	6%
Vietnamese speaking		15	100%
English speaking	Not at all	3	20%
	Poorly	5	33%
	So-so	4	27%
	Well	2	13%
	Fluently	1	6%
Other languages	French	1	6%
	Chinese	1	6%
Education	University or college	4	27%
	Some University or college	2	13%
	High school	3	20%
	Less than high school education	2	13%
	Others: grade 2-3	4	27%
Employment	Working full time	4	27%
	Working part time	–	—
	Full time homemaker	10	67%
	Laid off	–	–
	Unemployed	–	–
	Volunteer	1	6%
Occupation	Manufacturing industries	1	6%
	Whole sale and retail trade industries	–	–
	Business service industries	1	6%

	Accommodation, food service industries	1	6%
	Social service	1	6%
Yearly family income before tax	Less than $20,000	8	53%
	$20,000 - $29,000	–	–
	$30,000 – $39,000	3	20%
	$40,000 - $49,000	3	20%
	$50,000 - $59,000	–	–
	$60,000 - $69,000	–	–
	$70,000 - $79,000	1	6%
	Greater than $80,000	–	–
Use of health care modalities	Mostly Oriental medicine	–	–
	Mostly Western medicine	5	33%
	Both Oriental and Western medicine	10	67%
Type of health insurance	Public insurance	15	100%
	Private insurance	4	27%
	No health insurance	–	–
Has a regular doctor		15	100%
Has male doctor		11	73%
Has female doctor		4	27%
Has Vietnamese speaking doctor		8	53%
Has English speaking doctor		7	47%
From North Vietnam		5	33%
From South Vietnam		10	67%
Women came as refugees		8	53.3%
Women came via sponsored family members		7	46.7%

Appendix G. Initial Interview Questions For Vietnamese Women

Regarding Experience in Viet Nam:

1) In Vietnam, how did you and your family keep yourselves healthy?
2) In Vietnam, when was health problem a concern for you and your family?
3) When you and your family members were sick, what did you do? What kind of treatments, medicine did you use (traditional medicine, Western medicine)?
4) In Vietnam, when you and your family members were sick, who would help you, who would you ask for help?

Regarding Experience in Canada:

1) In Canada, how have your experience changed?
2) In Canada, when you and your family members are sick, what do you do? Who do you see or ask questions?
3) In Canada who would help you? Who would you like to seek help from?
4) If you need help from someone to practice health care, who do you think help you the most? In what circumstances?
5) If you need help from certain organizations to practice health care, which one do you call or go to?
6) Has it been easy for you to seek help here in Canada?
7) Have it been easy or difficult for you to get help from someone or some organization?
8) Thinking about the people who have been involved with you and your family since you are living here in Canada, what is it that they have said or done that stands out in your mind?
9) What did people do, that you think was most helpful to your health care?

Experience With Breast Cancer Screening:

1) Have you ever heard of mammography?
2) Have you ever had mammography?
3) How often do you think you have these tests done?
4) Who talked to you or reminded you about these tests?

Experience With Cervical Cancer Screening

1) Have you ever heard of Pap test?
2) Have you ever had Pap test done?
3) How often do you think you have these tests done?
4) Who talked to you or reminded you about these tests?
5) Do you think that Vietnamese women need to have breast examination and Pap test done?
6) If you have breast examination (ie, mammography, clinical breast examination) and Pap test done, how were your experiences?
7) Where do you go for Pap test, breast examination, and Mammogram?
8) Is it difficult for you to go to these places? If it is difficult for you, why is it difficult for you to go to these places?
9) What would make it easier for you to get this kind of health care?
10) Do you think these kinds of health care services are suitable to your needs?
11) Who do you think would be most appropriate to give you Pap test, breast examination, and mammogram?
12) In your opinion, what kind of Vietnamese beliefs and values influence Vietnamese women to seek health care, in particular, Pap test and mammogram?
13) If you need information to make decision about whether or not you would go to get Pap test and mammogram done, what kind of information do you think would be

most helpful?
14) In your opinion, what would make Vietnamese women go or not go for Pap test?
15) In your opinion, what would make Vietnamese women go or not go for mammogram?
16) What would be issues of concern for these women?
17) In your opinion, why are Vietnamese women concerned with these issues?
18) Is there anything else you want to tell me?

Appendix H. Initial Interview Questions For Vietnamese Women In Vietnamese

Suc Khoe Cua Phu Nu Viet Nam: Phuong Phap De Phong Benh Ung Thu Vu Va Ung Thu Co Tu Cung Cua Phu Nu Viet Nam o Canada

NHUNG CAU HOI

Nhung kinh nghiem ve suc khoe o Viet Nam

1) Khi o Viet Nam, chi /Bac va gia dinh giu gin suc khoe nhu the nao?

2) Khi nao thi van de suc khoe tro thanh moi quan tam doi voi chi/bac va gia dinh

3) Khi chi/bac va gia dinh bi benh thi chi/bac lam gi?, chi/bac chua benh bang cach nao? Chi/bac dung thuoc Nam hay thuoc Tay (thuoc Bac) trong nhung truong hop nao?

4) Khi chi/bac hoac la gia dinh co nguoi dau om, ai la nguoi giup do chi/bac? Thuong thuong thi chi/bac can nho ai giup. Chi/bac can su giup do cua nhung nguoi nao?

Nhung kinh nghiem o Canada

1) O tai Canada, nhung kinh nghiem vua roi cua chi/bac co khac khong, co thay doi khong?

2) O Canada, khi chi/bac hoac la nguoi trong gia dinh co om dau, chi/bac lam gi? Ai la nguoi chi/bac hoi y kien?

3) O Canada, nhung luc gap kho khan, dau om, ai giup do chi/bac va gia dinh? Ai la nguoi chi/bac tim den nho giup do?

4) Neu nhu chi/bac can su giup do cua mot nguoi nao do trong van de bao ve, giu gin suc khoe, chi/bac nghi rang nguoi nao se giup duoc chi/bac nhieu nhat? Trong hoan canh nao chi/bac thay la nguoi do se giup do duoc chi/bac?

5) Neu chi/bac can su giup do cua mot co quan nao ve van de suc khoe, co quan nao chi/bac su dung hoac goi toi?

6) Chi/bac thay rang tim kiem nguoi giup do o tren dat Canada nay co kho khan, hay la de dang?

7) Neu chi/bac can su giup do cua mot nguoi nao do hoac la cua mot co quan nao do, chi/bac thay la de dang hay la kho khan?

8) Tu khi toi Canada nay, nhung ai da giup do chi/bac va gia dinh, nhung gi ho lam ma chi/bac con nho mai?

9) Nhung gi ho da lam ma chi/bac thay la that tot cho su giu gin suc khoe cua chi/bac va gia dinh chi?

Kinh Nghiem Voi Su De Phong Benh Ung Thu Vu

1) Chi/bac co nghe noi qua ve Mammography bao gio chua?

2) Chi/bac da co di lam mammography lan nao chua? Va co thuong xuyen khong?

3) Chi/bac da di kham mamography may lan roi?

4) Ai da noi chuyen voi chi/bac ve van de tu kham vu, bac si kham vu, mammogram? Ai nhac nho chi/bac di kham vu, chieu dien vu?

Kinh Nghiem De Phong Benh Ung Thu Co Tu Cung:

1) Chi/bac co nghe noi qua ve Pap test bao gio chua?

2) Chi/bac da co di lam Pap test lan nao chua? Co thuong xuyen khong?

3) Chi/bac da di kham Pap test may lan roi?

4) Ai da noi chuyen voi chi/bac ve Pap test? Ai nhac nho chi/bac di lam Pap test ?

5) Theo y chi/bac thi phu nu Viet Nam minh co can di kham vu va kham co tu cung khong?

6) Neu chi/bac da di bac si kham vu, lam mammography, voi lam Pap test roi, chi/bac thay no the nao? Chi/bac thay nhung cai do co hop voi chi/bac khong?

7) Chi/bac di kham vu, mammogram va di lam Pap test o cho nao?

8) Chi/bac co thay di toi nhung cho do co kho khan lam khong? Neu chi/bac thay la co kho khan, chi/bac nghi la vi nhung nguyen nhan gi ma chi/bac co kho khan?

9) Theo y cua chi/bac thi nhung gi co the lam giam nhung kho khan do. Chi/bac thay nhung gi giup phu nu Viet Nam di kham vu va Pap test duoc de dang hon?

10) Chi /bac thay kham vu va co tu cung co thich hop voi phu nu Vietnam?

11) Chi/bac thay ai la nguoi thich hop nhat de kham vu, mamogram va lam Pap test cho phu nu Viet Nam?

12) Chi/bac thay nhung phong tuc, tap quan, nhung cach suy nghi (tu tuong) Viet nam nao co anh huong toi viec phu nu Viet Nam minh di kham vu, mammography va di lam Pap test?

13) De thuc day chi/bac di bac si kham vu, di lam mamography, di lam Pap test, chi/bac co can biet nhung gi ve nhung benh nay? Nhung chi tiet gi ma chi/bac thay la quan .trong. se quyet dinh la co di kham vu va Pap test hay khong, chi/bac can biet nhung chi tiet, tin tuc gi?

14) Theo y cua chi/bac thi nhung gi ngan can hoac thuc day phu nu Viet Nam minh di kham vu va di lam mammography?

15) Theo y cua chi/bac thi nhung gi ngan can hoac thuc day phu nu Viet Nam minh di lam Pap test?

16) Theo y chi/bac thi phu nu Viet Nam minh lo lang ve nhung van de gi?

17) Theo y chi/bac thi tai sao ma chi em phu nu Viet lai lo lang ve nhung van de nay?

18) Chi/bac co muon noi gi nua khong?

Appendix I. Socio-Demographic Data Form

Code No: _____

Vietnamese Women's Health: Vietnamese Canadian Women's Breast Cancer and Cervical Cancer Screening Practices

SOCIO-DEMOGRAPHIC DATA

Age (years): _____
Marital Status:
Married: _____; Number of years have been together: _____
Widowed/divorced/separated: _____; for how long: _____
Never married: _____ Living with Commonlaw_____
Children:
None: _____
Number of children: _____
Age of children_____
Living with children: Yes_____No_____
Provide help to children_____
Number of years of living in Canada: _____
Year of arrival: _____
Religion:
Buddist_____
Taoist _____
Confucianist _____
Catholic _____
Protestant _____
Cao Dai _____
Hoa Hao _____
Others _____
Not applicable_____
Language speaking:
First language: _____
Second language: _____
Others: _____

English proficiency:

	Speaking:	Reading:	Writing:
Not at all:	_____	_____	_____
Poorly:	_____	_____	_____
So-so:	_____	_____	_____
Well:	_____	_____	_____
Fluently:	_____	_____	_____

Are your friends:
Mostly Vietnamese _____
Both Vietnamese and Non-Vietnamese _____
Mostly Non-Vietnamese _____
When you watch TV or listen to the radio, is it:
Mostly Vietnamese _____
Both Vietnamese and Non-Vietnamese_____
Mostly Non-Vietnamese _____
Education:
University or college graduate: _____
Some university or college: _____

High school graduate: _____
Some high school education (grade level): _____
Less than high school education: _____
Others: _____

Employment:
Working full time: _____
Working part time: _____
Full time student: _____
Part time student: _____
Full time homemaker: _____
Laid off: _____
Unemployed: _____
Maternity leave: _____
Others: _____

Occupation: _____

Yearly Family Income before tax:
Less than $20,000 _____
$20,000- $29,000 _____
$30,000-$39,000 _____
$40,000-$49,000 _____
$50,000-$59,000 _____
$60,000-$69,000 _____
$70,000-$79,000 _____
Greater than $80,000 _____

Do you participate in:
Vietnamese community _____
Other community where you live _____

For your health care, do you use:
Mostly Oriental medicine _____
Both Oriental and Western medicine _____
Mostly Western medicine _____

Type of health insurance:
Public (MSI): _____
Private: _____
No health insurance: _____

Has a regular place of medical care: _____
Has a regular doctor: _____
Male doctor_____Female doctor_____
Has English speaking doctor: _____
Has Vietnamese speaking doctor: _____
Has other health care professional: Yes____; No _____
If yes, please specify:_____

_____

_____

Code No: _____

Formal Supports (Supports from professional health care providers or government agency workers)

(To be filled out by the interviewer and clarified with the participant after the interview)

Who (relationship to person – not name)

When:

Who (relationship to person – not name)

When:

Who (relationship to person – not name):

When:

Who (relationship to person – not name):

When:

Who (relationship to person – not name):

When:

(Attach additional data sheets as needed)

Code No: _____

Informal Supports (Support from the family members and friends)

(To be filled out by the interviewer and clarified with the participant after the interview)

Who (relationship to person – not name):

When:

Who (relationship to person – not name):

When:

Who (relationship to person – not name):

When:

Who (relationship to person – not name):

When:

Who (relationship to person – not name):

When:

(Attach additional data sheets as needed)

Appendix J. Socio-Demographic Data Form In Vietnamese

Suc Khoe Cua Phu Nu Vietnam: Phuong Phap de Phong Benh Ung Thu Vu va Ung Thu Co Tu Cung Cua Phu Nu Viet Nam o Canada

TONG QUAT VE XA HOI VA NHAN KHAU

Tuoi (nam): _____

Hon nhan:

Ket hon_____ May nam o voi nhau _____

Hoa bu/lydi/cach ly_____; Bao lau _____

Chu bao gio ket hon _____ Song voi ban_____

Con cai:

Khong co con _____

Bao nhieu con _____

Tuoi cua con_____

Song voi con_____

Giup do gia dinh cua con_____

Bao nhieu nam song o Canada _____

Nam toi Canada _____

Ton giao:

Dao phat _____

Dao lao _____

Dao Khong _____

Dao thien chua _____

Dao tin lanh _____

Dao cao dai _____

Dao hao hoa _____

Dao khac _____

Khong ung dung_____

Ngon ngu:

Ngon ngu thong thuong _____

Ngon ngu thu hai _____

Ngon ngu khac_____

Tieng Anh:	Noi	Doc	Viet
Hoan toan khong biet	_____	_____	_____
It oi	_____	_____	_____
Tam duoc	_____	_____	_____
Tot (thanh thao)	_____	_____	_____
Luu loat	_____	_____	_____

Ban be:

Phan dong la nguoi Viet _____

Ca nguoi Viet va nguoi ngoai quoc _____

Phan dong la nguoi ngoai quoc _____

Khi xem TV hay nghe radio, qui vi thuong xem va nghe:

Phan dong la tieng Viet _____

Ca tieng Viet va tieng Anh _____

Phan dong la tieng Anh_____

Phan dong la tieng Trung Hoa _____

Hoc van:

Tot nghiep dai hoc _____

Trinh do dai hoc (chua tot nghiep) _____

Tot nghiep pho thong _____

Trinh do pho thong (chua tot nghiep) _____

Chua dat truong pho thong _____

Hoc van khac _____

Viec lam:

Viec lam lien tuc (Full-time) _____
Viec lam that thuong (Part-time) _____
Sinh vien ca buoi (Full-time student) _____
Sinh vien nua buoi (Part-time student) _____
Noi tro ca ngay _____
Chu cho thoi viec _____
That nghiep _____
Ghi de _____
Viec lam cua gia dinh (self-emloyed) _____
Truong hop dac biet _____

Nghe nghiep: _____

Muc thu nhap moi nam cua gia dinh truoc khi dong thue:

Duoi $20,000 _____
Tu $20,000 den $29,000 _____
Tu $30,000 den $39,000 _____
Tu $40,000 den $49,000 _____
Tu $50,000 den $59,000 _____
Tu $60,000 den $69,000 _____
Tu $70,000den $79,000 _____
Tren $80,000 _____

Quy vi co tham gia voi:

Hoi Vietnam _____
Phuong hoi khac cho quy vi o _____

Khi om dau, quy vi dung thuoc gi?

Dung phan nhieu la thuoc Bac (Dong Y) _____
Dung ca hai thu thuoc Dong Y va Tay Y _____
Chi dung thuoc Tay Y _____
Dung cac thu thuoc hoac phuong phap chua benh khac _____
Neu co xin ke chi tiet: _____

_____

So bao hiem suc khoe:

Xa hoi bao hiem (MSI) _____
So bao hiem rieng (Bao hiem tu) _____
Khong co so bao hiem suc khoe _____

Co noi thuong xuyen kham benh _____
Co bac si thuong xuyen kham benh _____
Bac si la bac si nam_____Bac si la bac si nu_____
Bac si noi tieng Anh _____
Bac si noi tieng Viet _____
Bacsi noi tieng Trung Hoa _____
Bac si noi ca hai thu tieng (Viet va Anh) _____
Bac si chuyen gia kham benh khac: Co _____khong _____
Neu co, yeu cau ghi chi tiet _____
_____
_____

Co tiep xuc voi nhung nguoi lam viec khac trong nganh Y Khoa:

Co _____ Khong _____
Neu co, xin cho chi tiet _____
_____
_____

Appendix K. Initial Interview Questions For Health Care Providers

1) What is your experience in working with Vietnamese women?

2) What do you identify as their issues and concerns?

3) What kind of problems do you encounter?

4) Regarding Pap test, mammogram and breast examination, are there certain women whom you would referred or recommended and why?

5) Whom you would not referred or recommended and why?

6) For these tests, do you know if some women follow through and some don't?

7) Why do you think that was?

8) Do you have any ideas of why some Vietnamese women hesitate to go for Pap test, breast examination, and mammogram?

9) What would you think influence the ways in which Vietnamese women practice health care, in particular breast cancer and cervical cancer screening?

10) What do you think would promote or prevent Vietnamese women to participate in breast and cervical cancer screening?

Appendix N. Community Agency Project Information Letter For Recruitment Of Vietnamese Canadian Women's Participants in Vietnamese

Du Thao Ke Hoach Thu

Suc Khoe Cua Phu Nu Viet Nam: Phuong Phap Phong Ngua Benh Ung Thu Vu va Ung Thu Co Tu Cung Cua Phu Nu Viet Nam o Canada.

Kinh thua:

Ten toi la Tam Truong Donnelly, tien si nghien cuu sinh nganh Da khoa o UBC. Toi dang thuc hanh nghien cuu de tim hieu ve su phong ngua benh ung thu vu, va ung thu co tu cung (co hien hoanh) cua phu nu Viet Nam o Canada. Toi trinh bay la thu nay xin duoc cac ba va cac chi giup do cho viec nghien cuu suc khoe cua phu nu Viet Nam.

Muc dich cua cuoc nghien cuu nay la de tim hieu ve suc khoe cua phu nu Viet Nam, dac biet la trong van de phong ngua benh ung thu vu, va ung thu co tu cung. Toi muon tim hieu ve nhung van de co lien quan toi su bao dam suc khoe cua cac ba va cac chi o tai Canada nay. Nhung van de toi muon biet la: vi ly do nao ma cac ba va cac chi di kham benh, cac ba va cac chi chua benh va phong benh bang cach nao. Nhung nguoi nao co giup do cac ba va cac chi trong van de giu gin suc khoe. De giu gin suc khoe cho that tot, cac ba va cac chi lam gi, hoi ai, va can su giup do cua nhung nguoi nao. Toi dac biet muon biet la theo y kien cua cac ba va cac chi thi nhung viec phong ngua ung thu nay co dung va thich hop voi su can thiet cua cac ba va cac chi khong.

Trong cuoc hoc hoi nay, toi xin hoi kien mot so cac ba va cac chi nguoi Viet. Toi xin su giup do cua cac ba va cac chi nguoi Viet da o Canada tuoi tu Nam Muoi (50) tro len, nguoi mien Nam va nguoi mien Bac. Nhung nguoi phu nu nay can noi duoc tieng Viet thanh thao de tham du vao cuoc nghien cuu nay. Moi nguoi phu nu tham gia se co hai (2) lan hoi kien (not chuyen), moi cuoc hoi kien se khoang 60 phut toi 90 phut. Toi la nguoi Viet, co noi duoc tieng Viet va tieng Anh thong thao, se la nguoi noi chuyen voi cac ba va cac chi. Voi su dong y cua cac ba va cac chi, nhung cuoc hoi kien se duoc thau bang. Trong cac cuoc hoi kien, toi se noi chuyen voi cac ba va cac chi ve nhung kinh nghiem giu gin suc khoe va cac phuong phap phong ngua benh ung thu vu va co tu cung; hieu biet va cam nghi cua cac ba va cac chi ve nhung van de co lien quan toi viec thuc hanh phong ngua benh ung thu; theo y cac ba va cac chi thi nhung gi la tro ngai, nhung gi la khong tro ngai trong van de giu gin suc khoe va kham chua benh; theo y cua cac ba va cac chi thi su giup do cua xa hoi va y khoa trong su thuc hanh bao ve suc khoe co de dang va thich hop. Mot so chi tiet tong quat ve gia dinh va xa hoi cung se duoc hoi qua.

Boi vi day la su hoc hoi dau tien cua toi voi phu nu Viet Nam, toi hy vong la su hoc hoi nay se tang them su hieu biet ve cach su dung he thong y khoa va su giup do cua xa hoi cho su giu gin suc khoe cua phu nu Viet Nam o tai Canada. Dua vao ket qua cua su hoc hoi nay, toi se lam thanh mot thu ban. Thu ban nay se duoc dung de giup nhung nguoi lam viec trong nganh y va nhung nguoi giup ve di tru, nam nu, hieu them ve cach lam viec voi phu nu Vietnam. Thu ban se duoc san sang cho phu nu Vietnam o Canada dung voi muc dich la de cac ba va cac chi hieu them va de khuyen khich ho su dung thuong xuyen nhung phuong phap phong benh ung thu vu va ung thu co tu cung.

Sau cung, toi xin nhan manh rang tham gia vao su hoc hoi nay la hoan toan tu y cua cac ba va cac chi. Cac ba va cac chi co the cham dut su tham gia nay bat ki luc nao ma khong co anh huong lo lang gi toi ban than va gia quyen. Tat ca nhung giay to, ban thao se xoa bo khong co ten tuoi, dia chi, va bat ki chi tiet gi co lien quan toi ban than va gia quyen cua cac ba va cac chi. Nhung giay to co ten cua nguoi tham gia, ngoai nguoi nghien cuu, se khong co ai duoc biet. Sau khi du an hoc hoi da xong xuoi, nhung giay to co ten cua nguoi tham gia se duoc huy bo, nhung ban thao khong co ten se duoc giu lai cho hoc hoi sau nay.

Thank you for taking the time to read this letter and for your support.

Sincerely,

Tam, T. Donnelly, RN., MSN
Ph.D. Candidate.