

Les pratiques en matière de santé chez les Canado-Vietnamiennes : les influences culturelles en matière de dépistage de cancers du sein et du col utérin

Tam Truong Donnelly

Les cancers du sein et du col utérin figurent parmi les facteurs de morbidité et de mortalité majeurs chez les femmes canado-vietnamiennes. Les Vietnamiennes sont à risque en raison de leur faible taux de participation aux programmes de dépistage de ces cancers. S'appuyant sur le modèle exploratoire de santé et de maladie de Kleinman, cette étude a pour but d'explorer les points suivants : la participation des Canado-Vietnamiennes au processus de dépistage de cancers du sein et du col utérin; la pertinence des services de prévention du cancer actuels desservant cette population; et l'influence des facteurs sociaux, culturels, politiques, historiques et économiques façonnés par les rapports sociaux entre les races, les sexes et les classes sur les pratiques de ces femmes en matière de dépistage. Quinze femmes canado-vietnamiennes et six prestataires de soins ont été interviewés. L'analyse des entrevues révèle la présence de plusieurs facteurs qui influent sur la participation des femmes aux programmes de dépistage du cancer. Cet article fait état du processus par le biais duquel les connaissances et les croyances culturelles influencent les pratiques des femmes en matière de santé. L'étude révèle que les facteurs culturels suivants influent sur le taux de participation des femmes aux programmes de dépistage des cancers du sein et du col utérin : les connaissances et les valeurs culturelles relativement au corps féminin; la conceptualisation de la santé et de la maladie; et les croyances et valeurs en ce qui a trait à la relation patiente-prestataire de soins. L'auteure émet certaines recommandations concernant la promotion du dépistage des cancers du sein et du col utérin chez les femmes canado-vietnamiennes.

The Health-Care Practices of Vietnamese-Canadian Women: Cultural Influences on Breast and Cervical Cancer Screening

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Breast and cervical cancer are major contributors to morbidity and mortality among Vietnamese-Canadian women. Vietnamese women are at risk due to their low participation rate in screening programs for these cancers. The purpose of this exploratory qualitative study, informed by Kleinman's Exploratory Model of Health and Illness, was to explore the participation of Vietnamese-Canadian women in screening for breast and cervical cancer; the appropriateness of current cancer-prevention services for Vietnamese women; and the influence of social, cultural, political, historical, and economic factors, shaped by race, gender, and class, on the screening practices of Vietnamese-Canadian women. Fifteen Vietnamese-Canadian women and 6 health-care providers were interviewed. Analysis revealed that several factors influenced the women's participation in cancer screening. This paper reports on the process by which cultural knowledge and beliefs contributed to the women's health-care practices. The study revealed that the following cultural factors influenced the women's level of participation in screening programs for breast and cervical cancer: cultural knowledge and values with regard to women's bodies, conceptualization of health and illness, and beliefs and values concerning the patient/health-care provider relationship. The author offers recommendations on the promotion of screening for breast and cervical cancer among Vietnamese-Canadian women.

Keywords: Vietnamese women's breast cancer and cervical cancer screening, Vietnamese Canadian women's cancer preventive care, immigrant women's cancer preventive care, cultural influences on cancer screening practices

Introduction

Breast cancer is the second leading cause of cancer-related death for Canadian women over 50 years of age (National Cancer Institute of Canada, 2004). Although breast cancer is less common among Asian immigrant women, Asian women who migrate to Western countries have a significant increase in breast cancer risk compared to women in their native countries, and their breast cancer rates approach those of the general population (National Asian Women's Health Organization, 2004). Evidence shows that Asian women are the group least likely to have had

a mammogram (King County Public Health, 2004; McPhee, Stewart, et al., 1997; Pham & McPhee, 1992; Sadler, Dong, Ko, Luu, & Nguyen, 2001) and are more likely to be diagnosed at advanced stages of breast cancer (Hedeen, White, & Taylor, 1999; Pham & McPhee; Yi, 1994a, 1995).

Cervical cancer is the most common cancer among women in the countries where Papanicolaou (Pap) smears are not routinely performed (BC Cancer Agency, 2000). Evidence shows that Vietnamese women have a significantly higher incidence and mortality rate for cervical cancer than other populations (Black & Zsoldos, 2003; Cheek, Fuller, Gilchrist, Maddock, & Ballantyne, 1999; Lesjak, Hua, & Ward, 1999; McPhee, Stewart, et al., 1997). People of low socio-economic status and ethnic minorities have the greatest need for improvements in cancer prevention (Alberta Cancer Board, 2004; Gentleman, Lee, & Parsons, 1998). The 2001 Canada Census revealed that almost one quarter of all Vietnamese-Canadian women have an income of less than \$9,999 per year (Statistics Canada, 2001).

Early detection and treatment of breast and cervical cancer through screening programs significantly reduce the morbidity and mortality of these diseases (BC Cancer Agency, 2004a, 2004b). In the province where this study was conducted, it is recommended that women over the age of 20 have a clinical breast examination annually and perform breast self-examination regularly (BC Cancer Agency, 2004a), even though it has been argued that self-examination might not reduce breast cancer mortality and may increase women's chances of having a benign breast biopsy (Thomas et al., 2002). Regular mammography is recommended for women according to their age/risk group or at least every 2 years after age 50 (BC Cancer Agency, 2004a). Pap testing is recommended at least every 2 years for all sexually active women until age 69; women over 69 may stop having regular Pap smears if all their previous smears have been normal (BC Cancer Agency, 2004b).

Data from the Statistics Canada 1994/95 National Population Health Survey illustrate that Asian women are less likely than women in the general population to have Pap testing; more than nine times more Asian-born than Canadian-born women had never had a Pap test (Gentleman et al., 1998). A community-based survey of 776 Chinese women in British Columbia (Hislop, Teh, Lai, Labo, & Taylor, 2000) found that the proportion of Chinese women receiving Pap tests was lower than the provincial average (74% of the women had at least one previous Pap test and 56% had a test within the preceding 2 years). In 1996, the rate of Pap testing among Canadian immigrant women was 67%, compared to 90% for non-immigrant women (Black & Zsoldos, 2003).

Statistical data on the current rate of participation in screening for breast and cervical cancer among Vietnamese-Canadian women are not available. The sparse data available from the United States and Australia suggest that Vietnamese women have a lower rate of participation in cancer screening than the general population (Cheek, Fuller, & Ballantyne, 1999; Jenkins, Le, McPhee, Stewart, & Ha, 1996; Lesjak et al., 1999; McPhee, Stewart, et al., 1997; Yi, 1994a, 1994b). A recent study by Sadler et al. (2001) with 275 Vietnamese-American women found that their rate of mammography was below the recommended level and that only 36% reported having adequate knowledge about breast cancer screening. This low rate of screening suggests that Vietnamese women may be at risk for lack of detection and treatment of cancer in its early stages (Cheek, Fuller, Gilchrist, et al., 1999; Lesjak et al.; Sadler et al.).

A survey conducted in California found that Vietnamese social beliefs and values contribute to Vietnamese women's level of participation in screening for breast and cervical cancer (Jenkins et al., 1996; McPhee, Bird, et al., 1997). The way in which Vietnamese people conceptualize health and the causes of illness shapes their view and utilization of Western medicine (LaBun, 1988; Maltby, 1998; Stephenson, 1995; Uba, 1992). It has been argued that the benefits of Western biomedicine cannot be realized unless health services are provided in an accessible and culturally appropriate manner (Anderson, 1990; Waxler-Morrison & Anderson, 2005).

The present study was conducted in a western Canadian city whose immigrant population makes up 38% of its 2 million inhabitants. The Vietnamese population of the province in which the city is located has been estimated at 25,675 (Statistics Canada, 2001). The overall purpose of this qualitative study was to explore the participation of Vietnamese-Canadian women in screening for breast and cervical cancer, the appropriateness of current cancer-prevention services for Vietnamese-Canadian women, and the influence of social, cultural, political, historical, and economic factors that are shaped by race, gender, and class on the screening practices of Vietnamese women. Three research questions were addressed: (1) *How do Vietnamese-Canadian women participate in breast and cervical cancer screening programs?* (2) *What is the process by which the decision to engage in regular breast and cervical cancer screening is reached, and what are the key factors influencing this process?* (3) *How do contextual factors such as social, cultural, political, historical, and economic factors at the intersection of race, gender, and class affect screening for breast and cervical cancer among Vietnamese women?*

This paper reports on the process by which cultural knowledge and values influence the decision of Vietnamese-Canadian women to undergo screening for breast and cervical cancer. Other findings

regarding the women and their health-care providers will be reported elsewhere. In this paper, I will describe, first, the theoretical framework guiding the exploration of cultural influences on cancer prevention among Vietnamese-Canadian women, then the research design, and, finally, the findings of the study. I will then present a discussion and recommendations.

Ethical approval for the study was obtained from the University of British Columbia Ethics Board. Pseudonyms are used in referring to comments by the participants.

Kleinman's Explanatory Model

Arthur Kleinman (1980) theorizes that a given society's attitude towards and use of health services is shaped by the way in which it conceptualizes health and illness and its cultural beliefs, values, behaviours, and expectations regarding treatments. He further asserts that a person's explanatory model, which is specific to one's social group and culture, explains sickness etiology, symptoms, pathology, course of illness, and treatment (Kleinman, 1978). Conflicting explanatory models, coupled with cultural insensitivity, will lead to a relationship and communications breakdown between the client and his or her health-care provider. These factors, in Kleinman's view, are deterrents to client compliance, satisfaction, and appropriate use of health services. Kleinman (1978) defines culture as "a system of symbolic meanings that shapes [an individual's] social reality and personal experience" (p. 86). He considers social reality and clinical reality to be two important dimensions of health care (Kleinman, 1980).

Social reality symbolizes human interactions, which consist of meanings, norms, social structures, and expected behaviour within a society. The manner in which individuals view and react to illness and in which they choose among health-care options and evaluate their effectiveness are influenced by their social reality (Kleinman, 1980). Clinical reality, on the other hand, is a health-related aspect of social reality. It is "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). Social reality and clinical reality are culturally constructed and shaped in different social-structural settings within a society (Kleinman, 1980). To provide effective health care and to ensure client cooperation, Kleinman suggests, health professionals need to treat disease and illness in a way that clients can relate to culturally, socially, and individually.

Kleinman's explanatory model was used as a framework to examine the influence of cultural knowledge and values on the behaviour of Vietnamese-Canadian women with regard to screening for breast and cervical cancer. It was theorized that the view of Vietnamese women towards screening for breast and cervical cancer is influenced by their social reality and clinical reality, which consists of their beliefs about health and illness, their treatment expectations, and social norms regarding communication, health-care seeking, and relationships.

Research Design

Participants

Maximum variation purposive sampling, "the process of deliberately selecting a heterogeneous sample and observing commonalities in their experiences" (Morse, 1994, p. 229), was used in this study. Participants were recruited through letters sent to community agencies. Prior to interviewing, informed consent was obtained and the participants were assured that they had the right to withdraw from the study at any time. The identities of the participants were protected through the use of codes and pseudonyms. The researcher was a Vietnamese woman who had the experience of being a refugee in Canada. Being fluent in Vietnamese, she was able to conduct interviews in Vietnamese and to understand and closely attend to the participants' narratives.

The participants consisted of 15 Vietnamese immigrant women and 6 health-care providers. The immigrant women ranged in age from 49 to 78 years. Justifications for this selection were (a) the need for the age group to overlap for both breast and cervical cancer screening, (b) the aging population, (c) the increased risk for breast and cervical cancer with advanced age, and (d) the decreasing rate of screening utilization with advanced age. Of the immigrant women, all spoke Vietnamese; 5 came from Northern Vietnam and 10 from Southern Vietnam; they had been in Canada an average of 22.7 years (range = 9–26 years); their educational level ranged from Grade 2 to university completion in Vietnam.

The health-care providers consisted of 4 male Vietnamese physicians and 2 female community health nurses. (Although an effort was made to recruit female physicians, the only two female Vietnamese-speaking physicians available were too busy to participate.) The physicians had been working in Canada from 4 to 21 years. One of the community health nurses had been working with Vietnamese women for more than 15 years, the other for 4 years. All the health-care providers except for one of the community health nurses spoke Vietnamese fluently.

Data Collection

An exploratory qualitative approach was used to obtain detailed contextual information and to illuminate the diversity and complexity of the participants' thoughts and health-related behaviours. In-depth interviewing in the participants' language was the main method of data collection. A semi-structured questionnaire using open-ended questions in both Vietnamese and English was designed for the study. The questions concerned health-care knowledge and attitudes and past and current practices regarding clinical breast examination, breast self-examination, mammography, and Pap testing. They also investigated the respondent's motivation to engage in cancer-screening activities, their perceived barriers to such activities, and their perceptions about the best possible strategies for promoting breast and cervical cancer screening among Vietnamese women. The interviews with the immigrant women lasted from 3 to 4 hours. The interviews with the health-care providers lasted from 30 to 60 minutes. Four of the interviews with health-care providers were conducted in Vietnamese and two in English. The data were transcribed and analyzed by the researcher in the primary language of the participant. The interviews were stopped when no more new information could be identified in the data.

Data Coding and Analysis

Data collection and analysis were carried out concurrently. Data analysis was an ongoing, four-step process. (1) As data were obtained, they were transcribed in the language used by the participant. To ensure accuracy, the transcripts were rechecked against the audiotapes and corrected. A hard copy was printed for preliminary data analysis. (2) In the early stages of analysis, the transcripts were coded to identify preliminary themes. A list of code categories was formulated. These categories were refined as subsequent data were gathered. (3) Data coded in one category were examined for their relevance to data in other categories. The final outcome of this analysis was a set of interrelated concepts and themes. This process of analysis involved the systematic, rigorous development of code categories and subcategories, which were flexible, evolving, and used for the coding of subsequent transcripts. (4) Themes and concepts were used to compare within and across transcripts. From this, a higher level of data conceptualization and broader theoretical formulations were generated. To ensure rigour, the researcher sought input on the preliminary results from six participants who she believed could give insightful and reflective responses. This group comprised two immigrant women, three physicians, and one community health nurse. This process enabled the researcher to clarify, expand, and discuss with participants the emergent

themes, ideas, and concepts. It also allowed the researcher to validate the findings, develop a deeper understanding of the data, and gain further insight into the cultural process and social structures that influence the breast and cervical cancer screening practices of Vietnamese women.

Findings

Vietnamese social values differ from those of the general Western population. This divergence contributes to Vietnamese women's level of participation in screening programs for breast and cervical cancer (McPhee, Stewart, et al., 1997). However, Jenkins et al. (1996) found that their data did not support the notion that traditional beliefs and cultural practices pose barriers to the use of preventive health services. In the present study, analysis of the data revealed three themes illuminating the influence of culture on the participation of Vietnamese women in screening programs for breast and cervical cancer. The themes were: cultural knowledge and values concerning women's bodies, women's conceptualization of health and illness, and beliefs and values with regard to the relationship between the health-care provider and the patient.

Cultural Knowledge and Values Concerning Women's Bodies

The private body: Embarrassment and hesitation. The data suggest that conceptualization of the body as private greatly influences the ways in which Vietnamese women seek and receive examination for breast and cervical cancer. The women's narratives reflect the Confucian teaching "Nam nu tho tho bat than" (a woman and a man should never touch or be close, but should avoid each other). One of the immigrant participants commented, "A woman's breasts and cervix are private places; nobody but her husband should ever touch them." Because of this cultural designation of a woman's body as private, the women were uncomfortable with breast and cervical examination. The majority of the women participants said they were very embarrassed about having a breast examination or a Pap smear:

It's very uncomfortable when you let the doctor examine it, very uncomfortable, very difficult. It doesn't matter if it's a female or a male doctor. I don't like anybody to touch those things... It makes me uneasy.
(Mrs. Hai)

In contrast to the findings of other studies (Cheek, Fuller, Gilchrist, et al., 1999; Lesjak et al., 1999; Yi, 1995), the present study found that the degree of acculturation (good command of English, greater familiarity with Western ways of living, and number of years the women had lived in the host country) might not increase women's participation in

screening for breast and cervical cancer. Mrs. Phi had been living in Canada for 26 years, spoke English and French fluently, and had adapted well to the Canadian way of life:

Language is very important. But it's not just the language. Our culture doesn't permit us to talk about or share such taboo subjects with others. Talking about a woman's body cannot be publicly... I'm embarrassed even to touch my own breasts, let alone other people. They [health-care providers] need to understand that. ...the cervix is even more taboo [tham kin], more embarrassing. So they just don't go... That's what I mean by understanding Vietnamese culture. Even though we're here...we were always like that, so we remain the same. If there are no female doctors we hesitate to go for these kinds of check-up.

The body as an experiencing agent/the embodiment experience. The women's accounts revealed the role of beliefs and values concerning women's bodies in determining their health-care practices. Analysis revealed a picture of the Vietnamese woman's embodied experience of physical examination. The breast and cervix are considered the most private parts of a woman's body and should not be seen or touched by others. Discourse about examination was described as embarrassing, and verbal hesitation and the use of euphemisms and gestures during the interviews conveyed the depth of these embodied values. The women often cited this sense of embodiment as a force in directing their health-care practices. Furthermore, their health-seeking behaviour was guided by their physical sensations. The women did not think they had a health problem unless they were experiencing unusual physical discomfort. Because breast and cervical cancer are non-symptomatic in the early stages, the women did not conceive a risk for these diseases. This affected their willingness to overcome their sense of embodied selves and other social barriers to participate in screening programs. For several participants, the embodiment of health was defined in part as the absence of disease and illness. One is in good health if one feels well enough to work and has no physical symptoms of disease:

We're healthy if we can go to work as usual. We go to the doctor only when we have a disease or some evidence that we're sick... Normally we know we're healthy if we can work. If we feel that we're sick, have something wrong, or we're tired or in pain, then we go to the doctor.
(Mrs. Phan)

The manner in which the women experienced illness served to determine when and from whom they sought help. They were uncomfortable with the notion of allowing a doctor to examine their breasts or cervix when there was "nothing wrong." Ms. Lyn said, "I'm very embar-

ressed showing my breasts when nothing is wrong, very embarrassed.” Similarly, Mrs. Mai said, “Pardon me, but if you have nothing wrong and yet you lie on the table like that...that’s very embarrassing... It’s not the same as having your teeth checked.”

It is clear that women’s bodily experience is an important indication of how they will seek health care. However, as Kleinman (1980) suggests, these Vietnamese women also reacted to illness and made their health-care choices based on their social reality, which included their beliefs about health and illness.

Cultural Conceptualization of Health and Illness

“Health is gold” (suc khoe la vang). The women often pointed to the importance of health by referring to the Vietnamese proverb “health is gold” (*suc khoe la vang*):

Health is gold... Health is number one... I’ll always ask you, “How are you?” I’d 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’d be very happy if you said you’re fine.
(Mrs. Mai)

More significantly, in the context of participation in cancer-prevention activities, they placed great emphasis on the meaning of health and illness for both themselves and their families. For some Vietnamese, a person acts as an agent within family relationships. Many Vietnamese people internalize Confucianism, Taoism, and Buddhism — traditions in which the self is closely tied to family kinship networks, social position, and social obligations. For several of the women, therefore, health was important because without it one cannot accomplish much or take care of one’s family — financial stability and the family’s welfare depend on it:

We have to be healthy so we can go to work to make money, because if we don’t, then how are we going to pay the rent and all the bills...? We have to be healthy so we can handle all those things, take care of our family... If we aren’t healthy, we can’t...take care of our children. (Mrs. Mai)

Disease and illness are caused by an imbalance within the body. An ideology of mind-body harmony informed the women’s conceptualization of what makes a healthy body and what causes disease and illness. They believed that because health is achieved through a balancing of several forces, such as Am (yin) and Duong (yang) or the equilibrium of “hot” and “cold,” disease and illness will result if the body is thrown out of balance. Western biomedical conceptualizations of a healthy lifestyle were woven like a thread throughout the women’s narratives. Although the women cited poor diet, low activity level, emotional distress, and bad

weather as factors that can throw the body out of balance and cause illness, they believed that a healthy lifestyle serves to prevent disease:

We get sick and get diseases [breast and cervical cancer] because of how we eat, because of our diet. First, not eating properly... Second,...not exercising. Third, not eating enough fruit. Fruit is very important. Eat a lot of fresh fruit. And swim a lot... [then] you'll have no diseases. (Mrs. Chi)

Many of the women's narratives reflected the emphasis of Western medicine on reducing fat intake and maintaining a healthy body weight. These Vietnamese women, like many Canadians, were concerned with controlling their weight and their cholesterol levels. Mrs. Mai, aged 72, believed she needed to change her diet in order to stay healthy:

To keep ourselves healthy, we need to eat properly...not too much or too little. Here we worry about fat in the blood. So don't eat too much fat... Here it's different; back in Vietnam the more food we ate the better, but here it's not good to eat too much. Food is plentiful here but I wouldn't eat a lot. Control your eating. (Mrs. Mai)

Although the women's discourse about what one should do to remain healthy paralleled contemporary biomedical discourse and their dietary practices were influenced by Western ways, their understanding of food and eating habits may also have been culturally specific. Some of the women believed that foods that are considered *doc* (poisonous), such as bamboo shoots, could cause health problems and that certain foods could affect the body's healing process:

Diet is directly connected to medication. If you take cough medication, you shouldn't eat chicken. If you have an operation, you shouldn't eat beef. If you don't follow that, your disease will take longer to cure. If you have an operation and don't abstain from these foods, then your wound will take longer to heal...you'll have a big scar [theo lon]. (Mrs. Phi)

Disease and illness are caused by a bacterial invasion. The women's explanations for the cause of diseases, especially cervical cancer, were directly connected to the bacterial-invasion theory of contemporary biomedicine. From the women's perspective, bacterial invasion occurs as a result of either poor personal hygiene or negative environmental conditions. A common belief among the women was that a woman could get cervical cancer if she was not clean "down there" or if she had sexual relations with an "unclean man":

Women get cervical cancer because they're not clean down there. You get the disease when the bacteria get inside you... Women can get the bacteria from their unclean husbands. There are men who don't pay attention to

their hygiene and then sleep with their wives. Those wives then get the bacteria in their cervix. (Mrs. An)

Prevention of cervical cancer was, then, focused on cleanliness and sexual practices. In their discourse on the causes of cervical cancer and sexually transmitted diseases, the women often alluded to sexual relationships. The new Vietnamese policy encouraging people who have left the country to return for visits has resulted in many Vietnamese Canadians travelling to Vietnam. Several of the immigrant women expressed a concern that many men who had been back to Vietnam got “the disease”:

Hygiene is important... That thing should be kept cleaner than the mouth even. You clean your mouth, how many times a day? You clean that thing just as often... Also, you have to keep an eye on your husband. Don't let him do anything wrong. If he does something wrong, it doesn't matter how clean you are, you'll get the disease. (Mrs. Chi)

Disease and illness are predetermined by a higher power. A culturally specific aspect of the women's views about the causes of ill health was the belief that disease and illness are predetermined by a higher power. Several of the women believed strongly that everything is determined by “*nhan duyen*” and “*dinh menh*” (destiny). According to this universal law, one has little control over one's life: what is destined to happen will happen; it is up to God (*mac troi*). A person who adheres firmly to this belief does not seek treatment, believing that a cure is up to God. Mrs. An, a 70-year-old woman, described a conversation she had had with her 40-year-old daughter, who had breast cancer:

She told me, “Mom, I'm not going to the doctor.” I don't know exactly what she thinks, but she decided not to go to the doctor. The doctor tried to talk to her many times. He said, “You're still very young. I don't want to see you die.” She said, “Doctor, I have God. My destiny is in God's hands. I don't want to have the operation.” (Mrs. An)

Mrs. An's daughter had discovered a small lump under her arm. Despite the doctor's recommendation, she refused to have a mastectomy and lived for 7 years without treatment of any kind before passing away. Mrs. An said that one of the reasons why her daughter refused surgery was her faith in God. She thought that her daughter's surviving with breast cancer for 7 years pain-free was a miracle, a gift from God. However, not all the women viewed good health as God's doing nor illness and death as predetermined. One 73-year-old woman had this to say:

I don't believe in destiny. If we keep ourselves healthy, then we'll be healthy. God won't be able to help. We'll be healthy if we take care of ourselves. If you...don't look out for oncoming cars and you die, would

you say that is your destiny? You have your eyes — you have to watch out for those cars. You can't say that God plans all that. No, it's not your destiny. (Mrs. Mai)

Although many of the women expressed a firm belief in modern medicine, some remained sceptical about its ability to diagnose and treat contemporary diseases. For Mrs. An, cancer was a name given to diseases that cannot be cured by biomedicine. Such a belief might have been one of the reasons why some of the women did not seek treatment for cancer: if cancer cannot be cured, then seeking treatment for it is a waste of time and family resources:

I think that whatever diseases they can't cure they call cancer. If they try many different treatments but can't cure the disease, then they call it cancer... A disease that they can't cure they call cancer and a disease that takes too long to treat they call an allergy. (Mrs. An)

Beliefs and Values Concerning the Patient/ Health-Care Provider Relationship

The relationship between the health-care provider and the client, which Kleinman (1980) identifies as an aspect of clinical reality, is considered an important component of health care. Thus Vietnamese women's use of screening for breast and cervical cancer is influenced by how they view this relationship. Physicians hold 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 of character. The Vietnamese saying "bac si nhu tu mau" (doctors are gentle mothers) equates the care of a physician with that of a mother:

A doctor should act like a gentle mother. Even if the doctor is young, he should be friendly and calm and show respect for others. He should speak to his patients in such away that they feel they can come and talk to him. (Mrs. Chi)

The patient/physician relationship is a hierarchical one, with the doctor holding considerable power. The participants identified lack of information as one of the many barriers to women participating in screening for breast and cervical cancer. Yet many of them had difficulty asking their doctors for information. According to a female Caucasian health-care provider, some of the Vietnamese-Canadian women were intimidated by their physicians, and asking them for information was not the norm:

What [the women] grow up with and what they know traditionally is this huge hierarchy. Whatever information the doctor gives you, then that's the

information you get. You're questioning his authority if you ask questions... Although they [the Vietnamese women] have family physicians who are Vietnamese-speaking, one of the things they talk about is...they want to get information but [find it] difficult to ask the doctor. They feel awkward asking their doctor. ...unless the doctors [suggest] screening...they wouldn't...say, "I need to have my breast screened" or "I need to have a Pap [test]." They wait for the doctor to take the initiative. (Mrs. McDonald)

The heavy workloads of physicians and the limited availability of Vietnamese physicians (especially female physicians) have hindered the provision of health services for this population. The fact that Vietnamese physicians lack the time to spend explaining, talking, and listening to their patients has resulted in dissatisfaction with the care they are able to provide. Effective health care requires the building of trust between the physician and the patient. Dissatisfaction with the care provided has led to problems in the patient/doctor relationship, which in turn affects the willingness of Vietnamese women to seek medical help, especially with something that is viewed as very personal such as breast or cervical examination. For the participants, this situation created barriers to health care:

I think we should go to the doctors who aren't so busy, who have more time for us. I think the doctor should have more time to talk to you. If he's too busy, I don't feel there's 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's no time to talk about what I need to know or to ask questions... They have no time. They're very busy. They have many patients. When I see him, I wait and wait. It doesn't matter what day or what time I go...I have to wait. (Mrs. Hai)

Discussion and Recommendations

Congruent with Kleinman's theory, this study found that the explanatory models of disease and illness used by Vietnamese-Canadian women influenced their level of participation in cancer-prevention programs. Although some of the beliefs and values expressed by the participants differed from those of the general population, many of their conceptualizations about health, disease, and illness were congruent with the contemporary biomedical perspective. It is not clear, however, the extent to which these traditional beliefs and values deter Vietnamese women from seeking regular breast examination and Pap testing. The data show that the beliefs and values of Vietnamese women about women's bodies as private, which leads to a pervasive feeling of embarrassment, is a barrier to women seeking breast and cervical cancer screening.

For some Vietnamese women, especially older women, merely talking about the subject causes embarrassment. For example, in discussing breast cancer, a group of women on a Vietnamese radio program that airs weekly tried to avoid using the word *vu*, which means “breast,” speaking instead of “ung thu nguc,” or “cancer of the chest.” When they realized that this was inappropriate, they began to call it “ung thu nhu hoa,” or “cancer of the two flowers.” Finally, after much consideration, they began to call the disease “ung thu vu,” which means “breast cancer.” Health promotion and disease prevention programs for immigrant women need to take into account the fact that the dearth of health-care providers, especially female health-care providers, is a major deterrent to Vietnamese women seeking breast and cervical examinations.

Consistent with the findings of Kleinman (1980), this study found that the physician-patient relationship influences women’s health-care practices. For the immigrant women in the study, the hierarchical relationship between a woman and her physician served as a barrier, preventing them from seeking help. In refraining from asking for more information, they did not acquire sufficient knowledge about the disease processes to even consider undergoing breast or cervical examination. Although some of the physician participants recalled speaking with women about testing for breast and cervical cancer, interviews with the immigrant women revealed that they did not remember any such discussions with their doctors. This calls into question the effectiveness of patient-physician communication. Nguyen and McPhee (2003) assert that effective communication allows physicians to understand their patients’ life priorities, decision-making behaviours, and comprehension of the risk of developing cancer and the benefits and risks of testing. They observe that physicians’ care is guided by scientific evidence, whereas patients want care that addresses their largely culturally determined personal values. Thus, to have cancer screening methods that have maximum impact at minimum cost, we need decision-making that is shared by the patient and the physician, especially when the patient and the physician come from different cultures. Health-care providers must attend to where, when, and how they provide their patients with information about screening for breast and cervical cancer.

The women’s emphasis on their embodiment experience as the basis for their health-care practices served as a potential barrier to their active participation in cancer screening. Because breast and cervical cancer are non-symptomatic in the early stages, it was difficult for the women to conceive of being at risk, and this, in turn, affected their willingness to overcome other barriers to seeking health care. Thus promotional information should address the misconception that the absence of symptoms

does not negate the need for screening. Educational materials should clearly explain *why* and *how* early detection of breast and cervical cancer can increase women's treatment options and increase survival rates. Furthermore, information about breast and cervical cancer and screening should be provided in the language that is most understandable and accessible to the women.

Black and Zsoldos (2003) and Lam et al. (2003) suggest that education campaigns and outreach programs that use community lay health workers can be particularly effective in raising awareness, among Vietnamese women, of the importance of Pap testing, because such workers use their cultural knowledge and social networks to effect change. Thus cancer-prevention programs require collaboration between researchers, community members, and community-based organizations, thereby ensuring the sharing of expertise, knowledge, skills, and capacities.

The findings of this study show that the family of an immigrant woman can play a crucial role in her decision whether to seek screening for breast and cervical cancer. Some of the women who participated in the research saw health and illness not only as connected to an individual's body but within the broader social context of their lives — interconnected with factors such as a woman's ability to care for her children, participate in family activities, and contribute to the family's economic survival. This conceptualization of health and illness differs from that in Western ideology, which emphasizes the individuation of self. The reluctance of the women to access health services may have been the result of competing priorities, such as the family's financial situation, employment concerns, or the children's education. Thus outreach material that explains why participation in cancer screening can benefit both the individual and the family might be a more culturally sensitive and effective way of promoting cancer prevention among Vietnamese immigrant women. This idea was well expressed by one of the participants:

You have to say why it's 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're sick, then you stand to lose everything. Whatever you've invested in, you lose. You have to say that if they're 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'd 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. (Mrs. Le)

Conclusion

Several authors have pointed out that the mismatch between the concepts of health inherent in Western biomedicine and those valued by different ethnocultural clients can result in barriers to access to care and ultimately in poor health status (Kearns, 1997; Kearns & Dyck, 1996; Kleinman, 1978, 1980). Because clients tend to reject services that are incongruous with their health-care values and beliefs, providers should learn to recognize and negotiate between different ways of viewing health and delivering health care.

In the present study, the Vietnamese women's conceptualization of disease and illness was, to some extent, culturally specific (for example, the notion that disease and illness are predetermined by a higher power). However, their ways of preserving their health reflect the discourse and practices of Western biomedicine. Furthermore, it is evident that not all of the women's beliefs and values acted as barriers to their seeking Western health care. The comment that "health is gold" actually served as a motivator for the women to engage in cancer screening.

Although the results of this study cannot be generalized to all Vietnamese-Canadian women due to both the small size of the sample and the nature of qualitative research, the findings reveal that barriers to the use of preventive Western medicine might be due to other factors besides the women's traditional beliefs, values, and health-care practices. Therefore, the methods of addressing the screening practices of Vietnamese-Canadian women with regard to breast and cervical cancer should also be assessed, using theoretical and research methodology that examines the influence of not only culture but also social, political, historical, and economic background.

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