

Challenges in providing breast and cervical cancer screening services to Vietnamese Canadian women: the healthcare providers' perspective

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Breast cancer and cervical cancer are major contributors to morbidity and mortality among Vietnamese Canadian women. Vietnamese women are at risk because of their low participation rate in cancer-preventative screening programmes. Drawing from the results of a larger qualitative study, this paper reports factors that influence Vietnamese women's participation in breast and cervical cancer screening from the healthcare providers' perspectives. The women participants' perspective was reported elsewhere.

Semistructured interviews were conducted with six healthcare providers. Analysis of these interviews reveals several challenges which healthcare providers encountered in their clinical practice. These include the physicians' cultural awareness about the private body, patient's low socioeconomic status, the healthcare provider–patient relationship, and limited institutional support.

This is the first Canadian study to identify the healthcare providers' perspective on giving breast and cervical cancer preventive care to the Vietnamese immigrant women. The insight gained from these healthcare providers' experiences are valuable and might be helpful to healthcare professionals caring for immigrant women of similar ethno-cultural backgrounds. Recommendations for the promotion of breast cancer and cervical cancer screening among Vietnamese women include: (i) effort should be made to recruit Vietnamese-speaking female healthcare professionals for breast and cervical health-promotion programmes; (ii) reduce woman–physicians hierarchical relationship and foster effective doctor–patient communication; (iii) healthcare providers must be aware of their own cultural beliefs, values and attitudes that they bring to their practice; and (iv) more institutional support and resources should be given to both Vietnamese Canadian women and their healthcare providers.

Key words: breast cancer and cervical cancer screening, cancer prevention, immigrant women cancer-preventive care, Vietnamese Canadian women.

Breast cancer and cervical cancer are major contributors to the Vietnamese women's cancer morbidity and mortality (McPhee et al. 1997a, 1997b; Lesjak, Hua and Ward 1999; Cheek et al. 1999a; Wismer 1999). 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 (Wismer 1999). Because there are no published findings about Vietnamese Canadian women's breast and cervical cancer incidence, mortality and screening rates, the information was obtained from other countries. Data from the US National Cancer Institute for the years

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1988 through 1992 showed that Vietnamese women's average annual age-adjusted breast cancer incidence rate was 37.5/100 000 while Caucasian women's breast cancer incidence rate was 111.8/100 000. Data from the Northern California Cancer Center revealed that Vietnamese women's annual age-adjusted incidence rate was 47.7/100 000 for breast cancer from 1988 through 1993 (McPhee et al. 1997b). Although breast cancer is less common among Asian immigrant women, Asian women who migrate to western countries experience 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).

Vietnamese women also have the highest cervical cancer incidence in the US (Black and Zsoldos 2003; Vo et al. 2004). This high incidence of cervical cancer might be the result of low Pap testing among these women; hence, the precursor lesions are not detected and treated before progression to cancer. Studies from Australia also indicate that Vietnamese-born women have a significantly higher incidence of cervical cancer (Lesjak, Hua and Ward 1999; Cheek et al. 1999a).

Early detection and treatment of breast cancer and cervical cancer reduce these diseases' morbidity and mortality significantly (BC Cancer Agency 2004). However, Vietnamese women have a lower rate of participation in these cancer screening services than that of the general population (Pham and MCPhee 1992; Yi 1994a,b, 1995; Jenkins et al. 1996; MCPhee, Bird et al. 1997; Lee, Parsons and Gentleman 1998; Lesjak, Hua and Ward 1999; Vo et al. 2004; Cheek et al. 1999a; Cheek, Fuller and Ballantyne 1999b; Hislop et al. 2000; Sadler et al. 2001; King County Public Health 2004; National Asian Women's Health Organization 2004).

A study conducted in King County, USA shows a startling figure of only 18% of Vietnamese women reporting having had breast cancer screening in the last two years, compared to a rate of 67% of the women in the general population (King County Public Health 2004). Another study shows that 37% of the Vietnamese women did not know that a breast lump could be cancerous (Pham and MCPhee 1992). A telephone survey of 933 Vietnamese women living in California shows that 70% of these women had had at least one clinical breast examination, while only 30% had a mammogram (MCPhee, Stewart et al. 1997). A more recent study by Sadler et al. (2001) with 275 Vietnamese American women reveals a mammography screening rate below the recommended level and only 36% reported having adequate knowledge about breast cancer screening. Furthermore, in Australia, a questionnaire survey of 355 Vietnamese-born women by Lesjak, Hua and Ward (1999) and an interview

survey of 199 Vietnamese-born women by Cheek et al. (1999a) revealed that Vietnamese women had a lower level of participation in cancer screening than that of the general population of Australian women.

Sparse data from the USA and Australia also indicated that Vietnamese women's low participation rate in breast cancer and cervical cancer screening programmes is the result of different cultural beliefs and values, low level of education, poverty, never being married, recently migrated, and having a Vietnamese physician (Yi 1994a,b; MCPhee et al. 1997a, 1997b; Lesjak, Hua and Ward 1999; Cheek et al. 1999a). However, there is very limited information on how cultural concepts of health and illness, social relationships, gender and socioeconomic status that are specific to the Canadian social context affect Vietnamese Canadian women's breast cancer and cervical cancer screening.

This qualitative research took place in a western Canadian metropolitan city where the estimated number of Vietnamese was 25 675 (Statistics Canada 2001). The study's goal was to explore from both the Vietnamese women and their healthcare providers' perspectives the factors that influence Vietnamese women's participation in breast and cervical cancer screening. This paper reports on what healthcare provider participants perceived as the challenges in providing breast and cervical cancer screening services to the Vietnamese women living in Canada. The women's perspective was reported in previous publications (Donnelly 2006a,b; Donnelly and McKellin 2007). Although all participants were assigned pseudonym names, these names were not used in this paper as an additional effort to preserve confidentiality and anonymity of the participants. Ethical approval was obtained from the institution where the study was conducted.

RESEARCH DESIGN

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

Arthur Kleinman's explanatory model (1978, 1980) provides the conceptual framework for an understanding of how a different culture and cultural conceptualizations of health, illness and disease influence Vietnamese women's decision to engage in breast and cervical cancer screening programmes.

Social and cultural processes shape the ways in which people think, act and use healthcare services (Kleinman 1978, 1980, 1988). The ways in which people use healthcare services are influenced by how they conceptualize 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 healthcare practices available to them' (p. 38). For this study, Kleinman's explanatory model of health and health-care provided direction for the exploration of (i) Vietnamese women's conceptualization of health and illness, and their explanation of what causes breast and cervical cancer; (ii) whether or not Vietnamese women's healthcare behaviour is influenced by their cultural knowledge and values; (iii) how cultural knowledge and values influence Vietnamese women's healthcare decision-making and healthcare relationships; and (iv) what elements of culture can be identified as facilitators and/or barriers to healthcare practice.

Because Canada is a nation founded on colonization and immigration, and this research is with Vietnamese women who came from a colonized society, postcolonialism and feminism, with its conceptual framework, issues and debates provide valuable insights that incorporate the effect of social, political, historical and economic processes — at the intersection of race, gender and class into the analysis of Vietnamese Canadian women's breast and cervical cancer screening practices.

Postcolonial feminist perspectives, generated through the convergence of postcolonial and black feminist scholarship have informed nursing scholarship in recent years (Anderson 2002; Anderson and Kirkham 2002; Anderson et al. 2003; Guruge and Khanlou 2004; Racine 2003). Postcolonial feminism aims to

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, 11).

Thus, postcolonial feminism serves as a theoretical lens to examine issues of equity and social justice. This is particularly significant in studies of health-care, at the time when global migration and healthcare reform are taking place in many countries. Postcolonial feminism can shed a unique perspective on issues such as equity in health and accessibility in healthcare services (Anderson 2002). Details of the theoretical perspectives that guided the study were also reported in previous publications (Donnelly 2004, 2006a,b; Donnelly and McKellin 2007).

This exploratory qualitative study used a maximum variation purposive sampling, which is 'the process of deliberately selecting a heterogeneous sample and observing commonalities in their experiences' (Morse 1994, 229). Gaining access through Vietnamese community gatekeepers and healthcare organizations was the main recruitment approach of this study. Recruitment of Vietnamese healthcare providers was made through Vietnamese community-based organizations and by personal referral from the Vietnamese community workers. Letters specifying the study's purpose, objectives, research questions and recruitment criteria were provided to community agencies. Personnel from community agencies were asked to contact potential healthcare provider participants who fit the study criteria, to inform them about the study, and to ask their permission for the primary researcher to contact them. Once she received permission to make contact, she then talked to potential participants via telephone. During the initial telephone conversation, the primary researcher explained the study to potential participants in Vietnamese, answered any questions, and invited them to participate in the study before scheduling an interview.

In this study, breast and cervical cancer were explored together because both 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. It was found that having data on both breast cancer and cervical cancer screening practices did not complicate analysis of the data of this study.

Aspects of the study's findings were reported in previous publications (Donnelly 2004, 2006a, 2006b; Donnelly and McKellin 2007). Fifteen Vietnamese Canadian women and six healthcare providers (four Vietnamese physicians and two community health nurses) participated in the study. Although an effort was made to recruit more Vietnamese-speaking physicians as participants, other physicians and the only two Vietnamese-speaking female physicians available were too busy to participate (Table 1). All the healthcare providers, except one community health nurse, speak Vietnamese fluently.

Fluency in Vietnamese and English gave the primary researcher of this study who is a Vietnamese female healthcare provider the ability to conduct interviews in both Vietnamese and English, and closely attend to the participants' narratives.

Method of data collection

Individual in-depth ethnographic interviews using a semistructured questionnaire with open-ended questions was the main method of data collection. Before the interview, the informed consent was obtained. The interview questions

Table 1 Healthcare provider participants' profile

Years of practice	Physicians	Community health nurses	Country where degree was obtained
4		1 (female)	Canada
7	1 (male)		Canada
18		1 (female)	Canada
18	1 (male)		Vietnam
21	1 (male)		Vietnam
25	1 (male)		Vietnam

were asked regarding the participants' experience with providing health-care to Vietnamese women; what they believe as barriers for these women to engage in clinical breast examination (CBE), breast self-examination (BSE), mammogram and Pap testing practices; what information, healthcare programmes and services would best benefit Vietnamese Canadian women; and what they perceive as the best possible strategies to promote breast and cervical cancer screening among Vietnamese women. In-depth interviews with the community health nurses lasted one and a half hours, interviews with the Vietnamese physicians lasted between 30 minutes to 1 hour, three physicians were interviewed twice. Interviews were conducted in Vietnamese with all participants except two interviews with English-speaking community health nurses.

Data coding and analysis

The data analysis and data collection occurred concurrently. As data were obtained, they were transcribed and analyzed in the primary language of the participants by the primary researcher. The process of analysis involved a systematic and rigorous development of code categories and subcategories, which were flexible, evolving and used for the coding of subsequent transcripts. 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 conceptualization and broader theoretical formulations were generated. To ensure rigor of the study, seeking participants' input on the preliminary results was carried out with six participants (two Vietnamese women, three physicians and one community health nurse). This process enabled the researcher to clarify and validate with participants the identified themes, the social processes and structures that influence Vietnamese women's participation in breast and cervical cancer screening programmes.

Qualitative data analysis revealed that healthcare provider participants encounter several major challenges when giving

breast and cervical cancer preventive care to Vietnamese women living in Canada. These include the physician's cultural awareness about the private body, patient's low socioeconomic status, the healthcare provider-patient relationship and limited institutional support.

FINDINGS

Cultural awareness: the private body

Interviews with male physicians revealed that the Confucian teaching '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) makes male physicians very uncomfortable with breast and cervical examinations (Donnelly 2006a). Physician participants, although fully supporting breast and cervical cancer screening, acknowledge that these procedures generate uneasiness. One physician said that he can verbally teach the women how to do breast self-examination, but performing clinical breast examination might not be culturally sensitive for Vietnamese women. Some physician participants have also indicated that providing information about health-care related to breast and cervical, or discussing sexual relationship problems with Vietnamese women are not easy, even for those whom they have been providing health-care for quite some time. A general practitioner (GP), who has been providing health-care to the Vietnamese in Canada for many years, meets obstacles when it comes to encouraging women to talk about breast and cervical examinations:

Vietnamese women are very hesitant (ngai ngung) about these things. These are considered very private (tham kin) parts of the women. That is one of traditional Vietnamese thinking.... There was a woman who had a lump in her breast and she was still wondering if she should have [me] examining it or not.

Physicians also perceived challenging in communication with Vietnamese women about breast and cervical cancer is due to the effect of 'culture':

With Vietnamese women, because of the influence of culture, the ways they think are different with other [Caucasian] women. They don't tell you about what they want. They talk about their [breast and cervical cancer] concerns in a very ambiguous way and very indirectly. So it is very difficult.

Several male physicians acknowledged that knowing about the women's cultural beliefs and values have influenced how they feel about offering clinical breast examinations and Pap smears to Vietnamese women:

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 ... In this society, we do examine the women. However, it is still uncomfortable ... So it is true, I, myself, am quite hesitant.

As observed by a community health nurse:

I wonder how much the doctor was constrained with the cultural aspect ... A lot of time doctor waits for the woman to say 'I am due for my Pap.' I don't know how many family practices have a system where they call the women and say, 'you need to come in for your Pap.' So it might not just be a cultural thing, it might be a doctor thing.

Here, being more culturally aware of how women feel about breast and cervical examinations might have negative effect on how Vietnamese women participate in breast and cervical examinations. It is important to note that Vietnamese physician participants' hesitation to offer clinical breast examination and cervical examination are not limited to the fact that they are more culturally aware of how these examinations create anxiety for the women, but that these examinations are negatively viewed in the general population as well. A male physician who has been a GP in Canada for many years, talked about the difficulty that he and other 'mainstream' physicians encounter in clinical practice:

There was a study from the US which shows that 10% of physicians had sexually abused their patients. This study was taken as evidence to show that many doctors are abusive. Because of that, many doctors are not keen on doing clinical breast examination ... many women were very afraid that their physicians might take advantage of them.

Clearly expressing his disappointment of how the issue has been handled and popularized, this physician thinks that it had, in fact, been very harmful to women. Not only that, it has affected how he gives breast and cervical cancer screening to his patients:

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 they [male physicians] would then just send the patients to gynecologists ... I would only examine patients who had asked me many times ... I would not examine them before being asked.

Vietnamese women's low socioeconomic status

Another challenge which Vietnamese-speaking physicians encounter when providing breast and cervical cancer screenings to Vietnamese women related to the Vietnamese's low socioeconomic status. There are Vietnamese who do not stay permanently in one place. They move often in order to find a place with cheaper rent, thus many do not have permanent addresses and telephone numbers, which

make it difficult to reach them. A physician described this obstacle:

Housing for the Vietnamese people is different with that of Canadians ... For the Vietnamese, they sometime use others' telephones so the telephone numbers changed often, and so do their addresses ... 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 ... and I had to go to them asking for their help in contacting the patient. There was a case, where I had to phone [other city] asking for the address. These problems, a regular doctor would not understand. It is difficult, not at all simple.

Healthcare practice for the Vietnamese elderly depends upon both the individual and the family members. Effort to go for medical check-up is not just an individual's effort, but other family members as well. Therefore, for older Vietnamese women, utilization of breast and cervical cancer screening services involves not only their financial condition, but also their children's family's economic status. Life circumstances and living arrangement influence how elderly Vietnamese women participate in breast and cervical cancer screening programmes. As observed by one healthcare provider:

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 ... 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 ... the last thing they would think about is the preventative care for the senior while they are trying to survive.

Even though health-care in Canada is free for its citizen, for some Vietnamese women, obtaining health-care is not without any costs. Many Vietnamese women who are working in the lower echelon of the labour force often get paid hourly wages. For these women, taking several hours to wait for medical check-up at the doctor's office means there will be no pay for these hours. Thus, for some Vietnamese women, going to the doctor for a check-up, 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 losing time from work. This is what one GP observes:

There are people who know about it [prevention of breast and cervical cancer], 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 cannot just take time off from work any time. If they take one day off, they lose \$100 ... that \$100 is important to them ... They have to send \$100 to their families. So you see, there are many other issues.

This view, however, is not shared by all of the healthcare provider participants. Another physician feels that healthcare cost related to time constraints is not an important barrier because many Vietnamese women are unemployed. For some healthcare provider participants, the effect of an individual's socioeconomic status is seen mainly in its effects on an individual's educational level and knowledge about health and health-care.

That would only affect a very small number of women. The majority of women are not working. They are housewives, 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. 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.

Poverty is seen by physician participants as mainly affecting the woman's knowledge about breast and cervical cancer and its screening, which they perceive as the most important indicator of whether or not women will utilize breast and cervical cancer screening services.

If the people are poor, they are not as hygienic, so the cervical cancer incidence might be high. Because unhygienic conditions 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, [women] who are poor are disadvantaged because they don't have the knowledge.

For some healthcare providers, there is an assumption that Vietnamese women in general have little education, thus they might not have the necessary background to understand health information. Low educational level is being seen as direct influence on how the women understand health issues and practice health-care:

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. Many Vietnamese only have elementary education. Because they do not read or understand much, they tend to believe more in rumor than their doctors, The barrier is not related to poverty, but it is the educational background, the understanding of the problem.

Healthcare provider and patient relationship

For many Vietnamese, the relationship between patient and physician is a hierarchical relationship with the doctor holding considerable power. This hierarchical relationship impedes how women receive breast and cervical cancer screening. A community health nurse sees that lack of information is one of the many barriers to the women's participation in breast cancer and cervical cancer screening.

Yet, many women have difficulty asking their doctors for information. Some women are quite intimidated by their physicians' social status and asking them for information is 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 is the information you get. You are questioning his authority if you ask questions ... Although they [the Vietnamese women] have 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. 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.

Within the Vietnamese community, differences exist. The complexity of the social and political nature of Vietnam has created an obvious division between Vietnamese immigrants who came from the North and those who came from the South. More than three decades of war between North and South have produced many ideologies and assumptions that have divided its people. Division between some Vietnamese in Canada has often reflected the conflict between capitalism and communism. Vietnamese physicians who came from South Vietnam might hold certain social ideologies about North Vietnamese people who had lived under communist regime. Some participants express concern that women who lived under communism have limited knowledge about health and health-care, thus might have limited capacity to take care of their health:

[Women] who lived under communism don't pay attention to their health because they were brainwashed by the communists for 50 years ... They would only come [for check up] 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 to survive.

Quite frank about how they feel towards communism, some physicians insist that healthcare professionals should not let their personal feelings interfere with how they provide health-care to clients. To them, healthcare professionals need to recognize the effect of communism because this recognition would help physicians understand how patients live their lives and take care of their health. Theorizing that discrimination exists because it is innate to human beings, a doctor, just like everyone else might not be able to avoid discriminatory feelings:

Either we discriminate a lot or a little, everyone of us has some kind of discriminations ... Sometimes 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.

Another physician shared this view. He also advises that to provide good health-care, doctors need to act according to their professional ethical and moral codes of conduct:

The tendency to discriminate is in you since you were born. It is a human instinct. That is why a doctor might not be able to avoid discrimination toward a patient. However, 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, our conscience does not allow us to act that way ... But discrimination exists. The thing is that they [other doctors] don't want to talk about it.

Ensuring confidentiality is another challenge that Vietnamese physicians often encountered. The Vietnamese communities are often small, even in a big city. Community members are very aware of each other's circumstances. At the community gathering events, many Vietnamese talked to each other. For some Vietnamese, having a disease could mean disgrace to the family and 'loosing face' within the community. Especially, having cervical cancer might mean that one is promiscuous and the individual's moral characters might be judged by the community members; thus, for some women, the thought of other people knowing about their cervical cancer might be viewed as a greater risk than the disease itself. Recognizing confidentiality is an issue for the women, and that trust must be developed between a physician and a patient; a physician has taken precaution with how he gives care to his patients:

Yes, [confidentiality] 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 ... 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.

A limited number of Vietnamese-speaking physicians have resulted in a high patient/physician ratio. Vietnamese physician participants indicated that they have a very heavy workload, especially doctors who are well known 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. The physician's heavy workloads and the limited number of Vietnamese physicians (especially female doctors) have created problems with physician-patient relationship. Less time spent explaining, talking and listening to patients due to extremely busy schedule creates much dissatisfaction with the care these physicians are able to provide to patients. Dissatisfaction with the health-care

provided has led to doctor-patient relationship problems, which in turn affects the willingness of women to seek care, especially when it is for something that is viewed as very personal such as breast and cervical examination. Acknowledging the problem, a physician reflected:

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.

Limited institutional support

From the healthcare provider 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 healthcare information among the Vietnamese. This creates challenges for them to promote breast and cervical cancer screening among Vietnamese women. A community health nurse who has provided care to the Vietnamese for 18 years identified the need for more interpreter services and translations of breast and cervical cancer information into Vietnamese but found that shortage of funding is a big problem:

It is the funding ... it's really frustrating because I may have a piece of written material that I could have the interpreter translate. But through our organization, we are not allowed to do that now. It all has to go to a very structured process to have material translated. So sometimes professionals, nurses ... are just like, oh it is just so much work to have to go through that process. There is no funding ... That is a big, big problem.

A physician, who has been providing health-care to Vietnamese women for more than 7 years, indicated that although he has made an effort to promote breast and cervical examinations to Vietnamese women, it is not enough. Comparing with the health-care provided to Vietnamese living in California, he attributes women's low participation in preventative cancer screening to the lack of healthcare institutional support:

Language barrier is a big factor. But there is another bigger barrier ... 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's diseases and breast cancer. They also have conferences, teleconferences every week on TV. They organize these things for the Vietnamese. (pause) Here, we don't have those things ... Vietnamese women, actually Asian women in general, they don't pay attention (rat la tho o) to breast and cervical cancer. Only when they have the disease, then they worry about it. It might be because they hesitate (ngai), or even don't trust, or are

afraid of the results after examination. So I 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 danger of breast cancer. We should have a more active, stronger program. Right now, 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 ... 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.

DISCUSSION AND RECOMMENDATIONS

This study revealed that healthcare providers meet major obstacles in providing breast and cervical cancer screenings to the Vietnamese Canadian women. The cultural conceptualization of a woman's body as private leads to a pervasive feeling of embarrassment and hesitation and is a major deterrent for Vietnamese women to seek breast and cervical examination (Donnelly 2006a). Discourses around these issues often reflect Confucian views of modesty, male–female relationships, concealment and femininity. Vietnamese women are often hesitant to seek health-care if there is a great invasion of personal privacy. Breasts and cervix are body parts that are very private to women. Examination performed by male (sometime, even female) healthcare professional is viewed as a great invasion of personal privacy by some women (Donnelly 2006a). Because there is social stigma associated with cervical cancer, confidentiality is a key concern and seeking help for this disease is often done in secrecy. Thus, there might be a real danger that some women who are suffering from this disease do not get the kind of help they need.

The data reveal an important point that being culturally aware about feelings towards a woman's body might restrain male Vietnamese physicians from taking an active role in performing and reminding the women to have clinical breast examinations and Pap smears, because clinical breast examination and Pap smears are more doctor dependent. Hesitation by the doctors might negatively influence the participation rates for these examinations among Vietnamese women. Consistent with the findings of Black et al. (2006), Hislop et al. (2003), McPhee et al. (1997), and Taylor et al. (2001), physicians' support and encouragement for cancer screening are strong facilitator for women to obtain screening. It is very important to note that even though women's hesitation poses as a barrier to the women's participation in breast examination and Pap smear, physician participants also feel that this barrier can be overcome if healthcare providers provide adequate information to the women:

I do think that we can help [the women] 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 [difficult]. But this problem could be overcome if we explain these things to the women. [if we] would sit down to explain to them, to encourage them.

Even though high patient/physician ratio is an issue with most physicians in Canada, Vietnamese-speaking physicians are experiencing much higher patient volume because of the limited number of physicians per population within the Vietnamese community. High patient volume has led to insufficient time to spend with patients. This is a major deterrent for physicians to provide cancer preventive care and information to Vietnamese immigrant women. Thus, promotional programmes for Vietnamese immigrant women has to take into account that a dearth of healthcare providers, especially female healthcare providers, is a major deterrent to Vietnamese women seeking breast and cervical examinations (Donnelly 2006a,b). Thus, effort should be made to recruit Vietnamese-speaking healthcare professionals (especially, female healthcare providers) for health promotion programmes.

The woman–physician hierarchical relationship is a barrier to seeking help for Vietnamese immigrant women (Donnelly 2006a). Refraining from asking for more information limits their knowledge about the disease processes, which determines whether they even consider having breast and cervical examinations. This emphasizes the importance of reducing woman–physicians hierarchical relationship and fostering effective doctor–patient communication. Thus, healthcare providers need to pay attention to how, what, where and when breast and cervical cancer and its screening information are 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 programmes are shaped by the clients' interaction with healthcare professionals. It is equally important for healthcare providers to recognize that unequal power relationships will lead to resistance and ineffectiveness in health-care.

As suggested by the participants of this study, it is important that healthcare providers recognize that although appearing on the surface to have some commonalities, there is diversity among Vietnamese Canadian women, who come from different backgrounds, have different experiences and encounter different obstacles. To understand Vietnamese immigrants' healthcare experiences and cancer preventative practices, healthcare providers must understand the historical, political and economic issues that affect their patients' settlement and adaptation processes in Canada.

As pointed out by the participants of this study, political climate and conflict can result in negative assumptions

between healthcare providers and patients. Even though professional's moral and ethical code of conduct guide the ways in which healthcare providers treat patients, healthcare professionals ought to be cognitive about the extent to which negative assumptions might affect the way in which women receive health-care. Thus, healthcare providers must be aware of their own cultural beliefs, values and attitudes that they bring to their practice.

Healthcare provider participants had clearly identified that institutional budget constraints negatively affect Vietnamese women's utilization of breast and cervical cancer screening services. Because limited funding for the distribution of healthcare information and social resources to the Vietnamese is the most significant barrier for women to access the available healthcare services, more funding is needed. Therefore, the government's policy-makers need to recognize that to reduce breast and cervical cancer mortality and incidence rates among the Vietnamese Canadian women, redistribution of healthcare funding for immigrant women is a priority. Immigrant women truly merit equitable healthcare resources to access the available healthcare services (Donnelly and McKellin 2007).

In conclusion, this research has identified factors that influence Vietnamese women's breast cancer and cervical cancer screening practices and challenges which healthcare providers encountered when providing cancer-preventive services to Vietnamese immigrant women. Even though the findings of this qualitative study cannot be generalized and the number of healthcare provider participants is small, the insight gained from these healthcare providers' experiences are valuable and might be helpful to healthcare professionals caring for immigrants of similar ethno-cultural backgrounds. Because the study's results do not confirm the extent to which Vietnamese healthcare providers experience the challenges, future research could include healthcare providers' survey to assess the extent at which healthcare providers experience those identified challenges and to investigate the relationship between those challenges and Vietnamese women's utilization of breast and cervical cancer screening services.

Despite the above limitations, this is the first Canadian study that explores the healthcare providers' perspective on giving cancer-preventive care to Vietnamese immigrant women. As such, the findings of this study will help to raise awareness of factors that influence how healthcare providers promote breast and cervical cancer examinations, which in turn, influence Vietnamese immigrant women's breast and cervical cancer screening practices. The study highlighted that a combination of the attitudes of health professionals, poverty, healthcare resources and different cultural under-

standing can affect health-seeking behaviour. In order to give effective care to patients of different ethno-cultural backgrounds, healthcare providers should be encouraged to be open-minded and to explore how historical, political and social processes shape their patients' healthcare practices. Finally, the promotion of breast and cervical cancer screening should focus on both the general Vietnamese population and their physicians. To develop collaborative relationships with physicians, it is imperative for healthcare policy-makers to recognize that Vietnamese-speaking physicians are practicing in a 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; therefore, more support should be given to these healthcare practitioners.

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