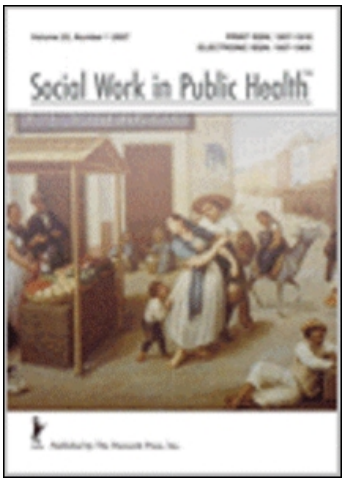

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Socioeconomic Influences on Vietnamese-Canadian Women's Breast and Cervical Cancer Prevention Practices: A Social Determinant's Perspective

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Socioeconomic Influences on Vietnamese-Canadian Women's Breast and Cervical Cancer Prevention Practices: A Social Determinant's Perspective

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Breast cancer and cervical cancer are major contributors to morbidity and mortality for the Vietnamese Canadian women. Vietnamese women face multiple barriers to obtaining effective preventive care and treatment for these diseases. This paper reports the influence of socioeconomic factors on Vietnamese Canadian women's breast and cervical cancer screening behaviors. In-depth semistructured interviews were conducted with Vietnamese Canadian women and health care providers. The study revealed that low socioeconomic status is a major barrier to women's participation in breast and cervical cancer screening, despite the fact that health care in Canada is funded publicly by the Medicare system. The Vietnamese Canadian women and health care providers in the present study identified a number of major dimensions through which socioeconomic issues were associated with Vietnamese Canadian women's access to and use of health care for

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the prevention of breast and cervical cancer, including (a) financial concerns; (b) language, occupational opportunities, and downward mobility; (c) economics and women's households; and (d) low socioeconomic status and screening behaviors. Implications are discussed for increasing Vietnamese Canadian women's utilization of breast and cervical cancer screening services.

KEYWORDS Cancer prevention, breast cancer, cervical cancer, Vietnamese Canadian, immigrant women

INTRODUCTION

By 2001, approximately 76,595 Vietnamese women migrated to Canada (Statistics Canada, 2001). Before coming to Canada, the majority of these women suffered from poor health, disadvantaged economic situations, and low educational levels and lacked adequate medical care. Once in Canada, Vietnamese Canadian women faced socioeconomic barriers to obtaining effective preventive health care and treatment, particularly for breast and cervical cancer. Therefore, the purpose of this paper was to examine the socioeconomic factors associated with Vietnamese Canadian women's health and health care behaviors related to breast and cervical cancer screening.

Low-income and working poor individuals face many stressors that limit their ability to adapt to a new environment and to access health care services and social resources. Moreover, stressors associated with low socioeconomic status increase tensions and family or personal chaos and contribute to poor decision making (Dyk, 2004). For some Vietnamese immigrant women, finding ways to improve their family's financial status, such as finding work, working extra jobs, and working overtime, are top priority. As Benzeval, Judge, and Whitehead (1995) stated, "Income provides the prerequisites for health, such as shelter, food, warmth, and the ability to participate in society; living in poverty can cause stress and anxiety which can damage people's health; and low income limits people's choices and militates against desirable changes in behavior" (as cited in Raphael, 2002, p. 2). Research supports the argument that health and well-being suffer when people are unable to obtain employment and cannot "access 'social safety nets' and supportive services" (Gottschalk & Baker, 2000, p. 7). Thus, low socioeconomic status may be associated with how Vietnamese immigrant women participate in cancer screening.

Epidemiological data are not available on breast and cervical cancer incidence and mortality rates for Vietnamese Canadian women; however, breast cancer rates of Asian American women have approached those of the general population in the United States (U.S. National Cancer Institute, 2004). Moreover, Asian women who migrated to the United States had a

sixfold increase in breast cancer risk compared with women in their native countries (National Asian Women's Health Organization, 2004) and were less likely to undergo regular mammography (McPhee et al., 1997; Pham & McPhee, 1992; Sadler, Dong, Ko, Luu, & Nguyen, 2001).

Cervical cancer is the most common cancer among women in countries where Papanicolaou (Pap) testing is not routine, which may account for the higher incidence and mortality rates of cervical cancer among Vietnamese women (Black & Zsoldos, 2003; Cheek, Fuller, Gilchrist, Maddock, & Ballantyne, 1999; Lesjak, Hua, & Ward, 1999). Vietnamese women are more likely to have cervical cancer diagnosed at advanced stages (Hedeen, White, & Taylor, 1999; Pham & McPhee, 1992; Yi, 1994a, 1995) and are the least likely to undergo Pap testing compared with other populations (King County Public Health, n.d.; McPhee et al., 1997; Pham & McPhee, 1992; Sadler et al., 2001).

Screening programs can significantly reduce the morbidity and mortality of breast and cervical cancers (BC Cancer Agency, 2004a, 2004b). In British Columbia, Canada, where this research was conducted, screening guidelines recommended that women older than 20 have regular annual clinical breast examinations and perform breast self-examinations (BC Cancer Agency, 2004a). Mammography is recommended for women according to their age and risk group or at least every 2 years after age 50 (BC Cancer Agency, 2004a), and Pap tests are recommended at least every 2 years for all sexually active women until age 69, if all previous smear results have been normal (BC Cancer Agency, 2004b).

Although data on the rate of participation in screening for breast and cervical cancer among Vietnamese Canadian women are not available, Vietnamese American women have rates of mammography below recommended levels (Sadler et al., 2001). American and Australian data indicate that Vietnamese immigrant women have lower rates of participation in cancer screening than the general population (Cheek, Fuller, & Ballantyne, 1999; Jenkins, Le, McPhee, Stewart, & Ha, 1996; Lesjak et al., 1999; McPhee et al., 1997; Yi, 1994a, 1994b).

Although some Vietnamese immigrants living in Canada have successfully achieved economic independence (Beiser, 1999), a large number have incomes below Statistics Canada's "low income" cutoff (Raphael, 2002). The data revealed that even though the average income among employed Vietnamese women in 2001 was $28,269 (Canadian), and for all Vietnamese women it was $18,560 (Canadian), almost one-fourth of the Vietnamese women living in Canada had an income of less than $9,999 (Canadian) per year (Statistics Canada, 2001). According to Statistics Canada, in 1996, the average income of Vietnamese Canadian women was just $14,054, compared to about $19,000 among all Canadian women. Not only that, both Vietnamese male and female unemployment rates were much higher in comparison to the larger Canadian population. Forty percent of Vietnamese surveyed across

Canada worked in manufacturing (factory) or construction jobs compared to about 20% of the entire Canadian population (Pfeifer, 2000). The 1996 and 2001 Canadian census revealed that most of the employed Vietnamese females aged 15 years and older worked in service industries that included manufacturing; wholesale and retail trades; accommodation, food, and beverage service; other service industries; health and social service; and business service industries.

Low socioeconomic status puts Vietnamese immigrant women at risk for significantly higher incidence and mortality rates of cervical cancer (Black & Zsoldos, 2003; Cheek, Fuller, Gilchrist, et al., 1999; Lesjak et al., 1999; McPhee et al., 1997). Low income can translate into financial stress and barriers to immigrants' participation in provincially funded health care programs (Anderson, 1998; Dyk, 2004; Jenkins et al., 1996). Immigrant women experience difficulty accessing health care services, even though in Canada the cost of breast and cervical cancer screening services are covered under the various provincial health insurance plans. Immigrant women who work in low-paying unskilled jobs with little or no opportunity or mobility in the workforce often experience difficulty availing themselves of these health care services (Anderson, 1998; Anderson, Blue, Holbrook, & Ng, 1993).

A recent profile of Vietnamese Canadians showed that 66% of Vietnamese immigrants could carry on a conversation in English; however, only 8% had a university degree and 21% had less than a ninth grade education. Limited language proficiency, lower education levels, and unmarketable professional training, along with the experience of being discriminated against in the labor force, have negatively affected immigrants' employment opportunities (Johnson, 2000; Samuel, 1987; Teelucksingh & Galabuzi, 2005), resulting in lower wages, long hours of work, and less opportunity for advancement (Johnson, 1988, 2000; Teelucksingh & Galabuzi, 2005). Moreover, working long hours under difficult conditions can directly affect women's willingness to overcome other barriers to participate in cancer screening programs. It is recognized that

> work is one of the most fundamental aspects in a person's life, providing the individual with a means of financial support and, as importantly, a contributory role in society. A person's employment is an essential component of his or her sense of identity, self-worth, and emotional well-being. (Supreme Court of Canada, 2001, p. 31)

Downward occupational mobility is a common phenomenon for Vietnamese immigrants (Beiser, 1999; Gold, 1992; Johnson, 1988, Kibria, 1993). Regardless of the educational background and previous occupation in Vietnam, many Vietnamese persons are employed in lower-echelon jobs paying minimum wage (Chan & Indra, 1987; Statistics Canada, 1996). Johnson's (1988) study of Vietnamese persons living in Vancouver, British Columbia,

revealed that 57% of the 772 Vietnamese respondents were working in low-paying jobs such as laborers, dishwashers, kitchen helpers, cleaners, janitors, fruit and vegetable pickers, and sewing machine operators. Vietnamese immigrants have been more likely than other immigrants and Canadians to work in manufacturing occupations (Statistics Canada, 1996).

The present study took place in a western Canadian city the immigrant population of which makes up 38% of its two million inhabitants. The number of Vietnamese persons living in this city has been estimated to be 25,675 (Statistics Canada, 2001). The broad purpose of this study was to explore how Vietnamese Canadian women participate in breast cancer and cervical screening; the appropriateness of current preventative cancer services for these women; and how their cancer screening practices are influenced by social, cultural, political, historical, and economic factors, which are shaped by race, gender, and class (Donnelly, 2004, 2006). The purpose of the present paper is to examine the socioeconomic factors associated with Vietnamese Canadian women's health and health care behaviors related to breast and cervical cancer screening. Although the impact of cultural beliefs and values influences Vietnamese Canadian women's screening practices (Donnelly, 2006), it is also important to appreciate the influence of socioeconomic status on screening activities. This paper focuses on the question, How is socioeconomic status, at the intersection of race, gender, and class, associated with Vietnamese Canadian women's participation in breast cancer and cervical cancer screenings?

METHOD

Participants

The study group included two groups of participants, Vietnamese Canadian women and health care providers who provided services to their community. Maximum variation purposive and snowball sampling were used to identify the 15 Vietnamese women and 6 health care providers. The immigrant women were all older than 50 years, with the exception of one 46-year-old woman. Justification for this selection included (a) the need for an age group that overlapped for both breast and cervical cancer screening, (b) the aging population, (c) the increased risk of breast and cervical cancer with advanced age, and (d) the decreasing rate of screening with advanced age. Six health care provider participants included four Vietnamese male physicians and two female community health nurses. An effort was made to recruit Vietnamese female physicians; however, the only two female physicians available were too busy to participate. The health care providers had worked with Vietnamese Canadian women for a period ranging from 4 to 21 years. All health care providers, except for one community health nurse, spoke Vietnamese fluently.

Data Collection and Analysis

The study participants were interviewed using a semistructured questioning format with open-ended questions. The interviews lasted between 3 and 4 hours for the immigrant women and between 30 minutes and 1 hour for the health care providers. All interviews were conducted in Vietnamese except for the two interviews with community health nurses, which were conducted in English. The primary researcher (TD) conducted these interviews. She is a Vietnamese woman who received her early professional education in Vietnam and came to Canada as a refugee. Fluency in Vietnamese gave the researcher the ability to conduct interviews in Vietnamese and to understand and closely attend to the participants' narratives.

Ethical approval for the study was obtained from the University of British Columbia Ethics Board. Participants gave informed consent prior to the interview. The participants' identities were protected by the use of codes and pseudonyms, which were used when quoting participants. Data collection and analysis occurred concurrently. As data were obtained, the primary researcher transcribed the data in the language that was used by the participants. To ensure accuracy, the transcripts were rechecked against audiotapes and corrected, and then a hard copy was obtained for preliminary data analysis. In the early stages of analysis, transcripts were read line by line and a list of categories was formulated. These categories were refined as subsequent data were gathered. Data in one category were examined for their relevance to other categories. The final outcome of this analysis was a statement about a set of interrelated concepts and themes. Themes and concepts were used to compare within and across transcripts. From this, a higher level of data conceptualization, broader theoretical formulations, and preliminary results were generated.

To ensure the study's rigor, the preliminary results were given to six participants (two Vietnamese women, three physicians, and one community health nurse) who provided insightful and reflective responses. This process of member checking enabled the interviewer to clarify, expand, and discuss with participants the emergent themes, ideas, and concepts. It also allowed the primary researcher to validate findings, to develop a deeper understanding of the data, and to gain more insight into the social processes and economic structures associated with Vietnamese Canadian women's breast and cervical cancer screening practices (Donnelly, 2006).

FINDINGS

The Vietnamese Canadian women and the health care providers in the present study identified a number of major dimensions through which socioeconomic issues were associated with Vietnamese Canadian women's

access to and use of health care for the prevention of breast and cervical cancer. These included (a) financial concerns; (b) language, occupational opportunities, and downward mobility; (c) economics and women's households; and (d) low socioeconomic status and screening behaviors. Before describing these dimensions, the women's demographic and socioeconomic profiles are presented to provide a context for understanding the dimensions.

Sociodemographic and Socioeconomic Profiles: Vietnamese Canadian Women Participants

The sociodemographic and socioeconomic profiles of the Vietnamese Canadian women in the present study are shown in Table 1. Ages ranged from 46 to 78 years, all spoke Vietnamese, most were from the south of Vietnam, most were long-term residents in Canada, and educational levels ranged from grade 2 to university graduate. Six were either widows or divorcees with little or no English skills. Regarding socioeconomic profiles, about half of the women reported family incomes below $20,000 per year. Only one woman reported a family income between $70,000 and $79,000. Four women (27%) said they worked full-time; one held a professional job; and the others worked as waitresses, as sewing factory workers, or in store customer services. The remaining women identified themselves as homemakers. Contrary to the participants' occupations, the Canadian national census (Statistics Canada, 1996, 2001) indicated that Vietnamese women were likely to be employed in manufacturing jobs. However, in the present study, the Vietnamese women who identified themselves as homemakers also did piecework at home, which might be considered low-wage manufacturing jobs. These homemakers also relieved other family members of domestic responsibilities, freeing them for employment.

Financial Concerns

The Vietnamese women in the present study were glad to be living in a Western society that gives them a level of material comfort they did not have in Vietnam. Their incomes came initially through government social support payments or low-paying jobs. When asked what they most appreciated when they came to live in Canada, several women talked about the government support they received when they first arrived.

> What I always remember about this nation for the past more than 20 years was that Canada is like a haven because of so many things it gives to its citizens. . . . Because of the support the government gives to people, I really like Canada. (Ling, personal communication)

Mrs. Phan came to Canada in 1990 with her husband and two children. She worked as a waitress at one of the local Chinese restaurants. With hard

TABLE 1 Vietnamese Canadian Women Participants' Sociodemographic and Socioeconomic Profiles ($N = 15$)

Variable	Range	*f*	%
Age, years	40–49	1	7%
	50–59	5	33%
	60–69	3	20%
	70–79	6	40%
Years living in Canada	5–9	1	7%
	10–14	3	20%
	15–19	1	7%
	20–24	5	33%
	25–30	5	33%
Region of Vietnam	From North Vietnam	5	33%
	From South Vietnam	10	67%
Marital status	Married	9	60%
	Widowed	4	27%
	Separated/divorced	2	13%
Vietnamese-speaking	Yes	15	100%
English-speaking	Not at all	3	20%
	Poorly	5	33%
	So-so	4	27%
	Well	2	13%
	Fluently	1	7%
Education	University or college	4	27%
	Some university or college	2	13%
	High school	3	20%
	Grade 4–11	2	13%
	Grade 2–3	4	27%
Employment	Working full-time	4	27%
	Full-time homemaker	11	73%
Yearly family income before taxes	<$20,000	8	53%
	$20,000–$29,000	0	0%
	$30,000–$39,000	3	20%
	$40,000–$49,000	3	20%
	$50,000–$59,000	0	0%
	$60,000–$69,000	0	0%
	$70,000–$79,000	1	7%

work and persistent saving, she and her husband now own their own home. There were 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. (Phan, personal communication)

Mrs. Phan was grateful that she now lives in Canada—a much richer country than Vietnam—and she acknowledged that as a Canadian citizen, she enjoys a high standard of living as well as many human rights. Narratives

of the women also revealed some ambivalent feelings about their new home. Although several women were very glad to be in Canada and expressed their gratitude to Canadians, they also admitted that living and working in Canada is not easy.

Mrs. Phan, who was younger and able to participate in the labor market, enjoyed a high standard of living in Canada. However, a significant number of older Vietnamese women who were dependent on government support lived on fixed incomes that were below Statistics Canada's "low income" cutoff based on family and community size (Raphael, 2002). Although some women participants reported incomes below $20,000 (Canadian), the actual income of some women was between $8,000 and $10,000 (Canadian) per year. These women found that even though they had everything they needed, such as sufficient food and clothing, they still had to budget carefully because of their low income.

Although these Vietnamese Canadian women lived with a very restricted income and encountered many difficulties because of language and culture differences, they were very glad to be living in Canada. The emotional burdens, stress, and limitations of the women's socioeconomic constraints was relieved, in part, when compared with their present living conditions, with life prior to migration, and with what they imagined their life would be if they were living in Vietnam.

Mrs. Mai was 73 years old and came to Canada with her husband in 1992. They lived in a basement apartment in a community where rent was cheaper than in other parts of the city. Although both Mr. and Mrs. Mai were older than 70, they did not qualify for Old Age Security income supplements because they had not lived in Canada long enough to qualify; instead, they were receiving social assistance. Still haunted by many memories of their difficult premigration lives and the experience of coping with illness, she said

> Back then, my life was so difficult. I did not make much money working as a blue-collar worker. 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, heaven 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 [older than] 70 years old ... (Mai, personal communication)

As grateful as she was to be living in Canada, Mrs. Mai and her husband lived on a restricted income and had to watch their spending very carefully. For example, Mrs. Mai rationed the use of her hearing aid and only used it on special occasions because she considered the batteries expensive, although they only cost a few dollars.

Although suffering from the pain of arthritis in her legs and arms, in order to generate extra income Mrs. Mai babysat for several children up until a couple of years ago. When she was not looking after other children, she cared for her grandchildren so that her daughter could go to work. For Mrs. Mai to see her doctor, she had to plan around both her own and her daughter's schedule because her daughter could only take her to the doctor on her day off. For older Vietnamese women, participation in breast and cervical cancer screening programs involved not only their financial condition but also their children's family's economic status and employment conditions. As observed by one health care provider

> Often the seniors are doing child care so that both parents can be working. 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. Those are the big barriers.... If the socioeconomic situation is better for the family and the status of living is higher, then there are not as many constraints on that family; [there is a higher] 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. (McDonald, personal communication)

Despite the fact that low socioeconomic status negatively affected some Vietnamese Canadian women's quality of life, for some other women, it was also a source of motivation. Coming from difficult living conditions—arriving empty-handed but with plenty of determination—the Vietnamese women anticipated that with hard work and thrift, they could rebuild their lives and establish a good life not only for themselves and their family members who accompanied them but also for those they left behind. Once on Canadian soil, many Vietnamese persons were eager to find work and to save money. Many have successfully achieved economic independence. Women, like Mrs. Hai, encountered socioeconomic constraints but did not let hardship and difficulty destroy their dreams.

> I think that made [us] more determined. If we [had] difficulty, we would try harder. We will [improve] 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 [improve].... 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 [had] said. (Hai, personal communication)

Language, Occupational Opportunities, and Downward Mobility

Several participants talked about how limited English skills, limited occupational opportunities, and underemployment affected their lives. Limited proficiency in one of Canada's official languages was a barrier that affected the immigrants' employment opportunities. Even though by 1991, the majority of Vietnamese immigrants could speak at least one official language, English and/or French (Government of Canada, Statistics Canada, 1996), their language proficiency was not necessarily adequate for them to enter professional training and obtain better-paying jobs. It was apparent that the women in this study experienced downward occupational mobility regardless of their Vietnamese educational background and previous occupations held in Vietnam. For example, 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 use these skills. The women with higher levels of education and professional training premigration experienced more disappointment with their present employment status. Mrs. Hai was a teacher in Vietnam; however, she could not practice her profession in Canada. When she arrived in Canada as a refugee, she completed only 5 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 5 months' English training, but after that they were encouraged to enter the workforce because financially independent immigrants meant less pressure on the government or sponsor agencies to provide financial support. 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 that would enable them to enter professional training or find professional jobs. This policy, coupled with the anticipation that families back in Vietnam were waiting for financial assistance made many Vietnamese immigrants eager to enter the workforce as soon as they could. Mrs. Hai reflected on her situation:

> 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[ing] 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.... If I [had] a better job, if I [had] time to study or train on different skills, then I would be better off. But I just keep on working the same job. (Hai, personal communication)

The brief language training did not give Mrs. Hai enough proficiency in English to find a job that would provide upward mobility in the workforce.

After working as a dishwasher for a few months, she found a job at a department store, where she remained for 20 years. Reflecting on her work, she said

> I don't like [this work], but I don't hate it either. So I just keep on working.... 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, [thieves], and drug addicts.... I [have] work[ed] there for 20 years, yet my salary is only a bit higher than [that of] the new workers. (Hai, personal communication)

Despite her low salary and the unfavorable working conditions, Mrs. Hai remained in the same job. One of her reasons for doing so is as follows:

> When I first came here, my English was limited. Back then, 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 [felt] that I need to find another job, it [was] too late. I applied for jobs at the bank. Before, it was quite easy [to get a full-time job]. But when I applied, [there were only] part-time or part-time on-call [positions available], and I need a full-time job. I don't want just to work part-time here and there and stay home waiting for a phone call. To work at some kind of professional job, I don't have the ability. I have never learned a professional trade. So I have to cope with it. Now, I am too old. Where would I go? Anywhere I go, it would only be a part-time job. I don't want to work part-time or [on-]call ... or get laid off at any time. (Hai, personal communication)

In the beginning, many Vietnamese immigrants would take English classes or other training courses during the day and work as cleaners or dishwashers at night. It is common for Vietnamese immigrants to work two or 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 working right away, first at a pizza restaurant, 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.

> 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[ed] right away. But that is only one thing. Another thing is that no one told me or showed me what to do.... I just worked day and night for many years instead of studying English. I worked until I fell and broke my arm. (Thanh, personal communication)

Economics and Women's Households

Some Vietnamese Canadian women move frequently in order to find housing with cheap rent; thus, they do not have permanent telephone numbers, making it difficult for physicians to keep track of them. Mrs. May, a community health nurse who had many immigrant women as clients noted that from her experience, low socioeconomic status led to poor housing, which affected women's health.

> I think socioeconomic issues, not having enough money ... some of the women are living in basement suites that are damp and moist.... I think probably accessing affordable housing is an issue.... Because most of the women [who] I see in this area are [receiving] social assistance, and many of them are single mothers. They are probably having difficulty finding housing. (May, personal communication)

Dr. Dau, who had been providing care to Vietnamese persons for 21 years, encountered poverty-related issues in housing. According to him, many Vietnamese women have a Pap test only once, some have it done every 7 years, and a few go for Pap testing every year or every 2 years. One strategy he thinks might increase Vietnamese women's participation in cancer prevention screening is to have physicians telephone to remind them that it is time for their test. However, an obstacle he encountered in his practice was difficulty in contacting some Vietnamese women.

> Reminding them through a telephone call is difficult because their telephone numbers change quite often. Housing [situations] for Vietnamese people [are] different than those of Canadians. [Generally,] Canadians live in one place [and] have a permanent mailing address. The Vietnamese [persons] sometime use others' telephones, so the telephone numbers change often and so do their addresses.... There are cases when this problem is quite severe. For example, there was a person who had tuberculosis and I could not get a hold of that 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 result, I would have to know who her friends are. Who came with her to the office. I have to remember all that.... There was a case. I just could not find any contact persons here. I had to phone [the patient's friend who lived in a different city] asking for the [patient] address. These problems, a regular doctor would not understand. It is difficult, not at all simple. (Dau, personal communication)

Low Socioeconomic Status and Screening Behavior

Low socioeconomic status was an obstacle for Vietnamese Canadian women to seek health care services because obtaining health care services costs

money. The women who were working in the lower echelon of the labor force were paid hourly wages. For these women, taking time off from work meant losing money. Thus, for some Vietnamese women, going to the doctor for a breast examination, mammogram, or Pap test cost money because they lost time from work. Vietnamese women who did not enter the "formal" workforce, worked "informally" at home to make extra money or to help out their own children. Some women also worked as babysitters, looking after two or three children at home. Some made Vietnamese sweets to sell to the stores, whereas others sewed at home for companies. For these women, taking time to see a doctor was difficult and costly. Many would rather stay at home to work than spend several hours waiting at the clinic or doctor's office. Thus, low wages from home-based piecework, domestic service, or their limited household incomes proved to be barriers to breast and cervical cancer screening. One general practitioner observed the following:

> There are people who know about [breast and cervical cancer screening], but they . . . 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 anytime. If they take one day off, they lose $100; $100 might not be important to you, but that $100 is important to them. They have to send $100 to their families. So you see, there are many other issues. (Dau, personal communication)

Women participants such as Ms. Ling shared this viewpoint:

> [P]eople 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. [For example,] they [could be] living in an apartment but the landlord 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, they don't have time to think about [breast cancer and cervical cancer screening]. They don't think about prevention [of these diseases]; only when they are very sick [do] they pay attention. (Ling, personal communication)

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

> The majority of women are not working. They are housewives. Also, women who are [receiving] social assistance . . . have plenty of time. Women who are working may [not], 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. The main barrier [to breast and cervical cancer screening] is their limited knowledge. (Dr. Thinh, personal communication)

Thus, some health care providers believed that Vietnamese women's socioeconomic status was related to their knowledge about health and health care and considered socioeconomic status the most important indicator of whether the women would participate in breast and cervical cancer screening. The same health care provider believed that poverty affected the women's knowledge about the diseases, which in turn created a barrier to cancer screening and prevention.

> If the people are poor, they are not as hygienic, so the cervical cancer incidence might be high. Because unhygienic condition[s] and multiple partners cause cervical cancer, people who are not educated or who are poor are more likely to get the disease.... In term[s] of its screening, people who are poor are disadvantaged because they don't have the knowledge. (Thinh, personal communication)

By contrast, other health care providers did not think that low socioeconomic status and poverty had a direct influence on a woman's screening behavior. They thought the woman's educational background had more influence on how she understood health issues and practiced health care behaviors. Health care providers assumed that Vietnamese women in general had little education and thus they might not have the necessary background to understand health information.

> 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 [persons] do not have [a] high school education. Many of them, although not illiterate, only have [an] elementary[-level] education. Because they do not read or understand much, they tend to believe more in rumor than [in] their doctors. I have patients who would not take the medication I prescribed [for] 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. A barrier not related to poverty, but [to] the educational background, the understanding of the problem. They do not understand. (Huy, personal communication)

Health care providers in this study also believed that health care for breast and cervical cancers should not be limited to the treatment of these diseases but should also encompass how Vietnamese women live their lives. Their economic conditions are important factors.

> We have to look at everything that influences people's lives. Their jobs [and whether] they have enough food to eat. 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. (Dau, personal communication)

DISCUSSION

Socioeconomic factors associated with immigration (e.g., low-income jobs, the occupational limitations created by language skills and education, and the more general domestic demands on women as a result of household finances), constrained Vietnamese Canadian women's access to primary health care and breast and cervical cancer screening and treatment. Vietnamese Canadian women in the present study generally considered stable household finances and caring for children and other family members as their highest priorities. These responsibilities, however, coupled with low income, insecure employment, and uncertain finances associated with their immigrant status impeded their participation in breast and cervical cancer screening programs.

A Vietnamese woman's hesitation to take time off of work for medical checkups and screening procedures also can be understood in light of class (Minh-ha, 1999). Whereas middle-class professionals or unionized workers may not suffer financially for taking "personal time," a Vietnamese Canadian woman working in a blue-collar position may jeopardize her job or experience guilt when she takes time away from work or from taking care of others. Because she comes from a family and a social context in which commitment to others is emphasized and time is valuable, taking time for oneself could mean having less money to take care of the family, to send back to family members in Vietnam, or for her own children's education. 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" (Minh-ha, 1999, p. 64).

Some health care providers such as physicians might not recognize the impact of low socioeconomic status on women's breast and cervical cancer screening behavior. Physicians hardly had time to talk about health concern(s) let alone about financial problems and their impact on health. Furthermore, socioeconomic status intersects with Vietnamese cultural values, where keeping face is important. It is inappropriate to discuss financial status and problems, especially if a woman does not know her doctor 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 with them. However, health care providers who worked closely with the women or who had the opportunity to see the social and environmental context in which these women live were more

likely to be aware of the impact of poverty on the women's health care behavior and on women's participation in cancer screening programs.

Limited language skills were the most cited problem linked to poor-paying jobs and poverty and contributed to the women's underutilization of breast and cervical cancer screening. For younger women, "knowing the language of the host country is an important criterion of labor market entry [and] an important factor in earnings" (Boyd, 1997, p. 155) and accessing health care services. In Canada, not knowing English or French not only limited the degree to which Vietnamese women could utilize health care services but also limited their ability to use previous education and work experience in a broad array of jobs (Boyd, 1997). Immigrants who do not know English or French have average annual earnings less than those of immigrants who can speak one or both of these two official languages (Boyd, 1997).

Poverty and the inability to find good jobs should not be construed as due solely to limited language skills. Although knowing either English or French and familiarity with Canadian culture and societal infrastructure were definitely an advantage, Vietnamese Canadian women's limited employment opportunities were also related to social inequalities embedded in social and institutional policies (Miles, 1989). Some Vietnamese Canadian women in the present study found that particular immigration policies and language training programs for immigrants did not provide adequate support for women who attempted to employ their new skills. These women had difficulty participating in these language training programs because training allowances were not accessible. These policies and programs forced women to choose between remaining in low-paying jobs with few prospects or quitting their jobs and losing their income while they enrolled in training programs. Consequently, Vietnamese Canadian women tended to work in jobs that did not require extensive language skills (e.g., in manufacturing).

The economic adaptation of immigrants is an important indicator of immigrants' adjustment to their new lives (Deschamps, 1987). Therefore, immigrants' ability to enter the workforce and to generate income is viewed as the best indicators for the success or failure of the integration process (Deschamps, 1987). However, limited language skills, lower education levels, and unmarketable previous professional training hinder many Vietnamese Canadian women's abilities to generate higher incomes in Canada. These various occupational, educational, domestic, and linguistic factors that contribute to these immigrant women's lower socioeconomic status constrained their ability to participate in breast and cervical cancer screening programs.

These Vietnamese women, similar to other immigrants living in Canada, reported that discrimination accounted for their inability to find suitable work and for their failure to succeed in a competitive labor market (Deschamps, 1987). Thus, ethnic inequality in relation to social class, education, and economic opportunities may also have had an impact on Vietnamese Canadian

women's experiences. Social discrimination affects women's well-being and the ways in which they practice health care behaviors. Several participants experienced both cross–ethnic group and within–ethnic group discrimination when entering the social support system and the workforce. Some Vietnamese Canadian women found that limited language skills contributed to ethnic discrimination and their unequal treatment in the workplace that extended beyond the language requirements for the jobs.

> They can't talk to anybody. 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 [people] who told me that they could only say "I upset." When being asked, "Why are you upset?" These Vietnamese could not explain why. So you see, [there] is no way out. That is the story of the Vietnamese. (Ling, personal communication)

Here, language skills, which heighten ethnic differences, contributed to unequal relationships that were socially constructed and maintained by differential power relations between a dominant and a subordinate group. These linguistic differences, generalized into ethnic distinctions, affected the educational and economic opportunity of these Vietnamese women in the same way that ethnicity has constrained the opportunities of other immigrant groups in Canada (Li, 1988, 1990). It has been argued that ethnic inequality is a systematic and institutionalized feature of Canadian society. Li (1988) and Teelucksingh and Galabuzi (2005) observed that structured social inequality is responsible for the disadvantaged positions of many ethnic groups. These disadvantages include unequal access to educational opportunities and earnings. These dimensions of social inequality combined with low earnings contribute to the poor health status of immigrants, poor quality of life, and the loss of control over life situations.

Thus, the more abstract social determinants of health, including an unequal distribution of wealth, privilege, and power in Canadian society, combined with the more immediate problems of low earnings and limited language skills created obstacles to breast and cervical cancer screening for the Vietnamese Canadian women in the present study. Thus, fostering increased incomes and economic adaptation will not only increase Vietnamese Canadian women's contribution to their host society but also promote their participation in health care programs. More attention should be paid to developing strategies that would help Vietnamese Canadian women overcome the social and economic barriers to health care. 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.

In an analysis of the power relations between health care providers and clients, we must take into account the historical and social contexts of the persons involved. In order to plan for appropriate health care services for different ethnocultural clients, health care providers need to have an understanding of how poverty impacts people's lives and their ability to take care of their health. We need to recognize that what contributed to the poor health status of marginalized populations is not only health care but also poverty, housing, education, employment, and unequal distribution of health care resources. Unequal distribution of wealth and an imbalance of power relations are 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 disease. 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 and economic conditions and institutional structures contribute to these problems. Thus, future health care research should focus on an 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.

CONCLUSIONS

Studies of the health practices of immigrants are often restricted to examination of the differences in health beliefs and cultural values of the immigrants and their new host society. Although it is important to appreciate the importance of cultural assumptions in health care, it is also imperative to examine the social and economic dimensions of the immigrant experience. Vietnamese women living in Canada have experienced both positive and negative consequences of changes in their economic status. In general, Vietnamese Canadian women have adjusted fairly well economically, and many have enjoyed the high living standard of Canadian society. However, a number of them have incomes below Statistics Canada's "low income" cutoffs, and their incomes are lower than those of people born in Canada as well as those of other immigrant populations (Government of Canada, Statistics Canada, 1996; Statistics Canada, 2001). Of note, "income inequality appears to affect health by undermining civil society, eroding social cohesion and political participation" (Hertzman, 2001, p. 542). Income, coupled with

the conditions of employment and underemployment, shapes these women's immigrant experience.

Occupation and income are key factors that affect women's health and the ways in which they access health care. Thus, it is important to keep in mind that in the promotion of breast and cervical cancer screening among Vietnamese women, economic adaptation and contextual factors that affect their economic condition must be considered. Not only do personal background, experiences, and skills affect how Vietnamese women participate in cancer screening programs, but other issues such as their economic situation, institutional policies, social structures, and social relations do as well.

Some of the misconceptions that health care professionals might have are that immigrant women should be able to access breast and cervical cancer screening services if they know about them, that they know the importance of having checkups, and that they have knowledge about these diseases and their risks. It is not that simple. Having knowledge and awareness of breast and cervical cancer and the availability of cancer preventive services might help, but for Vietnamese Canadian immigrants there are many barriers to accessing these services (e.g., limited language skills, limited health care providers, and limited health care resources). To many Vietnamese Canadian immigrants, struggling for economic survival takes priority. It is not that taking care of their health is not important. To many, health is very important, and while "health is gold," making sure 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 Canadian women (i.e., clients of different ethnocultural backgrounds), an alternative approach is needed that not only is culturally sensitive but also considers the socioeconomic factors that affect their lives. If health care professionals are to advocate for holistic health care, then health care services ought to examine how socioeconomic status at the intersection of race, gender, and class shapes an individual's multiple social positions and creates unequal social relations, which in turn affect health and health care behavior.

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