

Vietnamese health promotion project Assessment Report

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p.

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Table of Contents

p.

Vietnamese Health Promotion Project

p. 1

Assessment Report

INTRODUCTION

This assessment was conducted to assist project staff in determining:

1. What are the health-related risk factors, problems, beliefs, practices and barriers to health care access in Orange County's Vietnamese community?
2. How could the problems/needs be addressed through community health promotion strategies? Would a Community Health Promoter program be an effective health promotion strategy? What are the necessary characteristics of a health promoter? Which target groups would benefit most from such a program?
3. Which community organization(s) would be the most appropriate and willing to conduct a Community Health Promoter program?

METHODS

A literature search, data review, staff focus groups, and key informant interviews were conducted from June to November 1997. During that period, the following occurred:

- 7 Over 20 articles were reviewed.
- 8 Quantitative and qualitative data were collected from various studies and reports.
- 9 Four focus groups were conducted with 46 Health Care Agency Vietnamese staff (see Attachment A for summary reports).
- 10 Twenty-nine interviews were conducted with key informants in the community (see Attachment B for a list of key informants).

We recognize and acknowledge that our methods do not constitute a comprehensive needs assessment of all the health problems and concerns in the Vietnamese community. However, we feel that the information gathered is valuable in helping address the questions posed at the beginning of this report.

p. 2

FINDINGS

Demographics

Vietnamese are the fastest-growing Asian-Pacific Islander ethnic group in the United States. Bureau of Census projections for 1997 indicate that there are 848,600 Vietnamese in the United States, representing 8.4 percent of the total Asian and Pacific Islander American (APIA) population. Vietnamese are also the largest Southeast Asian group in Orange County. Asian and Pacific Islanders comprise 11.5% of the County's total population (1995 population estimates). Over 39% of this population are Vietnamese, with the largest concentrations residing in the cities of Garden Grove, Santa Ana, and Westminster. The Orange County Vietnamese population in 1995 was 116,632 (comprising 4.5% of the total Orange County population). This figure represents a 500% increase in 15 years (19,333 in 1980) (OPRP, 1997).

Immigration History

The historical immigration patterns for the Vietnamese population fall into three major waves. The first wave of refugees arrived in the United States between 1975-1981. They were highly educated, primarily urban dwellers, had worked with Americans in Vietnam, and had spent little or no time in refugee camps before immigrating to the United States. The second wave of refugees came between 1981 and 1985 and consisted of people with lower socioeconomic status, low education levels (average four years), a rural background (primarily farmers and fishermen), and experienced prolonged stays in refugee camps. A majority of the second-wave refugees were known as "boat people." They escaped Vietnam by boat, endured many hardships at sea, and were turned away from one country after another. The third wave of refugees arrived after 1986 and included Amerasian children and political prisoners released from reeducation camps (Lew, 1989 and Vu, 1996).

This immigration history is important to establish a context for tailoring health promotion programs to specific target groups. For instance, an educated Vietnamese person who arrived in America in 1975 will most likely be more acculturated, healthier, and more proficient in English than a political prisoner who arrived in 1990. These factors will substantially affect knowledge of and access to the American health care system.

Cultural Health Beliefs/Practices

p. 3

The information gathered from the literature, focus group members, and key informants was consistent in describing common health beliefs and practices. However, while these commonalities help in understanding health problems and needs in the Vietnamese community, one should be careful not to stereotype because there are too many individual variations.

Confucianism, Taoism, and spiritualism play important roles in the Vietnamese psyches and influence their beliefs of health, disease, birth, and death. Before the introduction of Western medicine, Vietnamese relied heavily on the Taoist model of health and disease. Traditionally, Vietnamese believe that disease and illness are caused by disharmony and an imbalance in the body of the humoral forces of yin/yang (*âm/dùòng*) and “hot” and “cold” properties in food, illness, medication, or treatment. For example, Western medicine may be viewed by some Vietnamese as too strong or “hot” and may be seen as upsetting to one's internal balance. Some illnesses are also thought to be caused by “bad wind” (*phong*) (Lew, 1989). The Confucian beliefs of privacy and female modesty have made the field of obstetrics and gynecology particularly susceptible to poor communication and misunderstandings. These beliefs may also discourage women from utilizing screening practices such as mammograms and Pap exams.

Many Vietnamese do not want to be impolite and are therefore unwilling to complain to their doctors. “Yes” and “no” questions are seldom helpful, as many avoid saying “no.” Some in the Vietnamese community, especially those who are elderly or more recently arrived, fear surgery or other invasive procedures, believing that surgery upsets the soul and causes the spirit to leave the body (Uba, 1992).

Lack of prevention practices and delayed treatment were identified as common problems. Many Vietnamese do not go to the doctor until an illness becomes very serious. Denial or tolerance of physical pain (considered a strong character trait), a tendency to accept illness as part of one's destiny, and a fatalistic attitude towards illness may cause a patient to delay seeking medical care (Jenkins et al., 1996). For example, a woman may feel an abnormal lump in her breast, but she will avoid going to the doctor because she doesn't want to “ask for trouble” or bring illness unto herself. Instead, she uses herbal remedies to try to make the lump go away, delaying care for a potentially malignant breast tumor.

Physicians were viewed as not emphasizing prevention practices to their patients. Combined with reluctance of the patient to ask questions, there is little discussion about

p. 4

prevention. This attitude toward illness was adopted and reinforced in Vietnam, with a crisis-oriented system of care in which preventive medicine is virtually ignored except for vaccinations.

Influenced by the Chinese, Vietnamese employ various folk medicines and practices to relieve minor discomforts or illnesses and to restore internal balance. For example, a common practice is *cao gió*, or coin rubbing. This practice is believed to drive away bad wind from the body. Only after herbal medicines and practices are tried without success will Western medicine be used. However, reluctance to take Western medicine on a long-term basis is also a problem. Medication side effects often prompt Vietnamese patients to reduce the appropriate dose or discontinue taking the medicine without notifying the medical provider (Uba, 1992). The overuse of antibiotics was also described as a common practice, stemming from the easy availability and use of antibiotics in Vietnam to relieve illnesses ranging from headaches to colds.

Health Risk Factors

Smoking is regarded as a masculine social practice and is a norm for Vietnamese men. A San Francisco study of Vietnamese adults found that among men, 56% were smokers (versus 32% in the general United States population). Male cigarette smoking was significantly associated with income below the poverty level, residence in the United States for nine years or less, not knowing that smoking causes cancer, and limited English proficiency (Jenkins, 1990). In a 1994 Orange County study, it was found that Vietnamese males were more likely than White and Latino males to smoke; Vietnamese females generally did not smoke. Also, while Whites and Latinos who were more educated were less likely to smoke, no such association was found for Vietnamese (OPRP, 1994).

Like smoking, alcohol consumption is a normal social practice among Vietnamese men. It is common for men to gather in a social setting and drink and smoke to relieve daily stress. In the same study by Jenkins, 35% of the men interviewed reported binge drinking (Jenkins, 1990). The 1994 OPRP study found that Latino and Vietnamese were more likely than White drinkers to report alcohol-related problems. Vietnamese drinkers were substantially more likely than White or Latino drinkers to drink alone. Drinking and driving among Latinos and Vietnamese increased in relation to the percentage of lifetime spent in the United States. Drinking among Vietnamese females was rare (OPRP, 1994).

p. 5

High blood pressure and high cholesterol are health risk factors in the Vietnamese community, especially amongst the elderly. There is a lack of awareness and knowledge about what causes high blood pressure. In addition to smoking, many Vietnamese do not control their salt and fat intake. In adapting to the American lifestyle, Vietnamese are exposed more to “fast” and “junk” foods and are consuming more meat and fat. Lack of exercise compounds the problem; Vietnamese Americans in general are much more sedentary than their counterparts in Vietnam.

Lack of cancer screening was also identified as a risk factor, and is due to the lack of emphasis on prevention practices by both providers and consumers. Jenkins found that among eligible

women, 32% had never had a Pap test (versus 9% of United States women), 28% had never had a breast exam (versus 16%), and 83% had never had a mammogram (versus 62%) (Jenkins, 1990). A Vietnamese Community of Orange County study revealed that about 50% of sampled women never had a Pap smear, and approximately 55% never had a mammogram. Reasons cited included lack of knowledge of the screening procedures, believing it was not necessary, and not receiving a doctor/nurse recommendation (VNCOC, 1995).

A Behavioral Risk Factor Survey of Vietnamese in California found that prevalence rates for several behavioral risk factors were higher for Vietnamese in comparison to the total population of California or the United States. These risk factors include a high smoking rate among men, low exercise rate, and low rates of cholesterol, rectal, breast and cervical cancer screening tests. (Centers for Disease Control, 1992.)

A few informants also identified poor food handling (inadequate refrigeration, undercooked food, poor hygiene) as health risk factors. These practices occur in restaurants as well as private homes.

Health Indicators

Perinatal Health.

The percentage of women seeking prenatal care in the first trimester in 1995 was higher for Vietnamese than any other ethnic group except Whites. Whites were the only group that met the Healthy People 2000 Objective that *90% of women seek prenatal care during the first trimester*. 88.2% of Vietnamese women sought prenatal care in the first trimester, followed by other Asians 87%, Blacks 83.8%, and Hispanics 75.6%.

Total births decreased by 5.3% in Orange County between 1990 and 1995. White and Black births decreased by 19.7% and 7.9% respectively. However, the number of Vietnamese births rose from 1,683 in 1990 to 2,232 in 1995, an increase of 32.6%. Vietnamese births in 1995 represented 4.6% of the County's total births that year. Hispanic births also increased during this period. Between 1990 and 1995, Hispanic births rose by 11.3% and in 1995 represented 47.6% of the County's total births.

p. 6

Preterm births (births before the completion of 37 weeks gestation), and low birth weight infants (weighing less than 2,500 grams at birth) among the Vietnamese were rare in 1995, occurring at rates of 9.1 and 6.7 per 100,000 respectively. These rates did not vary greatly from other ethnic groups except for Blacks, who experienced preterm births at a rate of 13.7 and low birth weight rate of 11.3. (OPRP, 1997).

Mortality:

From 1990-95 cancer was the leading cause of death among Vietnamese, representing 27% of the deaths. The most frequent cancer deaths among Vietnamese were due to lung cancer (26%), cancer of the digestive organs including colon cancer (26%), cancer of the genitourinary

organs (15.3%), and bone, skin and breast cancer (13%). Cancer was the second leading cause of death for other Asians (27%), Blacks (21.2%), and Whites (25%), and was the fourth leading cause of death for Hispanics (18%).

Cardiovascular disease was the second leading cause of death among Vietnamese, with 24% of deaths. During this period cardiovascular disease was the leading cause of death in all other ethnic groups, representing 31% of deaths among other Asians, 22% in Hispanics, 27.5% in Blacks and 39% in Whites.

The category External Causes of Death was the third leading cause of death among Vietnamese, representing 16% of all deaths. External Causes of Death was second among Hispanics (20.8%), fourth among other Asians (9%) and Blacks (14%), and the fifth leading cause of death among Whites (5.3%). The leading external causes of death among Vietnamese were homicide (34%), motor vehicle injury (29%), and suicide (22.5%). Homicide was also the leading external cause of death among Hispanics (40%) and Blacks (34%). Motor vehicle injury was the leading external cause of death among other Asians (37%) and suicide lead among Whites (34%). (OPRP, 1997.)

Tuberculosis (TB):

According to the Orange County Tuberculosis surveillance system, the morbidity rate for TB in 1995 among Vietnamese was significantly higher (109.0) than all

p. 7 other ethnic groups: other Asians (34.1), Hispanics (14.0), Blacks (12.8) and Whites (2.8). Age-specific incidence rates for TB among Vietnamese were highest in the range of 70—74 years old.

Hepatitis B:

The risk of hepatitis B virus (HBV) infection and death in the Vietnamese community within the United States is about 10 times greater than for the remainder of the United States population. Among those who arrived in the United States between 1984 and mid-1987, the prevalence rate was 14.4%, 28.8 times the rate in the United States general population (.5%). Approximately one in seven Vietnamese is a chronic HBV carrier. It can be anticipated that two out of every hundred Vietnamese will die of hepatitis B-related liver disease. Hepatitis B virus transmission occurs at a higher rate in Vietnamese families because HBV infection has been endemic in most Asian populations for many centuries (Centers for Disease Control, 1997). In Orange County in 1995 and 1996, Vietnamese accounted for 6% and 5.8%, respectively, of all acute cases of hepatitis B. In those same years, Vietnamese accounted for 51.7% and 38.7%, respectively, of all chronic hepatitis B carriers.

Other health problems:

In addition to tuberculosis and hepatitis B, diabetes, arthritis, heart disease, and cancer were the other chronic health problems most often identified by focus group participants and key

informants. HIV/AIDS/STDs, depression (including post-traumatic stress syndrome), domestic abuse/child abuse, family planning, prenatal care, child safety, insomnia, asthma, dental care, and adolescent problems (cultural adjustment, runaway teens, gang issues and teen pregnancy) were suggested by a handful of people as health problems needing more attention. Vietnamese youth, especially adolescents, were also a major focus for health intervention. Many felt that Vietnamese youth are a good group to focus on because problems of growing up in two cultures and generational conflicts have not been adequately addressed.

Barriers to Health Care Access

Deficits in cultural knowledge and ignorance of customs, beliefs and experiences of the Vietnamese on the part of American health care professionals were identified as major barriers to health care. Vietnamese who are unfamiliar with the American health system are intimidated by the lack of culturally relevant health practices.

Another very important barrier is language. It is common for individuals with no knowledge of medical terminology, such as children or other relatives, to translate for patients. Sometimes people will not even get to a hospital or clinic. It is common for some Vietnamese to

call and get someone who cannot speak Vietnamese, prompting them to hang up. Some informants felt that language and cultural barriers were not a significant problem since many in the community go to Vietnamese doctors. Language and cultural barriers do become apparent, however, when people have to deal with health structures outside of the community, a situation which may occur more frequently with the expansion of managed care.

p. 8

Most informants stated that there is a need for development and distribution of culturally appropriate health education materials. Translation of English-language materials into Vietnamese is not sufficient. Cultural themes and imagery and culture-specific explanations for illness should be incorporated into health education materials, an approach requiring substantial participation of Vietnamese informants (Frye, 1995).

Also mentioned as barriers were lack of knowledge of the health care system, including managed care, and lack of health insurance. In a random study of Orange County Vietnamese, 24% of the respondents had no health insurance (Gellert et al., 1995). In a community survey of random and convenience samples of Vietnamese women living significantly below the poverty level, 85% of both sample groups had health insurance (primarily Medi-Cal). About 40% of both sample groups reported having been without insurance in the past two years (VNCOC, 1995). For low-income families, health care takes second priority to more immediate needs such as food and shelter. Nhan Hoa clinic is the only outpatient health care facility for indigent Vietnamese. The clinic has a clientele of 10,000 patients. Most qualify for the Medical Service for Indigents program.

Lack of transportation is a significant problem for elderly and low income Vietnamese. Elders often must wait until the weekends for family members to take them to see the doctor. They sometimes will not mention any illness for worry of being a burden to the family. Some take the

bus to get to health appointments, but public transportation intimidates others due to language barriers.

Health Promotion Strategies

Media/Presentations

Overwhelmingly, focus group members and key informants stated that radio (stations 1480 AM and 106.3 FM) was the most effective channel for providing health information. If one walks into Vietnamese restaurants, workplaces or homes, it is highly likely there will be a

p. 9 Vietnamese program on the television or radio. Vietnamese physicians host weekly radio programs, providing information and answering listeners' questions. While these programs can be informative, they are also advertising vehicles for the physicians. Also, inaccurate information may be disseminated, such as advertisements for shark cartilage to cure cancer. It was recommended that the Health Care Agency conduct radio programs to inform the community about various health topics.

Newspapers and television were also identified as useful health promotion tools. Other suggestions included presentations and classes on various health education issues. It was repeatedly advised that these presentations and classes be incorporated into community programs such as ESL classes, clinic workshops, and citizenship classes. Health fairs were mentioned by a few as a good way to educate the community on health issues.

Health Promoter Program

Before program staff introduced the issue for discussion, neither focus group members nor key informants raised the concept of health promoters. Unfamiliarity with the health promoter concept may explain the reluctance by some informants to consider it as a viable community health promotion strategy. However, those who thought the health promoter program might be a good idea mentioned the following:

- 11 There were mixed comments on who would be appropriate health promoters. Some informants believed that the promoters needed to be doctors or nurses to be taken seriously. Others felt that having promoters with higher status or higher education than the target population would be sufficient. Still others believed that the community would be receptive as long as the promoters were knowledgeable and communicated well in Vietnamese. Overall, there was consensus that the promoters needed to be bilingual, bicultural, and well-trained, with stipends being the preferred incentive for the promoters.
- 12 The support of community leaders is essential for a successful health promoter program. If the Health Care Agency sponsors a program, it should be implemented in conjunction with community-based organizations. The Nhan Hoa Clinic, the Vietnamese Community of Orange County (VNCOC), and the Orange County Asian and Pacific Islander Community Alliance expressed interest in working with the Health

- 13 Care Agency to implement a health promoter program. They also expressed interest in helping to develop health education materials. Another option suggested would be for the Health Care Agency to recruit, hire and train health promoters, and then assign them to various community organizations. Organizations such as St. Anselm's and Catholic Charities offered consultation in program development, space for health classes, and assistance in publicizing a Health Promoter program and recruiting Health Promoters. p. 10

Recommendations for Consideration

This report describes some of the health-related risk factors, problems, beliefs, practices and barriers to health care access in Orange County's Vietnamese community. It also explores potential health promotion strategies, including the feasibility of a health promoter program. Any strategies implemented as a result of this assessment report will acknowledge and incorporate Vietnamese cultural beliefs and practices, and the risk factors and problems identified will be the priority health topics addressed. Based on the findings in this report, we developed the following recommendations for Health Care Agency / Public Health consideration:

1. Work in collaboration with community based organizations to review available Vietnamese health education materials and develop and disseminate culturally and linguistically appropriate materials.
2. Explore the feasibility of conducting programs on Vietnamese radio stations.
3. Provide consultation and technical assistance to community-based organizations in incorporating health promotion activities into their services. Provide these organizations with educational materials and speakers as appropriate to assist in these activities.
4. Pilot and evaluate a health promoter program in collaboration with the community. Options include funding a community-based organization or sponsoring the program and stationing the health promoters in community-based organizations.
5. Offer consultation to Vietnamese health care providers on how they can educate their patients about prevention and risk factor reduction. Provide supplemental materials. p. 11
6. Assist community-based organizations in becoming effective advocates for policies that would positively impact the health of the Vietnamese community.
7. Offer training to non-Vietnamese health care providers on Vietnamese health beliefs and practices. Provide practical recommendations for how they can incorporate these beliefs and practices into their patient care.
8. Increase HCA publication of health information in the Vietnamese press. Explore options for television programming.
9. Establish an ongoing process for assessing the changing health needs and problems of the Vietnamese community.

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p. ATTACHMENTS

p. 14 VIETNAMESE FOCUS GROUP

June 20, 1997

Major Health Issues and Risks:

14 Lack of knowledge regarding prevention issues.

- 15 People do not know what services are available to them for health care.
- 16 There is a lack of transportation for many people. New refugees have to depend on their sponsors and they may be working.
- 17 Because of a strong belief in customs, many believe in experience over Western medical knowledge. They may borrow medication from another or self medicate and not go to a doctor.
- 18 Many do not take their health problems seriously and they also do not have the knowledge of Western medications.

Oriental Medicine and Herbal Medicine:

- 19 Many try herbal medications at stores that do not have a license to dispense them. These storeowners may have their M.D. in oriental medications. They are found by radio, store, and newspaper ads. If they hear one thing about the oriental medicine and are told another by a Western doctor it can be very confusing to them.
- 20 In Vietnam herbal medicine is very common and they have access to it easily.
- 21 In the focus group there were mixed views on the harmful effects of herbal medicine.
- 22 Many problems of health are treated by herbal medicine. It is even given to children.
- 23 Herbal medicine has a very long history of success.
- 24 Western-trained Vietnamese physicians have mixed views: Some let it be the patient's choice to use oriental medicine. Some prefer their patient not use the oriental medicine at all.
- 25 Many prefer to use oriental medicine because their viewpoint is that Western medicine has side effects. It creates an imbalance in their Yin and Yang. They know this by experiencing hot flashes, etc. Herbal medicine is based on the belief of Yin and Yang. The Vietnamese culture strives for a balance of the Yin and Yang.
- 26 The beliefs regarding herbal medicine and its use are being passed on to the children.
- 27 The parents make sure the children are immunized because the school requires them to do that for enrollment. They do not get their children immunized because they believe in it.
- 28 There was an overall feeling from the group that health education was lacking in the community and there were not enough health educators in the community.
- 29 The health education needs of the community need to be addressed, especially in the area of prevention.

Ways to promote health education in the Vietnamese Community:

- 30 Radio is widely listened to.
- 31 Newspapers are widely read.
- 32 Television is watched.
- 33 Newsletters could be helpful for those who do not have transportation.

Health Problems in the Vietnamese Community:

p. 15

- 34 Tuberculosis
- 35 HIV

- 36 Hepatitis
- 37 Diabetes
- 38 Heart Disease
- 39 Hypertension
- 40 Lung Cancer

Reasons why health problems occur in the Vietnamese Community:

- 41 The patients do not volunteer to tell about their health history unless asked.
- 42 Many patients keep their health problems secret from family and friends.
- 43 Tuberculosis goes untreated and then it spreads throughout the extended family.
- 44 Smoking and drinking is seen as a masculine activity.
- 45 Exercise is not done regularly in the Vietnamese community and their life style is sedentary.
- 46 The Vietnamese diet consists of vegetables, high salt content, fish, rice, and no dairy products. They do not take calcium replacements.
- 47 Many people do not know what diabetes is or how to take care of themselves if they have diabetes.
- 48 Insurance is a major problem in the Vietnamese community. Many men do not qualify for Medi-Cal. Not everyone has the access to a community health center, and even if they do the fee for a visit can be \$20.00. To qualify for MSI you must already have a disease. Then you can only be in the program for 6 months, and you need to re-qualify. Many people are paid under the table and have no insurance through their work.
- 49 New immigrants are entering the country through sponsors and are still coming to America.

How to get Health Prevention Messages to the Community:

- 50 Radio messages were thought to be the most effective.
- 51 Newspaper ads were thought to be the second best.
- 52 Health fair in the middle of the community with focus on cholesterol and diabetes.
- 53 Outreach places for people to go once they get the information to make it meaningful.

Youth:

- 54 Youth listen to teachers and counselors more than they do to their parents.
- 55 Many parents have a gap in communicating to their children.
- 56 Some youth in grades 11 and 12 have a heavy involvement in drinking and drugs.
- 57 Some gang activity is present in the youth of the Vietnamese community.

General Health Concerns:

- 58 Exercise is important; most Vietnamese do not get aerobic exercise.
- 59 Alcoholism is a problem in the male population. A social outlet is drinking until you have passed out.
- 60 Depression is widespread, and many have a hard time adapting to the new culture.

- 61 It is a traditional society and men have the final say. Their wives have little influence on their health habits.
- 62 Vietnamese doctors are similar to Western doctors in that they do not talk to their patients.

p. 16

Health Promoter Program:

- 63 Health promoters need to work with the Vietnamese doctors.
- 64 Handouts would be helpful.
- 65 Health promoters need to have a variety of backgrounds. Neighbors might listen to someone whose own children have been helped by prevention practices.
- 66 The program would work in the community by increasing their medical awareness.
- 67 The program could serve as a reinforcer to what the community has already heard.
- 68 Give the same information to Vietnamese doctors.
- 69 Health promoters need to go directly into the community.
- 70 Health Care Agency staff needs to go into the community because the name offers a prestige to their community.

What Kind of People Should be Health Promoters:

- 71 Ones that have training
- 72 They need to be fluent in English as well as Vietnamese
- 73 Depends on the area they are serving, but always they need to have more education than the people they are working with.
- 74 High level of social skills, professional, educated
- 75 For new arrivals have the health promoters go out into the field, stores, restaurants, and temples.
- 76 A must to have different levels of health promoters.
- 77 The senior citizens need someone in their age group.
- 78 They need to be understanding, caring, and capable of establishing relationships. Respect is vital and they must possess personal qualities.
- 79 A model that could be used is the bilingual teachers.
- 80 This is a very traditional society and respect is important.

What to Focus on for the Health Promoters:

- 81 More favorable if the health issues are not focused on issues relating to tobacco or alcohol.
- 82 If you want to address smoking, target the newly married on Environmental Tobacco Smoke (ETS) issues for their new babies.
- 83 In the area of prenatal issues focus on the diet and ETS. Babies can be born small because of poor nutrition. Women can be underweight and working too hard before pregnancy.
- 84 The proper use of medication and using until it is all taken for treatment.

VIETNAMESE FOCUS GROUP

p. 17

JUNE 24, 1997

MOST IMPORTANT HEALTH PROBLEMS / RISK FACTORS:

1. Communication barrier of not speaking English
2. When they have a health problem, they may not get medical attention until the last moment
3. Do not understand prevention rather than treatment; do not believe in prevention: if no symptoms, then why go to a doctor?
4. May seek medical advice from friends or Oriental doctors
5. Hepatitis and diabetes are prevalent
6. Rumors persist about side effects of treatment (eyes blurry, headache)
7. Western medicine is very "hot"
8. Belief that illness is caused by an imbalance between yin and yang
9. After herbal remedies are tried without success, they will try Western medicine
10. They get misinformation
11. Patients with TB want to go to work or school, since that was customary in Vietnam
12. In Vietnam, people cannot afford prevention
13. They can change over time, as in diet changes
14. Hypertension is prevalent, as is lack of exercise
15. Vietnamese have a mostly healthy diet, except higher in fat and salt.
16. Prevention is not as important
17. Young people are more receptive to learning about prevention
18. Lack of transportation is an issue
19. Smoking is prevalent, especially among men
20. Alcohol is prevalent (beer and wine), consumed after work and on weekends
21. Drinking and driving in Vietnam is OK; there are also no age limits for drinking there, so kids smoke and drink at earlier ages. People drink for fun since there is not enough entertainment
22. No license to sell alcohol is necessary in Vietnam
23. People see beer as a beverage like "soda", not alcohol
24. Mental health problems are prevalent, among about 60% of refugees
25. Some suicide occurs
26. Elderly sometimes return home (Vietnam)
27. Men can't admit or accept mental health problems
28. Lack of insurance is a problem; only 8 months of medical coverage for refugees
29. People do know what they are eligible for, however, by learning from friends or through newspaper.
30. Low birth weight is not a problem
31. Sometimes Western doctors are not sensitive to Vietnamese
32. Herbal medicine can be harmful, especially if patients delay going to the doctor
33. Herbalist is often used to diagnose problems

HEALTH PROMOTION:

1. There are many Vietnamese doctors and dentists, but they are not very involved in health education and prevention. They have no time, and no experience.

2. Vietnamese health education materials would be helpful, as well as placing articles in Vietnamese papers.
3. Radio (106.3 FM & 1480 AM), newspaper, television (channel 62) are best ways to get to the community
4. Doctors do advertise in that medium
5. HCA could put on a show every week
6. People do respect the Health Department, and employees do get respect.
7. Need more booklets in Vietnamese, especially on diabetes and hypertension
8. Place those booklets in doctor's offices.

p. 19

HEALTH PROMOTERS:

1. Need more Vietnamese health educators
2. People are interested, and we need to go out to them
3. Community presentations could work
4. Health promoters could work; however, it probably would not if promoters were housewives. A health educator or nurse would be fine if they were given a title, such as "health education associate."
5. People will question advice of others and will confirm with own doctor.
6. Health Department would be best agency to coordinate because of experience and prestige.
7. Most Vietnamese trust and respect Health Department.
8. Promoter needs to learn about issues, have public speaking skills, be bi-lingual, good with people, and have a pleasant personality
9. Younger person may not get as much respect from older Vietnamese
10. Knowledge of Vietnamese culture is very important to be able to relate.
11. Being from Vietnam gives more credibility
12. Promoter should be middle aged, (40-45)
13. Older people are respected because of experience
14. Vietnamese doctors practice strictly Western medicine
15. It will be important for health promoters to instruct people on how to take medications

VIETNAMESE FOCUS GROUP

p. 20

June 25, 1997

HEALTH PROBLEMS

1. Tuberculosis is a major health problem because of the knowledge deficit about it and how to get care.
2. Depression is another major issue, especially for those who were released from "reeducation" camps. Many have become sad, hopeless, want to die; "what shall I do?"; relatives sometimes turn them away; chemical use is another problem that is related.
3. Abuse situations occur in family, and they are not aware of laws against it.
4. Smoking and alcohol are issues.

5. At risk of cancer
6. Hepatitis B is another problem---they are not aware that they are carriers; blood transfusions, unprotected sex, household contact (shaving, brushing); they feel healthy and symptomless until it develops. People are not aware of Hepatitis B; lack of education. It is very depressing to them, because family members have to go through screening.
7. Vietnamese are not believers in prevention, until they get sick.
8. They can get antibiotics from others and share them
9. Vietnamese wait too long to get care
10. They often do not complete full course of treatment.
11. Refugees often have parasites, due to sanitation issues in Vietnam. They need hygiene education. A videotape would help.
12. Family planning is another issue.
13. Nutrition, diabetes, high blood pressure are other problems; they are not knowledgeable. High consumption of sweets, cholesterol, and salt. A lot of lard is used in cooking. Patients often do not take medications for hypertension because of no symptoms. Patients do not see a connection between nutrition and high blood pressure.
14. Lack of physical exercise is a problem. Many used to work in the fields of Vietnam, and are now in offices without changing their eating habits.
15. High smoking rates, secondhand smoke in homes.
16. Runaway issues/gangs---teens. Teenage pregnancy, prenatal care, abortion.
17. Alcohol issues (beer); whisky; drinkers do not see beer as being real alcohol.

p. 21

INFLUENCES:

1. Tuberculosis medications make them feel "hot" and believe they damage liver.
2. Patients would prefer to take herbal remedies than pills, which they don't like.
3. "Yin" and "yang", hot and cold.
4. If they do not have symptoms, why comply? Lack of education about health.
5. If asked about their compliance to treatment, patients would be polite and cooperate when observed, and say "yes", but may not regularly comply. They do not want to show disrespect. Therefore, it is important to get feedback from them (since "yes" doesn't always mean "yes").
6. A person may believe what others say *instead* of nurse or physician. This could be due to a carryover effect because healthcare treatment is poor in Vietnam. A nurse is less educated in Vietnam than in U.S.
7. People may take same medications for other ailments. They do what they know. Some just believe in and want "French" medications.
8. Concept of prevention is not effective.
9. Some believe that they did "something bad" if they develop cancer, etc.
10. A good way to address and expose these issues is through use of the media.
11. Older people feel sad and depressed, and neighbors may not know their home language.

BARRIERS

1. Language, money, transportation; lack of information about what is available in resources and services; lack of knowledge about clinics.
2. Need health education booklets in Vietnamese.
3. Perception of treatment.
4. Free clinics not trusted as much as private clinics.
5. Some Vietnamese feel that they are being discriminated against because of language, nationality, or because they are poor.
6. Some feel that the Health Care Agency is recruiting patients to get more funds---they “need more business.”
7. Some feel threatened if health care employees call them for follow-ups. “Don't scare us”.
8. People do not want to be told that they have symptoms; that could be why they don't believe in prevention...they are in denial.
9. They are busy with work, and afraid of losing job because of taking off time for medical needs.

p. 22

HOW TO ADDRESS PROBLEMS:

1. Advertisements in radio or television are best; newspaper not as good, because there are many “throw-aways.”
2. Television is best; visual images can scare them. A short version of what could happen may be effective.
3. If they hear a message from someone they trust (like the media), it will be more powerful.
4. Social and regional groups who get together are also excellent sources. Have presentations to these groups.
5. Work with leaders.
6. Radio has different physicians and dentists who speak. Call-in show can be effective, with short questions and answers. Let it be relevant to their needs. The show should be regular and be advertised.
7. Kids learn from school and tell their parents about behavior.
8. Present to elderly.
9. People will listen to nurses, Vietnamese Doctors Association; it is important that person speaking is Vietnamese, that he/she has a title, and knows language.
10. Parenting in community; many kids aren't disciplined properly.
11. STDs; high rate of prostitution; Vietnamese go back to Vietnam on vacation and come back with STD.
12. With HIV, many feel they are safe if they are not gay or drug users.
13. Need to develop trust with patients; show respect to help understand; Patients would be more willing to trust and develop relationships.

HEALTH PROMOTER:

p. 23

1. Teaching leaders to teach health education is good, since there aren't enough professionals to teach.
2. Within a group, a person may already have medical knowledge. The group can identify them. A concern raised was ensuring that the information is effective.

3. Give out cards to call for other information (“hotline”), so if there are questions that can't be answered, staff at “headquarters” will be able to answer.
4. Prepare educational materials.
5. Translation errors can be a source of difficulty; must be written at a lower level. Pamphlets should be shorter, and written in easier to understand terms.
6. To be effective in the community, be fluent in Vietnamese, be mature, show respect, show what you can do, and do not be commanding (be down to earth).
7. Go through church or temple, Buddhist monks. Will involve themselves if project is good for community.
8. ESL classes would be a good audience.
9. Health Care Agency and outside community agencies should combine and work together.
10. Consider stipend for promoters. A difficulty could be that volunteer promoters might not be able to keep the project going. Paid staff would be more likely keep it going, and they could work with outside organizations.
11. Should have family's involvement. Must have husband's input.
12. International Fair (Tet Festival) a good place to promote.
13. Health screenings? Health fairs? Hospitals can be involved, since they offer them.

p. 24 VIETNAMESE FOCUS GROUP

June 27, 1997

Significant health problems/risk factors:

Food Handling:

- 85 Vietnamese restaurants do not follow guideline
- 86 Do not refrigerate meat & other foods.
- 87 Business owners lie about food contents.
- 88 Sugar cane machines contain lead in the paint.

Child Abuse:

- 89 Parents don't know that corporal punishment is not acceptable in this country.
- 90 No parenting support groups or resources in the Vietnamese community
- 91 Cultural misunderstandings about appropriate behavior
- 92 Friends or neighbors don't report child abuse.

Aging Population:

- 93 No resources specifically for older Vietnamese population
- 94 Existing centers are all American- can't adjust to language & American food
- 95 Children (influenced by American values) are too busy to care for older adults

Generation Gap:

- 96 Older population frustrated by the way the younger Vietnamese population acts
- 97 Children don't want to live with parents
- 98 Kids have too much freedom
- 99 American values are different- OK for kids to talk back to parents

Divorce Rate:

100 High

Community Education:

- 101 HIV- Message not reaching Vietnamese community
- 102 Education is only in clinics, not in community, not in media
- 103 Classes not offered in Vietnamese language
- 104 Anti-tobacco message is prevalent but people still smoke.

Teens:

- 105 Conflict between the two cultures
- 106 Peer pressure to be more American
- 107 Educators, counselors & principals don't understand different cultures

Sex Education:

p. 25

- 108 Schools teach sex ed. too early- offensive, intrusion
- 109 Parents feel pressure to comply (sign permission slip)

Child Care:

- 110 Many homes provide care that are not licensed
- 111 Homes are unsafe, care-givers don't know CPR
- 112 Need to know how to get license

Gangs:

- 113 Need to educate parents and children

Health Insurance:

- 114 Many adults don't qualify for coverage
- 115 Many don't work- no insurance

Hepatitis B:

- 116 Vietnamese have highest carrier rate
- 117 Other health care professionals don't believe that it is a problem

Tuberculosis:

- 118 Prevalence high among Vietnamese population
- 119 Don't complete all of prescribed medication
- 120 Believe that "doses are for big Americans" - often cut medicine in half.

Heart Disease:

- 121 Higher cholesterol after moving to United States

Diabetes Cancer:

- 122 More cancer after moving to United States
- 123 Due to more fermented products

Children's Disability:

- 124 Don't know where to screen children

Alcohol:

- 125 Drunk driving
- 126 Alcoholism

p. 26 Cultural beliefs/ practices:

Traditional Medicine:

- 127 Herbal Chinese medicine is often the first choice for treating chronic diseases
- 128 Use of traditional vs. Western medicine depends on level of education & level of acculturation
- 129 A lot of self treatment

Secretive about Diagnosis:

- 130 Shame
- 131 Believe family has been cursed
- 132 People will think that the family did something bad, especially in chronic diseases (i.e. cancer)

Relation with Health Care Providers:

- 133 Don't say no to health care providers- want to please
- 134 Don't challenge doctors
- 135 Don't believe that the doctor did a good job if she/he doesn't prescribe medication
- 136 Don't take antibiotics long enough

False Advertisement:

137 "Physicians" lie about credentials

138 False advertising about products

Barriers to accessing health information/services:

Language:

139 Information not available in Vietnamese language

Media:

140 Press releases not getting to Vietnamese media

Awareness:

141 Don't know about the services that are available

People Do Not Attend Health Fairs/ Meetings:

142 People don't care

143 Don't want to be identified as having a disease or health problem

144 Gathering to talk about health topics is a new concept

Mailings:

p. 27

145 Mail not seen as very important - may not read

146 Don't realize that important information comes via mail

How can we address health problems?

Cooperation (from):

147 Vietnamese physicians

148 Vietnamese leaders

149 Vietnamese media

Culture:

150 Show you understand and respect Vietnamese culture

151 Talk in the language/ culture (i.e. If patient says he doesn't want to take medicine because it's "hot," don't say no, it's not hot. Instead suggest balancing it out with lemon-aid or cold vegetables)

Information:

152 Needs to be accurate and consistent

Media:

153 Very effective way to reach Vietnamese community!

154 People like to listen to doctors on TV / radio talk shows, open-line Q & A

155 Radio: many listen while working (factory, assembly jobs)

Collaborate with Refugees' First Contacts:

156 Social services

157 Catholic Charities

158 Immigration

Support from Medical Community:

159 Work with well known Vietnamese physicians

Address Family Issues:

160 Offer classes/ support groups facilitated by Vietnamese leaders

Anonymous Phone Line:

161 Don't have to identify selves

162 Don't Overwhelm Newly Arrived Refugees

p. 28

Churches & Buddhist Temples:

163 Majority of Vietnamese population involved in religion

164 Priest could give health information, announce health events

Gay/ Lesbian Groups:

165 Newsletter for Vietnamese gay professionals

166 Gay / lesbian group in Vietnamese Community (didn't know name)

167 Orange County Vietnamese Professional Organizations

Effective "Health Promoter" Program:

Need Key People Who are Trusted:

168 Need credentials: Medical related field, teaching, or pharmaceutical

169 Older, more respected

170 Need younger "health promoters" to target teens

Who's More Credible, Health Care Agency or Community Based Organization?

171 Depends on topic.

172 TB: Health Care Agency

173 Cultural issues: Community Based Organization

Where?

174 Health fairs

175 Clinics

176 Markets - give incentive items

177 Meet at a home

178 Self help groups (include food, alternate homes)

KEY INFORMANTS

p. 29