



Learning From Communities

A Guide to Addressing the
Reproductive Health
Needs of Vietnamese
American Women

National Asian Women's
Health Organization
April 1998

Copyright © 1998 by the National Asian Women's Health Organization. All Rights Reserved. No part of this publication may be used or reproduced in any manner whatsoever without written permission except in the case of brief quotations.



ACKNOWLEDGMENTS

The National Asian Women's Health Organization (NAWHO) gratefully acknowledges the California Wellness Foundation for their generous support of our Southeast Asian Women's Reproductive Health Project (SEAWRHP).

NAWHO would like to thank the following individuals for their contributions to SEAWRHP and the development of this guide, *Learning From Communities*:

Sia Nowrojee, MSW
Author

Kim-Phuc Nguyen, MS
Project Coordinator

Project Advisory Committee

Mai Champlin
The Ha
Thao Le
David Nguyen
Kim Nguyen

Thoa Nguyen
Dawn Passar
Loan Pham
Trang Tran
Nancy Trung

Project Health Educators

Dr. Pham Qui Giao
Blue Cross California, Medi-Cal, San Jose

Dawn Passar
API Wellness Center, San Francisco

David Nguyen
API Wellness Center, San Francisco

NAWHO also thanks the East Bay Vietnamese Association, Inc., Oakland (EBVA) for kindly donating meeting space for this project. Additional assistance was provided by:

Kim Ha, Newark Health
Center
Do Minh Khai
Thao Le

Van Le
Lai Van Luu, EBVA
Dr. Tran Van Nam
Dung Nguyen

Hang Nguyen
Thu Nguyen
Tu Nguyen
Lan Tran
Hai Quan Truong

TABLE OF CONTENTS



SOUTHEAST ASIAN WOMEN’S REPRODUCTIVE HEALTH PROJECT	1
DEVELOPING & USING THIS GUIDE	3
IMMIGRATION & DEMOGRAPHIC BACKGROUND OF VIETNAMESE AMERICAN COMMUNITIES	4
HEALTH STATUS OF VIETNAMESE AMERICAN COMMUNITIES	6
TRADITIONAL & CULTURAL CONCEPTS OF HEALTH CARE AND MEDICINE	8
REPRODUCTIVE HEALTH ISSUES	10
NUTRITION	21
CONCLUSIONS	23
RESOURCES	24
REFERENCES	26

■ ■ SOUTHEAST ASIAN WOMEN'S ■ ■ REPRODUCTIVE HEALTH PROJECT

Southeast Asians are one of the fastest growing Asian communities in the United States (U.S.). At the same time, they remain one of the most neglected Asian American communities; their socio-economic status and health are poor compared to both the nation as a whole, and other Asian communities. In response to these concerns, the California Wellness Foundation funded the National Asian Women's Health Organization (NAWHO) to initiate the Southeast Asian Women's Reproductive Health Project (SEAWRHP) in 1996 to:

- ❖ Increase knowledge and awareness of reproductive health issues among recent immigrant and refugee Southeast Asian Americans;
- ❖ Increase awareness of available community health and social services; and
- ❖ Increase the skills of Southeast Asian American women to assess their health needs and access available services and resources.

To reach these objectives, the SEAWRHP worked with recent immigrant and refugee Vietnamese American women between the ages of 18 and 35, Vietnamese American men between the ages of 20 and 50, and several health care providers who serve the Vietnamese community in Alameda County, California.

Specifically, SEAWRHP:

1. Assembled an Advisory Committee comprised of leading Southeast Asian health care providers and advocates to guide and coordinate project activities and follow-up in the community;
2. Conducted an extensive literature review on Southeast Asian communities and their reproductive health status in their countries of origin and the U.S.;
3. Facilitated focus group discussions and interviews with 32 Vietnamese women and men, and their health care providers to assess reproductive health needs and barriers to addressing those needs;

4. Facilitated a series of 5 participatory training sessions with 66 Vietnamese American women, with a focus on self-help, to increase knowledge of reproductive health issues, as well as skills in assessing and addressing their health care needs; and
5. Conducted 6 presentations to health and social service organizations serving the Vietnamese American population on reproductive health needs of Vietnamese women, and strategies to overcome barriers to access of preventive health services.



DEVELOPING & USING THIS GUIDE

The information and recommendations in this guide are based on the activities and findings of the SEAWRHP.

As the *first* guide to address the reproductive health needs of Vietnamese women in the U.S., this document contains much needed information on specific experiences and needs of this community in the areas of birth control, pre-natal care, cervical and breast cancer, sexually transmitted diseases and nutrition. It includes the voices of community members - both women and men - as they identify and express their own needs and ideas, and incorporates relevant demographic, epidemiological and cultural information in an accessible way. A list of references and community resources in Alameda County is also included.

In working with the Vietnamese American community of Alameda County, the SEAWRHP is clearly not representative of all Southeast Asian -- or even Vietnamese -- communities in the U.S. However, the issues that emerged from the SEAWRHP's activities serve as a foundation for understanding Southeast Asian women in a health care setting. The guide also provides broader perspective on how listening to individuals can teach health care advocates and providers how to address specific community needs more effectively. Additionally, it clearly illustrates the relevance of immigrant and refugee experiences in how communities perceive and address their own health care needs. Emerging from participatory focus group discussions and training sessions, the guide is intended for a broad spectrum of health care and community advocates and providers, to enhance their work with Vietnamese Americans.

IMMIGRATION & DEMOGRAPHIC BACKGROUND OF VIETNAMESE AMERICAN COMMUNITIES



Since the end of the Vietnam War, approximately 850,000 Southeast Asians have arrived in the United States (Poss, 1989). Most have settled in the Western U.S., with almost half of all Vietnamese residing in California. From 1987-1992, 14% of all immigrants to the San Francisco Bay Area were Vietnamese. Alameda County, site of the SEAWRHP, has 14,000 Vietnamese; almost 5% of the entire Vietnamese population in California.

Vietnamese migration to the U.S. has taken place in four phases over the past 20 years. The *first phase* began in 1975, when many Vietnamese left their country in fear of reprisals from the communist regime. Many left for refugee camps in neighboring countries, often dividing traditionally extended families. Those Vietnamese who ultimately arrived in the U.S. were mostly well-educated, and had the financial means to re-settle. Some even had ties with the American government which facilitated exit visas during this exodus. The *second phase* occurred between 1978-1984 with those fleeing persecution and forced relocation to North Vietnam by the communist government. Escaping via neighboring ports on small fishing boats, these “boat people,” as they were called, found asylum in the U.S. This wave of immigrants was also generally financially stable, and had some level of education. The *third phase*, from 1985-1990, consisted of family members who were sponsored by those who had arrived before them, through the Orderly Departure Program. Many Amerasian children of U.S. servicemen arrived in the U.S. at this time. Generally, these immigrants had less education and financial stability. Finally, the *fourth phase* of immigration began in 1990, when the Humanitarian Operation was enacted, allowing released prisoners from Vietnamese re-education camps and their families to immigrate to the U.S. Many of these immigrants were middle-aged, with little financial security and had more difficulty acculturating than their predecessors (Ong and Blumenberg, 1994).

Vietnamese Americans are therefore a relatively new population in both Asian and mainstream America. Their immigration and refugee status continues to be shaped by political relations between Vietnam and the United States, as well as conditions in Vietnam. Their socio-economic status in the U.S. is generally vulnerable.

According to the United States Bureau of the Census (1990):

- ❖ Among Vietnamese over 24 years of age, only about 50% of women, and 70% of men have completed a high school education; compared to 75% and 76% respectively in the general population;
- ❖ Among Vietnamese over 24 years of age, 65% report that they do not speak English “very well,” affecting their ability to negotiate and advance in an English-speaking society;
- ❖ Almost 30% of Vietnamese live below the poverty level; twice the rate of the entire nation, and Vietnamese per capita income is only about \$9,000 -- about \$5,000 less than the U.S. average; and
- ❖ Finally, the average personal income of Vietnamese is less than that of other people of color in the U.S., including Asian groups such as the Chinese, Filipinos, Koreans, Japanese and Indians.

HEALTH STATUS OF VIETNAMESE AMERICAN COMMUNITIES



“Because I don’t speak English very well, (I need an interpreter). Sometimes, when the two or three main interpreters are not readily available, they call for this other person who was not very good. She would leave out details and just interpret general things...I would feel angry and resentful...I can understand some English, but she would not interpret fully what the doctor or I wanted to say.”

(Vietnamese woman, aged 35)

“I think our Asian community should speak up and do more to help Asian women obtain health care that is too costly. I would like society to be more concerned with women’s health. Asians should have more of a voice in the fight for universal health insurance, especially for women.”

(Vietnamese woman, aged 31)

The health status of Vietnamese communities in the U.S. is largely influenced by the trauma of their experiences in Vietnam and their journey to the U.S., the lack of adequate health care in Vietnam and their low socio-economic status in the U.S. Studies have indicated that 70% of Southeast Asian refugees were found to have post-traumatic stress disorder (Kinzie, JD, et al, 1990). Rates of sexually transmitted diseases are high, with rates of gynecological and pre-natal exams being correspondingly low. In addition, cervical cancer rates for Vietnamese women are the highest of any other ethnic group. In fact, from 1988 - 92, Vietnamese women had the *highest* rates of cervical cancer of *all* ethnic groups in the U.S., with 43 per 100,000 women developing the disease. This rate is almost five times higher than that for White women (Miller et al, 1996).

The under-utilization of the American health care system by Southeast Asian populations has been well documented (Uba, 1992). Language and financial barriers remain key barriers to accessing services. Many services do not provide interpreters, and those that do may be overworked or untrained. Low income and lack of health insurance was a key barrier to accessing, good quality or, any services at all.

Many participants in the SEAWRHP focus groups also mentioned lack of time as a barrier to accessing public services. Many Vietnamese immigrants are attending school or English classes while also working. The long waits at public or non-profit services often mean missing an important class or losing a much-needed job. Finally, cultural concepts of health care, including use of traditional remedies and a lack of preventive approaches to health care, also contribute to the under-utilization of more mainstream, and even some Asian community, health and social services.

TRADITIONAL & CULTURAL CONCEPTS OF HEALTH CARE & MEDICINE



Herbal Medicines and Other Traditions

“...In Vietnam, I rarely took medicine; coin-rubbing usually did the work. I used coin-rubbing because I had my mother and sister to do it for me. But here, my husband will not allow me to do it because he’s afraid that if I go to the doctor, the doctor may think that he abused me.”

(Vietnamese woman, aged 35)

In Vietnam, where Western medicines can be scarce and expensive, herbal medicines have been officially approved by the government. Traditional medicine is also taught as part of medical school curriculum (Nguyen, 1990). It is not surprising then that Vietnamese Americans continue to rely on common traditional health beliefs and practices. Researchers at the University of California, San Francisco found no evidence to suggest that traditional Vietnamese models of disease are harmful (Jenkins, 1996). However, health care advocates and providers need to be aware of these practices, in order to understand community approaches to health, and better assess what is needed to complement traditional practices.

Traditional Vietnamese forms of treatment focus on two main elements. Traditionally southern Vietnamese medicine, *thuoc nam*, relies on herbal remedies. Herbs, bark, roots and vegetable combinations are commonly used to alleviate symptoms and build strength. Northern medicine, *thuoc bac*, focuses on the need for balance between hot and cold. Illnesses are classified as either hot or cold, and treated accordingly by foods or herbs that are said to contain the opposite properties. Notably, Western medicines are often classified as too “hot” or potent for generally smaller Vietnamese physiques.

“Coining,” or pinching or rubbing to relieve pain and various ailments, is also commonly used. It often results in bruises that mainstream health workers have misinterpreted as evidence of abuse. Additionally, since traditional cures do not include drawing blood, there is often a reluctance of Vietnamese immigrants to submit to blood work in clinics.

Fear of Western needles, which are seen as too big for smaller physiques, is also common. Finally, based on poor facilities and bad experiences in Vietnam, there is a general fear of surgery (Hoang and Erikson, 1985).

Misinformation about Preventive Health Care

“The women do not use preventive health care...They don’t know about immunizations for themselves and their children. Women with a cough will come and see me after having coughed for 2-3 weeks; pregnant women will seek prenatal care when they’re 6 months pregnant or about to give birth. Most women don’t know about birth control, and are not concerned about having regular breast and cervical exams.”

(Vietnamese doctor working with Vietnamese women)

Often, community members will only use a Western clinic as a last resort. While traditional approaches may be effective in taking care of some ailments, the under-utilization of other services generally means that many community members miss out on important preventive screening and information, as well as care for asymptomatic conditions. This is particularly evident in the realm of reproductive and sexual well-being, in which *screening and prevention* are crucial steps toward good health. For example, birth control is by definition the prevention of unwanted pregnancy. Effective prenatal care consists of nine months of screening, preventive care and healthy development for both mother and child. The prevention and effective treatment of breast and cervical cancers and sexually transmitted diseases (STDs) requires routine screening due to their largely asymptomatic nature.



Breast and Cervical Cancers

“My sister was instructed on how to do a breast self-exam (by a male doctor)...I don’t know why they didn’t assign her a female doctor; they have them at the clinic. If it’s just plain instruction it would have been okay, but this involved touching her body. It made me worried, and very reluctant about having a physical exam.”

(Vietnamese woman, aged 18)

Background

Despite the general belief that Asian, and newly arrived Asian immigrants to the U.S. have low rates of cancer, breast and cervical cancers pose significant health risks in the Vietnamese American community.

The National Cancer Institute indicates that between 1988-1992, the average annual age-adjusted incidence of breast cancer in Vietnamese women was 37.5 per 100,000 nationwide, and 48.5 per 100,000 in California. While Vietnamese women are half as likely as women in the general population to develop breast cancer, it remains the most common cancer among Vietnamese women both in California and in Vietnam (Anh, 1993). At the same time, Vietnamese women in California are half as likely as women in the general population to have any screening for breast cancer at all. Not surprisingly then, the California Cancer Registry indicates that 16% of the breast cancers detected among Vietnamese women had regional and distant metastases compared to 8% of those detected among White women (Jenkins, 1994).

The situation is even more serious when it comes to cervical cancer. In fact, from 1988 – 92, Vietnamese women had the *highest* rates of cervical cancer of *all* ethnic groups in the U.S., with 43 per 100,000 women developing the disease. This rate is almost five times higher than that for White women (Miller et al, 1996). The California Cancer Registry indicates an annual cervical cancer incidence rate of 40 cases per 100,000 Vietnamese women, compared to 10 cases per 100,000 women in the general population - Vietnamese rates are *four times higher* than those of the general population. Case-control studies have found that the risk of developing invasive

cervical cancer is 3 to 10 times greater in women who have not been screened. As with breast cancer, screening for cervical cancer is low among Vietnamese women. One California survey found that only 53% of 434 Vietnamese women had never had a Pap smear, compared to 6% of women in the general population (Behavior Risk Factor Survey of Vietnamese – California, 1991). While some women in the SEAWRHP focus group discussions had regular Pap smears, many usually had their first only after getting pregnant, and some did not even know what they were.

Concerns & Barriers

Lack of preventive care and screening are key barriers to preventing breast and cervical cancers among Vietnamese women. In Vietnam, preventive care in general, and cancer screening in particular, are rarely practiced. This approach continues in the U.S. as members of Vietnamese communities may not see the value of preventive care and routine screening, and more traditional Vietnamese doctors fail to offer those services. Women often do not visit a doctor until the disease has advanced, is debilitating and is difficult to treat or contain.

Fear and misconceptions result in women not practicing preventive care. Fear of a positive diagnosis or of uncovering a disease better left alone was expressed among focus group participants. Some women said they did not do breast exams because they believed you only did them once you had breast cancer. Others thought that wearing tight bras could cause breast cancer. While participants had heard of Pap smears, many did not know what they entailed or what they were for. Some felt that only married women needed Pap smears.

Socioeconomic conditions once again play a role in determining whether the health needs of Vietnamese women are met. Health insurance is an important factor in limited access to cancer screening services. A recent California survey found that women with either public or private insurance are more than three times as likely to have ever had a mammogram than those without any coverage. Unemployed women are half as likely to have ever had a mammogram as employed women. Sixty percent of the Vietnamese women surveyed were unemployed (Jenkins and Kagawa, 1994). Lack of transport or time, as well as language barriers, play a key role in women not accessing preventive care.

Culture and tradition influence the use of preventive and treatment services, particularly in an immigrant community that has continuous waves of arrivals, reinforcing traditional values and practices. As in most other communities, shame often accompanies issues related to sexuality and the body. Many Vietnamese women find having either breast exams or Pap smears embarrassing and shameful, particularly when the practitioner is male. Pap smears may also be viewed as sexually inappropriate; some SEAWRHP participants thought that Pap smears should not be done on unmarried women, so as to preserve their virginity. Additionally, an acceptance of “fate” is a part of traditional Vietnamese culture. This fatalism often means enduring hardships, including serious illness, and viewing them as inevitable and untreatable.

Recommendations for Providers and Advocates

- ❖ Develop and conduct education campaigns within Vietnamese communities on the value of general preventive screening and practices;
- ❖ Educate other community and health service leaders on the significant rates of breast and cervical cancers among Vietnamese women;
- ❖ Ensure that information on cancer prevention and treatment is provided in a non-alarmist and culturally appropriate way, so that misconceptions and fears can be addressed and preventive practices encouraged;
- ❖ Advocate for universal screening services for Vietnamese communities through the coordination of existing public, private and non-profit services;
- ❖ Facilitate self-help groups to teach both married and unmarried women about their bodies, the need for screening, the ways in which they can screen themselves (for example, through breast exams and monitoring vaginal discharge), what Pap smears actually entail, and the services they need to access;
- ❖ Train Vietnamese American providers to give counseling and moral support to women having Pap smears; and
- ❖ Provide a female doctor on request for Vietnamese women whenever available. Train doctors to complete Pap smears in a sensitive manner and allow women to have translators and/or support with them during their appointment.

Birth Control

“I think birth control is a good thing because here in the U.S., if you have too many children, you wouldn’t be able to care for them adequately.”

(Vietnamese woman, aged 35)

“For me, birth control is necessary because my future is still bleak right now. Nothing is stable yet; I don’t dare have another child at the moment.”

(Vietnamese woman, aged 33)

Background

Vietnam has a well-established family planning program, dating back to 1963. In the late 1970’s, Decree Number 29, an official one-or-two child policy, was implemented, imposing economic penalties on non-compliant couples, and providing free IUDs and sterilization services (Goodkind, 1995 and Haughton and Haughton,1995). The demographic focus of Vietnam’s family planning history has resulted in relatively high contraceptive prevalence, (with 60% of women reporting ever having used modern methods), but little focus on comprehensive reproductive health. A focus on long-term, provider-dependent contraceptives and economic penalties precluded real reproductive choice. More recently, U.S. aid to Vietnam was reinstated, with a large budget for family planning. Whether these activities will include comprehensive reproductive health activities remains to be seen.

The Vietnamese women and men participating in the focus group discussions clearly expressed how their economic and immigration status directly affected their reproductive choices. While many participants were well-informed about different contraceptive methods, (some had even served as family planning “promoters” in Vietnam), specific reproductive and sexual health concerns were rarely mentioned. Instead, a focus on the socio-economic environment dominated discussions. For most, economic stability was seen as the key factor in deciding whether or not to have children. For others, the political uncertainty in being a recent immigrant or refugee made having children a frightening prospect.

There was disagreement about abortion. Some felt it was better not to bring an unplanned or unwanted child into what was seen as an economically and socially hostile environment. Others felt that if you found yourself pregnant, you should carry the pregnancy to term.

“Accidents can happen, and if you want to have an abortion - because if you keep the baby but can’t afford it, the child will suffer - people are so insensitive. When I was pregnant with my second child, I asked my doctor about it. He told me not to do it...But I think abortion is better in many circumstances.”

(Vietnamese woman, aged 22)

Married men were better informed about most aspects of reproductive health (birth control and even gynecological exams and Pap smears) than single men. With some exceptions, most single men seemed to think that because they were not married, they did not have to know about these issues. Notably, both unmarried and married women agreed that since women ultimately carried the burden of pregnancy, unmarried women should have access to information and services.

Interestingly, both married women and men saw birth control as an agreement between partners -- a commitment to prevent pregnancy in the face of difficult circumstances.

“The method that works for both the husband and wife should be used. Any method will have its benefits and its flaws; nothing is perfect. But if there is agreement and cooperation between the husband and wife, then whatever flaw there is will be minimized.”

(Vietnamese woman, aged 31)

“I think birth control is a good thing and it should be discussed and agreed upon between a husband and a wife. Just because I’m the husband, I shouldn’t be using my power to force it on my wife...Birth control is good because whenever you decide to have a child, you must be able to care for it adequately; if not, you should use birth control...We had two children and decided that it’s good enough.”

(Vietnamese man, aged 44)

“My wife and I have been using the withdrawal method. This requires a lot of discipline and self-determination, but it’s the safest to use.”

(Vietnamese man, aged 44)

Concerns & Barriers

While *economic factors* maintain the imperative to use birth control, they also create barriers to accessing necessary services. For both women and men, lack of money to pay for private services was a common problem. Many were aware of existing public services. However, overwhelming work or learning commitments, were common barriers to accessing any health care at all. Multiple jobs, English classes, limited child care and access to transportation all made either getting to a clinic or waiting at one endlessly impossible.

Misconceptions about birth control also exist. For example, some women felt that abortion or the pill would adversely affect their fertility. Others felt that the pill would cause retardation in children born after using the pill. Language-barriers exacerbated these misconceptions, as women and men are not always able to get comprehensive information on a full range of contraceptive methods. Written information in Vietnamese was appreciated and requested. Interpreters at services were also highly appreciated, but often overworked or unavailable.

Recommendations for Providers and Advocates

- ❖ Conduct reproductive and sexual health education in Vietnamese with both women and men to raise awareness of comprehensive reproductive health -- not just birth control;
- ❖ Provide information and services that make accessible the full range of contraceptive methods, including information on the mechanisms and efficacy of methods for preventing both pregnancy and STDs;
- ❖ Develop community programs, training married men to educate younger men about their responsibilities in protecting their own and their (future) partners' reproductive health; and
- ❖ Create mobile services for both women and men in the places they already frequent. For example, distribute Vietnamese and English pamphlets through existing community information booths and at ESL centers; provide mobile services at the workplace in collaboration with factory owners and managers.

Prenatal Care

“In Vietnam, we were not taught about the importance of preventive health. We go to the doctor when we’re sick, and if we’re not sick we don’t go. We don’t have the concept of going to the doctor and having annual examinations to detect a sickness that we may have. We are not taught that way.”

(Vietnamese woman, aged 27)

Background

Preventive medicine is not a priority in Vietnam. When symptoms do not exist, a visit to the doctor is unwarranted. This mentality generally remains constant in recent Vietnamese immigrants. As early as 1979, soon after the first phase of Vietnamese migration to the U.S., the Highland Hospital in Oakland, California began providing midwifery and prenatal services for the Southeast Asian community. Prenatal visits included education by midwives about pregnancy, labor, delivery, infant care, birth control and nutrition counseling. More recent immigrants, who are eligible for MediCal (California’s version of Medicaid), which covers the cost of the prenatal and midwifery services for low-income families at Highland Hospital, have kept their appointments and participated successfully in the program. Without MediCal most of them would not be able to participate at all. Asian community prenatal services also exist, providing services and written information in Vietnamese.

For many women, pregnancy and prenatal care is often their first visit to a health care provider. However, in 1992, 21.5% of Vietnamese mothers nationwide received no prenatal care in their first trimester (National Center for Health Statistics, 1995). Another study in California found that a higher percentage of Vietnamese women received no prenatal care or had no prenatal history than in the general population. Notably, almost all the Vietnamese women in that cohort were foreign-born (Morrow, 1993). Given the continuing waves of immigration over the past two decades, and the fact that the community remains a relatively “young” American community, it is likely that this trend may continue.

Concerns & Barriers

Misconceptions about prenatal care and nutrition exist within the Vietnamese American community. According to public health nurses who have worked with Vietnamese women in

California's Alameda and Santa Clara counties, some Vietnamese women believe that having a large baby will present difficulties during delivery. Consequently, many of these women eat less than recommended and do not take prenatal vitamins during pregnancy.

Cultural values also affect the ways in which pregnancy and delivery are managed. The Southeast Asian cultural commitment to stoicism affects the extent to which women are willing and able to express their own needs. Many Vietnamese women tend to have short, even precipitous labor and deliveries. This requires timely arrival at the hospital, and can be both physically and emotionally traumatic for the woman, particularly during first pregnancies. Vietnamese women may not express their urgent need to get to a hospital, and during delivery, they may be reluctant to express their pain, particularly in the presence of a man. Compounded by language differences, this situation could result in many women not getting the attention and care they need before, during and after delivery.

Socioeconomic conditions play an important role in whether Vietnamese American women receive the prenatal care they need. Without medical benefits, such as MediCal, many women could not access services at all. For many, their immigration status affects whether they are eligible for those benefits. For others, having a job precludes their eligibility for benefits, while not providing enough to support their families and access adequate care.

Recommendations for Providers and Advocates

- ❖ Expand existing prenatal services to make more comprehensive and relevant to Vietnamese American communities;
- ❖ Develop public health education campaigns on prenatal care, nutrition and healthy pregnancy in Vietnamese communities;
- ❖ Expand prenatal care and education to include information on the stages of labor, signs of impending delivery, and what to do in the case of sudden delivery;
- ❖ Train female interpreters and family members to advocate for Vietnamese women during labor and delivery, so that women's needs can be clearly expressed and met; and

- ❖ Campaign for public policies that continue and improve medical benefits for immigrants and refugees that many Vietnamese women require to access essential prenatal services.

Sexually Transmitted Diseases

Background

There is little data on the sexual attitudes and activity of Vietnamese Americans. This lack of data contributes both to a lack of understanding and an underestimation of sexual health risks, particularly with regard to the prevalence and transmission of sexually transmitted diseases (STDs). As in other communities, the stated sexual values and norms of the Vietnamese American community differ considerably from actual behaviors. Initial research indicates that despite cultural taboos against sexual expression outside heterosexual marital relationships (Aoki, 1989), Vietnamese American sexual behaviors do include multiple partners, same sex relationships or encounters, and the use of commercial sexual services (Carrier, 1992). Without explicit education on safer sex practices and risk of infection, these practices can lead to high rates of STDs in the community. The stereotypical perception that Asian communities in general are at low risk of STDs also contributes to a lack of advocacy and resources both within and beyond Asian American communities to address the growing risk of STDs.

Vietnamese Americans have some perception of risk of STDs. Disproportionately high rates of hepatitis B among Vietnamese may have raised some awareness of sexually transmitted and other infectious diseases. In fact, Vietnamese Americans have a hepatitis prevalence rate that is 30 times higher than that of the general population (Nguyen, 1995). Additionally, a survey conducted in Santa Ana, California found that 38% of Vietnamese men and women aged 18 to 45 worried about contracting HIV, and as many as 83% worried about a family member contracting the virus. However, misconceptions about HIV transmission prevailed, and almost half stated that they did not have enough information about HIV/AIDS to protect themselves (Gellert et al, 1996).

Concerns & Barriers

Lack of information on and for Vietnamese communities on sexual attitudes, behaviors and STDs makes it difficult to develop effective and appropriate sexuality education and STD prevention programs. Myths and misconceptions about STDs prevail in the Vietnamese American community, as do cultural taboos on talking about them. Fear of disease and lack of information and services exacerbate these misconceptions. Language barriers may make seeking help on these sensitive issues even more uncomfortable. Additionally, as immigrants and refugees from Asia, Vietnamese also face potential discrimination and vulnerability due to growing rates of HIV/AIDS in Asia and anti-immigrant sentiment in the U.S.

The lack of preventive care and practices mentioned in other sections is of particular concern because many STDs are asymptomatic, particularly in women, until they become debilitating and difficult to treat. Often women may not know they have an STD until they are in pain, and advanced infections can lead to infertility and sometimes death. Taboos on talking about sexuality make it difficult for partners to discuss multiple partners and infidelities, sexual history and behaviors. Women may think they are not at risk of infection if they are married and monogamous, even though their partner may not be. Without routine screening, it is difficult to assess risk, diagnose and treat STDs, and prevent future infections. While SEAWRHP participants mentioned condom use in relation to birth control, no one mentioned condoms as a means of preventing the spread of STDs, and no mentioned routine screening for STDs.

Lack of good STD surveillance in Vietnamese American communities undermines effective preventive efforts. This may be due to lack of services and preventive screening. Additionally, community agencies report anecdotally that some Vietnamese physicians, to protect the privacy of their patients, diagnose STDs syndromically rather than using laboratory tests. In so doing, they neither report STDs nor do they breach disease-reporting laws. Under-reporting infection affects both community perceptions, and effective surveillance of STD prevalence and risk, ultimately endangering both individuals and the public health of the community. While 1991 rates of AIDS among Vietnamese in California were reported at 6.4 per 100,000 (Jew, 1991), it is likely that under-reporting occurred.

Notably, when asked about their reproductive health concerns, STDs, including HIV/AIDS, were hardly mentioned by SEAWRHP participants. This lack of dialogue should not be overlooked as it could indicate a perceived lack of risk or a reluctance to discuss STDs due to stigma or misinformation.

Recommendations for Providers and Advocates

- ❖ Conduct community-based research to learn more about sexual attitudes, behaviors and sexual health needs of Vietnamese American communities. Use participatory methods that involve communities in collecting information and developing their own education and prevention programs;
- ❖ Conduct research to correctly assess the prevalence and range of STDs among Vietnamese American communities;
- ❖ Be aware of the particular risks and fears that immigrant communities face in dealing with sexual health and disease prevention;
- ❖ Train doctors on the importance of infectious disease reporting guidelines and surveillance studies, and how to explain guidelines to patients so that they understand that their privacy is not violated; and
- ❖ Teach community members explicitly the links between birth control, reproductive cancers, prenatal care, general well-being, STDs and the need for routine preventive care and practices. These connections may make it easier for them to think about their reproductive and sexual health holistically and protect their own and their partners' reproductive and sexual health.



"I try to eat foods that are appropriate for a woman's digestive system, such as vegetables. Fresh vegetables are healthy for women because they help to prevent cancer. I know because if I go for a day without eating vegetables, I feel irritable and my body is 'hot' all over...During menstruation, you should stay away from pepper, spicy foods, and 'cold' drinks because your blood is thinner. You may not believe me, but for example, it's okay to drink coconut juice before your menstrual period, but if you drink it during your period, you will experience heavy blood flow."

(Vietnamese woman, aged 31)

Background

Nutrition and diet can play an important role in cultural perceptions of health and medicine. This is true in the Vietnamese American community, as traditional medicine relies on the balance of ingesting "hot" and "cold" foods. In fact, although they were not asked about nutrition specifically, most SEAWRHP participants mentioned the importance of balanced nutrition, and adjusting the diet in response to ailments or conditions affecting well-being. They themselves made the link between general well-being and nutrition, and the relevance of that link to reproductive health and women's bodies.

Additionally, as in any immigrant community, food plays an important role in maintaining cultural identity. This can make it difficult to change poor nutritional habits, or habits that are no longer healthy given the change in environment or resources.

Concerns & Barriers

Reliance on traditional nutritional beliefs and lack of preventive care could mean that some community members do not receive the medical care they need as soon as they need it. While traditional nutritional balance may effectively treat some conditions, others may need alternative care.

Poor nutritional habits exist within the Vietnamese American diet. Rice dominates the diet, but so do several high sodium and high cholesterol foods. A traditional diet is maintained in many Vietnamese American households, including fish sauce, MSG and preserved foods that are high in sodium. Popular pork, shellfish and egg dishes, often fried, are high in cholesterol. The main source of calcium in the U.S. is dairy products that are indigestible for many Vietnamese who are lactose intolerant. A clear understanding of the need for a healthy diet existed among SEAWRHP participants. Many were aware that of the relative nutritional advantages and disadvantages of a Vietnamese diet compared to a more mainstream U.S. diet, and expressed the need for a balance.

Recommendations for Providers and Advocates

- ❖ Be aware of Vietnamese nutritional habits and how they impact health perceptions and practices. Be ready to provide complementary, and when necessary, alternative advice and treatments;
- ❖ Build upon the well-understood concept of nutritional balance within the Vietnamese American community to create culturally appropriate education campaigns about nutrition;
- ❖ Develop education campaigns to encourage Vietnamese American communities to use healthy substitutes or recipes without sacrificing the essence of Vietnamese dishes or culinary rituals. These could include using salt substitutes, steaming instead of frying and using fresh rather than preserved ingredients; and
- ❖ Recommend and make available non-dairy alternative sources of calcium, such as soy formulas or calcium supplements, for lactose-intolerant community members. This is particularly important for both pregnant and non-pregnant women and babies and children.



CONCLUSIONS

"I think women's reproductive health is very important because the woman is the most important member of the family, especially to our children."

(Vietnamese man, aged 40)

As the Southeast Asian American community grows, the reproductive health needs of the community also grow. By highlighting existing resources, and the gaps in services and information in one Vietnamese community, we hope that the SEAWRHP can shed some light on how other communities can begin to address the range of reproductive health issues in a comprehensive and participatory way. Additionally, the SEAWRHP was able to clearly establish how immigration and economic status, country of origin, language ability, gender relations, and culture and tradition impact the reproductive health of both individuals and communities. Finally, and perhaps most importantly, the SEAWRHP illustrates the value of involving community members in the identification of their own needs and solutions. It is only by listening to communities that health advocates and providers can better understand and address their reproductive health needs.



EDUCATIONAL MATERIALS

Sexually Transmitted Diseases

From API Wellness Center, San Francisco and the Center for Southeast Asian Refugee Resettlement, San Francisco:

- ❖ “Song lau va khoe manh hon” - “Live longer and healthier”
- ❖ “Van de tinh duc co an toan khong ?” - “Is sexual intercourse safe?”
- ❖ “Toi la nguoi Viet Nam suc may ma toi bi AIDS” - “I am Vietnamese, I don’t get AIDS”
- ❖ “Benh phong tinh” - “Sexually transmitted diseases”
- ❖ “Benh hoa lieu, benh sinh ly, la benh gi?” - “What are STDs?”
- ❖ “Benh Aids va cong dong Viet Nam” - “AIDS and the Vietnamese community”
- ❖ “Bao ve the he moi, hay chich ngua viem gan B” - “Protect the next generation, get immunizations against hepatitis B”

Nutrition

From UC Berkeley Cooperative Extension and California Milk Advisory Board:

- ❖ “Calcium rich foods”
- ❖ “Milk and other dairy products”
- ❖ “Asian Food Guide Pyramid”
- ❖ “Fat, a danger to your health”

Breast and Cervical Cancers

From Vietnamese Community Health Promotion Project:

- ❖ “Ung Thu co tu cung: Nhung dieu phu nu Viet Nam nen biet” - “What Vietnamese women need to know about cervical cancer”
- ❖ “Ung thu co tu cung va phu nu Viet Nam” – “Cervical cancer and Vietnamese women”
- ❖ “Ung the vu: Hung die phi gnu Viet Nam en bite” - “What Vietnamese women need to know about breast cancer”

Birth Control Methods

From API Wellness Center, San Francisco:

- ❖ “Lam Sao boa vet suc khoe Cho ban va nguoi than” - “How to protect you and your loved one”
- ❖ “What is right for you ? Choosing Birth Control Methods”

- ❖ “Song lâu va khoe manh hon” - “Live longer and healthier”

Prenatal Care

From Santa Clara County Health Department, San Jose:

- ❖ “San de, de vui. Tai lieu huong dan cho phu nu chuan bi sanh con”
- ❖ “Lam the nao de bao ve suc khoe”

COMMUNITY RESOURCES

These Alameda County agencies provide prenatal care, nutrition counseling, cancer support and health educational materials:

Vietnamese Community Health Promotion Project

Breast Cancer Research Project
545 E. 14th Street, Suite 204
Oakland, CA 94606
tel (510) 835-7812
fax (510)835-7832

Alameda County Health Care Services Agency at Fairmont Hospital

15400 Foothill Blvd
San Leandro, CA 94578
tel (510) 667-7800

14th Street Clinic/14th Street Medical Group

1124 E. 14th Street
Oakland, CA 94606
tel (510) 533-0700

Nutrition Education Project for Vietnamese WIC-Eligible Women

Cooperative Extension
University of California Berkeley
209 Morgan Hall
Berkeley, CA 97420
tel (510) 642-5382

Asian Health Services - prenatal

818 Webster Street
Oakland, CA 94607
tel (510) 986-6830

Highland General Hospital (prenatal)

1411 E. 31st Street
Oakland, CA 94602
tel (510) 437-4491

Central Health Clinic (prenatal)

470 - 27th Street
Oakland, CA 94602
tel (510) 271-4263

Eastern Health Clinic (prenatal)

2449 - 8th Street
Oakland, CA 94605
tel (510) 577-5696

Newark Health Center (prenatal)

6066 Civic Terrace Ave.
Newark, CA 94560
tel (510) 795-2414

Hayward Health Center (prenatal)

224 W. Winton Avenue, Suite 113
Hayward, CA 94544
tel (510) 670-5300

REFERENCES



American Cancer Society. (1996) "California Cancer Facts and Figures." Atlanta, GA: American Cancer Society.

Anh P.T.H, D.M. Parkin, T. N. Hanh, and N. B. Du. (1993) "Cancer in the population of Hanoi, Vietnam 1988-1990." Br. J. Cancer, Vol. 88:1236-42

Aoki B., C.P. Ngin, B. Mo, and D.Y. Ya. (1989) "AIDS prevention models in Asian American communities." Primary Prevention of AIDS, Psychological Approaches. Newbury Park, CA: Sage Publications.

"Behavior Risk Factor Survey of Vietnamese – California 1991". (1992) Morbidity and Mortality Weekly Report. Vol. 41(5): 69-72.

Carrier J., B., Nguyen, and S. Su. (1992, November) "Vietnamese American sexual behaviors & HIV infection." The Journal of Sex Research. Vol. 29, No.4, 547-560.

Gellert, G., R. Maxwell, K. Higgins, K. Mai, R. Lowery, and L. Doll. (1995) "HIV/AIDS knowledge and high risk sexual practices among Southern California Vietnamese." Genitourin Medicine. Vol. 71: 216-223.

Goodkind, Daniel M. (1995) "Vietnam's One-or-Two Child Policy in Action." Population and Development Review, Vol. 21, No. 1: 85-111.

Haughton J., and D. Haughton. (1995) "Son Preference in Vietnam." Studies in Family Planning, Vol. 26, No. 6: 325-337.

Hoang G.N. and R. V. Erickson. (1985) "Cultural Barriers to Effective Medical Care among Indochinese Patients." Ann.Rev. Med. Vol. 36: 229.

Jenkins, C. N. H, and Singer M. Kagawa. "Cancer", in , Zane, Takeuchi, and Young (eds.). (1994) Confronting Critical Health Issues of Asian Pacific Islander Americans. Thousand Oaks, CA: Sage Publications.

Jenkins C. , T. Le, S. McPhee, S. Stewart, N. T. Ha. (1996) "Health care access and preventive care among Vietnamese immigrants: Do traditional beliefs and practices pose barriers?" Social Science Medicine. Vol. 43. No. 7: 1049-1056.

Jew S. (1991, September) "AIDS among California Asian and Pacific Islander Subgroups." California HIV/AIDS Update of the Office of AIDS, Department of Health Service, State of California. Vol. 4, No. 9: 24-36.

Kinzie, JD, et al. "The Prevalence of Posttraumatic Stress Disorder and its Clinical Significance Among Southeast Asian Refugees." *American Journal of Psychiatry* 147, no.7 (1990): 913-7.

Miller, BA, L.N. Kolonel, L. Bernstein, J.L. Young, Jr., G. M. Swanson, D. West, C. R. Key, J. M. Liff, C. S. Glover, G. A. Alexander, et al. (1996) Racial/Ethnic Patterns of Cancer in the United States 1988-1992, Bethesda, MD: National Cancer Institute.

Morrow HW, G. F. Chavez, P. P. Giannoni, R. S. Schah. (1993) "Infant Mortality and Related Risk Factor among Asian Americans." American Journal of Public Health. Vol 84, No 9: 1497-1500.

National Center for Health Statistics. (1995) in National Institutes of Health (1997) Women of Color Health Data Book. Bethesda, MD: National Institutes of Health.

Nguyen T, S. McPhee, et al. (1995) "Promoting hepatitis B prevention among Vietnamese through outreach interventions." Abstract presented at 123rd Annual Meeting & Exhibition of American Public Health Association on October 29,1995 in San Diego, CA.

Nguyen V. D., T. N. Doan. (1990) "Medicinal Plants in Vietnam and Manila." World Health Organization and Hanoi Institute of Materia Medica. WHO Regional Publications. Western Pacific Series No. 3.

Ong P. and E. Blumenberg (1994) Welfare and Work among Southeast Asians in Ong P. (ed.) The State of Asian Pacific America Economic Diversity, Issues & Policies. Los Angeles, CA: LEAP Asian Pacific American Public Policy Institute.

Poss, Jane. (1989) "Providing Health Care for Southeast Asian Refugees." Journal of the New York States Nurses Association. Vol. 20, No. 2: 4-6.

Uba, L. (1992) "Cultural Barriers to Health Care for Southeast Asian Refugees." Public Health Reports. Vol. 107, No. 5: 544-548.

United States Bureau of the Census. (1991) Press Release #CB91-215, June 12, 1991.

NATIONAL ASIAN WOMEN'S HEALTH ORGANIZATION

250 MONTGOMERY STREET, SUITE 900 SAN FRANCISCO, CA 94104 PHONE: 415.989.9747
FAX: 415.989.9758 E-MAIL: nawho@nawho.org Web Site: www.nawho.org