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Health Needs of Vietnamese American Elder

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Abstract

Vietnamese Americans were the fourth largest immigrant group in 2000 and one of the minority populations that reported disparities in health status and barriers to care. Most research focuses on Vietnamese in large urban areas. Little has been reported regarding Vietnamese elders' access to care in smaller communities. The purpose of this descriptive

ethnographic study was to describe the barriers and facilitators to health care access and utilization for Vietnamese-American elders in a medium size urban area in the Midwest. The sample was a purposive sampling of *n* = 57 participants (27 Vietnamese elders ages 65 and over; 11 Vietnamese middle aged adults; and 19 community leaders and providers). Data collection included ethnographic interview, field notes and participant observation. The face-to-face interview was conducted in the language preferred by the respondent (Vietnamese, Chinese or English) and audio taped. Transcribed data was analyzed using *NVivo* 8 software. Results revealed low health literacy among elders in diabetes, cancer, hypertension and mental health issues. Undergirding themes included acceptability and affordability of care, and patient-provider communication. Elders' preference to receive health information was also elicited. Information gained will be important in designing and planning community-based health literacy interventions in this community and other minority populations.

Keywords: ethnography, health disparities, Vietnamese elders, gerontology, health needs, health utilization, health literacy

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Introduction

Among the health care disparities found among minority groups, the issues surrounding the health status of Vietnamese Americans and their experienced barriers to care remain relatively unexplored. Most research has focused on Vietnamese in large urban areas and little has been reported regarding smaller or medium size Vietnamese enclaves. *Census 2000* indicates Asian Americans account for 4 percent of the US population. By 2007, the Vietnamese American population was estimated to be over 1.6 million,[1] and are projected to increase to 11% of the total US population by 2050.[2] Two- thirds of Asian Americans are foreign-born and speak primary languages other than English. A high percentage of the Vietnamese population is not fluent in English (62%).[2-4] Asian Americans are predominantly concentrated in major metropolitan cities such as New York, Los Angeles, Chicago, Houston.[2] However, smaller clusters of Vietnamese can be found living in midsize cities or migrating to towns in the Midwest. The contrasts of culture, the barriers of language and health literacy, and the availability of healthcare facilities to these individuals provide the tapestry for this ethnographic study.

Study Purpose

The ultimate goals of this research were to gain knowledge of this community, to understand barriers and facilitators to health services utilization among Vietnamese elders in order to improve services, access to service and quality of health care through future interventions. To achieve this, it was important to understand cultural variations in access and the issues and health behaviors on which future culturally competent services and community-based research in the Vietnamese community could be based. Therefore, the specific aims of the study of community dwelling Vietnamese American elders were to: 1) Describe patterns of health beliefs related to cancer, hypertension, diabetes, dementia and depression. 2) Describe health and social services utilization patterns and barriers. 3) Describe the community formal and informal leaders and community structures. 4) Compare and contrast health belief and service utilization patterns of middle aged adults, community leaders, and health and social services providers.

Background and Significance

Vietnamese are the fourth largest group among Asian Americans in the US accounting for 10.5% of Asian population. However, they are the largest Asian American group residing in Oklahoma (13,000).[5-7] Since the fall of Saigon in 1975, Oklahoma has received immigrants throughout the three major waves of Vietnamese immigration. The first influx of 132,000 Vietnamese immigrants came to the United States between 1975 and 1977 settling in traditional gateway cities such as San Francisco, Boston, Chicago and New York.[8,9] This first wave of post-Vietnam era immigrants was more likely to be educated and speak English. The second wave of 127,000 refugees began in 1978 and was referred to as “boat people” because they fled their homeland in small wooden boats. The third wave of Vietnamese resulted from the 1987 Amerasian Homecoming Act.[8,9] Immigrants arriving in the United States after the first wave were more likely to have come from lower socioeconomic conditions, have fewer years of formal education, and be less fluent in English.[8,10,11] The majority of foreign born Vietnamese came between 1990 and 2000: an 82% increase compared to previous periods.[4]

An increase in immigration by a population with limited English language fluency poses a challenge to the health care system in providing effective communication and satisfactory patient outcomes.[12] There is a paucity of information on the impact of language barrier on health literacy and health disparities. The Office of Minority Health reports English language fluency as the percentage of persons five years or older who do not speak English at home.[3] In 2009, among Asian American groups 62% of Vietnamese are estimated to be not fluent in English, compared to 50% of Chinese, 24 % of Filipinos and 23% of Asian Indians.[3] Health literacy is the individual’s capacity to obtain, process and understand basic health information and services that is needed to make health decisions.[13] There is growing recognition that low literacy, language barriers and cultural diversity be addressed in order to ensure effective health communication.[14]

Health Disparities

Among the several existing definitions of health disparities, the comprehensive description by Carter-Pokras seems most relevant to considering the situation of the Asian Americans living in the US. "Health disparities should be viewed as a chain of events that are signified by a difference in environment; access to, utilization of, and quality of care; health status or; a particular health outcome that deserve scrutiny."[15p427] The Office of Minority Health reports high tuberculosis incidence among Asian Americans with a case rate of 26.3 compared to 1.1 for the White population.[3] In 2006 Asian Americans were 1.2 times more likely to have Hepatitis B than Whites.[3] Liver cancer incidence is three times higher than that of the U.S. population and the Vietnamese rank highest in incidence among Asian Americans. A national survey by the Commonwealth Fund on health found that Vietnamese Americans were more likely to self-rate their health status as poor or fair than members other Asian subgroups.[16] The cervical cancer incidence rate for Vietnamese women in the US is 47.3 per 100, 000 that is five times greater than the rate for white women.[17]Factors for this disparity have been attributed to low Pap smear rates among Vietnamese women, lack of preventive care prior to immigration, and lack of sensitivity by providers.[3,18]

Previous studies with Vietnamese populations identified the lack of knowledge about cancer, cancer screenings and hypertension and also underutilization of services.[19,20] It was also found that there are special barriers in seeking mental health services and lack of knowledge about depression and dementia among Vietnamese Americans.[10,21] Overall, it was reported that Vietnamese elders have difficulty mastering the new language; skills needed for daily living and have vastly differing social norms than those of mainstream American society; they tend not to ask questions or voice concerns and may indicate they will follow provider recommendations even though they have no intention of doing so.[11] Of concern to this investigator were the specific factors that caused available healthcare services to this population to be underutilized. Of particular interest was whether the factors were unique to this community or more consistent with knowledge, language, attitudes toward illness and care providers, or cultural issues addressed in existing literature.

Study Framework

The conceptual framework informing this research was Andersen and Newman's[22] utilization model which provided a context for exploring the barriers and facilitators to health utilization. This multidimensional incorporates *societal determinants* and *health service system* characteristics as well as *individual determinants* that influence *health services utilization.*[23] This framework proposes that *individual determinants* have the most immediate influence on a person's

decision about *health services utilization*: *Individual determinants* include such predisposing factors such as the individual's social structure and health beliefs; enabling factors such as the availability of resources; and needs which are perceived subjectively by the patient or clinically evaluated by providers.[22]

Research Design and Methods

Descriptive ethnography was the approach used to achieve the specific aims of this research. Ethnography is a family of methods that involves direct and sustained social contact with agents and writing up the encounter.[24] Data were collected through ethnographic interviews, field notes and participant observation. Data included systematic description of events, behaviors and artifacts in the social setting of study.[25] Field notes were used to describe the investigator's schedule, logistics, insights recorded in a reflexive journal. The investigator has been a long time volunteer in the Vietnamese community and is accepted in the community. She has attended and observed senior citizen meetings and Buddhist temple services at a regular basis for many years.

Sample and Setting

The sample (*n* = 57) was a purposive sampling of 27 Vietnamese elders ages 60+ who were previous or exiting members of the Asian Senior Citizens Association (ASCA),11 Vietnamese middle aged adults, and 19 community leaders and providers. The elders' ages ranged from 65-87 and were recruited from the monthly ASCA lunch meetings and by word-of-mouth with support from the president of ASCA. All participants who were fluent in Vietnamese language only were interviewed by a Vietnamese speaking interpreter. Those who are bilingual in Chinese and Vietnamese were interviewed by the investigator.

Six Vietnamese elders and seven adults were bilingual in Vietnamese and Chinese and were interviewed by this investigator in Chinese. The middle-aged adults, community leaders and providers were recruited by this investigator during visits to community organizations, businesses and by word-of-mouth. The adults' ages ranged from 35-55 with diverse socioeconomic status, employment varied from hourly wage jobs to professional positions. Six providers and 13 community leaders were recruited to this study.

Procedure for Data Collection

This project complied with all institutional requirements for conducting human subjects research and was approved by the university Institutional Review Board (IRB).The Vietnamese version of the IRB approved consent form was available for participants who do not speak English or with limited English proficiency (LEP). The IRB approved consent form was first translated into a Vietnamese version. A second translator back translated the Vietnamese version into English. The back translation process was to ensure equivalency and accuracy. Consent for interview was sought and explained, and the consent form signed by the participant prior to commencing the interview.

Each respondent was identified by a number code only and no name was used on the data collection form and interview guide, field notes or the audiotapes. The investigator kept the only master code list with participant names locked in a safe place in her private office which is kept locked. The investigator was the only person who had access to this list.

Interviews

The face-to-face interviews were conducted in the home of the participant or a place of his choice at a time that was agreed upon. Nineteen interviews were conducted in English, 13 in Chinese and 25 in Vietnamese. Interviews of the 19 providers and community leaders took place at their work setting or place of choice at a time that was convenient to them. The investigator interviewed providers about barriers they faced in delivering services and strategies they used to address these barriers.

Each interview was approximately one hour long and audio taped. A Vietnamese interpreter accompanied the investigator to interview the 25 respondents who only speak Vietnamese. The investigator who is fluent in Cantonese interviewed respondents who can speak this Chinese dialect. The participant was instructed to stop the interview at any time due to fatigue or any other reason and could choose to schedule a return interview or withdraw from the study. No participant chose to stop or withdraw.

Instrument

The investigator used a semi-structured interview guide with open-ended questions corresponding to the specific aims of this project; questions about patterns of health beliefs, utilization patterns, barriers and facilitators to health utilization, and community structure (see appendix). The interview guide was reviewed by an experienced ethnographer and piloted on three Vietnamese individuals. Open-ended questions allow for respondents to answer openly according to their previous

experience and background. The interview guide begins with a section that collects descriptive demographic information about the participant. There is no name to identify the participant on this form.

Procedure for Data Analysis

An experienced transcriptionist recorded the interviews spoken in English and the English portions verbatim from interviews conducted by the Vietnamese interpreter and investigator. The investigator checked each transcript for accuracy. The investigator transcribed the Chinese interviews into English. The investigator read each transcript at least two times to familiarize herself with the content and develop a schema of coding. The investigator was responsible for all phases of data entry and data analysis using *NVivo8* software to organize and manage the data; and to identify categories, themes and domains. Comparisons were made of the responses from the different groups of participants. An experienced ethnographer performed random checks on coding of the transcripts to ensure consistency in the coding schema.

Results

Demographics of the Sample

A total of fifty-seven participants were interviewed, 27 were elders (ages 65-87, mean=72.6) (see table 1), 11 were middle aged adults (ages 38-55) and 19 community leaders and providers. The background of the elders was diverse and year of arrival in the US spanned across three waves of Vietnamese immigration from 1975-1996 with the majority arriving during the 1990's. The middle aged adults arrived from 1975-1999 (five arrived before 1980, two arrived during the 1980's and four during the 1990's). Roles and professions of the 19 community leaders and providers appear in Table 2. The majority were volunteers in their organization or temple. The number of service providers interviewed was small because of their busy schedules. Services provided included medicine, dentistry, pharmacy and senior nutrition programs.

Perception of Disease

Cancer. The elders perceived cancer as "death and no cure", cancer is something "tough to solve and you die"; or something "scary and hopeless". The investigator noticed the elders do not have knowledge about cancer treatment or the different forms of the disease. Overall the adults interviewed expressed the same hopeless sentiment and lack of

knowledge about cancer. Another difficulty the elders had was they are not familiar with diagnosis. If someone they knew passed away, they are not aware of the cause of death as autopsies were rare in Vietnam.

Diabetes. Diabetes was another area the elders possess very little knowledge and have a very vague conception of this disease. One man was able to describe diabetes as “eat too much sugar” and he also knew how to detect diabetes in Vietnam by seeing,” ants crawl to the (sweet) urine”

Hypertension. Both the elders and adult respondents were not able to describe hypertension or high blood pressure clearly. One elderly man was a post-stroke patient and in rehab when he was interviewed. He was not aware what caused his stroke and how the stroke was related to hypertension. However a few respondents referred to lifestyles and diets briefly including “eat salty foods”, smoking and “eat too much fat”.

A retired physician who is Vietnamese gave a grimmer explanation in the following:
” I think 80% of them have at least one of the major diseases of this high blood pressure, 80%-90%...because of their diet. They eat a very rich diet and very salty diet at home, very high in salt. And these are poor diets; they don’t know how to eat properly. It is worse here (compared to Vietnam) because they eat a very rich diet. They eat too much meat. Because you see, in Asia meat is a luxury, but here meat is very cheap so they just gorge themselves with the meat. Like the buffet, I think the buffet is very bad for the elderly…and this starts a lot of problems, diabetes, hypertension, high cholesterol and heart disease and stroke…”

Dementia. The elders and adults interviewed did not express current knowledge on dementia. Dementia was viewed as forgetfulness and it comes with aging. A 70 year old man provided this physiological explanation, “old people, when they reach an age, the brain blood vessel is weak so they become slow.”

A 65 year old woman who works at an assembly-line job said, “of course if you are old your memory is gone or get worse.” Several elders attributed dementia to lack of sleep and poor appetite or attributing dementia to worries that are bottled inside the person.

Depression. The investigator was able to elicit very rich data about depression. Several elders were able to describe depression as unhappiness. Both the elder and adult participants equate depression with worries, sadness or unhappiness.

A 65 year old female gave her perspectives on keeping busy which negate depression, “I am not unhappy, I go to work, come home do chores and cook, I don’t have time to be unhappy”

A 73 year old man who was a former officer and prisoner of war in Vietnam revealed his emotions, “sometimes I quarreled with my wife or my children…I am sad, I failed the war in Vietnam so I feel very sad.”

For treatment the respondents all revealed they handled depressions by getting some sleep, praying or “willing the unhappiness to go away”. A pharmacist who is Vietnamese gave his observation about depression, “I think they have been diagnosed, it’s just…I don’t think they want the medication. They think they can do other non-drug treatment for that…like they just think to themselves ’I can handle it without it (the medication)…I don’t think they know how to handle (the depression)…they just don’t want to take the medications.”

The retired physician explained, “among Asians, the most important factor is the diseases that are very prevalent in America but not back home, it’s just like diabetes, cholesterol problems, and high blood pressure and some mental…like depression. The elderly, they came here, they have difficulty adjusting to the American way of life, and they lost their social status at home. So a lot of them suffer from depression…They are very reclusive, they do not socialize and they stay at home, they avoid society and they don’t know how to seek help, when and where and how to seek help, they just became very passive.”

The adults interviewed attributed depression to illnesses, having no money or no health insurance. Depression is also attributed to conflict, poor family relationships and environment in the home. They described depression as having “too much pressure” “thinking too much” and being unhappy.

Discussion

Specific aim #1: Describe patterns of beliefs of Vietnamese American elders related to cancer, hypertension, diabetes, dementia and depression.

Overall, there is low health literacy among the elders about these diseases from the interview data. Mental health problems exist but were of little concern. This might be due to the stigma mental illness is attached to in this culture.

A long time community leader/volunteer shared this observation during an interview, “we’ve got the health problems due to too many myths about illness and they listen to friends (rather than the doctor) and some of them don’t believe in medications.” For example they think “if I don’t eat this, I do this and that, then I won’t need to take the medications.”

Specific aim #2: Describe health and social services utilization patterns and barriers.

The health and social services pattern are influenced by affordability (insurance coverage or the lack of), availability of transportation, acceptability of care (appointments and wait times) and language barriers. Having insurance coverage is related to seeking care and having family support facilitates accessing the services. Ability to make appointment and communicate to the provider influences the elder to choose Vietnamese speaking providers. Hence patient-provider communication is a significant theme in the findings. There is heavy reliance on others to access health services; family support, transportation were mentioned frequently by the elders. Many of the elders do not drive and do not own a vehicle.

The most frequently used clinical settings are physician offices. Emergency rooms (ER) are frequently used for visits that could be avoided with medication management. An 87 year old woman with asthma had repeated visits to the ER related to the inability to use her medication and breathing machine correctly. She lives alone and her neighbor next door is 71 years old.
These findings are congruent with the factors that fit under *individual determinants* which impacts health services utilization patterns as described in Andersen and Newman’s model.[22]

Barriers as described by the elders included having to make appointments and wait in order to see the physician. This reluctance to get an appointment may be due to they were formerly from a country where appointments are not common, whereas a walk-in system is more the norm. Affordability, inability to pay or high copayments are also barriers. Many elders previously worked in low paying jobs that carry no retirement benefits; some are waiting for Medicaid eligibility in order to get health care.

Family was mentioned as a facilitator, same- language staff and provider was also a facilitator. A 72 year old woman lives with but has poor relations with her son and daughter-in-law; they do not offer her rides. She takes bus transportation even though it means walking several blocks and waiting at least an hour and making numerous transfers. This urban area has very sporadic public transit.

Having insurance coverage facilitates utilizing western medicine but if the individual does not have health insurance coverage, he will use home remedies or traditional medicine which is more accessible and cheaper than western medicine. An elderly man and middle aged woman relayed the harrowing experience of requiring emergency surgeries, they were able to get treated as indigent patients as they could were not employed and could not afford to pay.

Specific aim # 3: Describe the community formal and informal leaders and community structure.

The elders were generally not able to name a specific leader to which they aspired. Many of the elders receive health information through peers, an informal network and through informal leaders. Many elders listened to a Vietnamese local radio station's daily programming and indicated the advantage of radio is it frees one to do household chores and tasks while listening. Television is not a preferred media as indicated by the interviews.

There are formal organizations in the community that focus on promoting culture and organize cultural celebrations and social events. There is not a formal network of health and social services such as the *promotoras* (lay health care worker)programs that were piloted successfully in Spanish speaking communities. This investigator noticed some leaders are unaware of health problems, or barriers to services issues. These individuals have an idealistic view that elders are sufficiently taken care by their own family.

Specific Aim #4: Compare and contrast health beliefs and service utilization patterns of middle aged adults, community leaders and health and social services providers.

The elders and adults perceptions are about the same on the diseases with the exception that a few adults are aware of exercise and the importance of diet. Adults who are in low-paying jobs or who are unemployed are less aware of health promotion and forgo seeking health care services. The health providers have the most insights and awareness of the health status of the elders whereas the religious leaders refer to faith and prayers in describing health problems especially mental health issues.

Limitations

The findings are limited to a specific group in an urban area and may not be applicable to rural or fishing communities. Because the participants were recruited from the Asian Senior Citizens Association (ASCA) which meets monthly, this

investigator might not have reached more isolated elders or elders in poor health. However, because the sample represents three waves of Vietnamese immigrants, the diversity in backgrounds and socioeconomic status offer richness and depth in the data. The prolonged engagement of this investigator also prevents her to have a biased and preformed perspective of the needs of this community.

Recommendations

There is a need to design community-based interventions to increase health literacy in this population and other vulnerable populations. Interventions need to be acceptable to the target audience, involve the community and stakeholders and tested for effect by future research. For example in this community, engage partners such as the local radio station, retirees, community leaders and volunteers, local churches and temples in future projects.

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Interview questions:

1. Can you describe briefly what does cancer (ask about each of these conditions separately -high blood pressure, diabetes, dementia and depression) mean to you?
   Probe: Do you or someone you know have this condition?
2. Tell me how would you (or someone) go get care or have it (name the condition) checked out?
   Probe: I am interested in your opinion of the services you get (or provide). Very good, okay, very bad……etc.
3. Could you describe the main or important things that help or prevent you or someone to get health care or help for this condition (name the condition)?
   Probe: language, car problems ……..etc.
4. Please name the people in your community or neighborhood that are important to you?
   Probe: In what way (this person) is important or helpful?