

HEALTH CARE AND
REFERENCE TO VIETNAM:
EXPERIENCES OF
IMMIGRANTS AND REFUGEES
IN SASKATOON

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By

Rachael Smith-Lammie

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ABSTRACT

This thesis focuses on the experiences of Vietnamese immigrants and refugees in accessing health care services in Saskatoon. Within Canada, terms such as *immigrant* and *refugee* are assigned to reflect the differing circumstances that “newcomers,” i.e. foreign-born residents, arrive under, who are typically classified as either temporary or permanent residents (Gushulak et al. 2011). Research has suggested that newcomers to Canada from non-European countries tend to under-utilize health services (Curtis and MacMinn 2008; Luu, Leung and Nash 2009; O’Mahony and Donnelly 2007; Whitley, Kirmayer and Groleau 2006), while language and cultural differences are cited as barriers to health care (Asanin and Wilson 2008; Gushulak et al. 2011; Kirmayer et al. 1996). Qualitative health research regarding Vietnamese immigrants and refugees in Saskatchewan is currently lacking. The purpose of this study was to elicit a deeper understanding of experiences in accessing health care services through open-ended interviews. A total of 14 interviews were conducted regarding the health care experiences of members of the Vietnamese community in Saskatoon. The aim was to examine the possible socio-cultural determinants affecting the experiences of this study’s participants, to explore whether or not these determinants resulted in health care under-utilization, and to determine areas for future research, particularly, in working to resolve barriers to care for immigrant and refugee groups.

Participants iterated the challenges that newcomers face in accessing health care, such as language, cultural, geographical, and socio-economic differences, as identified within the literature. However, the most elaborate responses given by the Vietnamese-born participants in this study were built around references to Vietnam (their country of origin). In particular, they described their experiences in Saskatoon through comparisons of health care and larger

socio-economic circumstances in Vietnam. While participants described both positive and negative experiences, the consensus was that health care is generally better in Canada than in Vietnam. This thesis illustrates the value of examining the participants' descriptions of Vietnam in understanding their experiences with health care in Saskatoon. These findings contribute to a contextual understanding of the socio-cultural determinants affecting the experiences of immigrants and refugees. I follow previous research studies to suggest that the cross-cultural contexts of health and illness need to be continually explored in health research regarding immigrants and refugees.

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INTRODUCTION

Background

This thesis concerns the health care experiences of Vietnamese immigrants and refugees in Saskatoon. Terms such as *immigrant* and *refugee* are assigned to reflect the differing circumstances under which “newcomers,” i.e. foreign-born residents, arrive to Canada, who are typically classified as either temporary or permanent residents (Gushulak et al. 2011).¹ Research has suggested that newcomers to Canada from non-European countries tend to under-utilize health services (Curtis and MacMinn 2008; Luu et al. 2009; O’Mahony and Donnelly 2007; Whitley et al. 2006), while language and cultural differences are cited as factors affecting access to health care (Asanin and Wilson 2008; Gushulak et al. 2011; Kirmayer et al. 1996). However, the distinction between foreign and Canadian-born, often cited within health research, does not fully account for the factors affecting experiences and patterns of service utilization for specific groups arriving under different circumstances.² Furthermore, research conducted with marginalized Canadian-born individuals also reveals issues regarding health care access and service utilization.³ Variables such as length of time in Canada, age, socio-economic status, and gender also impact people’s experiences, which will be explored in this thesis.

¹ According to the Government of Canada, “a refugee is different from an immigrant, in that an immigrant is a person who chooses to settle permanently in another country. Refugees are forced to flee” (Government of Canada [1]).

² There has been a tendency within health research to introduce an overarching comparison between immigrants and non-immigrants (Leduc and Proulx 2004), even though more nuanced variations and complexities are also addressed. The term “immigrant” is often used as an umbrella term to include foreign-born residents who arrive under various statuses, where the distinction between “immigrant” and “refugee” is not always clearly articulated. For examples see Dunn and Dyck 2000; Lebrun 2012; Newbold 2009; O’Mahony and Donnelly 2007. As such, I adopt the term “newcomers” to refer to foreign-born Canadian residents who have arrived under a variety of different circumstances.

³ For examples see Browne, Fiske, and Thomas 2000; NCCAH Report 2011; and Reading and Wein 2009.

Researchers have used the term the *healthy immigrant effect* (HIE) to suggest that immigrants are healthier upon arrival than the mainstream population, but that this health advantage declines over time (Chen, Ng and Wilkins 1996; Islam 2013; MacDonald 2006; Ng, Pottie and Spitzer 2011). However, based on a review of the available literature regarding the HIE, Islam (2013) suggested that more research is needed, particularly concerning mental health, to account for the factors affecting health status. The HIE “may actually depend on the immigrant wave being analyzed...have more to do with country of origin and circumstances of migration than with immigrant status” (Islam 2013:173). Further, utilization and health status may not be directly correlated, particularly among refugees who might have experienced traumatic events prior to migration (Islam 2013; Kirmayer et al. 1996). O’Mahony and Donnelly (2007:454) reported that “depression and anxiety are the most common mental health problems among immigrants,” but how some groups are hesitant to use services for various reasons such as language and cultural barriers.

More than 20 percent of Canada’s population is comprised of people born outside of Canada (Asanin Dean and Wilson 2010; Gushulak et al. 2011). However, “despite this rapid and continuous increase in the cultural diversity of the Canadian population, the unique health needs of immigrants have not received adequate attention” (O’Mahony and Donnelly 2007:454). Research indicates that the health of newcomers was an under-researched area of study, where past studies focused on economic growth and development (Laroche 2000). While conducting a nation-wide review of research on immigrant health, Ilene Hyman (2001:14) found that “variables such as country of origin, visa category (immigrant or refugee), or English-language proficiency” had not typically been explored in detail. More recent research regarding the health of immigrants and refugees can be found within several

disciplines, including interdisciplinary research regarding the social and biomedical sciences from journals such as *Qualitative Health Research* (for examples see Kim, Heo and Park 2014; Kosny et al. 2014; O'Mahony and Donnelly 2007; van der Velde, Williamson and Ogilvie 2009). These studies have contributed to a more comprehensive understanding of the determinants of health and health status of various groups of foreign-born Canadian residents, which will be expanded upon in the next chapter.

In recent years, the province of Saskatchewan has implemented changes to its immigration policy to promote population and economic growth (Government of Saskatchewan 2009). There is a lack of qualitative health research regarding Vietnamese immigrants and refugees in Saskatoon, yet the Socialist Republic of Vietnam is one of the countries listed in Table 9: Immigrants to Saskatchewan by Source Country - Top Ten 2009-2011 (Government of Saskatchewan 2011). As such, this study is intended to engage in open-ended interviews with members of the Vietnamese community in Saskatoon. I had fostered long-term connections with people from the community in my pursuit of learning the Vietnamese language over a five-year period. My interactions within the community inspired me to pursue this topic, with the intention that the findings could provide better understanding of individual experiences and generate questions for future research. Some of my Vietnamese-born friends had disclosed challenging aspects of their encounters within the Canadian health care system. Specifically, the fear of being misunderstood and frustration regarding cultural differences in how illness is treated were described.

Discussing the context of family caregiving in Canada, Donovan and Williams (2014) stated that the body of research related to Vietnamese families and their health care encounters was outdated, while primarily addressing only specific illnesses and health care

practices. Further, the authors suggested that this outdated knowledge “continues to inform the literatures specific to the delivery of culturally competent healthcare for Vietnamese populations,” even though it may not reflect current beliefs and practices (Donovan and Williams 2014:80). Studies suggest that more current research is needed to understand the health needs of this population in Canada as a whole. For example, Canadian Vietnamese scholar Tam Truong Donnelly (2008:158-159) found “no published findings about Vietnamese Canadian women’s breast and cervical cancer incidence,” despite the fact that Vietnamese women have “the highest cervical cancer incidence” in the United States.

Literature discussing the French occupation in Vietnam, from the 17th Century missionary presence to the battle of Điện Biên Phủ in 1954, has been criticized for presenting a simplistic understanding of the struggle for independence (Le 2011; Nguyen 2011).⁴ Nevertheless, the historical-political context surrounding the Fall of Saigon in 1975, including China’s economic sanctions against Vietnam in the 1970s, contributed to Vietnam’s subsequent economic reforms (Path 2012). The publically funded health care system of Vietnam was considered “well-structured” until governmental reforms and the privatization of services began in the 1980s (Huong et al. 2007; Luong et al. 2007). Geographically, the term *Indochina* refers to the Southeast Asian countries of Vietnam, Laos, and Cambodia (Beiser 1999). Of the 132,000 Vietnamese people who fled after the fall of Saigon in 1975, approximately 9,000 were settled in Canada (Beiser 1999). A second wave of migration occurred between 1979 and 1981 when approximately 60,000 people from Indochina came to

⁴ Le (2011) discussed the tendency of western scholarship to depict a colonial lens, biased towards the notion of “rescuing” the Vietnamese from their nationalist history, while failing to present more dynamic historical circumstances. Nguyen (2011) described how the response to French occupation has often been depicted as only a binary opposition between “collaborator” and “patriot.”

Canada to escape the tumultuous political upheaval occurring in Southeast Asia at the time (Beiser 1999).

More recently, the Vietnamese diaspora has been reported to be the fifth largest minority population in Canada (Donovan and Williams 2014; Statistics Canada 2011). Over half of Canada's Vietnamese population was born outside of Canada, where the largest waves of immigration were the refugee groups who came prior to 1991 (Donovan and Williams 2014). According to the 2011 National Household Survey, Canada included a total of 168,420 individuals enumerated with Place of Birth as "Viet Nam." The metropolitan centres with the largest population included: Vancouver = 23,380; Calgary = 14,995; Montréal = 25,885; and Toronto = 60,555 (Statistics Canada 2011). Based on the data collected for Saskatoon, 256,430 people provided information regarding birthplace, where 31,440 people reported being born outside of Canada, and 770 were from Vietnam (Statistics Canada 2011).⁵

Regarding Vietnamese immigrants and refugees, much of the available research has been conducted in the United States (Donovan and Williams 2014; Espiritu 2006). Espiritu (2006:410) discussed the over-documentation of Vietnamese refugees that over-emphasizes "specific ideologies about the US role in the Vietnam War and its aftermath" where the concept of the "Vietnamese refugee" does not account for a wider perspective of the war, life in Vietnam before or after the war, along with the multitude of Vietnamese people living in the United States arriving under various circumstances. Espiritu (2006:411) further critiqued the tendency to consider their participants as "objects of rescue," while urging researchers to

⁵ For comparative purposes, Mother Tongue listed as "Vietnamese" included the following: Canada = 144,885; Vancouver = 21,695; Calgary = 12,510; Montréal = 24,605; Toronto = 45,270 and Saskatoon = 680 (Statistics Canada 2011). While Place of Birth likely included individuals with other ethnicities who were also born in Vietnam (such as Hmong or Chinese), Mother Tongue is not exclusive to individuals who might have been born elsewhere, including Canada.

move beyond stereotypical notions of the “Vietnamese subject” and recognize the variations among different groups, ranging from “political exiles to immigrants to transmigrants, as well as a larger number of native-born” Vietnamese people.

The research objectives that guided the development of this study are as follows: 1) To what extent does narrative data from a social scientific lens provide nuances in understanding the determinants of health service utilization for Vietnamese immigrants and refugees in Saskatoon? and 2) To what extent are socio-cultural factors such as ethnicity, language, gender, age, socio-economic status, and traditional or religious beliefs discussed within the narratives and experiences of the participants of this study regarding health service utilization in Saskatoon? The outcome of this study will serve as a preliminary step towards identifying the possible factors influencing health service utilization among Vietnamese immigrants and refugees within Canada by promoting questions for future research.

Thesis Statement and Overview

The purpose of this study was to examine the qualitative descriptions of experiences elicited from volunteer participants about accessing health care services in Saskatoon. The main research objective of this study is to explore the extent to which language and cultural differences, which have been identified within the literature regarding Vietnamese immigrants and refugees, impact the health care experiences of Vietnamese immigrants and refugees in Saskatoon – a population where qualitative health research is limited. The most frequent and elaborate descriptions with the participants involved the discussion of experiences relating to Vietnam. *As such, this study posits that the use of Vietnam as a reference point is central to the participants’ discussion of health care. The participants draw*

on their past experiences in Vietnam to understand and describe their present experiences with health care in Saskatoon.

Chapter One highlights the literature regarding health care service utilization among newcomers to Canada, Vietnamese immigrants and refugees, cross-cultural and qualitative health research. Chapter Two introduces the theoretical orientation that informed the approach to designing this project, along with the methodology regarding data collection and analysis. In Chapter Three, I illustrate the initial responses to the interview questions and discuss the most prevalent themes that occurred throughout.

Chapter Four includes a discussion of how references to Vietnam are essential to understanding the participants' descriptions of health care in Saskatoon. Specifically: 1) the participants described health care through comparisons to Vietnam; 2) larger thoughts regarding diet, the environment, and knowledge provided deeper understanding regarding these descriptions; and 3) the participants indicated that health care, and other circumstances, in Canada are "better," than they are in Vietnam. Whether or not the participants discussed positive or negative aspects of their experiences with health services, they invoked past experiences to discuss the present. Experiences in Vietnam, as their country of origin, are inherent within this past-present comparison. Based on these findings, I follow previous research studies to suggest that the cross-cultural contexts of health and illness need to be continually explored in health research regarding immigrants and refugees.

CHAPTER 1

LITERATURE REVIEW

The following search engines and databases were consulted: Google Scholar, JSTOR, PubMed, University of Alberta NEOS catalogue, and University of Saskatchewan Usearch catalogue. Particular key words and phrases included: *Vietnamese; Canada; health care services; utilization; immigrants; refugees; Saskatchewan; Saskatoon; and qualitative health research*. Specific journals presumed to hold particular relevance to this topic were also consulted, such as, *Medical Anthropology Quarterly, Social Science & Medicine, and Qualitative Health Research*. The main topic included qualitative research regarding the health service utilization of Vietnamese immigrants and refugees in Canada, and in Saskatoon in particular. In addition to this specific topic, literature regarding two larger, related topics was also consulted: 1) health research regarding immigrants and refugees in Canada, and 2) cross-cultural and qualitative health research.

The purpose of this literature review is to provide context and background information regarding the thesis topic: health service utilization and descriptions of health care experiences of Vietnamese immigrants and refugees in Saskatoon. In this review of literature, I present: 1) an overview of the findings regarding immigrant health and service utilization in Canada. Some of the main themes from the studies that were found pertained to determinants affecting health care experiences, such as: the healthy immigrant effect, language and cultural differences, acculturation, gender, age, and socio-economic status; 2) a review of the health research conducted with Vietnamese immigrants and refugees in particular; and 3) an introduction to cross-cultural and qualitative health research, which promote a deeper understanding of the barriers to care for immigrants and refugees in Canada.

Immigrant Health and Service Utilization in Canada

Overview

Research indicates that approximately 20 percent of the current national population consists of people who were born outside of Canada (Asanin Dean and Wilson 2010; Gushulak et al. 2011; Newbold and Danforth 2003; Wang and Hu 2013). Being a multi-cultural society, immigration is important to Canada (Donnelly 2002). However, the health needs of immigrants, refugees, and other newcomers to Canada have not been given sufficient attention in past years (Hyman 2001; Laroche 2000; O'Mahony and Donnelly 2007). More recently, research regarding the health of immigrants and refugees has become a focus within many disciplines, some of which will be reviewed in this chapter. Regarding health service utilization, several groups within Canada have been found to display a lower rate of use. For example, geographic barriers have been cited regarding Canada's rural populations (Pong et al. 2011); marginalized Canadian-born individuals also experience issues with health care access and service utilization (Browne, Fiske, and Thomas 2000; Reading and Wein 2009); and various groups that comprise Canada's foreign-born population have been cited to under-use health services (O'Mahony and Donnelly 2007; Sinding 2010; Wang and Hu 2013).

Individuals coming to Canada arrive under various circumstances, and are typically classified as either temporary or permanent residents (Gushulak et al. 2011). For immigrants arriving to Canada with the intent to remain as permanent residents, the Government of Canada website states that all individuals must undergo a medical examination by a CIC-approved physician prior to immigrating, while also stating that students and temporary workers may also be expected to undergo medical screening (Government of Canada [2]). Refugee claimants (individuals waiting to know if their application to stay in Canada will be accepted) have been covered for emergency health care under the Interim Federal Health

Program (Merry et al. 2011). Currently, the Interim Federal Health Program (IFHP) is under appeal; according to Citizen and Immigration Canada “effective November 5, 2014, the Government of Canada will implement temporary measures while appealing the July 4, 2014 Federal Court decision concerning the IFHP” (Government of Canada [3]).

Created in 1957, the IFHP was repealed in 2012 by the federal government to propose changes that will alter who is eligible and what they will be covered for (Evans et al. 2014; Olson et al. 2014). While the IFHP was set up to provide temporary and limited coverage for specific refugee groups, such as claimants, rejected claimants, and individuals protected under the Immigrant and Refugee Protection Act (Olsen et al. 2014), the specific impact of the IFHP changes on the health of refugees is not yet well-known (Evans et al. 2014). However, those in need of care for conditions such as diabetes, mental illness, and maternal health will be affected, as coverage for medications will only be provided if a condition is considered a public health risk (Evans et al. 2014; Olsen et al. 2014). One of the negative consequences already occurring is the confusion over interpreting who should be covered, based on the modifications and cutbacks that this program has already seen (Evans et al. 2014).

Healthy Immigrant Effect

Research regarding the *healthy immigrant effect* (HIE) suggests that immigrants are in better health upon arrival compared to the majority of the Canadian-born population, yet often lose this health advantage over time (Chen et al. 1996; Curtis and MacMinn 2008; Islam 2013 MacDonald 2006; Ng et al. 2011). The notion that immigrants receive medical examinations prior to immigrating has provided some evidence that most people should be in

relatively good health when they arrive to Canada (Chen et al. 1996; Gushulak et al. 2011; Laroche 2000). Past studies have also suggested that people in ill health are less likely to migrate to new countries (Chen et al. 1996; MacDonald 2006). While these findings imply that health service utilization is affected by health status, studies also suggest that more research is needed to investigate factors influencing health care service utilization beyond the notion of the *healthy immigrant effect* (Islam 2013; McDermott et al. 2010). For example, Islam (2013) identified that the circumstances of migration and country of origin are determinants where more research is needed.

Research has also suggested that the HIE overlooks factors relating to mental health (Islam 2013; Whitley et al. 2006), particularly concerning refugees, who may have experienced traumatic events prior to immigrating (Gabriel et al. 2011; Kiramyer et al. 1996).⁶ In past years, research in Canada has found that psychological ailments might have gone undetected during medical screening for refugee populations settling in Canada during earlier immigration waves (Fowler 1998; Strand and Jones 1983), such as the approximate 60,000 Southeast Asian refugees settled in Canada between 1979 and 1981 (Beiser 2009). Regarding this population, researchers identified that under-utilization of mental health services did not indicate a lack of need (Dinh et al. 2009; Kirmayer et al. 1996; Luu et al. 2009) and that issues were under-diagnosed due to cross-cultural differences in conceptualizing health and illness (Buchwald et al. 1995; Dinh et al. 2009). However, other studies suggested that issues of mental illness were not widely prevalent across all groups of

⁶ During a discussion of the HIE among Soviet and Bosnian refugees in the United States, the authors explain how refugee populations are often subsumed under the larger immigrant/newcomer umbrella, and how the HIE does not adequately address their unique health concerns (Garbriel et al. 2011).

refugees, but were present mainly for those who had experienced severe levels of trauma (Beiser 2009).

Language and Cultural Differences

Researchers suggest that other factors affect health care access, not just health status. Particularly, language and cultural differences can act as barriers to communication and care (Fowler 1998; Gushulak et al. 2011; Kirmayer et al. 1996; Kleinman 1986; Zanchetta and Poureslami 2006; Whitley et al. 2006). Specifically, researchers have reported how language differences can constitute an obstacle for various immigrant and refugee groups in accessing health care (Beiser 1998; Katz 2012; Lai and Chau 2007; Stephenson 1995; Wood and Newbold 2012). It has also been suggested that cross-language research poses challenges, particularly in ensuring that meaning is understood between researchers and participants (Kosny et al. 2014). Other factors that affect utilization rates have been described as: lack of knowledge about what services are available (Beiser 2009; Lai and Chau 2007; Ng and Newbold 2011; Zanchetta and Poureslami 2006), the use of traditional or other methods of treatment (Luu et al. 2009; Zanchetta and Pourselami 2006), long wait times⁷ (Lai and Chau 2007; Wu, Penning, and Schimmele 2005), and issues regarding the availability of culturally sensitive health services (Asanin and Wilson 2008; Wood and Newbold 2012; Zanchetta and Poureslami 2006).

It has also been described that newcomers to Canada will be less likely to access services on a regular basis because they have had previous negative experiences as a result of these barriers (Kirmayer et al. 1996; Laroche 2000). Kirmayer et al. (1996) also found that

⁷ Long wait times have also been cited to affect Canadian-born participants, which will be discussed in Chapter Three.

many of their participants were reluctant to use services because of fear that health care professionals would not be sensitive toward cultural differences. Advances regarding cultural competency and culturally appropriate services have been made within health care and health research. However, obstacles to cultural sensitivity in clinical settings have also been cited more recently (Asanin and Wilson 2008; Song, Hamilton and Moore 2012; Wang 2007; Wood and Newbold 2012; Zanchetta and Poureslami 2006). Asanin and Wilson (2008) noted that finding culturally appropriate services in close proximity is a significant issue for many of the immigrant and refugee participants in their study.

Acculturation

Another element within health care literature with varied findings is the notion of *acculturation*. “Acculturation” involves “culture change which results from continuous, first hand contact between two distinct cultural groups” (Berry 1987:491–492).⁸ MacDonald (2006) suggests that the longer immigrants reside in their country of adoption, the more likely they are to display similar behavioural patterns to the people from their host country. It can be presumed that if immigrant health declines over time, then utilization of services would increase over time (Hyman 2001). However, Kirmayer et al. (1996) found that the length of time spent in Canada did not increase immigrants’ frequency of utilization. Some researchers have suggested that studies need to further articulate and explore how the term *acculturation* is defined (Strand and Jones 1983) and to distinguish between cultural and personal differences in conceptions of health that may affect people’s utilization patterns (Vega and Rumbaut 1991).

⁸ The initial research on acculturation is largely attributed to the cross-cultural psychologist John Berry (Hyman 2001; Kirmayer et al. 2007).

The definition of *acculturation* has been explored within qualitative health research more recently. For example, Kim et al. (2014:1139) posit that *acculturation* includes “the process of embracing and/or navigating a new culture.” In response to the focus of acculturation research on non-European immigrants in North America, the authors explored this process among western immigrants in Korea. Their analyses illustrated that despite challenges adapting, the participants claimed that the immigration experience had a positive impact on their health and well-being.⁹ Hunt, Schneider and Comer (2004) found that acculturation has become a common variable within research on health disparities regarding certain ethnic minority groups in the United States, but that key concepts such as the definition of culture are often ill-defined. In a critical review of the literature on *acculturation*, Salant and Lauderdale (2003) identified conceptual and methodological issues within this growing body of research regarding the use of this term. Specifically, the authors found that “that measurement difficulties posed by the experiences of heterogeneous Asian groups compound theoretical and disciplinary disparities between acculturation instruments” (Salant and Lauderdale 2003:71). In reference to the length of time spent in one’s host country, Lebrun (2012) found that more recent immigrants will be less likely to have family physician and regular access than more established immigrants.

Gender, Age and Socio-Economic Status

In addition to length of time in one’s host country and acculturation variables, other determinants, such as age, gender, and socio-economic status are discussed as factors that impact health care utilization within the literature on immigrants and refugees (Newbold and

⁹ Kim et al. (2014) also discussed how research indicates that the acculturation process can be difficult and stressful for many immigrants.

Danforth 2003; Pottie et al. 2008). Lai and Chau (2007) reported how factors affecting elderly immigrant people can differ from other age groups, but how earlier studies have not adequately addressed this variable. Their participants from the Chinese immigrant community (N = 2,214; Mean = 67.74) reported similar themes, such as language difference being a main issue; however, the authors also found that older women from communities where patriarchy might be more prevalent could be at a higher risk of being disadvantaged, in terms of access to knowledge and resources, than their younger counterparts (Lai and Chau 2007).

Gender inequalities among immigrant and refugee groups in North America have been widely discussed (see Erving 2011; Rahman and Witenstein 2014; Read and Reynolds 2012). In a critical review concerning post-partum depression among immigrant and refugee women in Canada, O'Mahony and Donnelly (2010:923) found that "gender sensitive research has become more focused on the notion of intersectionality, meaning that gender is experienced by women at the same time as their experiences of class, race and sexual orientation and any other forms of social difference." Lu and Racine (2015) also demonstrated the value of conducting critical analyses from a post-colonial feminist perspective regarding the diversity of experience among Chinese immigrant women in western countries. Specifically, the authors identified how there is a lack of research that recognizes the heterogeneous social, economic, and cultural characteristics of this population in relation to their experiences with health care.

Socio-economic class as a contextual factor affecting immigrant and refugee experiences with health care has also been explored. Individuals from economically disadvantaged circumstances are at a higher risk of experiencing factors that may compound language and cultural differences, such as financial constraints that impact access to services

(Beiser 2009; Kirkham et al. 2002; O’Mahony and Donnelly 2010). For example, O’Mahony and Donnelly (2010), in their study regarding post-partum depression among Vietnamese immigrants and refugees, reported that women of lower socio-economic status were more likely to report a lack of support in accessing education on post-partum care.

Mental Health

While advances in knowledge regarding the mental health needs of immigrant populations have been made, researchers and practitioners still face “challenges of defining and operationalizing key concepts and dimensions” (Khanlou and Jackson 2010:3). Research also suggests that there is still a lack of diagnostic tools that are culturally sensitive and available to health professionals (Khanlou and Jackson 2010; Mustafaeva and Shercliffe 2010; Wood and Newbold 2012).¹⁰ Other factors affecting the utilization of mental health services have been described to include: shame, stigma, cross-cultural differences in expression, and family values (Kirmayer et al. 1996; Mak and Zane 2004; Wood and Newbold 2012). Kirmayer et al. (1996:127) also found that “other important barriers to care include...mistrust of the health care system and practical obstacles including getting time away from work.” Limited longitudinal data regarding mental health for immigrant and refugee groups has been identified more recently (Gabriel et al. 2011; Khanlou and Jackson 2010).

¹⁰ In a critical review of culturally sensitive treatment measures that are used in the United States for depression, Kalib and Leong (2014) found that health disparities for ethnic populations still exist.

Vietnamese Immigrants and Refugees

Canada's Vietnamese population has recently been reported to be the fifth largest minority population in the country (Donovan and Williams 2014; Statistics Canada 2011). Findings regarding the experiences of Vietnamese immigrants and refugees in past years have been consistent with the larger pool of research on immigrant health, particularly concerning how under-utilization does not indicate a lack of need (Kirmayer et al. 1996; Luu et al. 2009). The Vietnamese, and other refugees from Southeast Asia who came to Canada during the post-war era, were found to under-utilize health services, mental health services in particular (Hoang and Erickson 1985; Ito 1999; Luu et al. 2009). However, mental illness was considered to be higher than what was reflected by utilization rates (Kinzie 2006; Kirmayer et al. 1996; Luu et al. 2009; Phan 2000).¹¹ Research regarding refugees from countries with more recent war and conflict reflect the same patterns of issues and under-utilization that were reported for Vietnamese refugees during the earlier immigration waves (see Gabriel et al. 2011; McKeary and Newbold 2010; Merry et al. 2011). Research also indicates that challenges to accessing services for Vietnamese immigrants also exist more recently (Donnelly 2008; Donovan and Williams 2014; Ho and Birman 2010; Kirmayer et al. 2007; McBrien 2011).

It has been suggested that the more Vietnamese immigrants subscribe to traditional beliefs, the less likely they are to access western services (Luu et al. 2009). Researchers describe that mental illness is a stigma within many eastern cultures (Kirmayer 1996; Lin et al. 1985), largely based on traditional beliefs that relate mental illness to "malevolent spiritual

¹¹ Vietnamese scholar Phan (2000) reported on a study from the United States that found utilization of specialized outpatient mental health clinics to be virtually non-existent among Vietnamese refugees, while indicating that immigrants from Southeast Asia displayed the lowest levels of utilization in comparison to other immigrant groups in Canada and in the United States.

beings, curses, imbalance between the body and spirit, and lack of blessings from a religious person” (Luu et al. 2009:480). Some of these beliefs have roots in Traditional Chinese Medicine, such as the concept of Yin and Yang (Nguyen 1985; Phan et al. 2004), and “hot–cold” theories of illness, which can manifest as cultural idioms that lead to illness, such as being “hit by the wind” (Hinton et al. 2003).¹² However, other research suggests that “the extent to which the experiences of the Vietnamese diaspora is still reflective of indigenous Vietnamese counterparts living in Vietnam is far from clear” (Phan et al. 2004:219).

Based on these findings, tradition and belief may affect utilization and experience. However, it has also been suggested that French occupation, and more recent economic and market reforms, have brought western beliefs and practices to Vietnam (Monnais and Tousignant 2006; Phan et al. 2004). The notion of “tradition” or “modern” belief systems are not always so clearly distinct, as discussed by Monnais and Tousignant (2006) in their research on medical pluralism in Vietnam. Huong et al. (2007) describe how before Vietnam’s shift toward modernization and market reforms that began in the 1980s, health care was publically funded. The move toward privatized health care decreased access to and affordability of health services for the majority of people in Vietnam (Huong et al. 2007; Luong et al. 2007).

Evidently, factors beyond traditional beliefs as factors affecting health service utilization need to be considered. One study found that marital status and levels of education

¹² According to Phan et al. (2004:202), well-being is dependent upon a balance of Yin/Yang energy or *Qi*, where a person’s state of health is influenced by both external/environmental and internal forces; these “biophysiological and cosmological frameworks of health regard body–mind as a circle of interaction between internal organs and their emotional aspects.” For a more detailed discussion of Traditional Chinese Medicine, see Yanchi 1995. Phan et al. (2004) also recognize that having a high degree of colonial influence, Vietnam displays western concepts of health, along with more traditional folk concepts, and not just Traditional Chinese Medicine.

were the main predictors affecting utilization among their study with Vietnamese immigrants (Buchwald et al. 1995). Specifically, Buchwald et al. (1995:344) stated that “the multivariate analysis excluded sex, age, and duration of residence as predictors of depressive symptoms, yielding marital status and educational level as the most salient factors.” A previously conducted study regarding health service utilization discussed how “although lack of education is also a commonly cited utilization barrier...education is not related to utilization among the most recently arrived immigrants” (Strand and Jones 1983:1090). Information provided about the available health services was found to be more of an issue than education levels (Strand and Jones 1983).

While interviewing health care professionals and Vietnamese patients in Victoria, British Columbia, Stephenson (1995) found that language and issues of interpretation were cited by both groups as being the main challenge. Stephenson also found health professionals to report that Vietnamese patients typically presented serious health issues, never anything trivial, while suggesting that most of their Vietnamese patients could have accessed services sooner. Health care providers also said that a lack of psychiatric assistance for this population was a serious issue (Stephenson 1995). The availability of culturally competent measures of health care delivery has become an important area of study (Vega 2005). Research conducted in the United States, for example, with Asian Americans suggests that there are issues concerning the educational procedures designed to address cultural competency (Park et al. 2011) and a lack of health professionals who are able to provide culturally and linguistically competent services (Lee et al. 2009). The discussion of cultural competency will continue in the next section of this review in more detail.

Another study found that age was the most prevalent variable affecting mental health, where older Vietnamese immigrants and refugees were considered more susceptible to depression (Dinh et al. 2009). While the researchers did not find gender to be a factor in their findings, they described that the majority of research with Vietnamese refugees suggested that females are more likely than males to display symptoms of depression (Dinh et al. 2009). This could be related to several factors, including instances of post-partum depression, (O'Mahony and Donnelly 2010; Sutton et al. 2007). Donnelly (2008:159) stated that "there is very limited information on how cultural concepts of health and illness, social relationships, gender and socioeconomic status that are specific to the Canadian social context affect Vietnamese Canadian women's breast cancer and cervical cancer screening."

Regarding Vietnamese immigrants and refugees in Canada, past research has suggested that:

The most important factors appear to be the understanding and interpretation of psychological symptoms, the desire to deal with personal problems on one's own or within the family and the perception that health care professionals who understand the immigrants' cultural background are not available (Kirmayer et al. 1996:14).

More recent studies also support the notion that culturally sensitive services are still necessary for Vietnamese immigrants and refugees (Donovan and Williams 2014; Steel et al. 2002; Sutton et al. 2007; Truong et al. 2011). In addition, Sutton et al. (2007) described how a lack of knowledge of the available services, transportation issues, and language issues were also

reported as barriers in their study with Vietnamese women regarding the need for pre-natal and post-partum health services. While Donovan and Williams (2014:79) discussed the importance of culturally appropriate services, they also indicated that the Vietnamese family caregivers in their study were “likely to use healthcare and social services if they are language-accessible, built on trust and demonstrate respect for their values as individuals.”

Vietnam was reported to be one of Saskatchewan’s top ten source countries of immigrants from 2009-2011 (Government of Saskatchewan 2011). As outlined in the introduction section of this thesis, the amount of qualitative research regarding health service utilization among Saskatoon’s Vietnamese community is lacking. Searching for qualitative-based health research relating to Vietnamese immigrants and refugee in Canada, as well as other western countries, more generally elicits more results (see Auroa et al. 2014; Donnelly 2008; Donovan and Williams 2014; Groleau and Kirmayer 2004; Hyman and Dussalt 2000; Jenkins 1994; Truong et al. 2011), which will be discussed further below.

Cross-Cultural and Qualitative Health Research

Responses to Biomedicine

One of the roles of cross-cultural health research is to illustrate how biomedicine is a culturally constructed system, while acknowledging that the biological experience, expression, and interpretation of illness cannot be separated from the socio-cultural context in which it exists (Charon 2006; Fabrega 1990; Kleinman 1973; Mishler 1981). Within biomedicine, cultural difference is often perceived as a variable that masks the “true” origins of disease, where health professionals often assume that “culture” is separate from the underlying biological problem (Littlewood 1996; Vega and Rumbaut 1991). While biomedicine and “western medicine” are often used synonymously (Finkler 1994; Wiseman

2004), medical practices do not have a single origin. Social scientific inquiry has suggested that the expression of illness is shaped by the socio-cultural context in which it occurs (Kleinman 1986; Obeyesekere 1985), as are the diagnostic procedures that seek to define categories of health and illness (Good 1994; Kleinman 1973; Mishler 1981).

Mishler (1981:1) identified a key assumption in biomedical discourse: “the presupposition that there are specific disease entities, each associated with a specific biological process.” This assumption underlies medical thought and leads to the assumption that the “true” origins of disease are inherently biological, with specific symptoms, which are considered separate from social or cultural facets of human life. More recently, Cora-Bramble, Tielman and Wright (2004:107) described the importance of recognizing cultural diversity within the biomedical model, while providing an example of differences that may lead to confusion and miscommunication: “western cultural norms suggest that maintaining direct eye contact conveys a sense of integrity, sincerity, and good will. Hmong families may consider maintaining friendly eye contact a disrespectful intrusion into personal space.”¹³

Western medicine has been characterized by its compartmentalization and specialization of diagnostic criteria and treatment procedures, which is ultimately expressed as a division between general medicine and psychiatry (Fabrega 1990). Cross-cultural theories caution against this “false dichotomy”: a dichotomy which espouses the assumption that western medicine relies on a mind-body duality, compared to non-western practices that are considered to be more holistic (Halliburton 2002). It is important to recognize that cross-cultural differences in conceptions of health and illness are more complex than a western/non-

¹³ For a tragic example of the consequences to such communication barriers within health care settings, see *A Spirit Catches You and You Fall Down* (1997). Written by journalist Ann Fadiman, it pertains to the death of a Hmong child of a refugee family in California and the clash between the western and traditional perspectives regarding her condition.

western distinction. For example, Ots (1990:26) suggested that a difference between western and Chinese theories are not reducible to a western mind/body vs. Chinese holism dichotomy; rather, the distinction is how certain Chinese theories include the notion of an emotional body, where the “Chinese are culturally trained to “listen” within their body.” To account for the unique and complex variation in conceptions, some researchers have adopted a broad definition of health that “encompasses mental, economic, social and spiritual well-being” (Young, Spitzer and Pang 1999:6).

The western medical emphasis on dichotomies has in part led researchers to highlight the importance of studying cross-cultural variation. Significantly, the way in which the term *culture* has been operationalized is inconsistent across disciplines.¹⁴ As such, researchers in the social sciences have called for a more comprehensive definition, which “would begin with an assumption that in any “community” or “society,” there will be multiple, subdominant and partially submerged cultural traditions” (Keesing 1990:57). The definition of culture has also evolved within health research. For example Kirkham et al. (2002) reported how the concept of culture has often been construed as being a fixed entity, where cultural groups have been positioned in opposition to “mainstream” culture. Health researchers have described theories that include more interpretive frames, such as post-colonial theories that provide “insights into racial prejudices, discrimination, and disadvantage throughout the history of Canada” (Kirkham et al. 2002:226). O’Mahony and Donnelly (2007:457) have recognized that “culture

¹⁴ For example, in the 1990s cross-cultural psychiatrists lobbied for the inclusion of “culture” in the 4th edition of Diagnostic and Statistical Manual of Mental Disorders. Their objectives were misinterpreted, and “culture” in the DSM–4 appears within the appendix section, reflecting the notion that cultural difference is separate from the biological experience of illness (Mezzich et al. 1999). The latest version, DSM–5 (American Psychiatric Association 2013) includes a chapter on “Cultural Formulation” in Section III, and expands on the importance of understanding the cultural contexts of illness.

must be seen in its particular context in relation to historical, economic, political, and geographic elements.” The view that culture is not static or unitary adds to the understanding of cultural sensitivity practices within health care settings. These practices encourage health professionals to recognize that not every individual from a particular cultural group will display identical expressions of illness (Kleinman and Benson 2006).

Cultural Competency and Qualitative Health Research

Cultural competency “addresses the concepts of cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounter” (Montenery et al. 2013:52). Campinha-Bacote (2002:181), the original author who developed this model, stated that cultural competency should be “the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community).” This model stresses the importance of viewing cultural competency as a *process*, as well as the importance of recognizing the diversity that exists within cultural groups (Campinha-Bacote 2002). An example of the value of this approach is illustrated by Phan and Silove (1997:87) who identified that there has been a “mistaken tendency to stereotype all Asian refugee-immigrants as behaving homogeneously in the clinical setting and as holding the same values of health and health care.”

Qualitative health research has become more common within health disciplines that have traditionally used more quantitative-based methods (Caldwell, Henshaw and Taylor 2011; Sandelowski and Leeman 2012). Janice Morse, editor of the *Qualitative Health Research* Journal (established in 1991), has been a leader in the development of qualitative methods within health disciplines such as nursing (see Morse 2011). In its early development,

Field and Morse (1985) described the purpose of applying qualitative approaches within nursing research. Particularly, they illustrated how qualitative methods are useful when seeking to describe the insider view, or an “emic” perspective, such as the perspective of patients. Critiques regarding qualitative research include how a universal set of standards is lacking, and how methods that are interpretive are difficult to generalize or replicate in other studies (Denzin 2009; Sandelowski and Leeman 2012). However, one of the goals of qualitative research has been described as theory-building, where measurements associated with more quantitative approaches, such as replicability, might be inappropriate in determining the reliability of qualitative data (Yardley 2000).

An example of the nuances that cross-cultural and qualitative health research can address relates to how translation issues extend beyond language difference. When words in one language are translated into another, meaning is not necessarily consistent across the socio-cultural contexts in which they are used. For example, when depressive-like symptoms in English are translated into Vietnamese along depression scales, a participant may typically choose between the feelings of “being sad” or “being very sad.” However, symptoms could be misinterpreted because, in Vietnamese, there is little distinction between an adjective such as “sad” compared to the adjective/intensifier such as “very sad” (Phan and Silove 1997).

The issue of translation can also be seen in how the concept of sadness or suffering is not always perceived of or experienced the same way across individuals or across cultures:

Although Vietnamese adhere to a diversity of religions, Buddhism has exerted an important influence on the development of the language and culture...Suffering can be transformed into an enlightenment experience

through the appreciation of the impermanence of earthly things... There is a risk that in the transcultural context the expression of *Duhkha* (*kho/rau/sau*) may be misconstrued as representing depressive symptoms, rather than an experience that is a virtue and indeed necessary in the quest for enlightenment” (Phan and Silove 1997:88).

In other words, while not all Vietnamese people identify as Buddhists, the semantic association between Buddhist beliefs about suffering and the word “suffering” is built into the Vietnamese language structure.

Obeyesekere (1985:135) described the western concept of *depression* as being: “a painful series of affects pertaining to sorrow.” He contrasted this with the idea of suffering as it is experienced and expressed among Sri Lankan Buddhists, where it is grounded into the larger existential idea about the inevitability of suffering in Buddhist thought. The implication is that while the word *depression* can be translated, the concept of *depressive-like* symptoms as they are defined in one cultural context may not accurately represent the meaning and experience within another. A study of Indochinese immigrants and refugees suggested that Buddhism is considered the most prominent religion within Indochina and how “seeking medical help for a physical pain may either be delayed or considered inappropriate” due to how suffering is conceptualized in terms of Buddhist thought (Hoang and Erikson 1985:232).¹⁵

¹⁵ Catholicism, and other religions, in Vietnam are also prominent.

Summary and Limitations

To summarize the literature findings related to health and service utilization among Vietnamese immigrants and refugees (both past and present): language differences may discourage utilization (Donovan and Williams 2014; Kirmayer et al. 1996; Stephenson 1995; Truong et al. 2011); previous negative experiences may discourage utilization (Kirmayer et al. 1996; Laroche 2000); stigma associated with conceptions of mental illness among many Asian cultures may decrease the use of western services (Mak and Zane 2004; Wood and Newbold 2012); traditional beliefs and practices may discourage utilization (Luu et al. 2009; Nguyen 1985; Phan et al. 2004); the availability of culturally sensitive services may be limited (Donovan and Williams 2014; Steel et al. 2002; Sutton et al. 2007; Truong et al. 2011); geographic issues regarding transportation exist (Asanin and Wilson 2008; Sutton et al. 2007); age, gender, and education are additional factors to consider (Buchwald et al. 1995; Dinh et al. 2009; O'Mahony and Donnelly 2010; Sutton et al. 2007); and the concept of health and illness, particularly mental health, may not maintain similar meaning or significance when translated from one language and cultural context to another (Hoang and Erikson 1985; Obeysekere 1985; Phan et al. 2004).

Regarding the literature specific to Vietnamese immigrants and refugees, the main limitation identified by this review that needs to be further explored is that the discussion of health service utilization among Vietnamese immigrants and refugees in Saskatoon is lacking. Studies found were most often conducted in larger urban centres, particularly within eastern Canada or the United States (see Asanin Dean and Wilson 2008; Buchwald et al. 1995; Groleau and Kirmayer 2004; and Truong et al. 2011). Regarding Vietnamese immigrants in Saskatchewan, one relatively recent qualitative study was found: Chow (2006) conducted a

survey-questionnaire study with immigrant university students from Vietnam in Regina pertaining to their educational experiences and degree of cultural adaptation.

Health research has been defined as “any study addressing understandings of human health, health behaviour or health services, whatever the disciplinary starting point” (Green and Thorogood 2009:5). Some researchers suggest that qualitative studies are limited, where the majority of health research draws from population health statistics, clinical, and more quantitative based methods (Asanin and Wilson 2008; Berkman 2011; Sinding 2010). Based on this review, it is evident that qualitative health research is a growing body of literature. However, there are critiques surrounding the reliability of qualitative research (Denzin 2009; Sandelowski and Leeman 2012). Further, there are debates regarding what constitutes qualitative health research and who should be conducting it. Discussing whether or not qualitative health research should be considered its own sub-discipline, Janice Morse (2010:1463) suggested that “a background in a health profession is crucial for the conduct of qualitative health research.” She also discussed both the advantages and disadvantages of “outsider” and “insider” health research, where the definition of “outsider” includes patients, as well as other researchers without a health-related background (Morse 2010).

Responses to critiques about the standards in qualitative research include advocating for multidisciplinary approaches (Berkman 2011; Lambert and McKevitt 2002).¹⁶ Multidisciplinary approaches have been critiqued for relying upon researchers operating in isolation from each other (Jessup 2007; O’Cathain, Murphy and Nicholl 2008). However, others have suggested that multidisciplinary approaches in health research are essential, as

¹⁶ Multidisciplinary approaches include research conducted by specialists from different disciplines, whereas interdisciplinary approaches are a combination or integration of approaches and methods (Jessup 2007).

they include the specialist knowledge of researchers from particular disciplines, not solely the use of qualitative methods employed by researchers from health disciplines: “we need research methods that are less generic, less atheoretical, and less narrowly focused, together with a more widespread application of concepts and knowledge originating in source disciplines” (Lambert and McKeivitt 2002:210). O’Cathain et al. (2008) identified that the characteristics of interdisciplinary, multidisciplinary, and mixed-methods teams have not been analysed in detail, but that team building and collaboration are key components to successful outcomes.

The purpose of this review has been to identify the key themes within the literature regarding immigrants and refugees in Canada, and Vietnamese immigrants and refugees in Saskatoon in particular. While advances have been made in health research to include qualitative methodologies, most of the studies consulted in this review were not conducted from a multidisciplinary approach. Multidisciplinary approaches in qualitative health research contribute to a deeper understanding of experiences of the immigrants and refugees within western health care settings, drawing on the knowledge of specialists from a variety of disciplines.¹⁷ Further, the research consulted within this review has identified that issues still exist for immigrants and refugees accessing health care in Canada, which need to be further explored. Multidisciplinary approaches involve the contribution of researchers from a variety of disciplines the specialist knowledge specific to their field of study. As a social scientist analysing the descriptions of health care experiences, the findings of this study add nuances from the field of medical anthropology to the study of immigrant health and health research.

¹⁷ For example, Mah and Ives (2010) described the positive impact that multidisciplinary teams within health care settings can have as being able to address the many different needs of their clients in their study regarding refugees with HIV in Canada.

Specifically, this study explores the complex nuances in the participants' descriptions, where they were able to draw on more than one "voice" to describe both the positive and negative aspects of their experiences, which will be explored in Chapter Four.

One of the goals of this study is to promote questions for future research in working to address these gaps. Based on this review, I have adopted a narrative interview approach and thematic analysis to explore the participants' experiences from a medical anthropological perspective. The collection of narrative data lends itself to a systematic analysis through the method of thematic analysis. In this light, the interview content and the consequent analyses are used to both highlight the unique aspects of individual experience, and identify shared experiences expressed through common patterns and themes.

CHAPTER 2 THEORY AND METHODOLOGY

In this chapter, I introduce the theoretical principles used to examine the main interview theme. First, a culturally relativistic understanding of the participants' references to Vietnam provides a more comprehensive discussion of their experiences.¹⁸ Second, I outline the anthropological theories of narrative and memory that are used to illustrate how the participants draw from their past experiences to describe the present. I also outline the perspectives that informed my approach to designing this project, along with the methodology used during the data collection and analysis. I describe the recruitment phase and the participants' demographic information. Finally, I discuss the methods of thematic analysis used to determine the most prevalent interview themes.

Theoretical Orientation

The investigative principle within which this thesis is written is *cultural relativism*. This core principle of modern-day anthropology is rooted within the early writings of Franz Boas, who sought a more comprehensive understanding of human civilizations than the unilinear, social evolutionary theories that dominated the 19th Century (see Herbert Spencer 1860 in McGee and Warms 2008). Melville Herskovits, a student of Boas, wrote that in adopting this theory as a method, “one seeks to understand the sanctions of behavior in terms of the established relationships within the culture itself, and refrains from making interpretations that arise from a preconceived frame of reference” (in Herskovits, ed. 1972:38). I concur that

¹⁸ A paradigm can be described as “a collection of logically connected concepts and propositions that provides a theoretical perspective or orientation that frequently guides research approaches towards a topic” (Field and Morse 1985:138). Hence, a theoretical approach or paradigm can be considered an over-arching group of theories or ideas in which concepts, perspectives and theories are interconnected and related.

cultural relativism is necessary to understand how the participants' discussions are shaped by a particular lens, i.e. norms, values, experiences, beliefs, practices etc., that are associated with Vietnamese culture, which guide the analysis of the interviews with this study's Vietnamese-born participants.¹⁹

Arising from this approach is the Sapir–Whorf Hypothesis, which has influenced two overlapping traditions that also contribute to the theoretical orientation of this thesis.²⁰ First, I draw from the socio-linguistic study of narrative to suggest that an interview can be analyzed as a single unit (see De Fina and Georgakopoulou 2012). Exploring the inter-relationship between language and social context allows for the understanding that the various themes and parts of each interview are connected. Second, my framework includes a socio-cognitive and linguistic understanding that meaning extends beyond what is verbally communicated during the interviews (see Carston 2009). This will be used to examine how the participants conceptualize and describe their experiences, while drawing from their past experiences in both explicit and implicit ways. As part of this discussion, the distinction between implicit and explicit (i.e. conscious and unconscious) mental processes will be explored (see Nosek 2007).

¹⁹ As noted in the literature review, a fluid definition of culture is needed to account for inter-cultural, as well as individual, variation. I recognize that “Vietnamese culture” is not a static phenomenon, and that individuals of Vietnamese descent will display a unique array of experiences. It is also important to recognize we must reconcile the notion of cultural relativism with the realism of health care practice, where evidence-based medicine is prominent.

²⁰ Initially developed within the Boasian school of anthropology, this hypothesis suggested that language structures influence thought and shape our cognitive processes. While the original hypothesis has since been critiqued for being too deterministic and for reflecting primarily western concepts, it has led to subsequent research from multiple disciplines, which further explore the relationship between language and culture (see Gumperz and Levinson 1996).

The main theoretical contribution to this thesis draws from anthropological theories regarding memory and narrative. I will illustrate how the participants tell stories about Vietnam to make sense of their experiences with health care in Saskatoon. The act of narrating or telling stories is central to how we understand and interpret the meaning within our experiences (Garro and Mattingly 2000). Particularly, stories of the past shape and bring meaning to how we understand the relationship between our past, present and future (Bruner 1997). References to Vietnam represent “the past” in the sense that they are comprised of the participants’ memories, i.e. their *mental models* (van Dijk 2009). Theories regarding the influence of mental models, the idea that “our understanding of new information is influenced by what we already know,” (Garro 2000a:277) is applied to explain how the participants frequently refer to experiences in Vietnam during their discussions of health care in Saskatoon.

This thesis contributes to the discussion that narrative expands the understanding of health and illness to include specific and important elements of experience that can be missed by quantitative methods. While research conducted through surveys and questionnaires elicits general, socio-demographic information regarding specific target groups, a more nuanced understanding at the level of individual experience is overlooked. As such, I adopt the *illness narrative* paradigm by conducting one-on-one interviews with volunteer participants. The importance of studying “illness narratives” was spearheaded by Arthur Kleinman; he wrote on how interpreting the meaning of illness from the perspectives of patients and their families “is a core task in the work of doctoring, although the skill has atrophied in biomedical training” (Kleinman 1988:xiii–xiv). By exploring the stories that people tell, narratives enable

researchers, as well as clinicians, to include a more comprehensive analysis regarding the meaning of experience.

The act of telling stories allows people to mediate between their individual experience, collective understandings, and the broader context of daily life (see Garro and Mattingly 2000; Groleau, Young and Kirmayer 2006; Hunt 2000; Kleinman 1988). A narrative interview approach provides participants the opportunity to expand the descriptions of their experiences in a manner that is meaningful to them. This approach is useful because it allows for a more detailed discussion about what is important from their perspectives. I adopted this approach because the health care experiences of immigrants and refugees, which involve language and cultural differences, need to be more clearly understood from the perspectives of immigrants and refugees themselves.

I expand on the framework developed by Linda Hunt and Nedal Arar (2001), where researchers contrasted the data collected from two focus groups, patients and practitioners, regarding “non-compliance” issues in the self-care of chronic illness management.²¹ In developing this framework, the authors emphasized how “this approach may prove especially useful for research aimed at a clinical audience, since it maintains a clinically relevant focus while giving serious consideration to the patient's perspective” (Hunt and Arar 2001:347). While I use this approach put forth by Hunt and Arar (2001) to guide the methodology, the focus of this study is not on the perspectives of health care professionals. Data collected from the health professional group served to augment the analysis with contextual understanding of the experiences of immigrants and refugees in Saskatoon. In accordance with the importance

²¹ A conceptual framework can be described as “a theoretical model developed to show relationships between constructs. It is often used in qualitative research for the identification of variables” (Field and Morse 1985:137).

of studying the perspectives of both patients and practitioners, I compared the themes elicited from three groups: Vietnamese participants who have accessed health services in Saskatoon, members of the community who have not accessed services, and health service providers, such as physicians and nurses who have worked with this population.

Recruitment and Participants

Formal ethical approval to conduct interviews with volunteer participants was obtained through the University of Saskatchewan's Behavioural Research Ethics Board. Recruitment posters were approved by the University of Saskatchewan and Saskatoon Health Region administration at the time of distribution. Thus, participation was elicited on a volunteer basis. Key informants were established in the community, which aided the recruitment process with Vietnamese-born participants. Snowball sampling became a means of recruitment, where the first two interviews led to subsequent interviews. Rapport within the community also aided the recruitment process where posters were distributed in various community locations, such as business establishments.

Participant confidentiality was ensured through a coding system, password protected data, and the use of pseudonyms. At the community level, participant involvement remained confidential, following the discretion of the participant. At no point during the study was the identity of participants revealed to other community members. After reviewing the ethical protocols with each participant (i. e. how the participant's personal confidentiality would be protected at all times; the participants' right to withdrawal any or all of their information from the study at any time prior to dissemination; a project description; proposed questions; the consent form; and how the data would be used) they indicated a willingness to participate by signing the written consent form.

Recruitment for volunteer participants was sought in two ways. First, posters with a project description and my contact information were placed in various settings: newcomer organizations, Vietnamese-owned businesses, community establishments, the Royal University Hospital, St. Paul's Hospital, Saskatoon City Hospital, and various places around the University of Saskatchewan campus, such as the International Centre. Second, recruitment for participants largely occurred via word-of-mouth among community connections I had made.

The intention was to elicit data from the following three groups, including an equal number of male and female adults over 18 years of age: 1) Vietnamese participants who had accessed health services in Saskatoon; 2) members of the Vietnamese community who had not accessed services; and 3) health service providers, such as physicians and nurses.

Following the methodology of Hunt and Arar (2001) who compared the perspectives of patients and practitioners, I sought to compare interview data from these three sub-groups. The theoretical rationale for including the sub-group of participants who had not accessed health care services was consistent with the literature review findings showing that Vietnamese immigrants and refugees were reported to under-utilize health care services (see Donnelly et al. 2009; Donovan and Williams 2014; Ho and Birman 2010; Kirmayer et al. 2007; McBrien 2011). The criteria of inclusion for each sub-group were:

- Members of the Vietnamese community who have accessed health care in Saskatoon: must be over 18 years of age; have accessed health care services in Saskatoon; and was born in Vietnam.

- Members of the Vietnamese community who have not accessed health care in Saskatoon: must be over 18 years of age; and was born in Vietnam.
- Health care professionals such as doctors and nurses, who have worked with immigrant and refugee communities in Saskatoon.

Recruitment elicited only one individual who was born in Vietnam, who had not accessed health care in Saskatoon since his arrival to Canada six months prior to the interview.²²

Recruitment for health professionals elicited a low participation rate; two mental health professionals volunteered to participate in interviews. Both mental health professionals are Canadian-born citizens and their native language is English. A key informant who was connected to the community was initially sought to assist with interviewing the Vietnamese-born participants. However, based on the confidentiality agreement outlined in the ethics approval process, and based on the discretion of the participants, interviews were conducted one-on-one instead. However, this also led to the inclusion from another sub-group: second generation Canadian-born individuals of Vietnamese descent. As such, the three sub-groups of participants elicited from the recruitment process who have been included in this study are (N = 14):

- 9 Vietnamese-born participants, all of whom were 18 years of age. An equal number of male and female participants were sought (see Table 2-1).

²² This interview focused more on his conceptions of health and health practices, which is discussed in Chapter Three and Four. The interview also supports one of the main themes: that health care in Canada is considered better than Vietnam, since the participant described hearing this from other community members, and that he would access services when needed.

- 3 Second-generation Vietnamese-Canadian participants, all of whom were 18 years of age, whose parents were born in Vietnam.
- 2 mental health care professionals who worked with immigrants and refugees at the time of this study.

The interviews with the Vietnamese-born sub-group comprised the focal point of the analysis. The intended criteria of inclusion and sampling strategy did not elicit enough participants for the type of comparative analysis outlined in the proposed methods. As such, the interviews from the health professional and second generation sub-group provided support regarding the analysis of the interviews with the Vietnamese-born participants. Further, the interviews with the health care professionals were conducted to provide a point of reference to Saskatoon's mainstream clinical context regarding their perspectives and experiences in working with immigrants and refugees. While the Vietnamese-born sub-group consisted of individuals with wide array of socio-demographics (see table 2-1), along with varying immigration statuses, one goal of the study was to promote questions for future research to be conducted with members of the Vietnamese-born community in Saskatoon, a study population where qualitative data regarding health care experiences is limited.²³

The demographics for the Vietnamese-born participants are presented in Table 2-1 (youngest to oldest):

²³ There are numerous ethnic groups in Vietnam, such as the Hmong people, who are not of Vietnamese descent, who are not represented within this study. There are also many people born in Vietnam who are of Chinese descent.

Table 2-1. Vietnamese-Born Participant Demographics

Pseudonym	Gender	Age	Length of Time in SK	Length of Time in CAN	Religious Affiliation	Accessed Health Care
Em Mai	Female	19	3 years	3 years	Catholic	Yes
Em Quý	Female	21	5 years	5 years	Catholic	Yes
Em Liên	Female	26	4 years	4 years	Catholic	Yes
Bạn Minh	Male	29	1.5 years	1.5 years	Cao Đài	Yes
Bạn Lành	Male	29	5 years	5 years	Catholic	Yes
Em Phương	Female	29	14 months	14 months	Catholic	Yes
Anh Ngái	Male	37	6 months	6 months	Buddhist	No
Chú Vân	Male	57	32 years	32 years	Buddhist	Yes
Chú Peter	Male	58	7 years	30 years	Christian	Yes

Two of the participants came to Canada as refugees after the War in Vietnam, and have been living here for over 30 years. Two of the more recently arrived participants were living in Saskatoon with applications for permanent residency at the time of this study. Four of the five university students already have family members living in Saskatoon and intended to apply for permanent residency. One student did not share the information pertaining to his/her immigration status. The three Canadian-born participants of Vietnamese descent were: Jane, Matt and Chì Kim. Having parents who were born in Vietnam, their interview narratives provided insight into the health care experiences of the Vietnamese-born group. As such, themes from their interviews as discussed in Chapter Three are presented separately from the interview narratives of the experiences of the Vietnamese-born participants.

All names presented in this thesis are pseudonyms. In the event that the participants declined to choose their own pseudonyms, I selected a name to reflect the same language of

the name, i.e. English or Vietnamese, the participant used when speaking to me.²⁴ I refer to Vân and Peter as “Chú Vân” and “Chú Peter,” which is similar to calling someone “Uncle” or “Mr.” in English. I refer to the two oldest participants as “Chu” as a sign of respect.²⁵ One refers to oneself in different ways depending on the relative age of the person whom one is speaking with. While I speak conversational-level Vietnamese, I am not fluent. However, while the interviews were conducted primarily in English, portions of the interviews took place in Vietnamese. The interview narratives presented in this thesis reflect the participants’ direct quotes, with a few minor exceptions. I translated some of the passages into English, I deleted linguistic pauses in speech such as the use of *like*, *um*, and *oh*, and I corrected some of the English grammar for the purposes of clarity. Most portions spoken in Vietnamese were quite small and easy to translate. For examples: “How are you?” “How long have you been living in Saskatoon?” and not central to the analysis. Words and phrases that extend beyond conversational-level Vietnamese that were spoken in Vietnamese, such as concepts like “sport is good for your health” and “mental health” were discussed with members of the Vietnamese community for more clarification.

Interviews were conducted in locations based upon each participant’s suggested locale. Locations included: the Saskatoon Public Library, coffee shops, and study areas located around the University of Saskatchewan and SIAST. The participants were encouraged to choose a setting in which they felt comfortable to have an interview take place, being reminded that their participation would remain confidential. The participants agreed to face-to-face, one-on-one interviews, except for Quý. She requested that the interview be conducted

²⁴ It is common for people to have names in both English and Vietnamese, each used in different contexts.

²⁵ Not only is this considered respectful, it is built into the Vietnamese language structure. Pronouns such as “you” and “I” exist, but are not commonly used.

by email due to her busy schedule. The three main questions, along with common follow-up questions asked during other interviews were emailed to her, and her responses were returned in the same manner. Confidentiality was ensured by printing off her email responses to include in the analysis process and promptly deleting any identifying information.²⁶

Data Collection

Interview Grid

In *The Ethnographic Interview*, anthropologist James Spradley (1979) identified the inter-relationships between data collection and analysis within ethnographic research, while indicating that the interview is a bridge to cultural understanding. He outlined how interviews can be treated as “friendly conversations” that are guided by a specific purpose (Spradley 1979:58–59). This allows researchers to explore their questions in detail, but to allow for direction from the participants to take place. The development of the interview grid specific to this study follows an open-ended interview format. This interview technique can be described as a guided process, where the interview is guided according to the informant’s responses to the initial questions (Field and Morse 1985). As such, the first interview conducted for this study was a guide to which follow-up questions were developed to explore in subsequent interviews. Following Spradley’s “grand tour” and “mini tour” question format (1979:86–88), I developed an interview grid that began with an open-ended question (see Appendix A).²⁷ Subsequent questions were asked, following the content derived from

²⁶ The limitation of the data presented by email is that it does not lend itself to the same type of open-ended structure and narrative analysis that was used for the other interviews. However, the themes that were elicited from her responses are still explored in Chapter Three and Four.

²⁷ Spradley described how “grand tour” questions encourage informants to provide a general, elaborative overview, where “mini tour” questions then build on specific parts of these larger

responses to the main question. “Mini tour” questions were used to follow-up with specific information provided by the participant, and to guide the interview further along the themes presented in their responses. For example:

- “Grand tour” question: Tell me about your experience with the health care system?
- Participant’s Response: ...I saw a total of three different doctors.
- “Mini tour” question: Please tell me about the first doctor that you saw.

I structured the grid to reflect the key themes regarding immigrant health that were identified by the literature review, but also to allow each interview to be guided by each participant’s response. Following the literature review that identified challenges in accessing health care services, along with cross-cultural differences in conceptions of health and illness, the questions asked of every participant were: 1) Please tell me about your experience with health care in Saskatoon; 2) How do you define health / What do you do to be healthy? and; 3) How do you define the term *mental health*?

Each interview was approximately one hour in length. No follow-up interviews were scheduled. However, I stayed in contact with participants and discussed my findings with those who showed interest. By attending regular events and activities within the community, I was accessible to the participants if they had questions or concerns about their participation.

descriptions. See also Appendix A: A Taxonomy of Ethnographic Questions (Spradley 1979:223).

Participant Observation

While my primary methodology consisted of the elicitation and analysis of narrative interviews, my contacts within the community helped me to clarify terms and definitions, as well as provided me with a general level of knowledge regarding Vietnamese cultural norms and practices.²⁸ Having connections in the community in order to practice my language skills aided the recruitment process, in that people were aware of who I was and of my project. Participant observation was carried out in two ways. First, I assisted one family in the community by helping their son with his homework on a weekly basis. This took place within the family's business establishment, which provided me the opportunity to discuss aspects of the Vietnamese language and culture with many people. Second, I attended events and festivities, such as the New Year's celebration, and religious ceremonies, such as church services. These events gave me an understanding of the importance of family and community within Vietnamese culture. Participation in these events also gave me the opportunity to discuss my travels to Vietnam in 2007, which inspired my initial interest in conducting research with Vietnamese newcomers to Canada.

Ethnography, considered the primary research methodology within the field of anthropology, involves partial immersion within the intended group of study. This positions researchers, along with their subjective experiences, as the main research tool. While this method has been critiqued for being subjective and therefore unscientific (see Clifford 1986), the value of ethnography as a qualitative research method can be described as eliciting a

²⁸ An example of a term which benefited from clarification by consulting members of the community surrounds the concept of *mental health*. In the Vietnamese language, there are different terms that are related to this concept, such as "tam than" or "binh tam than." The conceptual issues regarding translating this term from Vietnamese to English are discussed in the section on Mental Health in Chapter Three of this thesis.

deeper understanding of people's experiences at the local, individual level. While my analyses centres on the open-ended interviews conducted with volunteer participants, I recognize that my subjective, reflexive role as researcher influenced the data that was collected. Specifically, my intention was to elicit a deeper understanding of the participants' experiences with health care services, where the content of what the participants discussed was largely guided by this context. The subjectivity associated with ethnography can be a tool that allows researchers to enter into the field and develop appropriate friendships. This can lead to recruitment, as well as an understanding of cultural nuances. However, I recognize that subjectivity also influenced who chose to participate, which will be discussed in Chapter Four.

Questionnaire

While data were predominantly collected through the narrative interviews, participants were also asked to complete a brief questionnaire (see Appendix B). The primary objective of the questionnaire was aimed at determining whether or not participants had accessed health services, and if so, what type of services they had used. The secondary objective was to gather basic socio-demographic information about the participants in order to augment the understanding of their interviews with this background information. Upon completion, participants were asked whether or not they would like to participate in the interview, all of who agreed.

Data Analysis

Thematic analysis is one of the most basic forms of categorizing data elicited through qualitative research methods. It has been described as the process of "coding" qualitative

information, whereby specific words and phrases are classified, based on similarity, and can be grouped into themes (see Boyatzis 1998). More specifically, “coding” data can be defined as: “the process of identifying persistent words, phrases, themes or concepts within the data so that the underlying patterns can be identified and analyzed” (Field and Morse 1985:137). This allows researchers to move from a generalized reading to classifying specific patterns for a more organized and systematic analysis. Hence content, such as the information derived from an ethnographic interview, can be coded and classified according to patterns or themes. Classifying and developing an understanding of the concepts that are elicited through such methods is essential to interpreting meaning and “making sense out of the data” (Babbie and Benaquisto 2014:380).

Following this approach, analysis of this study’s interviews involved two phases. Analysis of the participants’ interviews began with the transcription process. This process prepares researchers to begin coding data. Through transcribing, “the researcher is able to recognize the persistent words, phrases, themes or concepts that are within the data” (Field and More 1985:99). Therefore, transcribing the interviews allowed for a general sense of what was important or meaningful to each participant. Data trustworthiness was ensured by discussing the preliminary findings with the participants who showed interest. Participants were asked if they would like to review their transcripts, which were made available to those participants who requested them.

The first phase continued with narrative analyses whereby, “stories reflected human feelings and lived experience...”. This analysis can be described as “...loosely formulated, almost intuitive, using terms defined by the analysis” (Manning and Callum-Swan 1998:250). This process allowed for themes specific to each participant’s interview to emerge. This

process also involved a hand-written (as compared to computer-generated) coding of the data. This hand-coding system is described as follows: “categories are initially as broad as possible without overlapping resulting in few categories being chosen in the initial steps of the analysis” (Field and Morse 1985:101). Next, the interviews were compared with each other to assess whether there were patterns, contrasts, and/or themes that were shared, and whether or not the interviews with the Canadian-born and health professional participants could provide insight into the analyses regarding the Vietnamese-born participants’ experiences.

The second phase consisted of coding the interviews using Atlas Ti, a qualitative analysis software program. Key words and phrases were highlighted as “codes,” which Atlas Ti sorted into groups. The codes presented in Table 2-2 represent the most frequently cited codes (those cited over 20 times). A complete list of codes and frequencies is provided in Appendix C. While coding data allowed for a systematic organization of possible themes, comparing the coded data to the initial, hand-written analysis was essential to developing meaningful themes. This is described further below.

Table 2-2. Atlas Ti Most Frequent Codes

Code	Frequency Distribution
Vietnam	56
Mental	47
Medicine	40
Family	39
Doctor interactions	35
Stress	35
Work	32
Family doctor	29
Staying active	28

Language difference	23
Diet	23
Education or knowledge	22
Expensive health care in Vietnam	22
Wait times in Saskatoon	22

Based on this coding system, Atlas Ti elicited the most recurring words and phrases within the interviews with the Vietnamese-born participants. Approximately 50 codes were initially derived and merged so that similar codes such as *the brain* and *the mind* or *stress* and *worry* were combined. This merging process, associated with grounded theory, can be described as a constant comparative method, which involves comparing coded data, in order to refine related data into themes (Gale et al. 2013). This qualitative method was used to amalgamate related codes such as *stress* and *worry* into more refined themes.

Next, the broader context of each code (i.e. the content of the specific passage in the interview and what was discussed during that portion of the interview) was analysed to determine its relevance as being considered a theme. For example, the term *mental* was coded based on the frequency with which it appeared in the interviews. However, considering that the discussion of *mental health* had been elicited by the third interview question, *mental health* was not considered a theme, even though it was frequently discussed. Further, I analysed the content in which the codes appeared. *Medicine* and *family*, for example, were not considered themes even though they were frequent codes. The participants mentioned taking *medicine* such as Tylenol, or the fact that their *family* lives in Saskatoon, but without much elaboration or emphasis.

The codes were grouped into “code families” so that similar descriptions could be understood in relation to one another. The following code families were developed: 1) *health*

care services, such as family doctors or walk-in clinics, 2) *health care experiences*, such as positive or negative circumstances or interactions, 3) specific *health practices*, such as staying active or eating healthy, 4) *health concepts*, such as stress or happiness, and 4) *more general thoughts and experiences*, such as comparisons between Canada and Vietnam, including topics such as diet and environment.²⁹ These code families provided an outline of what the participants referred to when they described their experiences with health care services in Saskatoon. This also contributed to the emergence of themes. For example, regarding the code family *more general thoughts and experiences*, diet and environment were often discussed simultaneously and with more detail than other codes within this family. As such, and based on the repeated association with references to Vietnam, “diet and environment” is discussed as one of the main themes within the results of this study.

Based on both phases of analyses, “Vietnam” emerged as one of the most important themes. It was the most frequently cited code, it was evident within all of the interviews with the Vietnamese-born participants, and it was associated with virtually every other theme and code that they discussed. Based on the initial analysis prior to using Atlas Ti, the participants’ descriptions of Vietnam were among the most meaningful aspects of their interviews, in terms of elaboration, detail, and emphasis. Given the above, this thesis examines references to Vietnam as central to the participants’ discussions during the interviews, along with other themes derived from the interviews. The main aspects of this frame of reference are explored in detail in Chapter Four, which include: 1) discussions about health care in Saskatoon in

²⁹ The distinction between the code “eating healthy,” which was grouped into the *health practices* code family and the code “diet,” which was grouped into the *health concepts* code family was the context in which these concepts were discussed. Participants described the importance of eating healthy with respect to their personal health practices, whereas they described larger or more general thoughts regarding the differences in diet between individuals living in Canada and Vietnam.

relation to Vietnam; 2) circumstances regarding diet and environment in Canada and in Vietnam; and 3) the importance of knowledge and access to resources. Chapter Three introduces and explores some of the other themes regarding the participants' discussions beyond their emphasis on drawing comparisons Vietnam.

However, led by these data, illustrating the various ways in which the participants made sense of their experiences with health care services in Saskatoon through references to Vietnam gradually became a central focus of this thesis. I drew on psycho-socio-cognitive studies to illustrate how the participants' past experiences in Vietnam were brought out in a way that shaped and added meaning to what they described about the present. To elaborate, I found that references to Vietnam occurred on both explicit and implicit levels of thought and communication. While the focus of my project was to discuss health care in Saskatoon, the participants were inclined to discuss experiences in Vietnam as a basis of comparison. Whether or not the participants intended to discuss Vietnam, these descriptions were central to the other aspects of discussion within the interviews.

Following socio-linguistic theories of narrative analysis, I perceived the interview to be a single unit (De Fina and Georgakopoulou 2012), where the elements of what the participants described were embedded within the same context of the interview as a whole. As such, comparison to Vietnam and descriptions of larger circumstances provided a backdrop to understand the participants' discussion of health care, which is discussed in Chapter Four. It is beyond the scope of this thesis to analyze health care in Canada and health care in Vietnam. However, the participants' descriptions represent their unique, subjective experiences, which are the focal point of the analyses. The literature regarding immigrant health in Canada has found that experiences prior to migration impact the experiences of

individuals in their host country. This importance of this notion is illustrated in Chapter Four through discourse and narrative analysis that expands on the understanding of how the participants' experiences in Saskatoon are shaped by their past experiences in Vietnam. In this thesis, I adopted a holistic definition of health to suggest that health is "more than the absence of disease, but encompasses mental, economic, social, and spiritual well-being" (Young et al. 1999). While I do not suggest that the participants follow this definition of health, it served to guide the interview and analysis process to include questions and discussion relating to conceptions of health and illness, along with contextual factors affecting health. I explore the participant's conceptions of health in Chapters Three and Four of this thesis.

CHAPTER 3 INTERVIEWS AND PROMINENT THEMES

In this Chapter I present the Vietnamese-born participants' initial responses to each "grand tour" interview question: 1) Please tell me about your experience with health care in Saskatoon; 2) How do you define health / What do you do to be healthy? and; 3) How do you define the term *mental health*? I also illustrate the various themes and follow-up questions that emerged in response to these questions, followed by analyses regarding the responses. This chapter concludes with a discussion of the Canadian-born participants, and the participants' descriptions of health care in Vietnam.

Health Care in Saskatoon

Regarding health care in Saskatoon, the type of health care services that the participants described using included: family doctors, walk-in clinics, specialists, the university health clinic, and the emergency room. The participants widely discussed physical aspects of health. Most participants said that they visit their family doctor on a consistent basis, either for regular check-ups or when they felt ill. Other reasons participants accessed services related to back problems, trouble sleeping, and chronic stomach aches.

Overall, Chú Peter, Chú Vân, Quý and Lành largely described positive health care experiences and Liên and Mai discussed mostly negative experiences. Phuong and Minh illustrated a mixed combination or more neutral experiences, whereas Ngái had not accessed services, however he said that he heard they were good from other community members and that he would access them if needed. Participants discussed the importance of health and the importance of seeing a doctor when needed. Several themes emerged during the discussions of health care experience, namely, the significance of Canada's universal health care system,

interactions with health professionals, language, and long wait times. I illustrate these themes by presenting interview passages that reflect elements of discussion that were common across the interviews, followed by an analysis regarding these themes.

Initial Responses

Liên is a university student who has continually worked to improve her English language skills since arriving in Saskatoon four years ago. Her reply to the initial question was:

I think it's much better than in Vietnam. Because I think here it is free. In Vietnam we have to pay. And the people who work in the [health] services, they are much nicer... Because in Vietnam everything is, from my point of view, everything is based on *money*...

She continued by disclosing a recent incident. Her Uncle in Vietnam was in an accident and taken to hospital. Liên described how “they did not do anything to him. They did not treat him accordingly. They waited for his family to come.” By the time his family arrived to pay the medical fee “it was too late for the doctors to save him.” Evidently, this was upsetting. I asked Liên if she wanted to cancel the interview. She declined and continued:

I am very emotional. Yeah so I feel very bad about the system, the health system in Vietnam. And I, my cousin who came here a few weeks ago, he said

“that’s Vietnam for you.” If you don’t have money or can’t pay the fee, they’re not going to do anything for you even if you are *dying* there. So, I feel, I am lucky to have the very good, much better health system here than in Vietnam.

Similarly, Quý, a university student who wanted to conduct the interview via email because of her busy schedule, also described how health in Saskatchewan is “is way better compared to my country” during her initial response.³⁰

Chú Vân has lived in Canada for over 30 years and came to Canada as a refugee shortly after the War in Vietnam ended. His initial response was: “The health care in Saskatchewan is very good.” He repeated this several times while describing how it is “very easy” for his family to access health care. Initially, he stated that health care in Canada is good without elaborating why. However, as an advantage of qualitative research, asking follow-up question provided further information about his experiences. Later, when I asked him why is health care good in Canada? Chú Vân replied: “Because it is important [to see the doctor]. When we see the family, when we see the doctor, or go to the hospital, we don’t have to pay.” One of the most prevalent themes from Chú Vân’s discussion was the importance of health and seeing his family doctor on a regular basis. Descriptions of doctor interactions will be elaborated on further below.

Chú Peter similarly described his experiences in Calgary, where he and his family first lived as refugees after the war. Particularly, he emphasized that he has been living in Canada for over 30 years and that he does not have questions or problems with the health care services. However, he went on to say that “I don’t know if it’s good enough for some other

³⁰ In this passage, she was referring to dental services. However, she compared health care in Saskatchewan in general as better than health care in Vietnam throughout her email response.

people, but for myself it is ok because when I came here, I have *nothing*.” Chú Peter further discussed a newcomer organization that helped him a lot when he first came, and how he thinks that Medicare in Saskatoon is good.

While both Chú Vân and Chú Peter described health care as good, Mai’s initial response was negative in comparison:

Mai: “I, like they don’t, they don’t care really much.”

Rachael: Yeah?

Mai: I don’t know because, when I came there, they just ask a few questions, and then they check because I have some, my stomach was very hurt. And then I came there and the doctor was just, he pressed on my abdomen a few times and then he said “it’s ok.” And then he gave me some medication. And it doesn’t really help.

Rachael: The medication didn’t help?

Mai: It didn’t help much. But.

Rachael: And then so.

Mai: But yeah. So I want them to check *more*. Because I don’t know if there is any *more*, like *problems*.

Rachael: Did they explain what they think it was?

Mai: No. I just, they gave me some prescription. Something like that. And I just went to the Shoppers Drug Mart to get it. Because I think because they have so many clients. So they just do it really quick.

In this passage Mai emphasized that she did not feel her symptoms of abdominal pain were checked thoroughly enough by the physician at the walk-in clinic. It is inferred from this passage that Mai did not think the physician she saw in this instance “cared,” primarily, as she described, because the appointment felt rushed, she felt her symptoms were not examined thoroughly enough, and because the physician did not explain what he thought the problem was, but gave her a prescription that did not help. By referring to “they,” Mai was making reference to another physician she saw regarding the same symptoms, where she reported similar negative feelings about the appointment. This instance is discussed further below.

In contrast, Minh shared about his experience at the University of Saskatchewan student clinic in a more positive light, with descriptions such as “friendly” and “comfortable.” However, he also mentioned that he thought it took too long to see a specialist, illustrating an issue brought up by most participants regarding long wait times. The discussion of wait times was commonly associated with descriptions regarding the participants’ busy schedules. For example, Lành described how it has been easier to see a doctor this year compared to last year, when he was working nine hour days while also attending night classes. Long wait time is also an issue reported by non-immigrants and Canadian-born citizens, which will be discussed in the analysis section below.

Finally, Phuong’s initial response included descriptions that seemed both positive and negative: “Oh! It is to *wait a long time* [we both laugh]. Yeah it’s [pause] some services are good. Some services are not good, like *confusing*. Yeah. Like behavior. Oh [pause] that’s good though. It doesn’t matter to me. I think the services are good.” While Phuong described how there were confusing aspects to her experience, she concluded her response in a way that seemed like she changed her mind about what she wanted to say. When I asked her to follow-

up on the services that were “confusing,” Phuong described how medical terminology is difficult to understand, long wait times, and not knowing if and when someone would call back with her results.

Themes

Several themes emerged regarding the participants’ descriptions of health care in Saskatoon. Specifically, 1) the idea that health care is good because it is “free;” 2) that long wait times are problematic; 3) interactions with health professionals, both positive and negative; and 4) the issue of language difference and importance of interpreting services. I developed “mini-tour” follow-up questions based upon recurring themes. One question that was consistently asked was: How would you improve health services in Saskatoon? This question elicited some commonalities, but also variation among the participants’ responses.

To illustrate, Lành responded with a comment regarding receptionists, that “they’re usually not friendly” because they work under pressure in a busy clinic. He continued by describing how:

The rest I think, everything is good. Because when I see the doctor, because he has the experience and the solution for my problem...And the one thing that I believe why he is better than [the doctors] in my country is because, if they sell the drugs [here] it is the real thing. Not like our country where sometimes you buy drugs, but they are not the real ones.

He concluded this discussion about pharmaceuticals with the thought that Canada is better because “Canada is a developed country, compared to my country, which is *developing*.”

While Lành suggested that health care is better in Canada than Vietnam, he further explained how more clinics are needed because of Saskatoon’s growing population. In contrast, Chú Peter did not offer a suggestion for improving Saskatoon’s health care services in response to this question. He repeated that he thought health care is “very good.” Like Chú Peter, Chú Vân described mostly positive experiences. However, Chú Vân described the issue of long wait times when I asked how the services could be improved. Whether in response to the follow-up question about improving services or elsewhere in the interview, long wait times was one of the most frequently described aspects of the health care system in Saskatoon.

Another commonality was comparing services in Canada, the United States and/or Vietnam, specifically for Minh who had lived in the United States before coming to Canada. Minh described the long wait times he experienced when he took his niece to the emergency room because she fell and broke her arm. He commented that “maybe because they don’t have enough doctors” as one possible reason why wait times are too long in Saskatoon. He also described how “in the U.S. private hospitals are better, if you have the money...In Vietnam they don’t have enough hospitals, extremely crowded. And very dirty too...So here, long but ok compared to Vietnam. I will never go to hospital in Vietnam.” Minh’s description led us into a conversation about the advantages and disadvantages of public and private health care. Regarding health care in Canada and the United States, Minh also said: “Actually people use the clinic more often in Canada... The health care here is better I think. People are

more concerned with health here I think.” Chú Vân also talked about health care in the United States. He said that “health care in Canada of course is better than Vietnam and even better than the U.S.A. too.”

Phuong replied with a more general comment about how to improve health, not specifically in Saskatoon, but as a larger comparison: “So you can improve by yourself, but somebody else *no* because they don’t know how to use a computer. That’s why in my country, lots of people *die*. Like they get some heavy disease.” I asked if she thought that access to knowledge improves health. She replied with a definitive “yes” and emphasized how Canada has “good health services because if you get some heavy disease, you go to the emergency automatically. *You don’t need to pay*. They just save your life *first*. Right? But in some countries, *you need to pay first*.” She repeated this notion of having to pay, and the severe consequences of not being able to do so by comparing the services in Canada to Vietnam.

Another central theme was a discussion of patient–doctor interactions. The positive experiences with health care shared by Quý, Lành and Minh were connected largely to their doctor interactions. Specifically, they described how their doctors listened, made them feel comfortable, and have effective medical knowledge and resources compared to Vietnam. For example, Lành described how “his doctor has the solution and experience to solve his problem.” Minh also described: “Yeah it’s good, so I definitely will visit them if I need to go... Comfortable is important, so whenever I feel comfortable, I will come back to that place.” Quý described the importance of doctor interactions while drawing on a comparison. She mentioned how in Canada patients feel “very comfortable” to talk with medical professionals because they are well trained in “both medical and communication skills.” She

compared this to Vietnam where “doctors just tell patients what to do” and do not explain things clearly. Quý continued by describing that in Vietnam “many people die” due to a lack of knowledge regarding illness, along with a lack of financial resources with which to treat it.

Regarding doctor interactions involving negative experiences, Liên and Mai shared similar complaints about health care in Saskatoon. Mainly, they described that their symptoms were not checked thoroughly. Mai had seen two physicians for a total of four visits because of abdominal pain. Both physicians were recommended by a family member. However, Mai indicated: “Well I came to see one doctor, and then, I don’t think he is really good, so I switch to another one. But I don’t think she’s good either so I just came back to that doctor because it is closer to my house.” Liên had seen several physicians trying to find one that she liked. Phương had seen only one physicians, but explained that she also wanted to find a different one. Mai had also elaborated on her negative experiences. Particularly, she sought a second opinion, and described: “She [took] urine, to do the test. And I don’t know what happened after that.” This led us to discuss how doctors in Canada typically only call with test results if there is something wrong, but how we both would prefer a call back regardless.

When I asked Liên to follow-up with her perspective that hospital staff in Saskatoon are “nicer” compared to Vietnam, she explained: “When I have to book appointment with my family doctor, I have to wait a long time. And then when I get there on time, or even earlier than my appointment, I still have to wait.”³¹ She also mentioned how the physician “did not really check, she just asked some questions.” Liên emphasized her frustration: “that was the

³¹ While the participants largely did not describe experiences at any of the Saskatoon Health Region hospitals, Liên could be referring to the staff she interacted with during these visits to two different walk-in clinics. Minh described his experience at an emergency room with his niece, which was discussed earlier in this thesis.

first and last time I have been there.” Continuing, Liên said that the second physician was “nicer” than the first. However, she also repeated how long waits associated with this visit conflicted with her busy schedule. This led her to search for another physician, even though she had not found one yet.³²

The issue of language, an aspect of patient–doctor interactions that is frequently cited within newcomer health research, was not emphasized by the Vietnamese-born participants.³³ However, all of the participants described language difference or the importance of translation services at some point during their interview. Chú Peter described a newcomer organization in Calgary that helped him find a family doctor who spoke Cantonese. While he was born in Vietnam, Chú Peter was of Chinese descent and grew up speaking both Cantonese and Vietnamese. He did not speak English when he first came to Canada. When his family moved to Saskatoon, he explained that: “I lived in a small town. And at that time in the small town, they just had one Canadian doctor. That’s the only choice. But I already have, can speak a little bit of English, I can understand and I have no problem [he smiles].”

Even though Lành emphasized how his family doctor in Saskatoon is good, he also described how he felt when he first came to Canada. He mentioned that he did not speak English very well and how he used an electronic dictionary to help explain his symptoms during appointments. He also mentioned that non-verbal cues such as body language, and that

³² Later she described how this clinic tried to accommodate her schedule by squeezing her in for an appointment instead of having her wait, which she seemed to really appreciate.

³³ Perhaps the higher level of education that some of the participants had, being university students, contributed to their lower rate of discussing language difference as an issue. However, Mai discussed having problems based on language difference when she first came to Saskatoon and Lành described the importance of using a translation dictionary during his appointments. Participants also described taking night classes to learn English after work and/or school, as well as the issue that medical terminology is difficult to understand. These experiences are explored in more detail throughout Chapter Three and Four.

fact that his English has improved more recently has helped with communication. However, when I asked him to elaborate on the use of the electronic dictionary, Lành described how medical terminology is still difficult to understand in English. While many of the participants commented on how medical terminology is difficult to understand, Lành was the only participant who mentioned the use of a translation dictionary, and how it gave him the ability to verify word meanings during his appointments.

Some participants described language difference in more general terms, such as Mai: “Some [people] they can’t even speak English. To go to the clinic it is hard to say what problem they have.”³⁴ Other participants made reference to the importance of interpreters, which implies that the participants recognize and perhaps have experienced challenges due to language differences. Quý talked about the importance of language interpreters for newcomers, indicating that Canada is a country that accepts lots of immigrants. She went on to describe how “new immigrants usually cannot speak English and they don’t feel comfortable to visit doctors because they cannot communicate.” During this discussion Quý emphasized the importance of translation services, which would encourage newcomers to access health services.

While Minh described his health care experiences to be mainly positive, I had asked him what he thought about my project. He replied with how it is important to bring “this issue” into awareness to promote more services being available, such as language interpreting services. By “this issue” he was referring to some of the challenging experiences of being a

³⁴ As another example, Chú Vân described how it was very easy for him to talk with his doctor. However, I was invited to a gathering with other members of the Vietnamese community after the interview. Chú Vân made reference to something he emphasized within his interview: that health is very important. He pointed to an elderly gentleman and said ‘see that guy there? He does not speak English so it is hard for him when he goes to the doctor.’

newcomer to Canada. While Mai described the issue of language difference in more general terms, I asked her if she experienced any problems when she first moved to Canada. She replied by saying yes, and suggested that patients need to bring family members with them to appointments to translate on their behalf. I suggest that the issue of language and interpretation could be a key part of physician interactions regarding the participants of this study, which I explore in the following analysis to promote questions for future research regarding the larger immigrant and refugee communities

Analysis

Several aspects of the participants' descriptions overlapped and provided insights into the socio-cultural determinants that may have affected their experiences with health care in Saskatoon. In this section, I provide analyses regarding: 1) the participants' experiences with different types of services within the health care system, such as the distinction between walk-in clinics and family doctors; 2) whether the participants described positive or negative experiences, doctor interactions were central to their discussions; 3) even though the participants did not emphasize language differences, they were mentioned by every participant. I suggest that language and cultural differences affected the participants' experiences on some level; and 4) the participants' issue with long wait times and their busy schedules could have been amplified by these differences, along with the type of clinical setting that was being accessed.

The different types of services accessed by the participants likely contributed to how their experiences differed. Minh described how the student clinic suited his busy schedule, compared to booking an appointment with a busy family doctor. Alternately, Chú Vân

discussed the importance of seeing his family doctor regularly. Lành described his satisfaction with the care at the walk-in clinic. However, Mai, Liên and Phuong illustrated the desire to find family doctors instead. Literature suggests that finding a family doctor can be difficult, where the point of entry with health care for many newcomers is often walk-in clinics or the emergency room (Asanin and Wilson 2008). Many of the participants commented on how they typically accessed services located close to where they live, even if they were not satisfied with the services.

Geographic barriers are reported as a major issue for newcomers, who may typically rely on public transportation more so than the majority of the Canadian-born population (Asanin and Wilson 2008; Wu et al. 2005). Leduc and Proulx (2004) described that increased utilization of walk-in clinics compared to family physicians can be seen among recent immigrants, based their study conducted in Montréal. Specifically, they reported that many of their participants (N = 24) did not consider health a priority during the early years of arrival, since finding employment and housing were considered more important, and thus how it is “not surprising to find that the vast majority of the medical consultations initiated by the families since their arrival...were visits to emergency rooms or walk-in clinics (Leduc and Proulx 2004:19).” Interestingly, the participants of the current study emphasized the importance of health, which is elaborated on in the discussion in Chapter Four. However, I infer that the types of services that some of the participants of this study accessed had likely been affected by similar factors reported by Leduc and Proulx (2004) concerning time and access to walk-in clinics compared to family physicians.

Gushulak et al. (2011) remind us that newcomers to Canada arrive under various circumstances, such as having refugee, temporary, or permanent resident status. This is

evident within the experiences of this study's participants. For example, Chú Peter and Chú Vân arrived as refugees over 30 years ago, whereas the majority of the participants came more recently as international students and temporary or permanent residents. Lebrun (2012) finds that more recent immigrants are less likely to have regular access to family doctors than more established immigrants. Chú Vân said that it was hard to find a family doctor, but now that he has been living in Canada for a long period of time, he has more established connections. In contrast, Mai, Liên, and Phương who had all been in Canada for four years or less described difficulty in finding a family doctor. It seems evident that the less established immigrants and temporary or permanent residents of this study had a lower degree of access to family doctors than Chú Vân and Chú Peter who had been in Canada for a longer period of time.³⁵

The *healthy immigrant effect*, which was identified in the literature review as a possible determinant affecting health care utilization, is not necessarily supported by the interviews with this study's participants. Instead, their discussions regarding the stigmatization of mental illness supports critiques of the HIE concept. Specifically, Islam (2013) finds that nuances affecting the experiences of immigrants and refugees, particularly regarding mental health, such as refugees who might have experienced traumatic events prior to migration, are not addressed by the *healthy immigrant effect* concept. The discussion of mental health will be explored in more detail below.

³⁵ Social status would likely affect the experiences of Vietnamese immigrants and refugees in Saskatoon, which is not clearly represented within this small sample. However, the majority of the participants were international students applying for permanent residency, which will be explored elsewhere regarding language differences, along with the contextual understanding of who chose to participate in this study.

Interacting with health professionals was a prominent interview theme. With regards to the negative experiences, Mai described that the physician at the walk-in clinic ‘did not care very much’ because her medical examinations were not thorough. She also mentioned that a prescription she was given did not help, and how no one offered an explanation regarding her symptoms.³⁶ Phuong also described the frustration of not receiving information or explanation regarding her health. Regarding the aspects of her medical encounters that felt “confusing,” Phuong described medical terminology that was difficult to understand, and went on to say: “but you know sometimes some doctors do not explain for you.” To follow-up, I asked: “did they explain for you?” “No,” Phuong replied, “yeah he didn’t explain for me, he just told me take vitamin C, drink lots of water.” Regarding “he,” Phuong was referring to the same physician at a walk-in clinic she had seen during on separate occasions. She had also explained how this clinic is close to her place of residence, but that she would like to find a different physician.

Theory on patient–doctor interactions suggests that there needs to be trust, shared understanding, and communication for effective medical treatment to take place (see Kleinman 1988; Waitzkin 1991). This is evident where Lành, Minh and Quý described how their doctors listened carefully and took the time to explain things clearly. In contrast, Mai, Liên, and Phuong discussed rushed appointments, and how they did not understand what was happening. These findings are consistent with the findings of Asanin and Wilson’s (2008) study, where their participants also described impersonal and rushed appointments as being a major barrier to care. While trust and cultural sensitivity are reported as key elements for effective health care delivery (Tucker et al. 2003), I do not imply that rushed appointments

³⁶ In contrast, Lành described more positive experiences regarding the physician he sees on a fairly regular basis, also at a walk-in clinic, as described above.

represent instances of cultural insensitivity. However, one could infer that rushed appointments might not leave room for culturally sensitive health care practices to be fully realized.³⁷

I suggest that negative occurrences experienced by this study's participants may have been amplified by language and cultural differences. While the Vietnamese-born participants did not discuss language difference in great detail, all three Canadian-born participants described instances where they or their siblings have acted as translators for their parents. Some of the Vietnamese-born participants mentioned having family members present during appointments, or for translating for other family members themselves. I attended a medical appointment with a friend from the community, upon her request, since her daughter who usually attends was out of town at the time. Phuong's description that she wanted to find a different doctor was part of her discussion about the difficulty in understanding medical terminology. As such, I propose that even though these issues were not a major element of discussion in the interviews, they had affected the experiences of this study's Vietnamese-born participants on some level.

While the participants described health care in Canada as good because it is "free," they also shared some of the negative aspects of their experiences. Particularly, long wait time was one of the most prominent issues with health care in Saskatoon that the participants described.³⁸ Even though Chú Vân stated that health care in Saskatoon is good, he emphasized the issue of long wait time. These discussions were often related to descriptions

³⁷ For examples of sources discussing barriers to cultural competency practices such as rushed appointments, see: Holmes 2012; Shapiro, Hollingshead Morrison 2002.

³⁸ The existence of long wait times is a factor of the Canadian health care system extends beyond health care in Saskatoon. However, the focal point of the analysis is on the narrative descriptions of this study's participants.

about how busy the participants were, such as Liên, a full-time student, who was also working part-time. This is consistent within the Canadian literature, where long wait time and busy schedules are reported as barriers (Asanin and Wilson 2008; Wu et al. 2005). Further, participants in a study conducted in Montreal were found to report on language, cultural, and socio-economic barriers *despite* Canada's universal health care system (Kirmayer et al. 2007), indicating that other factors are present despite the fact that health care is "free."

The issue of wait time is described as an issue beyond the newcomer experience, as a negative aspect of Canada's universal health care system. Wu et al. (2005) reported that a large percentage of both immigrants and non-immigrants described long wait time as one of the main factors contributing to unmet health care needs. Many of the participants in this study also mentioned how they were completing English language courses in addition to working and/or attending school full time. For example, regarding a family doctor appointment she had, Lien described how "that was the first and last time I have been there... Because I don't really have that much time." As another example, Lành described that it has been easier to see a physician this year compared to last year, when he was working nine hour days while also attending night classes. Further, one of the Canadian-born participants, Chi Kim, described the "double burden" that many newcomers face: having to navigate services in a second language is time-consuming and difficult. Based on these findings, I suggest that the combination of wait times, busy schedules, and a "double-burden" could have impacted the Vietnamese-born participants' experiences with health care in Saskatoon.

Conceptions of Health

The second “grand tour” question was a two-part question. I asked the participants: How do you define health? and What do you do to be healthy? Liên and Quý mentioned the importance of mental and physical health, whereas the majority of the participants described mostly physical aspects of health. Participants discussed personal health practices; namely, staying active, working hard, avoiding cigarettes and alcohol were the most common themes. Participants also emphasized the importance of health, where some participants drew on an analogy related to a Vietnamese saying: sức khỏe là vàng, meaning *health is gold*. Discussions about socio-economic circumstances, specifically, diet, environment, and the importance of knowledge also emerged. These descriptions were often elicited by a comparison to Vietnam. This often led to the follow-up question: Is what you do to be healthy in Vietnam the same or different? The question fostered more detailed descriptions and comparisons regarding differences between Canada and Vietnam.

Initial Responses

Lành’s initial definition of health was: “health depends on *the way you live*.” He illustrated this concept with a saying “live strong,” which he explained relates to eating right and exercising. Lành discussed how he does not think fast food is healthy, and commented that many Canadians eat a lot of fast food. He contrasted this with how in Vietnam “we a different culture. We usually eat rice. Everyday.” He continued by describing the negative effects of fast food, and how “it affects your life, and also your health.” When I asked Lành what “live strong” meant in Vietnamese. He replied with a saying that translates into “sport is good for your health,” and further described:

Yeah because in my country [pause] my country long time ago we have the war, so we very *poor*. We not even have a lot of food to eat...I hardly see someone obese. But now it is changing a lot, now lots of people living in the city...and people don't want to exercise too much, and they just sit in front of the T.V.

Lành's emphasis was on diet, but he also brought up circumstances such as war and poverty. In contrast, some participants offered a definition health as being the absence of disease, such as Liên: "If you don't have a problem, [or] pain" and Chú Peter who said "if you don't have to go see the doctor" as opposed to larger circumstances.

Regarding how the participants stay healthy, Chú Peter's response was: "You have to work at the right time. You have to eat at the right time, you have to eat the right stuff, eat the right food. You have to rest, and you need exercise too. You have to *enjoy your life*. So that's your health." Chú Peter talked about the importance of balance, much like the other participants. For example, Minh also described eating a "balanced meal, going to the gym, and going to the doctor when you don't feel well." Some participants talked about what they "should" do to take care of their health, even though they do not have time. Liên described how she "should do exercise" and get more sleep, but how it is difficult to do so being a university student. She also described the importance of laughter regarding mental well-being. Quý also described how her time is limited because of school activities.

Chú Vân mentioned the idea that working hard is good for your health: "Yeah working hard, that reason to keep you healthy, when you are working hard and not sitting by the T.V. Because I know some people after work they go home and watch the film on T.V. or something like that. That's not healthy." This is consistent with how many of the

participants indicated that staying active is important for good health. Recall how Lành also said that too many people in urban Vietnam are sitting too long while watching T.V., which is not healthy in his opinion.

When I asked Lành what he does to be healthy, he repeated the comparison of diet in Canada to Vietnam that was brought out during his definition of health. He went on to describe a negative aspect of diet in Vietnam: “I think one problem is that we only eat three times a day because of the culture, because our country is agricultural.” He compared this to Canada, where he eating five or six times a day is healthier from his perspective. He talked about how many people, mostly men, smoke and drink a lot in Vietnam, but how many people feel obligated to do so because of social pressure and tradition.

Themes

Some participants drew on an analogy regarding how health is more important than material wealth. At the end of our interview, Chú Vân said:

“Health is important right? Yeah because everybody knows, if you have good health you can do everything. If you don’t have good health you cannot do anything. Even if you have money ok? But if you do not have good health you cannot to everything. You cannot [be] happy. Because health is very important.”

Ngái also said that “if we have health, we can do everything in life.” Minh described that “you don't need to be very rich, but you need to be healthy.” During his initial definition of

health, Minh also described that “sức khỏe là vàng” – a Vietnamese saying that translates into “health is gold.”

The theme of diet and environment emerged largely in response to my inquiry about how the participants would stay healthy in Vietnam. When I asked Minh if it would be the same as it is in Canada, he replied that is “different” mainly because Vietnam does not have “good” restaurants. He elaborated with how things are cleaner in Canada, and how Canada has a larger degree of access to knowledge regarding healthy eating practices. Minh listed specific examples, along with the implications of what he described: “Vegetables are cleaner. Fruit is cleaner. You feel safer to eat...you can even drink fountain water.” To clarify his response, I asked Minh if he thought it was easier to be healthy in Canada. He replied by describing: “Yeah *different*. More opportunities to be healthy.” While Minh previously mentioned diet, he also described how Canada has more facilities for exercise and how more people can afford them here in comparison to Vietnam.

This discussion led Minh to reflect on some of the differences he noticed when he returned to Vietnam after living in North America: “I don’t feel healthy when I was in Vietnam. And also the environment, the air is not fresh in Vietnam too. More pollutants than in Canada. And noisy too.” Minh described his personal health practices, but here he also speculated on more general circumstances that impact health. Mai’s interview illustrated similar descriptions about diet and environment. She drew on some of the same descriptions, such as in Canada, it is “more healthy, because everything is cleaner.”

In contrast, when I asked Chú Peter about what his health practices in Vietnam were like, he responded with an elaboration about why he perceives that health care in Canada is good. In his response Chú Peter drew comparisons to Vietnam during the war and the

present-day. He described how the country was poor when he left, whereas “today, a little bit better. But just for a small number. For most people it’s still not good.” He continued by comparing the health care systems in Canada and Vietnam: “Over there if you want to go see the doctor, you have to pay. But here you don’t have to worry about that. So [he laughs] it’s like I say. Everything in Canada is *so good* to me.” Chú Peter also referred to Vietnam as being “different” than Canada, such as how Minh explained.

Similarly, Quý responded to my question about health practices with a discussion about the socio-economic differences between Canada and Vietnam. She drew a distinction between the “poor, medium, and rich” classes of people in Vietnam, while indicating that “poor people definitely have no time to even think about their health because they need to work.” Her discussion included the notion that wages are low in Vietnam, where “saving money for health treatment can be impossible.” In contrast, she described how “rich people will have time for going to gyms or play tennis.” Quý also discussed the impact of socio-economic circumstances on education as well as health:

For students in Vietnam, the level of competing for grades is very high...And for kids from rich families, they might go to extra English classes because they have money to pay for it. By the time they get home, they are too tired to do any exercise. Thus, students in Vietnam are more likely to be unhealthy physically as well as mentally.

While Lành began his response by indicating that in it is easier to be healthy in Vietnam than Canada in terms of diet, he continued by describing other circumstances:

In Vietnam we have to face different situations, like pollution...Our country is a developing country and we want to become the developed country as soon as possible...And they [the government] don't worry about the pollution, they don't worry about the environment...And then people who are consumers, use that produce and then for a few years, they're not affected right away, but in a few years you have cancer or something. That's a problem in my country also. Lots of people have cancer, and if you see some hospitals in the big city, [they are] overloaded.

This passage illustrates the complexity of experience that can be drawn out in qualitative research. Lành discussed how it is easier to be healthy in Vietnam in terms of diet, yet here he described some of the negative effects of industrialization and the exportation of heavy industry to Vietnam from other countries. Liên's response also illustrates this complexity. She described the differences between urban and rural Vietnam, where it is "much healthier" in the rural areas compared to the cities, "where there are so many factories and smoke and pollution and stuff."

During a conversation we had about situations that cause stress, Chú Vân compared summer and winter time in Canada, and how the winter can cause stress because it is too cold to be outside. His description turned into a comparison between Canada and Vietnam, based on a trip he and his family recently took:

When we come back to my country, it changed so much. So *different*. So *crowded*, and *heavy traffic* and so *noisy*. And *hot too*. [He laughs]. And we come back here, you see different. So *clean*...Looks like Vietnam is in *hell*. In Canada looks like *heaven*. You go from hell to heaven! [We both laugh]...We can compare my country and here. Yeah because the environment and everything here makes you feel very happy and healthy.

The above passage represents the socio-economic differences between Canada and Vietnam, particularly regarding the environment that many of the participants described. Chú Vân concluded this passage by indicating that there is a connection between health and the environment.

Differing levels of access to education and knowledge was another prominent theme. Participants frequently described the importance of knowledge. At one point during the interview, Lành was discussing some of the traditional aspects of Vietnamese culture. He gave examples of traditions he thought were “good,” such as family values being passed down and taking herbal medicines, and others that he considered “dangerous,” such as “wind letting.”³⁹ When I asked him to elaborate, he described educational differences between the urban and rural areas of Vietnam, where people in the cities “can go to university.” However, Lành described how the majority of the population lives in rural areas, where access to

³⁹ Lành’s description of “wind-letting” was from a negative standpoint where he felt that it is “dangerous.” He described it as where people try to “put the wind” out of your body using fire and/or a “knife or something that they cut in your back.” Another participant referred to a similar practice, but did not describe it to be negative or dangerous. Less invasive variations of Lành’s description could be traditional practices such as “coin rolling/rubbing” or “cupping” where literature indicates a range of positive and negative perceptions about the impact of such practices on health (see Gregory 1999; Nguyen 1985).

education is more limited. He further described how access to knowledge about health is also limited, where people do not have access to the information one can obtain from reading a magazine in a doctor's office, as an example.

Lành also indicated that knowledge, in the more rural areas, is passed down from generation to generation, where “people are very close. We don't have electricity there. We cannot connect to television.” Initially, the discussion of tradition arose when I asked Lành what he meant by saying health depends on culture. He elaborated by referring to Vietnam as an “agricultural country,” and described how they have “very strong communication in the family, and health [knowledge] is collected from the traditions or through family.” Lành referred to Vietnam as an agricultural and developing country several times throughout the interview, particularly with regards to differences in diet and health care in comparison to Canada.

Two participants described the importance of health promotion, where the idea of knowledge is reflected within their conceptions about the importance of health. When discussing how students in Canada are knowledgeable about health, Quý provided a list of things that could help newcomers better navigate the health care system in Canada. She outlined how presentations about the importance of health would encourage healthy lifestyles. She also suggested that presentations should emphasize the consequences of unhealthy eating habits, inactivity, and the excessive use of tobacco and alcohol. It seemed likely that she believed knowledge about health will increase healthy life choices.

Similarly, during a discussion about the differences between mental health and illness in Canada and Vietnam, Phương described an increase in awareness about mental health issues through presentations in the urban areas of Vietnam. This was in response to my

question about whether or not people in Vietnam talk to doctors about mental illness, where Phuong described: “The volunteer people to go to some, they organize some place to visit some people, like presentations. And on TV. Yeah lots of [presentations]. But they still happen.” By “they” – she was referring to suicide. Earlier in the interview, Phuong described how suicides occur when someone gets “the mental” – usually caused by stress, where they cannot overcome it.

To introduce the next section, I illustrate how Minh and Quý’s discussion of mental health reflected the importance of knowledge. When I asked Minh how he would define the term *mental health*, his replied: “Mental health. So I am thinking about some severe abnormal people. That they can’t get along with normal people and they just stay in the mental hospital and *they just stay* [he laughs].” I suggest that Minh laughed because this description depicted the stereotype an extreme case of mental illness, as opposed to a definition of what *mental health* refers to in general.⁴⁰ When I asked how he would define *mental health* in Vietnamese, he provided the term *tâm thần*, which is outlined in the next section. Minh continued: “I understand a little bit more about mental health. You can have just mild symptoms, [compared to] severe abnormal people.”

When I asked why he thought there is a difference in meaning in English compared to Vietnamese, he responded that in Vietnam “mental health” is “very severe.” In contrast, Minh described how Canada people could have “mild to moderate to severe” symptoms. I posed my question again, asking *why* there are differences. Minh described how knowledge is less available in Vietnam: “We don’t have psychology class in Vietnam. Yeah, so that’s why

⁴⁰ According to the World Health Organization, “mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (World Health Organization [1]).

many people cannot recognize the different stages of mental health.” He further suggested that a lack of knowledge contributes to why “mental health” is conceptualized as “very severe,” and also why people in Vietnam are hesitant to access mental health services. Quý had the perception that there are differences regarding mental health in Canada and Vietnam. When I asked her what the term *mental health* means in Vietnamese, she replied: “I don’t know [smiles]. I never heard or discussed with anyone about health until I took classes in University. So I don’t know what it means in Vietnamese, did not know mental health word until a psychology class in Canada.”

Discussions of mental health were at times more multifaceted than a comparison of the availability of knowledge. For example, Lành discussed strategies that individuals can employ to overcome mental illness. He first explained the types of things that could cause mental illness, such as tragic life events. Then, he said that while we cannot change unpredictable negative events, we can change how we deal with them. He too described the importance of knowledge and access in determining whether or not people will have the ability to change how they deal with life circumstances. However, earlier in our interview he defined “mental health” similar to the negative descriptions that most of the other participants gave: “Oh it means you are crazy.” Yet when we talked about differences in Canada and Vietnam, Lành said that: “mental problem is anywhere because we are *human*, and it depends on the way you live.”

Analysis

Regular comparisons to Vietnam were evident across the participants’ responses to questions regarding their conceptions of health and illness. Based on their comparisons, I

found myself drawing on the follow-up question relating to what their health practices in Vietnam were like. In what follows, I will illustrate: 1) that the phrase “health is gold” represented the importance of health in light of socio-economic circumstances; 2) that regarding Saskatoon, personal health practices were discussed; however, regarding Vietnam, descriptions of circumstances that impact health and health practices emerged; and 3) the participants’ descriptions of these circumstances were shaped by a variation in access to knowledge and resources largely available in Canada compared to Vietnam.

Sức khỏe là vàng, or “health is gold,” is a common Vietnamese saying that reflects the importance of health (Donnelly 2002; National Institutes of Health 2010). One of the Canadian-born participants, Chì Kim, commented on the frequent usage of metaphor in the Vietnamese language. While Minh was the only participant to say ‘health is gold,’ other participants alluded to how money cannot buy health. However, money *can* buy access to health services in Vietnam, as the participants described. I speculate that the significance of universal health care to the participants of this study (recalling that they largely described how health care in Canada is good because it is “free”) could be related to the metaphor health is *gold*. In this light, the metaphor relates to the disparity in access to knowledge and resources in Vietnam that the participants described to impact health. Regarding gender differences, it seemed more common for the male participants to discuss circumstances that affect health practices, such as diet and environment, in greater detail. However, Quý also discussed the issues of education and other circumstances in Vietnam, even though they were more commonly discussed within the interviews with the male participants.

In reference to the question about health practices, Lành illustrated socio-economic circumstances that negatively affect health when he discussed pollution from heavy industry.

Heavy industry in Vietnam has been described as a major development initiative, largely during the 1960s to the 1980s, aimed at transforming the agricultural base to become a more industrialized nation (Ha 2012; Sikor and O'Rourke 1996). Research suggests that environmental and safety standards were not considered priority during this time (Sikor and O'Rourke 1996). Government efforts to modernize in the 1980s led to economic shifts and rapid industrial growth, along with the privatization and promotion of direct foreign investments, creating more strain on the environment (Ha 2012; Sikor and O'Rourke 1996). These circumstances were indicated by the participants' discussion of environmental pollution in Vietnam.

“Agent Orange,” and the devastating impact of the war, are other factors that need to be addressed. Between 1961 and 1971 the United States forces sprayed an estimated 19.5 million gallons of toxic herbicides over Southeast Asia (Tenenbaum 2003). The most common herbicide used in the war is known as Agent Orange, which is composed of a highly toxic chemical called dioxin (Palmer 2007; Stone 2007). Aimed at cutting off the food supply and exposing the North Vietnamese and allied forces, somewhere between 2.1 and 4.8 million people were sprayed directly (Palmer 2007). Recently, “studies have revealed that dioxin causes many harmful effects in animals – birth defects, cancers, and endocrine disorders – sometimes at vanishingly low concentrations” which are linked to the toxic chemicals that were used (Stone 2007:177). While there are conflicting opinions regarding the level of damage Agent Orange has caused, “the land has still not recovered and people may never be free from the genetic damage deeply embedded in their gene pool” (Franklin 2007:33). This sheds light on how Lành described the high rates of cancer occurring in Vietnam, and how Quý described that she has seen “many people die” due to illness and disease.

Regarding socio-economic circumstances, access to knowledge was another prominent theme. Quý and Phuong both described the issue of limited access to knowledge in Vietnam, which negatively affects health. Minh’s description of mental health, being a “new concept” for people migrating to Canada, reflects a distinction in the type of knowledge that is largely available in each country. The participants indicated that there is a wide disparity between the rich and poor classes of people living in Vietnam, where the poor comprises the majority. Socio-economic status, and therefore access to knowledge and other resources, does not necessarily change or improve once people arrive to Canada. Hoang and Erickson (1985) noted how the second, larger wave of refugees to North America after the war were people from lower income and rural areas, compared to the first wave, comprised largely of physicians, educators, and the like. More recently, socio-economic status is still cited as a barrier for many newcomers (Asanin and Wilson 2008; Kirmayer et al. 2007). However, not all newcomers are from the same socio-economic background, and various circumstances contribute to people’s experiences, both before and after migration.

The distinction between mental health and illness is important to note. Following the holistic definition of health outlined in Chapter Two, the participants largely responded to my question about mental *health* with definitions relating to mental *illness*.⁴¹ When I asked Minh why the concept of mental health is different in each country, he referred to knowledge and services, describing how the knowledge of mental health, along with mental health services, is not as available in Vietnam as they are in Canada. Following Lành’s distinction between

⁴¹ The World Health Organization states that “mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of *abnormal* thoughts, emotions, behaviour and relationships with others” (World Health Organization [2]; emphasis added). The participants largely referred to “mental health” as “crazy” or “abnormal,” which is illustrated further in the next section.

traditional and modern knowledge, we can identify the *type* of knowledge that Minh referred to when he said: “we don’t have a lot of knowledge from school teaching about health and mental...we don’t have psychology classes in Vietnam.” By referring to “psychology classes” and “education from school teachings,” Minh represented forms of western knowledge, which he considered to be more accessible in Canada than Vietnam.

These discussions also represent an important aspect of experience that can be challenging to articulate. Lành described how “things are changing in Vietnam,” and illustrated shifts between historical and modern-day circumstances, along with differences between the urban and rural areas of Vietnam. He mentioned that there are increasing numbers of people moving into the cities. He also mentioned that circumstances in the cities have been changing, where there are fast food establishments, and where people can “sit in front of the T.V., or play video games or watch movies.” Lành further described this aspect of modernization as negative: “they’re inactive, so that’s a big problem.” Research often captures stories told in a particular context at a specific time. Yet the participants’ experiences are not static, but shifting based on personal, socio-cultural, historical, and geographical circumstances that are constantly changing within and between Canada and Vietnam.

Mental Health

The final “grand tour” question I asked related to mental well-being. While none of the participants described experiences with mental health services, the question - What do you think about *mental health*? - served to gain a deeper understanding of their conceptions of health. Most participants considered *mental health* to refer something negative or unhealthy. This led to the development of a follow-up question: What do you think about the *health of the mind*? Interestingly, participants recognized the importance of the health of the mind even

though mental health was considered to be negative. This contrast illustrates how the concept/condition of mental health differs cross-culturally.

Initially, most of the participants seemed unsure of how to respond to my question regarding a definition of mental health, and replied with phrases such as “I don’t know.” Some participants followed-up their response with definitions holding negative connotations. For example Mai said: “It's like, mental health, I think about, it's like they have a problem with their brain? Mental?” Similarly, Chú Vân stated: “Mental health? I think it [pause] I don't know how to answer mental health.” While most participants responded in a similar negative and/or ambiguous manner, Liên and Quý gave more positive descriptions, and described the importance of mental health. Liên’s definition of health included: “I think if you are comfortable, it's hard to say. If you, yeah if you are comfortable and mentally healthy, is like happy. When you are happy, it's healthy.” Quý described health as: “To be healthy is not only to be strong physically but also mentally.”

To follow-up I asked participants: What does the term mental health mean in the Vietnamese language? This question elicited more detailed responses, where participants offered both English and Vietnamese terms. The English term *mental health* was almost unanimously compared to the Vietnamese term *tâm thần*. As it appears in the dictionary the term *tâm thần* refers to “the mind” or “mental” (vdict.com website), also “mental illness” (Langenscheidt Pocket Dictionary 2006). However, I have heard the term referred to more negatively, similar to the English term *crazy*. Regarding “*tâm thần*,” most participants elaborated with phrases such as: “very stressed; fight with your family; you should go to the hospital; you lose control; crazy; abnormal; can’t do or think.” While not every participant

indicated that *tâm thần* and *mental health* hold equivalent meanings, both terms were associated with similar descriptions, such as “crazy” and “abnormal.”

Due to the negative and ambiguous connotations associated with mental health, the follow-up question – What do you think about the health of the mind? – emerged. The participants’ descriptions differed significantly. However, both *mental health* and *the health of the mind* contained similar elements of discussion. For example, stress was considered to cause problems, and religion was associated with healing or helping these problems. In reference to my question about *the health of the mind* Chú Vân replied:

Any religion, like Buddhist or Catholic...The people who have religion is the best for people's health. If some people don't have religion, when they have illness or troubles, they don't know how to get help. They don't know how to pray. So if we are a member of a religious organization, then we feel illness... So we can pray. So then maybe *help your mind* it will [praying].

Chú Vân also said that “mental health, maybe religion is going to help that.” Interestingly, another study found that religion and health are “hand in hand” (National Institutes of Health 2010), illustrating the importance of these questions regarding the participants’ conceptions of health in understanding their experiences.

While the word *mental* seemed to hold a negative connotation, it was during the follow-up discussions regarding *the mind* that the participants revealed more detail regarding a definition of well-being beyond the physical sense. Chú Peter and Mai both described the negative impact that stress can have on the mind and therefore on one’s state of health. When

I asked him what he does to be healthy, Chú Peter described how “you have to eat at the right time. You have to eat the right stuff, eat the right food, and you have to rest.” After this discussion which I suggest illustrates the importance of balance, Chú Peter concluded with “you have to be happy with what you have” regarding how stress is unhealthy for the mind.⁴² Mai also described that “some people [pause] they just want one goal and then they can achieve that goal. And they just get stressed about that. But some people are just satisfied with what they have. They just live happily and stuff.” These examples illustrate a how a wider discussion of mental well-being emerged based on a variation in the question being asked.

Research suggests that mental illness is considered a stigma in many Asian cultures, where it is considered more appropriate to express physical, rather than emotional symptoms of discomfort (Lin et al. 1985). The term *somatization* indicates that when it is considered inappropriate to express personal emotions, people are more likely to communicate emotional distress in physical terms (Dastjerdi 2012; Isaac 1996; Karasz, Dempsey and Fallek 2007; Kleinman 1986; Mak 2004; North 2002). This sheds light on an idea discussed by a Canadian-born participant, Jane, in reference to her mother’s experience. She described how her mother would not discuss mental health with her, but that she would with her peers, suggesting that her mother felt it was inappropriate to discuss emotional symptoms of

⁴² I draw on a general definition regarding the term *balance* to mean: “a state in which different things occur in equal or proper amounts or have an equal or proper amount of importance” (Merriam Webster Online Dictionary). While Chu Peter did not use this term in his discussion of doing things such as eating, sleeping at the “right” time, many of the participants used this term and discussed the importance of a balanced lifestyle, not specific to the concept of the *health of the mind*.

discomfort with her daughter.⁴³ This led Jane to speculate that some things are appropriate to share in different contexts, and suggested that perhaps ‘going to the doctor is for physical things’ from her mother’s point of view. The stigmatization regarding mental illness seemed evident within the Vietnamese-born participants’ interviews, based on their negative descriptions regarding “mental health.”

Mental well-being in Vietnam has been recently reported to be a major health initiative, yet government reforms have negatively affected the availability of resources, and stigmatization has limited the use of services among the general population (Vuong et al. 2011). Moreover, traditional concepts, such as having a “weak mind,” have been considered taboo within Vietnamese culture (Nguyen 1985). This could increase stigmatization, and therefore decrease the utilization of mental health services, among people who adhere to this belief.⁴⁴

Obeyesekere (1985) devised the term *the work of culture* to explain how our experiences and expressions of illness are embedded within the social structure in which we live.⁴⁵ I want to highlight how we cannot assume that categories of illness will simply translate into another language, where meaning will remain the same (see Phan and Silove 1997). This is illustrated by the variation regarding *mental health* and *the health of the mind*. This suggests that the participants indeed have a conception of mental well-being, but that the

⁴³ Jane further reflected that perhaps if/when she had her own children, perhaps her mother would discuss such things with her.

⁴⁴ In his article regarding the “culture shock” of Vietnamese immigrants and refugees coming to North America, Nguyen describes the contrast in perspectives regarding the role of psychiatrists: “A psychiatrist is either a “nerve doctor”-which underscores the biologic label attached to the specialty- or a “doctor for the insane”” (1985:409).

⁴⁵ This discussion is largely based on his work studying Buddhist practices in Sri Lanka, where Obeyesekere (1985) found that the western concept *depression* as being a mental disorder did not fit within the conceptualization of sadness and suffering that is considered a necessary part of the human condition from the perspective of his participants.

phrase *mental health*, as defined by the World Health Organization, did not adequately address it. Donnelly (2002) reminds us of the importance of recognizing the socio-historical, cultural, and political contexts that affect people's experiences; she explores the context of stress and coping among Vietnamese immigrants while identifying issues with traditional modes that assess levels of coping and stress without taking the cultural context into consideration.

Canadian-Born Participants

The interviews conducted with participants born in Canada who are of Vietnamese descent added support to what the Vietnamese-born participants described. As outlined in Chapter Two, Matt, Chì Kim, and Jane comprise the Canadian-born study group.⁴⁶ Jane was a working professional and student at the time of the interview. Her parents were both born in Vietnam, and her line of work related to the newcomer experience. Chì Kim's parents were also born in Vietnam, and she also worked in a field that was connected to immigrants and refugees. Matt was born in Saskatoon, and his parents and siblings were born in Vietnam. Their interviews were structured to elicit a discussion about their parents' experiences as well as their own. Largely, their parents can be described as 'the boat people' generation, who migrated to Vietnam as refugees after the war. However, Jane's parents arrived to Canada under different circumstances. She described her dad as being an intellectual who 'left with the Americans' during the earlier wave, where her parents had not met until they were living in Canada.

⁴⁶ When asked to choose a pseudonym, "Kim" chose "Chì Kim." The pronoun "Chì" is similar to "older sister" in English, reflecting the relative age difference between Kim and I.

Matt used the term *first-generation Vietnamese-Canadian*. Jane and Chi Kim did not identify themselves as such. The literature more typically describes “first generation” in reference to people who have migrated to Canada, whereas Canadian-born Vietnamese-Canadians are referred to as “the second generation.” Their personal experiences were reported to be quite different, which will be illustrated below. However, regarding their parents’ experiences, they described similar themes. Namely, they described how language and cultural differences exist, the role of acting as interpreters, and how health care in Vietnam is very different than health care in Canada.

Matt described his experiences with health care in Saskatoon as good overall, except for his name being incorrect on his birth certificate, due to a miscommunication between his parents and hospital staff. Matt described his parents’ experiences as generally good, but how they are hesitant about certain aspects of the health care system. In one instance he described how his parents were hesitant “mainly because they weren’t really sure what was going on.” He further described how his parents use western health services for certain things and traditional medicines for others, depending on the context of symptoms and desired treatment. Matt also described how his parents “respect and access” health services in Saskatoon, but how they prefer traditional practices for certain things. For example, while Matt described how “with my mom, she tries traditional medicine first. That being said, if something is wrong, like if the kids are sick, they go to the doctor.” Matt also described the influence of his parents regarding his own health practices, where he uses lemongrass to treat a certain skin condition he sometimes experiences.⁴⁷

⁴⁷ I was cautious to avoid presenting very specific ailments that the participants have had, as the Vietnamese community in Saskatoon is quite small, and I indicated that I would not reveal identifying information as outlined in the ethics protocol regarding confidentiality.

Chi Kim described in great detail the challenges her family has faced with health care in rural Saskatchewan, as well as in Saskatoon. In regards to her own experience, Chi Kim discussed issues such as racism and other forms of discrimination. For example, Chi Kim described how one physician she sought out as a possible family doctor in Saskatoon thought that she was from China:

I think he meant well, but it was offensive. He was trying to make conversation with me, but instead of asking ‘oh, what is your background, were you born here or have your parents come here from where?’ he just naturally assumed that I was Chinese. And came from China. And started speaking about his experiences in China...So I thought, you know, if he hasn’t taken the time to actually know who I am, or just to know a little bit about me, how is he going to effectively treat, or help me medically?

Chi Kim also described how being born in Canada does not necessarily indicate that a person will only want to access western health care. She said that she accesses health care services only when absolutely necessary, while preferring traditional or holistic practices. Regarding these practices, Chi Kim described specifically a medicinal type of tea that her father makes. She described how she prefers to use such remedies for ailments such as headaches, colds and flus. Regarding the use of a western biomedical practitioner, Chi Kim described “I use services for things that I absolutely need. So if I need a prescription, I go to the doctor. If I am really really sick and I can’t do anything about it, then I’ll go.” The Vietnamese-born participants also made reference to using traditional or non-biomedical

medicine or practices. The most commonly described practice was the use of herbal medicine or teas. For example, Mai described obtaining “natural” medicine from Vietnam that her mother suggests taking to help treat her stomach ailment. Another example is how Liên described what she does if she has a cold or flu: “instead of taking medicine, I would have hot honey lemonade. I say that to my friends a lot. I tell them to take that.”

The theme of language and cultural differences emerged frequently during Chì Kim’s interview. She described the issues that her parents have faced living in rural Saskatchewan while having to access specialist services in Saskatoon. In part, she described the inconvenience of having to drive to Saskatoon from their small town. More significantly, she talked about her father’s experience, where his family doctor in rural Saskatchewan was considered “accommodating and understanding,” but that he only practiced in their hometown every second week. More positively, his specialist doctor (who was of Chinese descent) “took the time to explain in very easy terms.”

In contrast, a physician he had seen at one of the hospitals in Saskatoon was referred to as “very in/out, very restrictive.” She described her father as saying “the doctor didn’t even do anything.” Some of these descriptions reiterate the themes that the Vietnamese-born participants drew on regarding the importance of communication within medical encounters. Regarding cross-cultural medical encounters, Chì Kim suggested that some newcomers might feel more comfortable with a doctor from the same country-of-origin. However, she mentioned how health professionals ought to go through cultural sensitivity training regardless of where they or their patients are from.

Jane did not share the difficulties that Chì Kim described regarding her own experience. However, she described “difficulty in the language, interpretation and

understanding” particularly regarding her mother’s experiences, even though her mom liked the services and used them frequently. In reference to her father, Jane speculated that he does not like using services because he is a “stubborn man,” not because he is from Vietnam specifically. However, Jane described the challenges that newcomers face on a more general level. Her line of work is associated with the newcomer experience. Particularly, she mentioned language, challenges connecting to resources, in adjusting to the changes in food and lifestyle, and fitting in with the mainstream population.

With Canada’s increasing population diversity, the role of family members as interpreters is becoming a growing research interest, where “children’s brokering constitutes an important, often overlooked, linkage between research on immigrant family dynamics and on immigrants’ interactions with host country institutions” (Katz 2012:195). As such, the discussions with the Canadian-born Vietnamese-Canadian participants are essential to this research study.

Health Care in Vietnam

Many participants described health care in Vietnam during their discussion of health care in Saskatoon. Recalling how Minh described hospitals in Vietnam as “overcrowded” and “dirty,” Lành also said that “hospitals in Vietnam are overloaded” and continued with: “we [in Vietnam] don’t usually see a doctor often. Because usually it is very expensive. When we see doctor, we don’t have a health care system. And usually we have lots of private pharmacy.” At one point during the interview with Chú Vân, I asked him what he thought about health care in Vietnam: “Oh of course [Chú laughs]. Vietnam, I think just the health care [pause] they don’t have much health care, because it is a poor country. In Canada I think it is very good.” By describing Vietnam as a “poor country,” Chú Vân brought awareness to

the issue of economic disparity, which reflects the themes presented in the previous sections of this chapter.

Liên and Mai suggested their physicians in Saskatoon did not provide thorough enough examinations. Interestingly, they both elaborated on what a “complete check-up” would include in Vietnam, describing procedures such as x-rays, ultrasounds, and blood tests. Liên compared this to Canada, where a check-up is “something simple, not that complicated.” She also mentioned that while they could request these tests in Vietnam, they would also have to pay for them. Perhaps Liên and Mai had expected that the doctors in Saskatoon would offer these same tests during examinations, as they did in Vietnam.

The Canadian-born participants also discussed health care in Vietnam. While describing the issues of confidentiality within a small community, such as the Vietnamese community in Saskatoon, Chị Kim said: “There’s that misunderstanding that, what it means in terms of confidentiality with the medical system here because what they’re used to is their own medical system.” She described a typical doctor’s office in Vietnam as “very different,” indicating how there is not much privacy, where “you can hear the doctor talking to the patient about whatever medical issue is going on.” She highlighted the fact that “confidentiality means different things,” which supports the theory of cultural relativism that this thesis draws upon.

I shared my preliminary thoughts regarding an analysis with Jane, in how it seemed that most of my participants discussed experiences in Vietnam during our interviews. Jane informed me that she had not accessed health care in Vietnam, but that she had heard many family discussions similar to the ideas that the Vietnamese-born participants described: “If you don’t have money, you don’t get health care. Basically. If you *do* have money, depending on how much money you have, depends on what kind of services you get.” Jane elaborated

on the implications of moving to Canada from Vietnam, being given a health care card, and how positive this would seem. However, she also emphasized that “free” health care “doesn’t change the fact that there are communication barriers.”

When I asked Matt to elaborate on that fact that his dad was attending medical school in Vietnam, but was forced to quit and join the war efforts, Matt replied: “The sad, well one of the unfortunate things about my family history is that my parents, they talk about Vietnam a lot. But it’s very romanticized or glorified ...they don’t talk about the negative.” He went on to describe how he had not learned about the history of the ‘boat people’ until he attended university. He also commented on what he thought about the context of my project regarding health care experiences in Saskatoon: “The first thing that I thought is well, these people kind of jumped on a boat and sailed, compared to what it was like in Vietnam, as opposed to here, it would be better here.”

The Canadian-born and Vietnamese-born participants shared similar descriptions regarding health care in Vietnam. Namely, that health care in Canada is better in comparison. However, Jane noted the fact that health care in Canada is “free,” does not preclude the fact that barriers still exist. Particularly, both participant groups illustrated an array of challenges and negative experiences. Regarding the Vietnamese-born participants, the claim that health care in Canada is good was repeatedly connected to discussions about health care in Vietnam. Namely, they described that health care in Vietnam is expensive and access is therefore limited to those who can afford it. Chapter Four is dedicated to exploring the participants’ frame of reference, in how their past experiences shape their understanding and assessment of health care in Saskatoon.

CHAPTER 4 DISCUSSION AND CONCLUSION

In this chapter I present an interpretation of how the participants' frame of reference to Vietnam shaped their descriptions of health care in Saskatoon; I discuss the usefulness of the findings in terms of some broad recommendations for future research; and I discuss the context and limitations of this study, followed by my concluding thoughts about the connection between the participants' descriptions of Vietnam and health care in Saskatoon. The purpose of this discussion is to explore the significance of the findings presented in Chapter Three. Specifically, I will explain how the implications of what the participants described extends beyond health care; how circumstances in Vietnam are relevant to the participants' present experiences; and how a "west is best" discourse pervaded and perhaps minimized a more detailed discussion of language and cultural differences.

Frame of Reference

The context of this project pertains to health care in Saskatoon. However, the participants frequently made reference to Vietnam. Within this context, several types of descriptions emerged. Participants discussed experiences with health care in both Canada and/or Vietnam. Participants also described larger circumstances regarding both countries, including political, economic, socio-cultural, environmental, and historical factors. Within their comparisons, several patterns emerged: 1) participants often described health care in Saskatoon in relation to health care, and other circumstances, in Vietnam; 2) discussions about the socio-economic differences between Canada and Vietnam were prevalent, especially relating to diet, the environment, and knowledge; and 3) western health care and western approaches, generally, were described as "better than" those in Vietnam. It is beyond

the scope of this thesis to draw general comparative analyses between the two countries. However, the participants' descriptions represent their unique experiences, which are the focal point of my analyses.

In particular, stories can bring meaning to how we understand our past, present and future (Bruner 1997). The supposition that the participants widely made sense of their more recent experiences while comparing them to the past fits within the understanding that their perceptions in Saskatoon are influenced by the cultural context in which they lived in Vietnam. I draw on existential anthropology, which articulates how experience is inherently relational. Jackson writes about the intersubjective quality of our existence and the importance of studying the “in between” states between objects and subjects, where “inter-existence is given precedence over individual essence” (1998:3). In this sense, the relationship between the individual and the social is one of interconnectedness. I posit that the dialogue between the local and global, between the individual and social, rests within our capacity to draw comparisons.

Following Garro's observation that “our understanding of new information [i.e. the present] is influenced by what we already know [i.e. the past]” (2000a:277), I suggest that what the participants already “know” is rooted within past experiences in Vietnam. However, “the past” can also be a non-linear representation of experience. The interview I conducted with each participant represented a particular moment in time, where they described elements of both past and more recent experiences. Drawing from theories deemed the “narrative turn” within medical anthropology, I suggest that “temporal unfolding and sequencing bring meaning to narrative,” (Del Vecchio Good et al. 1994:855) where the participants “emplot” descriptions, not in the chronological sense, but in terms of what is meaningful to the

present.⁴⁸ I recognize that the process of migrating from one country to another is a significant experience. Therefore, I also explore how memories of Vietnam have not only shaped, but were shaped by the participants' experiences living in Saskatoon.

I draw on American linguist Wallace Chafe's (1994) discussion of semi-active memory, where he describes how we can only *consciously* focus on a limited amount of information at a time. In the context of this thesis, "life in Vietnam" was not the intended focus of our interview. As such, I speculate that by recalling experiences in Vietnam, the participants may have been drawing from semi-active or inactive memories, not directly targeted by the purpose of our interview. Moreover, Chafe (1994) highlights the importance of studying experience beyond consciousness by presenting an analogy to vision: "we would miss something important if we only dealt with focal consciousness, just as we would miss something vital in human vision if we studied only foveal sight" (Baars 1993:135 cited in Chafe 1994:54).⁴⁹ While peripheral to the discussion of Saskatoon, I find that by analysing the participants' descriptions of Vietnam, we gain deeper understanding of their experiences.

These theories draw attention to the significance of context. I propose that the relational aspect of experience, where comparison of past and present experiences is inherent, is a universal phenomenon. It follows that the Vietnamese-born participants would inevitably compare their experiences in Saskatoon with past experiences in Vietnam, insofar as those experiences largely comprise the basis of knowledge that they have with which to understand and describe the present.

⁴⁸ Rooted in literary theory, *emplotment* is mainly associated with the work of Cheryl Mattingly in describing the narrative plot within therapeutic/clinical encounters. This work expands on philosopher Paul Ricoeur's concept of "narrative time" into the context of social action (Del Vecchio Good et al. 1994; Mattingly 1994).

⁴⁹ Examining the distinction between consciousness and unconsciousness is beyond the scope of this thesis, and I suggest that the participants drew from both types of memories.

Health Care in Canada and Vietnam

That the participants' understanding of life in Saskatoon is affected by earlier experiences was evident in Minh's interview, for example, where he drew on experiences he had living in the United States, as well as descriptions of Vietnam. The most prevalent example of this past–present comparison is how the participants highlighted that health care in Canada is good because it is “free.” This was mentioned by all the Vietnamese-born participants to varying degrees and in different contexts. Ngái, who had not yet accessed services in Saskatoon, said that he heard that they are good and would access them if needed. Even Liên and Mai, whose experiences seemed largely negative, described health care in Canada as good because it is free. Symbolic interactionist theories highlight the importance of studying process over structure, and the inclusion of context in the analysis of social (inter)-action (Ballis Lal 1995). Building on theories that recognize intersubjective contexts, I suggest that the participants consider health care in Canada to be “good” *relative* to health care in Vietnam.

I turn to social and cognitive psychological theories to explain how the participants compared their past and present experiences. While some participants stated that health care in Canada is “good,” others verbally stated that health care in Canada is “better than [Vietnam],” providing descriptions of what health care in Vietnam is like. I suggest that reference to Vietnam occurred on both explicit and implicit levels. Social psychologist Brian Nosek defines an explicit response as “controllable, intended, made with awareness and [requiring] cognitive resources” (2007:65). Given the fact that the direct and intended purpose of the interviews was to discuss health care in Saskatoon, references to Vietnam occurred on an unsolicited and unintended level. Nosek further describes how “implicit evaluation reflects

accumulated experience that may not be available to introspection” (2007:69). In this sense the participants’ “accumulated experiences” included past memories regarding Vietnam, which they may or may not have consciously intended to be shared prior to the interview.

Recall that Liên began her interview by saying that health care is better in Canada, compared to Vietnam, because “here it is free, in Vietnam we have to pay.” She also mentioned that staff members were nicer in Saskatoon. Nosek suggests that constructs such as attitudes, goals or identity, “have active existence distinct from conscious, deliberate, and intentional experience” (2007:65). Liên’s attitude toward health care in Vietnam was formed at the implicit level that Nosek describes, since the initial interview question did not demand her to draw such a comparison. Similar implicit processes can be seen in Chú Vân’s description that “health care in Saskatoon is very good,” where the idea of “good” is an implicit comparison to something.

To explore the underlying context of what the participants described, I draw also from the work of linguist Robyn Carston. Carston (2009) suggests that statements necessarily contain implied meaning, where it is nearly impossible to express the entire meaning of a statement verbally. Carston defines a “conversational implicature” as “not something [a speaker] says explicitly; rather, it is an indirect or implied answer to [a] question” (2009:36). I suggest that while my participants answered my questions in the verbal sense, implied meaning was also inevitable. To illustrate this concept, Carston describes the process of “finding the intended content (or value) [i.e. meaning] for a linguistically indicated variable,” such as:

d. It’s hot enough [*to what*]

e. I like Sally's portrait. [*portrait in what relation to Sally?*] (Carston 2009:49).

Carston explains that “[t]his ‘completion’ process [i.e. the bracketed phrases] is obligatory on every communicative use of these sentences, since without it there is no fully propositional form, nothing that can be understood as the explicit content of the utterance” (2009:49).

Hence, the meaning found within these verbal statements cannot be separated from the non-verbal, implied meaning.

Carston presents another set of examples that likely have implied meaning even though they technically, linguistically could stand alone:

15.a. She has a brain. [*A highly-functioning brain*]...

c. It's snowing. [*in location x*]” (2009:50).

She explains how there could be “somewhat unusual” contexts where these utterances do not contain implicit meaning, such as for 15.a. “in a situation in which the removal of certain people's brains has become common practice” (Carston 2009:50). Hence, these utterances likely have implicatures that render them more meaningful.

In this light, Chú Vân's statement: “health care in Canada is very good,” should be read with the following implicature: “health care in Canada is very good [*relative to x*]”. Based on the participants' past experiences in Vietnam, I suggest that $x = \text{Vietnam}$, so that ‘health care in Canada is good compared to Vietnam’ is a most probable implicature. This statement contains explicit meaning, where the idea of Canada having “good” health care can be understood without the implicature. However, since experiences are relational, and the

understanding of experience is therefore comparative, I suggest that analysing the implied meaning expands our understanding of the explicit form of the statement.

Let us look at another example of a “conversational implicature,” illustrated by Carston in the following dialogue:

1. Max: How was the party? Did it go well?

Amy: There wasn't enough drink and everyone left early (2009:36).

She explains how Max can assume that Amy did not think the party went well, suggesting that there is implied meaning within the exchange, as Amy did not explicitly state that it did not go well. Next, Carston presents the most likely intended meaning in italics:

2. There wasn't enough *alcoholic* drink to satisfy the people at [*the party*]_i and so everyone who came to [*the party*]_i left [*it*]_i early (2009:36).

In this example, Carston (2009) highlights how Max can assume that when Amy said “everyone,” she was referring to the people who were at the party. While this reference is verbally absent, it is implied. Verbal reference to Vietnam was absent during Chú Peter's initial discussion that health care in Saskatoon is “very good.” He elaborated on health care at a later point in the interview, echoing the idea that health care in Canada is good because it is free. Chú Peter went on to say: “So it's like I say [he laughs]. Everything in Canada is *so good* to me.” I suggest that “everything” in Canada being “so good” includes the health care

system that he so positively described, where the meaning within Chú Peter's statement rests within both explicit and implicit comparison to Vietnam.

Easier to be Healthy in Canada than Vietnam

Another theme that emerged through the participants' discussions of Vietnam was the idea that it is easier to be healthy in Canada. This theme was connected to stories shared regarding diet, environment, and socio-economic circumstances. These stories were largely presented in response to the question about health practices. Participants described personal health practices, but also larger socio-economic circumstances that impact health and health practices. They described how things in Canada are cleaner and how there are more opportunities to take care of one's health. They described a lack of access to opportunities such as good foods, environmental pollution caused by heavy industry, as well as poverty as a result of the War in Vietnam. While many of these stories were not directly related to health care, the participants' descriptions of larger circumstances provided insight into the context of their past experiences.

Drawing on the narrative principle that "narrative occurs in some kind of discourse environment...as an embedded unit" (De Fina and Georgakopoulou 2012:43-44), I suggest that the discussions about socio-economic circumstances in Vietnam are connected to what the participants described about health care in Saskatoon. As such, the interviews can be considered "units of analysis," where descriptions of health care, conceptions of health, and past experiences overlap and add meaning to their discussion as a whole. Participants spoke about unequal access to health care, but they also described larger socio-economic circumstances in Vietnam that impact people's health and health practices. For example,

Lành disclosed his thoughts about the impact of pollution from heavy industry, along with the devastating effects and lasting impacts of the war on people's health. The privatization of the health care system in Vietnam, which has widened the disparity of access to resources (Huong et al. 2007; Luong et al. 2007), is not separate from, but part of the socio-economic circumstances that have influenced the participants to describe how it is easier to be healthy in Canada than in Vietnam.

For another example, the idea that it is easier to be healthy in Canada is evident in Minh's description of diet, where "everything is cleaner" and he feels "safer to eat" the food. I am of the opinion that this description of "everything" reflected Minh's conceptions beyond diet. Elsewhere in the interview Minh discussed the uncleanliness of hospitals in Vietnam as part of why he thinks that health care in Canada is better. Similarly, Chú Vân implied that the environment in Vietnam is unhealthy as part of a larger comparison to Canada. Chú Vân's illustration of a visit his family took to Vietnam illustrates the importance of viewing his interview as a contextual unit. Chú Vân did not elaborate on why health care in Saskatoon is good in much detail. However, by stating that "looks like Vietnam is in hell," compared to Canada, which "looks like heaven," Chú Vân provided insight into why he described health care in Canada as "very good" during his initial description.⁵⁰

Returning to Wallace Chafe (1994), I follow his idea that the different states in which mental models (memories) exist are: active, semi-active or inactive. Over time, we forget many, perhaps even most of the day-to-day specific details of our experiences, rendering them largely inactive; instead "we usually have access only to striking, crucial events in our life...such as a vacation, a trip, our study at such and such a university or living in a particular

⁵⁰ The tone of the interview was much lighter than the analogy between "heaven" and "hell" might suggest.

city, or to traumatic experiences such as an accident or a divorce” (van Dijk 2008:62). It makes sense that the process of migrating from Vietnam to Canada is a “striking” or “crucial” event, enabling certain aspects of the past to be “active” within the minds of the participants, and therefore drawn out during our interview. The *type* of past experiences that seem most active or accessible were the general references to circumstances, such as pollution, or events, such as war, that the participants described.

I suggest that these more general references to circumstances in Vietnam were active not only because they are easier to recall than day-to-day personal experiences, but because they are more significant. Considering that “memory is shaped by the contexts in which it is told” (Skultans 2007:118), an interview regarding ‘health care from a *newcomer* perspective’ may have inspired, whether consciously or not, the participants to draw broad comparisons to Vietnam. However, when I asked Lành to elaborate on why he thought his doctor in Saskatoon is better than doctors in Vietnam, he replied: “from my understanding, Canada is a developed country and Vietnam is *developing*.” While he initially described his experience on a personal level, how his doctor in Saskatoon “has the experience and solution for my problem,” Lành later stated that health care in Canada is better *because* it is a developed country, where the socio-economic circumstances differ compared to Vietnam.

Following Garro’s idea that “past events are reconstructed in a manner congruent with current understandings,” (2000b:70) I propose that the migration process broadened the participants’ frame of reference, which shaped how they remembered and described the past. Participants would often say “it’s different” when referring to Vietnam. This is evident within Chú Vân and Minh’s descriptions regarding visits back to Vietnam. They recalled similar images, such as it being “hot, crowded, polluted, and noisy” while explaining how it is

“different” there compared to Canada. The notion of *difference* rests within the fact that the participants have had experiences in both countries to draw on. Liên illustrated how her frame of reference had shifted, where she described what she thought about health care in Canada before she arrived: “Like, I thought that it was the *best*. But now I find that nothing is perfect.” The participants described how Canada has “better opportunities” than Vietnam, and how it is easier to be healthy in Canada. While these discussions were not always directly related to health care, it is evident that they complemented and added meaning to what the participants described about their health care experiences in Saskatoon.

The West is Best Discourse

A discussion of knowledge was another prevalent theme, and it occurred on two levels. The first level involved the participants’ descriptions of the importance of education and knowledge, which occurred during many of their discussions. For example, Phuong and Quý emphasized the disparity in access to knowledge and resources in Vietnam compared to Canada. Second, there was a discursive aspect to the participants’ descriptions of knowledge. Sociologist and cultural theorist, Stuart Hall, describes discourse as “a group of statements which provide a language for talking about—i.e. a way of representing—a particular kind of knowledge about a topic” (2007:56). I found that the participants conceptualized ideas that represent a particular discourse: the *west and the rest* discourse that is described by Hall in his writings on colonialism and the formation of modern society (2007; 1995; 1992).

Within this discourse, “the west” is defined as a “*historical*, not a geographical, construct...a society that is developed, industrialized, urbanized, capitalist, secular, and modern” (Hall 1992:277). By identifying “the west” as a historical construction, Hall (1992)

brings attention to how “the west” is often positioned as superior to “non-western” societies, i.e. “the rest.”⁵¹ I am of the opinion that the participants’ statements regarding health care largely reflect a “west is best” discourse. For example, when I asked Phuong how she would improve health services in Saskatoon, she replied with a more general comment about the importance of having the knowledge of how to use a computer. She went on to talk about the severity of not being able to afford medical treatment in Vietnam.

Aspects of Lành’s perspective also illustrate this discourse. He talked about traditional aspects of Vietnamese culture, where some are good, but some are “dangerous,” while indicating that he prefers western practices and the Canadian health care system. Lành’s perspective also reflects that his understanding of health care in Canada is relative to his beliefs regarding certain aspects of Vietnamese culture. Herskovits wrote how the basic principle of cultural relativism includes the idea that “judgements are based on experience, and experience is interpreted by each individual in terms of his own enculturation” (in Herskovits, ed. 1972:15). I suggest that Lành’s discussion of tradition is based upon this notion, in that his perceptions of experiences in Saskatoon are shaped by the cultural context of his past experiences.

The following excerpt from Chapter Five in *Formations of Modernity* characterizes Stuart Hall’s notion of how *the west and the rest* discourse operates. “The west” as an idea or a discourse, is:

⁵¹ Hall’s notion of the *west and the rest* discourse has been widely cited within Indigenous Studies, particularly in how western superiority is both propelled by and used to justify colonial expansion within Canada and elsewhere. For example, Silver et al. reveal the consequences of colonialism on the lives of First Nations people within Canada, where “various state apparatuses were systematically used to degrade and erode their way of being in the name of ‘civilizing’ them,” such as the tragedy of the residential school system (2006:10).

An image or set of images. It condenses a number of different characteristics into one picture...it *represents* in verbal and visual language – a composite picture of what different societies, cultures, peoples and places are like. It functions as part of a language, a ‘system of representation’. (I say ‘system’ because it doesn’t stand on its own, but works in conjunction with other images and ideas with which it forms a set: for example, ‘western’ = urban = developed; or ‘non-western’ = non-industrial = rural = agricultural = under-developed.) (1992:277).

When I asked “so here it is better?” referring to the health care system, Lành replied with the idea that it is *because* Canada is a developed, *western* nation that things are better.

The idea of “new concepts,” a distinction made by Minh in the type of knowledge that is more widely available in Canada, also reflected a “west is best” discourse. Specifically, Minh described how the term *mental health* is a new concept for people who moved from Vietnam to Canada. His distinction “I understand a little bit more about mental health [since moving to North America]” suggests that his perspective had shifted. Quý reflected this same notion when she described how “there are no psychology classes in Vietnam.” It is important to recognize that whether or not there are psychology classes in Vietnam is irrelevant to understanding the participants’ subjective experiences. To put it in Chafe’s words, the absence of psychology classes in Vietnam in this case is an “idea that exists in the minds of the speakers and listeners whether or not they have correlates in the “real world” is irrelevant” (1994:67).

While I suggest that a “west is best” discourse influenced the participants’ descriptions of health care in Saskatoon, I also recognize that qualitative research allows for analyses that reveal the complexity of individual experiences. In what follows, I present examples that illustrate this complexity through variations and nuances that were evident within the interviews. Mai’s interview largely surrounded negative experiences with a doctor in Saskatoon who did not check her symptoms carefully. Phuong’s description of both positive (i.e. “good”) and perhaps negative (i.e. “confusing”) elements illustrates how the participants’ experiences are multifaceted.

Drawing from literary theory, medical anthropologists have adopted Mikhail Bakhtin’s term *heteroglossia* to define how “disease and human suffering cannot be comprehended from a single perspective” (Good 1994:62), where multiple and often competing “voices” can be attributed to explaining the same phenomena.⁵² I suggest that the participants drew on more than one voice to describe their experiences with health care in Saskatoon. By adopting the concept *heteroglossia*, it is possible to recognize that people frequently illustrate multiple, sometimes even contradictory voices to describe their own experiences (Smith 2004). As such, I find that Liên and Mai were able to describe negative aspects of the health care system, while still drawing on the idea that health care in Canada is better than it was in Vietnam.

This brings up an aspect of health research regarding Vietnamese immigrants and refugees, where my analyses may contribute further insight. The idea that people who are more likely to subscribe to traditional beliefs are less likely to access health services has been

⁵² Writing on the “multiplicity of voices” within medicine and academia, Good (1994) suggests that these voices are not necessarily dialectical or complementary to one another; and where particularly the voice biomedicine has long assumed precedence over other perspectives.

described (see Luu et al. 2009). While it was not the focus of our conversations, participants often discussed their use of traditional Vietnamese remedies, even though they also accessed health care services. Matt's description of how his parents use both western and traditional practices for different types of ailments adds insight into the generalizations found within the literature regarding traditional belief and utilization. All three Canadian-born participants said that they subscribe to "traditional" beliefs, such as Buddhism, even though they were born in "the west." Chì Kim noted that she only accesses western health services when absolutely needed, and that she prefers more traditional remedies.

I have suggested that the *west is best* discourse is prevalent within the participants' discussions that health care, along with other circumstances, are better in Canada than Vietnam. However, it is also evident within these interview passages that individual variation and nuances of experience should be recognized, where a west/rest distinction is not always clear. Furthermore, this study does not suggest that the west is somehow "best." The participants illustrated a variety of contrasting views regarding their perspective on traditional and more modern or western practices. Even though Lành described some traditional beliefs as "dangerous," the participants largely used traditional as well as western health practices, depending on the context, where certain ailments are better treated by the former or the latter. It was more specifically regarding health care services, along with other socio-economic circumstances, that the participants described as better in Canada than Vietnam.

Contributions to Health Research

The findings of this study contribute to the larger body of health research by confirming some of the evidence stated in previous studies surrounding barriers to care that the foreign-born residents of Canada might experience. There is a tendency within the

literature to draw upon general discussion of the experiences of immigrants and refugees (Leduc and Proulx 2004), as well as the experiences of immigrants and refugees from particular groups. The findings of this study contribute to the knowledge regarding the health care experiences of Vietnamese immigrants and refugees in Saskatoon, a population where there is a lack of qualitative health research available. This study confirms that some of the general themes in the literature, such as how language and cultural differences, also exist for the participants. However, this study also illustrates the complexity of their experiences through discourse analysis, as illustrated in this chapter through exploring their frame of reference to Vietnam.

It is beyond the scope of this thesis to generalize these findings to the entire Vietnamese diaspora; however, it serves to promote questions for future research. While the majority of the participants accessed health services in Saskatoon on a fairly consistent basis, their discussion of health care in Saskatoon was embedded within a comparison to circumstances in Vietnam. Based on the nuances identified in this research regarding the participants' discussions of Vietnam, I suggest that a multidisciplinary approach to health research can augment the understanding of immigrant and refugee experiences with health care in more detail by providing the expert knowledge of researchers from a variety of disciplines and perspectives.

These findings were elicited because of the narrative interview approach, which allowed the participants to illustrate their experiences through stories and comparisons that are meaningful to them. I concur with researchers who find that the role of narrative, or "stories of illness" are significant in understanding health in the broader context of people's lived experiences to include more than just the biological interpretation of health and illness

(see Charon 2006; Frank 1997; Garro and Mattingly 2000; Kleinman 1988; Mischler 1981). I suggest the importance of a multidisciplinary approach to health research, where qualitative analyses from researchers from various disciplines provide this deeper understanding (Lambert and McKeivitt 2002). I also highlight the contributions of cross-cultural research to the field of health care through examples from the findings of this study.

The patient–physician interaction was one of the most prevalent themes within the interviews. Research at the intersection between medicine and the social sciences has recognized that medical encounters are social, as well as clinical, interactions, which significantly shape the meaning of health and illness for both patients and practitioners (Kirmayer, Groleau and Looper 2004; Kleinman 1988; Waitzkin 1991). While the stories that patients tell have been typically thought to be more significant within the field of mental health (Garro and Mattingly 2000), Rita Charon explains how “taking a narrative life history is slowly entering clinical practice...[where] eight-minute visits do not suffice to expose all that must be said” (2006:ix). Medical encounters have been more recently described as client–health professional encounters, where participation from patients and communities has become more recognized (Nunes, Ferreira and Queirós 2014). In terms of the participants in this current study, their life history includes past experiences in Vietnam. The insight that these descriptions brought to their discussion of health care was augmented by the use of qualitative research methods from the social scientific field of medical anthropology and the use of discourse analysis. Gale et al. (2013) have suggested that multidisciplinary approaches are becoming more common in applied qualitative health research.

I draw from Lambert and McKeivitt (2002) to suggest that multidisciplinary approaches to health research that include the “specialist” knowledge of researchers from the

social scientific, as well as health-related disciplines, could augment the understanding of health care experiences with more detail. An example from this study is the identification that the participants' descriptions of mental health contained negative connotations that resembled a mainstream definition of mental *illness* more so than well-being. However, they emphasized the importance of the "health of the mind" in comparison. This indicates that the term *mental health* did not fit within their conception of mental well-being, but that it represented a more negative or stigmatized stereotype. This is exemplified by the health professional, Liz's, experience at a newcomer-based organization in Saskatoon. She described how people attending her presentation about mental health services were hesitant to talk to her: "people really reacted to the word *mental*." She further described how after she explained what the services included, some people seemed interested.

Conducting open-ended interviews from a social scientific field of study elicited nuances regarding the participants' descriptions of health care. Specifically, this thesis illustrates that there is a discursive aspect to the participants' descriptions of health care: while they felt that health care in Saskatoon was better than Vietnam, the participants drew on more than one "voice" to describe both positive and negative experiences. For example, all of the participants described issues surrounding language differences, even those who described their experiences with health care as largely positive. Participants described that medical terminology was difficult to understand, even among the participants who felt their level of English comprehension was quite good. Conducting narrative interviews allowed the participants to articulate the complexity of their experiences. I suggest that health research that draws from multidisciplinary fields of study can explore the value of such narratives in greater detail.

Contextual Understanding

The members of the Vietnamese community who chose to participate in my study largely accessed health services in Saskatoon. However, I do not suggest that the participants are representative of the entire Vietnamese population, either in Saskatoon or in Canada as a whole. It is the purpose of this section to present possible reasons regarding why people may or may not have chosen to participate, while discussing the broader context of health research within the Vietnamese community. For example, Matt described how his parents often talked about Vietnam in a romanticized way, where he did not learn about the history of the boat people until university. Liên echoed a similar notion during a discussion we had about the stress she was experiencing at school, and how she coped with it: “Yeah if something makes me stressed, I don’t want to talk about it.” Perhaps people who had negative experiences did not want to discuss them.

Several community members were interested in talking about their experiences, but chose not to participate in formal interviews. Two reasons were given. First, two Vietnamese gentlemen explained that their experiences with health care services in Saskatoon have been positive. When I said that I was interested in any experience, positive or negative, one man replied that because the goal of my research is to help improve services for newcomers, he felt that he was not a good interview candidate because he came to Canada many years ago. The second reason pertained to language difference. One woman volunteered to participate and talked about her experiences off the record in great detail. However, when we met to conduct the interview, she decided not to participate because she felt her English was not good enough. While I do speak Vietnamese, I am not fluent, and the interviews were conducted primarily in English. This could have affected the decision to participate or not.

My project description indicated that I proposed to ask volunteer participants questions about health and health care experience in Saskatoon. It seems plausible that those who were less likely to access health care services may have also been less likely to participate in health research. While most people I met claimed that they accessed services regularly or when needed, a few people mentioned someone who had not. For example, one of the participants described a family member who had not used health services in Saskatoon. From his perspective, this family member had not yet accessed services because of how expensive they are in Vietnam. Further, my presence as a non-community member could have influenced whether people wanted to discuss their experiences with a health researcher or not. Further, international students applying for permanent residency of both male and female gender volunteered to participate. However, recruitment did not elicit participants among the next level generation of Vietnamese women (i.e., women of my mother's or aunt's age group). While I developed relationships with women from this age group, perhaps there are cultural nuances that discouraged them from participating in an interview with me, based on gender, social status, age and/or other factors.

I have suggested that the experiences of Chú Vân and Chú Peter arriving as refugees over 30 years ago differed from the participants who came more recently. Two of the participants described how English classes are available in Vietnam for those who can afford them, which suggests that the level of English comprehension that the participants may have had upon arrival would be different across time. Moreover, the participants who migrated to Saskatoon within the last ten years all had family members already living here. In contrast, Chú Vân and Chú Peter did not know anyone when they first came. The notion that circumstances in Vietnam and Canada have changed over time needs to be considered. The

bulk of the literature regarding Vietnamese immigrants and refugees originated within the early post-war period (Espiritu 2006). While much of our current understanding and research builds on this earlier work (Donovan and Williams 2014), more research conducted with specific populations, such as the research conducted with Vietnamese immigrants in Alberta (see Donnelly 2002), and Vietnamese immigrants in Saskatoon where research is limited, would provide more nuanced and recent findings regarding this population.

As discussed above, the participants accessed both traditional and western resources, which highlights the idea that the “west is best” discourse does not fully account for the complexity of their experiences. This brings up the important question of personal agency. While I find that the “west is best” discourse impacted participants’ descriptions of health care, it is important to recognize that they have agency regarding the choices they make within the context of larger socio-economic circumstances. Furthermore, personal agency is illustrated in regards to what the participants chose to talk about in our interviews. Matt described how his parents chose not to talk with him about negative memories they had from living in Vietnam during the war. Similarly, while reference to Vietnam occurred on both direct and unintended levels, I recognize that my participants chose to discuss only certain aspects of their experiences with me.

Limitations and Future Research

As described in Chapter Two, my role as researcher conducting open-ended interviews was the primary tool of data collection. Inevitably, my presence shaped who decided to participate, and the research questions guided what the participants shared. Being a non-community member could have influenced my findings in a variety of ways. First, in a small community, some people may have felt more comfortable to share because of the

confidentiality of speaking with an outsider about their personal experiences.⁵³ In contrast, being an “outsider” could have discouraged people from wanting to participate. However, because I was involved in the community and spoke conversational-level Vietnamese, many people were interested in speaking with me, even if they did not participate in an interview. The context of my project, to explore health care experience in Saskatoon, perhaps limited the discussion of more traditional aspects of experience and health practices. Therefore, further research that explores health care within a wider context of experience is a recommendation of this study. It is also a recommendation of this study to explore what constitutes effective and culturally appropriate health promotion strategies among different immigrant and refugee communities. One of the Canadian-born participants emphasized the importance of ensuring that health promotion materials are distributed within settings where community members would have access, such as locally-owned business establishments, or at community events.⁵⁴

The participants largely described how they moved to Canada in search of better opportunities. When they discussed that ‘health care in Canada is good,’ it is important to note that this could be considered the politically correct or culturally appropriate response someone who has invested moving to a new country might offer to a non-community member. Some of the members of the community alluded to the idea that I was a representative of the Canadian or western health care system because I was inquiring about health care experiences. Phuong mentioned that there is an increasing number of “volunteers like me” presenting about the importance of health in the urban areas of Vietnam. For future

⁵³ Chì Kim discussed the issues with translator services within smaller communities regarding confidentiality.

⁵⁴ Awareness of health care services is not solely the responsibility of health care providers. The idea of shared responsibility, and what that entails within specific community settings, would also be important to explore.

research, I suggest a notion put forth by Chi Kim who emphasized the importance of community-based research, which often includes community members in the research design, collection and analysis process. It would be interesting to compare the findings from this study to findings from a similar study conducted by a member of the Vietnamese community in Saskatoon. It would also be interesting to explore the availability of language interpreting services in Saskatoon in more detail. None of the participants made reference to accessing these services themselves. As such, the extent to which Vietnamese language services are accessed and/or available in the Saskatoon Health Region was not explored within this study. However, various members of the community, as well as two of the participants, mentioned that these services exist and that they are an important resource.

While I have suggested that multidisciplinary health research augments the understanding of the health care experiences of immigrants and refugees in more detail, I recognize that a multidisciplinary approach would augment the findings of this study. Specifically, research involving participant observations of clinical encounters would expand the findings of this study concerning health care delivery in Saskatoon.⁵⁵ A multidisciplinary study that included clinical and qualitative aspects of health research from a health-related discipline, as well as qualitative analyses from a social scientific lens would augment the findings of this study in that regard.

⁵⁵ Following the concept of *emplotment* discussed in Chapter Four (see Mattingly 1994), a study that focuses on the participant observation of clinical interactions between patients and health care professionals would provide rich data with which to explore health care experiences in more detail.

Concluding Thoughts

In this thesis I have explored how the participants described their experiences with health care in Saskatoon in relation to their frame of reference – Vietnam. While participants described negative socio-economic circumstances in Vietnam, there was a sense of nostalgia and fondness that members of the community expressed as well. Particularly, people seemed glad that a non-community member wanted to learn about Vietnam. I attended many events where food, music, and language was proudly celebrated and shared. I stayed in contact with many of the participants after the interviews were complete, while sharing my analyses with those participants who showed interest. While some described their experiences as positive, later they would also add that this type of research, which helps to bridge the gap between newcomers and health services, is important. Whether the participants described positive or negative experiences, it is evident that a culturally relativistic understanding of their descriptions of health care in Saskatoon is necessary.

This thesis has contributed to the value of recognizing that people's stories add meaning to their experiences. By specifically asking my participants what *mental health* means in the Vietnamese language, for example, a more comprehensive understanding of their definitions emerged. While the term *mental health* was stigmatized, virtually all of the Vietnamese-born participants discussed the importance of the *health of the mind*. How does it affect clinical encounters if health professionals specifically ask their patients about such cross-cultural conceptual differences? I suggest that this explicit inquiry, and more discussion on the issue of cultural sensitivity, is necessary to better understand and improve the health care experiences of immigrants and refugees. Research has found that we need to directly acknowledge and address language and cultural differences. I follow previous studies to propose that in order to help treat the biological experience of illness, researchers from

various disciplines must work toward a more nuanced understanding of the cross-cultural contexts in which health and illness exist.

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APPENDIX A
INTERVIEW GRIDS⁵⁶

Questions asked the Vietnamese-born Participants:

1) Grand Tour Question: Please tell me about your experience with health care in Saskatoon.

Mini Tour Questions:

Tell me about your first visit? Subsequent visits? Most recent?
How would you compare your visits? Can you give me an example?
How was it to talk with the doctor?
How did you know where to access services when you first came to Canada?
What did you hear about the services before you came?
How often do you see a doctor? For what reasons?
Do you know anyone who does not access services?
How would you improve health services in Saskatoon?

2) Grand Tour Question: How do you define “health”? What do you do to be healthy?

Mini Tour Questions:

In Canada and in Vietnam is what you would do the same or different?
If you are sick, what do you do?
What do other people in your family do if they are sick?
How do you define the word “stress”? What can you do to help “stress”?
What are the things that cause illness? What helps treat illness?
What do you think about the mind?

3) Grand Tour Question: What does the term “mental health” mean?

Mini Tour Questions:

What does the term “mental health” mean in the Vietnamese language?
What is *tâm thần*?
What do you think about mental health services?

4) Wrap up Questions:

Is everything we talked about ok to discuss in my project?
What is the most important thing we talked about?
Is there anything else you would like to add?

⁵⁶ Regarding the one participant who had not accessed health services in Saskatoon, the open-ended interview question began with “Please tell me what you know about the health care services in Saskatoon,” along with “Please tell me about your experience living here.” Some of the mini tour questions were elicited based on the content asked within the interviews themselves. As such, variations in these questions occurred.

Questions asked the Canadian-born Participants:

1) Grand Tour Question: Please tell me about your / your parents' experience with health care in Saskatoon.

Mini Tour Questions:

Tell me about your / your parents' first visit? Subsequent visits? Most recent?
How would you compare visits? Can you give me an example?
How was it for you / your parents to talk with the doctor?
How did your parents know where to access services when they first came to Canada?
What did they hear about the services before they came?
How often do you / your parents see a doctor? For what reasons?
Do you know anyone in the Vietnamese community who does not access services?
How would you / your parents suggest to improve upon health services in Saskatoon?

2) Grand Tour Question: How do you / your parents define "health"? What do you / your parents do to be healthy?

Mini Tour Questions:

In Canada and in Vietnam is what you / your parents would do the same or different?
If you are sick, what do you / your parents do?
What do other people in your family do if they are sick?
How do you / your parents define the word "stress"?

3) Grand Tour Question: What does the term "mental health" mean?

Mini Tour Questions:

What does the term "mental health" mean in the Vietnamese language?
What is *tâm thần*?
What do you / your parents think about mental health? About mental health services?

4) Wrap up Questions:

Is everything we talked about ok to discuss in my project?
What is the most important thing we talked about?
Is there anything else you would like to add?

Questions asked the Mental Health Care Professionals:⁵⁷

1) Grand Tour Question: Please tell me about your experience working with immigrants and refugees in Saskatoon. What are the first thoughts that come to mind?

Mini Tour Questions:

Can you describe any general similarities or differences regarding your experience working with clients who are immigrants or refugees compared to Canadian-born clients?

Can you provide a general example, keeping with respect to client confidentiality?

Are translation services something that you have used? If not, is it available? How do you think it impacts the interactions you have with your clients?

2) Grand Tour Question: What are some of the reasons why you think someone from an immigrant or refugee community might choose to access or not access mental health services?

Mini Tour Questions:

Please describe some of the tools you use while working with members of the immigrant and refugee community.

How does having different first languages affect your communication?

Are there other services or places that your patients could go to help with their symptoms?

How would you compare your conception of health with the clients that you have seen?

What would you change about the existing services to improve upon for immigrants and refugees?

3) Wrap up Questions:

Is everything we talked about ok to discuss in my project?

What is the most important thing we talked about?

Is there anything else you would like to add?

⁵⁷ Due to the small sample of health professionals elicited from the recruitment process, the grid was revised to include questions specific to “mental” health.

APPENDIX B
QUESTIONNAIRE

General Information

1) Age _____

2) Gender: Male ___ Female ___

3) When did you arrive in Canada? _____

4) How long have you lived in Saskatoon? _____

5) Did you live anywhere else in Canada before Saskatoon? Y / N

If so, where? _____

6) What is your marital status?

Single___ Married___ Widowed___ Divorced or separated___

7) Do you have any children? Y / N

If so, how many? _____ Do they live with you? Y / N

8) What is your employment status?

Full time___ Part time___ Unemployed___ Student___ Home___ Retired___

9) What is your highest level of education?

Elementary School___ High School___ College___ University___

10) Where do you live?

House___ Apartment___

11) Do you have a religious affiliation? Y / N If so, what? _____

Health care in Saskatoon

1) Have you accessed health care services in Saskatoon? Y / N

2) If so, please describe what type of services you have accessed.

APPENDIX C
ATLAS TI CODES/FREQUENCIES

Vietnam	56	Summer/winter	8
Mental	47	Walk in clinic	8
Medicine	40	Think/worry too much	8
Family	39	Preventative health practice	7
Doctor interactions	35	Balance	6
Stress	35	Health care experience negative	6
Larger discussion ⁵⁸	35	Brain	6
Work	32	Pharmacy	6
Family doctor	29	Happy/healthy	5
Staying active	28	Student clinic	3
Language/interpretation	23	Population increase	3
Diet	23		
Education/knowledge	22		
Wait time	22		
Emergency			
Room/hospital/specialist	19		
Health care experience positive	17		
Religion/spirituality	16		
Don't have to pay for health care	14		
Control	13		
The mind	13		
Happiness	12		
Don't drink	10		
Traditional concept	10		
Clinic/doctor busy	10		
Don't smoke	9		
Crazy	9		
Environment/pollution	9		
Rest/relax	9		
Abnormal	8		

⁵⁸ Larger discussions included political, historical, economic, socio-cultural, and environmental descriptions about Canada and Vietnam. This code was not included in Table 2-2, as it encompasses a variety of themes that could be broken down into smaller codes, such as diet and environment. Diet and environment were the most frequent themes within the larger discussions, and thus were coded.

APPENDIX D
ETHICS APPROVAL



UNIVERSITY OF
SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB)

Certificate of Approval

PRINCIPAL INVESTIGATOR
Sadeq Rahimi

DEPARTMENT
Archaeology & Anthropology

BEH#
12-116

INSTITUTION(S) WHERE RESEARCH WILL BE CONDUCTED
University of Saskatchewan

STUDENT RESEARCHER(S)
Rachael Smith

FUNDER(S)
CANADIAN INSTITUTES OF HEALTH RESEARCH (CIHR)

TITLE
Narrative and Experience: Investigating the Utilization of Health Services by Vietnamese Immigrants and Refugees in Saskatoon

ORIGINAL REVIEW DATE
18-Apr-2012

APPROVAL ON
03-May-2012

APPROVAL OF:
Application for Behavioural Research Ethics
Review
Appendix 1: Volunteer Opportunity Poster
Appendix 2: Letter of Invitation
Appendix 3: Participant Consent Form
Appendix 4: Project Description for
Vietnamese Community Members
Appendix 5: Questionnaire
Appendix 6: Interview Grid
Questions to ask the health
professional/caregiver
Questions to ask the non-patient community
member

EXPIRY DATE
02-May-2013

Full Board Meeting

Date of Full Board Meeting:

Delegated Review

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

Please send all correspondence to:

Research Ethics Office
University of Saskatchewan
Box 5000 RPO University, 1602-110 Gymnasium Place
Saskatoon SK S7N 4J6
Telephone: (306) 966-2975 Fax: (306) 966-2069

- 2 -

PRINCIPAL INVESTIGATOR
Sadeq Rahimi

DEPARTMENT
Archaeology & Anthropology

Beh #
12-116

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: http://www.usask.ca/research/ethics_review/



University of Saskatchewan
Behavioural Research Ethics Board

Please send all correspondence to:

Ethics Office
University of Saskatchewan
Room 306 Kirk Hall, 117 Science Place
Saskatoon SK, S7N 5C8
Telephone: (306) 966-2084 Fax: (306) 966-2069

APPENDIX E
CONSENT FORM**Participant Consent Form****Project Title**

Narrative and Experience: Investigating the utilization of health services by Vietnamese immigrants and refugees in Saskatoon

Student Researcher

Rachael Smith-Lammie, Graduate Student, Department of Archaeology and Anthropology, University of Saskatchewan, Phone: 306-341-3698,
Email: rms312@mail.usask.ca

Supervisor/Principal Investigator

Sadeq Rahimi, Assistant Professor, Department of Archaeology and Anthropology, University of Saskatchewan, Phone: 306-966-5765,
Email: Sadeq.Rahimi@usask.ca

Procedures

- Let's make sure the location feels safe and comfortable for you before we begin.
- The researcher would like to record the interview, so it will be easier for her to remember what we talked about when she writes the research. Please let her know if you feel comfortable with this. If not she will only write notes instead.
- Please ask Rachael any questions you have about the project or about your role.
- The interview will be approximately one hour long. It will begin with a general question: Please tell me about your experience with the health care services in Saskatoon.
- Rachael will ask you follow up questions. Please remember that you do not have to answer any questions you do not want to.
- We will talk about the interview after it is done, to see how you felt about the questions asked.
- Rachael will ask you if it is ok to contact you by email or phone if she has any questions about the interview. She might ask if you could meet again for another interview, but you do not have to say yes.
- Please contact Rachael, Sadeq or the research ethics office at the University of Saskatchewan if you have questions or concerns.

Potential Risks There are no anticipated risks to you by participating in this project.

Potential Benefits I hope you enjoy the process of talking with me about your experience. I hope that your knowledge that I share could help improve health care for people in the future.

Confidentiality

- Only the student researcher and the principal investigator will have access to the raw data (audio files, transcripts, and consent form) from your interview.
- Hardcopies with your personal information will be stored in a locked file cabinet in the office of the principal investigator at the University of Saskatchewan for 5 years after the completion of this project.
- Digital copies of your files that the student researcher uses during the data analysis phase of this project will be kept under a file-encrypted, password protected computer system.
- Consent forms and any identifying information about you, such as the master list with participant names/codes will be kept in a separate file from the transcripts and all other research documents pertaining to this study to ensure confidentiality of your information.
- Your personal information (your real name and contact information) will be kept confidential at all times; at no point during or after this project will your real name or any other identifying information be revealed to a third party. When data with identifying information is no longer required, this data will be destroyed.
- At the level of dissemination, data will be published and presented at conferences in aggregate form. In the event that direct quotes are used, your anonymity will be protected by the use of pseudonyms, and all other identifying information will be removed.

Right to Withdraw

- Your participation is voluntary. You have the right to refuse to answer questions, stop the interview, and/or withdraw from the project, and withdraw any or all of your information from the project at any time before, during, or after the interview up until the time that research is disseminated in May 2013.
- After this date, it is possible that some form of research dissemination will have already occurred and it may not be possible to withdraw your data.
- If you choose to withdraw, all of your information will be returned to you or destroyed.

Follow up

- If you would like to see the results of the study, please contact Rachael and she will be happy to send you a summary of the results.

Questions or Concerns

This research project has been approved on ethical grounds by the University of Saskatchewan Research Ethics Board. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office ethics.office@usask.ca (306) 966-2975. Out of town participants may call toll free (866) 966-2975.

Consent

I, _____, understand that my signature below indicates that I have read and understand the above description. I have had an opportunity to ask questions and my questions have been answered. I consent to participate in the research project based on the above description. A copy of this consent form has been given to me for my records.

Name of Participant

Signature

Date

Researcher's Signature

Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.