

Developing Health Communication with Displaced Populations: An Exploration of Cultural Barriers to Health Care Experienced by Southeast Asian Refugees

Margeaux Rose Corby*

Journalism and Biology
Elon University

Abstract

Culture is primary in shaping an individual's perception of illness and compliance with prescribed medical regimens, making identification of health-related cultural elements critical. This research attempts to identify the cultural barriers to displaced populations' acceptance of "Western" medicine and compliance to its tenets. Evidence-based cross-cultural health knowledge of the Montagnard community in Greensboro, North Carolina was collected via snowball sampling in this ethnographic study. Subjective narratives, in combination with investigator observations and review of previous research, were used to analyze the overall patterns observed in both first- and second-hand accounts of health-related activities and health care utilization by the Montagnard community. Patterns found included misunderstandings between patient and provider due to differences in defining illness and false perceptions of Western medicine and health services. These fostered patient noncompliance and explained ignorance of clinical appointment and payment systems. The possibility of new health concerns related to an unbalanced diet was also found due to the introduction of American fast food and formation of new dietary habits by refugees.

I. Introduction

Health communication can increase an audience's awareness of health problems and solutions, influence perceptions and beliefs, prompt action, demonstrate healthy behaviors, and reinforce existing knowledge or behaviors (Freimuth & Quinn, 2004). Customization of health communication programs and health services to better meet the needs of minority and vulnerable populations is done by recognizing and practicing culturally relevant modes of appropriating knowledge (Kreuter & McClure, 2004).¹

Non-native and refugee populations are especially vulnerable to significant discrepancies in health care access and are in great need of culturally relevant, accurate, and timely health information (Kreps & Sparks, 2008). To provide a reference that health agencies and communicators can draw from when creating public health materials for isolated communities, this paper will explore the cultural barriers to displaced Southeast Asian populations' acceptance of "Western" medicine and compliance to its tenets. Before the stories of these cultural groups can be told, an introduction to the populations being examined and the reasons behind their exodus to the United States must be understood.

For the past 35 years, 1.3 million refugees have arrived from Southeast Asia. Cambodia, Laos and

* **Keywords:** Refugee health, health culture, Western medicine, Montagnards, displaced populations
Email: mcorby@elon.edu

Vietnam are the three major countries represented by the immigration of Hmong, Cambodian, Laotian, Vietnamese and Montagnard communities following the end of the Vietnam War (2009). The importance of health care providers understanding Southeast Asian refugee populations' cultural tenets and ideologies in order to establish patient-doctor relationships and ensure successful provision of care has been documented in both scientific studies and practitioner observations (Ito, 1999; Stephenson, 1995; Uba, 1992).

Southeast Asian refugees in the United States, despite many cultural, linguistic, and national differences, share common pre-emigration experiences of war and flight from oppressive governments and common governmental benefits once in America (Ito, 1999). As such, information about Montagnards normative cultural values and their direct and indirect influence on health care will be supplemented by findings of other Southeast Asian refugee experiences and cultural patterns observed by other health care providers and documented in anthropological studies.

II Literature Review

Modeling health messages in a culturally appropriate framework is primary for health communication to be effective between health provider and patient or health agency and target community. The significance of cultural awareness in health communication has been explored by scholars via 1) an examination how health culture develops and its influence on patient compliance, 2) the role of health providers in establishing culturally appropriate communication, and 3) the special need for culturally appropriate health care for refugee populations.

Culture is best thought of as an adaptive system of meaning, in which behavior, values, and ethnicity contribute to, but do not encompass the mass of, its depth and density. While not inherently cultural, factors such as familial roles, religiosity, the importance of individualism versus collectivism, and specific behavioral engagement can help define culture for a group if the aforementioned factors have a special meaning to group members (Kreuter et al., 2002). These integrated patterns of human behavior are the underlying determinants of individual decision-making, especially those related to the use and trust in health care (Paez et al., 2008). Developing culturally appropriate programs and materials requires the identification of authentic community structures, beliefs, and roles instead of relying on easy but ultimately superficial identifiers like ethnicity and race (Kreuter et al., 2002). Examining cultural issues that impact and influence the way in which members of vulnerable populations respond to health communication and care is crucial for success in disease prevention and health management (Kreps & Sparks, 2008).

Health culture is also transmitted through social networks and interactions with others. This reinforces an individual's interpretations of illness and appropriate reactions and solutions to a given disease or sickness (Ito, 1999). Health culture includes the belief systems, spiritual values, and behavioral decisions that filter health messages, instructions, and communications. After such processing, the program's message is either ignored or accepted (Institute of Medicine, 2002). Health culture has the capacity to determine from whom health care is sought, how symptoms are described, and whether treatment options will be complied with or even considered (Andrulis & Brach, 2007). Patient beliefs can impede preventative care efforts, delay, or complicate clinical care and result in a lack of treatment or inappropriate remedies (Flores, 2000).

In addition, health providers' willingness to acknowledge the existence of a patient's unique health culture and its potentially conflicting etiologies is critical. By accepting the idea of a different sociocultural context through which patients are communicating their concerns as well as hearing medical professional's instructions, health care providers can begin taking steps to modify their own messages for greater treatment success. In order to assure that patient-provider interactions are successful, clinicians must learn about their patients' health literacy and health culture and use that information to improve communication with diverse patients (Andrulis & Brach, 2007). The health culture in which a patient is immersed affects several levels of health care. This includes interpretations of the origins of disease and decisions concerning compliance and overall efficacy of care (Ito, 1999). The elicitation of symptoms and evaluation of signs and descriptions of illness are highly related to a patient's health culture and the selection of medications or treatment plans must be done with regard to patient culture (Horner et al., 2004).

Thus, reaching non-native populations is a tremendously complex but acute need in the United States as these groups are the most vulnerable health care consumer population. Refugee populations are minor-

ity groups that are not only subject to discrimination based on ethnicity and race but often have low, if any, English language proficiency, occupy low socioeconomic status, and have been displaced from their native country and sometimes even their families. They are at greatest risk for higher levels of death and disease than other segments of the population (Kreps & Sparks, 2008). Traditional culture and accompanying values are highly valued by populations who, because of violent and horrific circumstance, are forced to live without the basic comforts of a familiar language, nationality, and political structure (Frye & D'Avanzo, 1994). Cultural traditions provide stability to these groups, who have become stripped of most all worldly possessions, and help them face the challenges of a foreign and intimidating environment. Often these belief structures have been threatened in their native country and refugees have suffered violence from the governing bodies that forced their exodus (Frye & D'Avanzo, 1994).

Refugees, therefore, are leaving one volatile and violent environment for a potentially safer but more unpredictable and foreign one. The loss of possessions, loved ones, and the experience of actual or threatened violence take a toll. So do the emotional and physical demands of flight and uncertainties encountered in an alien country. These are just some of the many hardships refugees must face when entering the United States (Starr & Roberts, 1982). These numerous potential sources of stress refugees face make them prime candidates for health problems, but because of the cultural and linguistic barriers before them, refugees are the least likely population to take advantage of necessary and available health care systems.

Culturally appropriate health communication targeted at health care providers or agencies is thus necessary to limit health disparities and encourage medical compliance in non-native and refugee populations. In order to fully demonstrate this need for cultural awareness in a clinical and public health setting, the cultural barriers experienced by Southeast Asian refugees, specifically the findings of an ethnographic study of the Montagnard refugee population in Greensboro, North Carolina, were examined.

III. Methods

This ethnographic study, which was conducted between September 2008 and February 2010, focused on the subsection of Montagnard refugees in the Greensboro area, as well as community members who have worked extensively with the population. Snowball sampling was used to locate and interview subjects since organizations familiar with the community mainly work exclusively with the local Montagnard religious leaders and are not in contact with other individuals except on a case-by-case basis. The sensitive nature of questioning, as it regarded health-related information, made introductions through acquaintances beneficial in securing source confidence. Since there is very little current literature about the Montagnards in general, much less about those living in North Carolina, the researcher began the process of contacting members of the Montagnard community by contacting refugee resettlement agencies and requesting referrals for community leaders. By attending regular Sunday worship services at the United Montagnard Church, the researcher established a familiarity with the community and recruited interviewees, most of who suggested other family members or friends as potential interviewees.

Interviews, which ranged from 45 to 90 minutes in length, were conducted individually, although family members were sometimes present, and participant narratives were recorded and transcribed. Interviewees were asked questions that covered a variety of topics, including inquiries about their health histories, personal experiences with health care in the United States and Vietnam, challenges they faced during the resettlement process, religious beliefs, Montagnard traditions and health experiences related to them by friends and family members. Visual material (photographs and video of some informant interviews) and audio material from taped conversations were collected. These subjective narratives, in combination with investigator observations and review of previous research, were used to analyze the overall patterns observed in both first- and second-hand accounts of health-related activities and health-care utilization by the Montagnard community. Analyzing techniques involved 1) the identification of indigenous themes that appeared to characterize the health care experience of an interviewee and 2) the comparison of these themes to other interviewee accounts and current scholarly research.²

² Interviewees are not identified in the paper, unless their position is relevant to the quoted information.

IV. Results

Patterns found among Montagnard refugees included misunderstandings between patient and provider due to differences in defining illness and false perceptions of Western medicine. The introduction of American fast food is leading to the formation of new dietary habits by refugees, forecasting the possibility of new health concerns related to an unbalanced diet.

Defining sickness

Modern health care is highly regarded by many Southeast Asian groups. Problems related to these groups' utilization of health care are due more often to misunderstandings rather than a lack of acceptance (Kemp, 1985). Since health culture shapes the way in which sickness and its severity are defined, it also influences the actions necessary to treat it and the way in which it is described to others. Ideas concerning the source of sickness and disease, something many mistakenly believe are universally understood and accepted, are susceptible to varying explanations. For instance, the idea of preventative care is not a familiar mode of thinking for many Montagnards. "They work until they get hurt or are too sick to go into work," said one interviewee. "If someone gets them to a medical provider, then they get care, and if they don't they don't."

An individual's understanding of illness etiologies are created well before a clinical encounter (Ito, 1999). Such interpretations of symptoms and causation of sickness are conceived through interactions with people within important social networks and can influence behavior both before and after a doctor's visit (Ito, 1999). Moreover, procedures such as circumcision or tonsillectomies, which are considered routine in the United States, are frightening to many Southeast Asian refugees. Some groups believe such invasive procedures have long lasting and multiple effects that outweigh the benefits of surgical relief or cures (Muecke, 1983). Religious beliefs also play a role in why many routine procedures are refused by Montagnard patients. "Circumcision [the doctors] explain is cleanliness, for a better health, but in our culture and belief you shouldn't take off anything that's given, you go against God's will and those are the things that are so sensitive because once it's done you can't sew it back."

Southeast Asians who decide to seek health care are often apprehensive about the treatments and diagnostic tools used in Western medicine because of their lack of familiarity with and misinterpretation of the functions of such procedures, no matter how non-invasive or simple they may seem to Westerners (Uba, 1992). One Montagnard woman gave birth to a son with a malfunctioning liver and although the doctor suggested a transplant, she refused to give permission for such an operation. "They keep him two months and they said they want change for him, change his liver," she said. "I say he still little, I'm scary for him. At the meeting they say 'Why you say no?' I say no I can't do it, they want me to sign the paper, and I say no I just speak to God I pray to God." This Montagnard mother's lack of knowledge about the technology, process and safety measures taken before, during and after organ transplants in the United States led her to refuse a potentially health-improving, even life-saving, surgery for her son.

Unfamiliarity and misunderstandings of Western health care systems

Those familiar with the Western medical system often consider intake procedures routine but these same situations are often confusing to Southeast Asian refugees new to the process. Members of minority groups may try to hide or mask their limited health literacy or unfamiliarity with Western systems of care by not asking questions or simply feigning comprehension (Andrulis & Brach, 2007). The American appointment system is often misunderstood both in terms of needing an appointment and the fact that once an appointment is made, patients still must often wait past the scheduled time (Muecke, 1983). According to one Montagnard interviewee, the concept of needing to make an appointment time, arriving at the doctor's office or clinic at that specified time and then having to wait several minutes past that time is unusual and frustrating. "It's different from Vietnam and here. When I was in Vietnam when I got to doctor, when we go there, it's like they working when we get hurt but over here we have to wait. No, in Vietnam when you get hurt just go, you don't need to make an appointment or anything." The appointment system continues to be a source of confusion and sometimes a reason behind a lack of health care seeking behavior, according to community leaders. "They keep say 'Why doctor make appointment for me and I have to come on time, but I wait over 30 minutes or one hour how is that?'" Frustration felt by Montagnard patients already dealing with stresses of relocation can lead to bitterness toward Western health services, a dim prospect for the resolution of future medical conditions.

The purpose behind physical examinations and the listing of health histories is not understood by many refugees. Indochinese groups tend to focus on treatment of symptoms rather than discovering the underlying causes (Kemp, 1985). In addition, obtaining medical histories from many Southeast Asian patients tends to be unproductive because they are rarely told the names of previous illnesses or medicines given to them. "Many time when they do a family health history, we don't know," an interviewee said. "We know our folks died, but we don't know what they die from. We just say one day we come home and after meal she die. It's hard for [doctor] to acknowledge that." Thus knowledge of past diagnostic procedures and the results of such tests are rarely known (Muecke, 1983).

Any foreign-born person's first contact with Western health services requires them to fill out questionnaires. These situations reveal unfamiliarity with Western medicine's typical instructions such as check boxes and rating scores of symptoms, and require the patient to reveal private and possibly embarrassing health-related information (Zanchetta & Poureslami, 2006). "They ask you how many partners you have," one interviewee said. "We don't ask that back home or are you active and things like that, we don't ask those things. When they asked me for the first time I was like 'What do you mean? I'm single.' You didn't understand the question to be honest." Such misunderstandings of important medical questions have the potential to lead to inaccurate health histories, which may cause clinicians to order unnecessary, expensive and time-consuming diagnostic procedures or misdiagnose a patient.

The medical billing system, which remains enigmatic and confusing for many natural born citizens, is also challenging for many Montagnards since even hospital staff are unsure about the exact cost of some procedures, and the prices are not readily available to patients at the time of care. "You go to a doctor in this country and they don't tell you how much it's gonna be," an interviewee said. "You get a bill later, and then you get a different bill from different department and they are like 'I only went one time.'" Some of them said, "Well, I felt better until I saw the bill." It appears that Western health services generally lack in easily accessible pricing information about procedures and treatment plans interject even more uncertainty into a situation where Montagnard patients already feel lost and uneasy, foreshadowing a potential lack of health-seeking behavior.

The roles of hospital or clinical personnel differ from country to country, and the breadth of responsibility exercised by a nurse versus a doctor or a receptionist may be unfamiliar to a patient. A Montagnard woman who was a nurse in her native country continually seemed confused by how little nurses seemed to influence care regimens. "Everybody know the nurse in Vietnam not same as here," she said. "Here somebody sew they only sew, somebody take out baby they only take out baby and over there I do everything. I take out baby, I can see ear, can see jaw, can see everything. I give the medicine. I don't need the doctor." The idea of specialization or different fields of medicine is also a hard idea to grasp for some Montagnards used to a more generalized system of care. "In Vietnam they have a general doctor," one interviewee said. "One doctor he can make decision to do things. Here you go to primary doctor, and he cannot do the family practice he sent you to specialist and that is different way of treatment." Montagnards wanting to see a physician must find some form of transportation and potentially secure a translator, in addition to the regular scheduling steps taken by most Americans needing to use health services. After putting so much effort into seeing one doctor, it can be incredibly disheartening for a patient to realize the process must be repeated. The prospect of repeating such a daunting task may lead to an abandonment of efforts all together.

Changes in diet and lifestyle

The "bigness" of American lifestyle, including the availability of high calorie, large proportioned food not available in Vietnam has contributed to the formation of new health concerns for Southeast Asian populations. According to one interviewee, the Montagnards have adopted all of the American bad dietary habits. "Over here it's like it's kind of easy," according to one interviewee. "It's like hamburgers, in Vietnam it's tree leaves and what we found in jungle just eat something we found in jungle. In America it's like kind of get bigger, in Vietnam it's not get big." The vast selection of food and its availability in America appears to be in stark contrast with what many Montagnards experienced in their native country. "In Vietnam no food, no anything," one interviewee said. "In America you have salt, you have food, you have anything." Another interviewee emphasized the people's dependence on the natural environment for sustenance in Vietnam. "I told Montagnard one word in the beginning, Montagnard have never die by food. Many people surprise when I say that. But when we are in Vietnam we are starving, we don't have food enough, and we eat nature; we not eat meat too much because we don't have."

This new selection of food and its unhealthiness is compounded by the sedentary lifestyle propagated by Western luxuries such as public transportation and factory jobs that don't involve manual labor. "I never exercise," one interviewee said. "Because they used to work a lot so they don't need exercise and they all skinny. When they get here they are kind of big. Even me when I was in Vietnam I was so skinny." High blood pressure and other diseases associated with weight gain are very plausible future medical concerns for these populations not used to having to compensate for lack of everyday exercise and the accessibility of cheap, unhealthy fare. "In America many people get wrong food, high blood pressure, cholesterol, diabetes and often if you not careful with nutrition you get because of that," said the leader of a local Montagnard congregation. "I have over history 30 Montagnard die in America. Same cause from stroke because of high blood pressure, and they never heard that in Vietnam."

V. Discussion

In this study, cultural barriers to the Montagnard refugee populations' acceptance of "Western" medicine and compliance to its tenets have been examined. The findings point to the need for greater acceptance and understanding of Montagnards' definition of illness and false perceptions of Western medicine by health care professionals to improve the quality and accessibility of information and treatments. A clinician seeking to learn about the Montagnard needs to know about how these cultural factors can negatively influence a clinical encounter.

The sensitive, non-judgmental clinician is able to learn about a patient's belief system and practices and replace harmful or ineffective remedies with harmless ones that are consistent with individual beliefs (Flores, 2000). Providers who accommodate folk illness beliefs and practices, and are able to integrate them into suggestions for appropriate care, will be better able to explain the rationale behind a particular biomedical condition and treatment plan (Flores, 2000). Cross-cultural exploration by providers will better allow them to appropriately diagnose and treat culturally diverse, minority patients. An understanding and culturally appropriate approach must be taken by providers to support their patients' self-management efforts (Andrulis & Brach, 2007).

Accomplishing this is possible if clinicians are willing to adapt their own approaches to accommodate multiple needs of culturally diverse minority community members (Andrulis & Brach, 2007). This can be accomplished by establishing cultural competency training in collaboration with local resettlement agencies or building relationships with community leaders who can communicate the needs and cultural nuances of their group to medical professionals and health educators. When meeting with patients individually, providers can attempt to gauge patient understanding by asking the patient, and any accompanying relative or friend, to repeat instructions. The scope of these methods can be as large as instituting new training programs or as small as assuring understanding in a single patient encounter. No matter the extent of these accommodation efforts, all bring providers and refugees one step closer to real understanding and effective care that continues outside the hospital or clinic.

All of those working in a patient-care, health provider setting must be able to acknowledge and move beyond their own personal perceptions of perceived lack of time, lack of care coordination, racial and ethnic prejudices and assumed patient ignorance in order for the cultural competency process to begin (Paez et al., 2008). Further cataloging of the problems of limited health communication between provider and patient is no longer necessary—identification and implementation of strategies and knowledge bases to remedy such disparities in the access and utilization of care should now be at the forefront of social science as it relates to medicine and managed care practices (Paez et al., 2008).

No matter the extent of these accommodation efforts, an increase of cultural awareness and knowledge by providers and educators can bring refugees one step closer to real understanding and effective care that continues outside the hospital or clinic. This progress is sorely needed by refugee communities, especially the Montagnards, whose want for comprehensive health care is great because of intense pre- and post immigration experiences but ability to access and understand such beneficial health services is limited by cultural barriers.

Acknowledgments

The author is thankful to Dr. Copeland and Dr. Padgett at Elon University for their supervision, suggestions and support. Without their time and advice, as well as the input of numerous reviewers who helped review this work, this article could not be published.

Bibliography

- Andrulis, D. P., & Brach, C. B. (2007). Integrating literacy, culture, and language to improve health care quality for diverse populations. *American Journal of Health Behavior*, 31, S122-S133.
- Flores, G. (2000). Culture and the patient-physician relationship: Achieving cultural competency in health care. *The Journal of Pediatrics*, 136(1), 14-23.
- Freimuth, V. S., & Quinn, S. C. (2004). The contributions of health communication to eliminating health disparities, editorial. *American Journal of Public Health*, 94(12), 439-455.
- Frye, B. A., & D'Avanzo, C. (1994). Themes in managing culturally defined illness in the Cambodian refugee family. *Journal of Community Health Nursing*, 11(2), 89-98.
- Horner, R. D., Salazar, W., Geiger, H. J., Bullock, K., Corbie-Smith G., Cornog M., & Flores G. (2004). Changing healthcare professionals' behaviors to eliminate disparities in healthcare: What do we know? How might we proceed? *The American Journal of Managed Care*, 10, SP12-SP19.
- Institute of Medicine of the National Academies. (2002). *Speaking of health: Assessing health communication strategies for diverse populations*. Washington, D.C.: National Academy of Sciences.
- Ito, K. L. (1999). Health culture and clinical encounter: Vietnamese refugees' responses to preventive drug treatment of inactive tuberculosis. *Medical Anthropology Quarterly*, 13(3), 338-364.
- Kemp, C. (1985). Cambodian refugee health care beliefs and practices. *Journal of Community Health Nursing*, 2(1), 41-52.
- Kreps, G. L., & Sparks, L. (2008). Meeting the health literacy needs of immigrant populations. *Patient Education and Counseling*, 71, 328-332.
- Kreuter, M. W., & McClure, S. M. (2004). The role of culture in health communication. *Annual Review of Public Health*, 25, 439-455.
- Kreuter, M. W., Lukwago, S. N., Bucholtz, D. C., Clark, E. M., & Sanders-Thompson, V. (2002). Achieving cultural appropriateness in health promotion programs: Targeted and tailored approaches. *Health Education & Behavior*, 30(2), 133-146.
- Muecke, M. A. (1983). Caring for Southeast Asian refugee patients in the USA. *American Journal of Public Health*, 73(4), 431-438.
- Paez, K. A., Allen, J. K., Carson, K. A., & Cooper, L. A. (2008). Provider and clinic cultural competence in a primary care setting. *Social Science and Medicine*, 66, 1204-1216.
- Southeast Asian Communities. (2009). Retrieved Mar. 29, 2003, from Southeast Asia Resource Action Center, Washington, DC. Web site: <http://www.searac.org/commun.html>.
- Starr, P.D., Roberts, A.E. (1982). Community structure and Vietnamese refugee adaptation: the significance of context. *International Migration Review*, 16(3), 595-618.
- Stephenson, P. H. (1995). Vietnamese refugees in Victoria, B.C.: an overview of immigrant and refugee health care in a medium-sized Canadian urban centre. *Social Science & Medicine*, 40(12), 1631-1642.
- Uba, L. (1992). Cultural barriers to health care for Southeast Asian refugees. *Public Health Reports*, 107(5), 544-548.
- Zanchetta, M. S., & Poursalami, I. M. (2006). Health literacy within the reality of immigrants' culture and language. *Canadian Journal of Public Health*, 97(2), S26-S30.
-