DEFINING BARRIERS TO ACCEPTANCE OF WESTERNIZED MEDICINE AMONG MONTAGNARD REFUGEES
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ABSTRACT

As culture is a primary component in shaping an individual’s perception of illness, this research attempts to discover the cultural barriers to displaced populations’ acceptance of “Western” medicine and observance of prescribed medical regimens. In this ethnographic study, evidence-based cross-cultural health knowledge of the Montagnard community in Greensboro, North Carolina, was collected via snowball sampling. Subjective narratives, investigator observations and review of previous research were used to evaluate 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 the use of passive obedience to avoid revealing ignorance. Such findings appeared to encourage patient noncompliance and explained ignorance of clinical appointment and health care systems.

INTRODUCTION

What are the cultural barriers to displaced populations’ acceptance of “Western” medicine and compliance to its tenets? How can medical practitioners overcome potential barriers to improve the health of displaced populations? Culture is primary in shaping an individual’s perception of illness and compliance with prescribed medical regimens. The importance of health care providers understanding Southeast Asian refugee populations’ cultural tenets and ideologies, especially in establishing patient-doctor relationships and ensuring successful provision of care, has been documented in both scientific studies and practitioner
observations (Ito, 1999; Stephenson, 1995; Uba, 1992). These refugee populations, typically the poorest and lowest educated members of modern society, are more likely to suffer from significantly higher levels of death and disease than other population segments when acceptance and accessibility to Westernized medicine is lacking (Kreps & Sparks, 2008). Identification of health-related cultural elements is critical for providers and health educators wanting to establish appropriate health care programs and materials for culturally diverse populations. Respect for cultural factors, such as familial roles, spirituality and communication patterns, are essential to the acceptance of recommended care regimens and preventative programs (Kreuter et al., 2002).

Refugee populations are at greater health risk than other segments of the population (Kreps & Sparks, 2008) because they are the most likely to experience dissonance with Western medical culture. In order for the target population to accept the medical notions of their new nation, a bridge must be created between cultural axioms and the foreign, yet effective interventions that Western medicine provides. In this paper, I present findings from an ethnographic study of Southeast Asian refugees, a Montagnard population in particular, residing in Greensboro, North Carolina, to fully demonstrate the need for cultural awareness in a clinical and public health setting. Some of the key cultural barriers for this population that will be examined in the article are Montagnards’ varying definition of illness that may limit health-seeking behavior, the use of passive obedience to avoid shame or revealing ignorance, reliance on traditional medicine and false perceptions of Western medicine. Before the stories of these cultural groups can be told, it is necessary to introduce the populations examined in this study and briefly discuss the reasons behind their exodus to the United States.
Over the past thirty-five years, 1.3 million refugees have arrived from Southeast Asia. Cambodia, Laos and 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). Montagnards are not Vietnamese, a distinction that has steered the course of these peoples’ history and future in Vietnam, as their religious and ethnic differences have been the catalyst for much of their persecution. Raleigh Bailey, director of the Center for New North Carolinians and a senior research scientist at University of North Carolina at Greensboro was heavily involved in the first Montagnard immigration waves in the 1980s. His experiences and study of the uniquely tragic history of these people from the time of their involvement in the Vietnam War was a significant source of the following historical information. According to R. Bailey, although some live in urban areas, the majority of Montagnards are rural, farm people from Vietnam, very ethnically different from Vietnamese. The U.S. Special Forces recruited them as frontline allies to fight in the highlands of Vietnam during the Vietnam War; another reason the Vietnamese government continues to harass the Montagnards (R. Bailey, personal communication, April 30, 2009).

The life of Montagnards in Vietnam and their relationship with the ruling Vietnamese government eerily parallels the calamitous history of the Native Americans in the United States, according to R. Bailey. Land treaties between Montagnard leaders and the ruling Vietnamese government were struck and subsequently broken. Montagnard Christian churches, especially the evangelical churches in Vietnam that had become the organizing place for Montagnards in terms of social change, were made targets of governmental oppression; many were burned. Stories of physical violence, mysterious imprisonment of family members and forbiddance of church
attendance were common amongst interviewees—many fled to the jungle between Vietnam and Cambodia to escape persecution (R. Bailey, personal communication, April 30, 2009).

“They’re always like ‘You came from Vietnam’ and we’re like ‘No, we’re running away from Vietnam,’” one interviewee said. The distrust Montagnards have of the Vietnamese is truly pervasive throughout the majority of the community, stemming from the violence inflicted on these Christian people attempting to worship in a communist country. Human rights violations continue today and Montagnard churches both in the United States and Vietnam continue to petition Congress and the United Nations for help.

The very first large group of Montagnard refugees came in 1986 and subsequent immigrant waves and natural born generations have led to the 7,000 or so that reside in North Carolina. Montagnard refugees, made to flee because of their beliefs, hold tightly to such values in America, and these traditions and principles directly influence health care decisions, compliance and pursuance.

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 Montagnard 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 various health care providers, all of which have been documented in anthropological studies. The influence of culture on health-related activities, provider responsibility and the need for health professional-targeted interventions will also be examined extensively, in addition to an exploration of suggested approaches to improving cultural competency of patient care providers.
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 importance of culturally appropriate care has been explored by public health and communication scholars via 1) examining the significance of cultural awareness in health communication, 2) the special need for culturally appropriate health care for refugee populations and 3) the role of health providers in establishing culturally appropriate communication. Such issues have proven to be forefront in the struggle to overcome cultural barriers to appropriate health care (Barr & Wanat, 2005; Paez et al., 2008; Kreps & Sparks, 2008).

Significance of Cultural Awareness in Health Communication

Examining cultural issues that impact and influence the way in which members of vulnerable populations respond to health communication and care is crucial for successful disease prevention and health management (Kreps & Sparks, 2008). The necessary customization of health communication programs and health services to better meet the needs of minority consumers is accomplished by recognizing and practicing culturally relevant modes of appropriating knowledge (Kreuter & McClure, 2004). Healthy People 2010 is a set of health promotion and disease prevention initiatives meant to help health organizations develop programs to improve the overall health of the nation during the first decade of the new century (U.S. Department of Health and Human Services & Office of Disease Prevention and Health Promotion, 2010). It was established by several federal agencies, health departments, businesses and community partners working to increase life expectancy and quality, as well as eliminate
health disparities. The program’s objectives, which include increased access to quality health services and establishment of more educational and community-based programs, acknowledge the significance of maintaining a focus on culture when developing intervention strategies (Kreuter et al., 2002). It charged health practitioners to explore not only the unique concerns of different cultural groups, but investigate how such needs can be met when conventional services have failed (Kreuter et al., 2002). Health care providers play a critical role in the interaction with patients from diverse populations and their improved cultural competency would yield improved communication with patients and potentially reduce disparities in health and health care utilization (Horner et al., 2004).

Necessity of Culturally Appropriate Health Care for Refugee Populations

Consequently, 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). Reaching immigrant populations is a tremendously complex but acute need in the United States, as these groups are the most vulnerable health care consumers (Kreps & Sparks, 2008). Traditional culture and accompanying values are highly esteemed 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). Often these belief structures have been threatened in their native country and refugees have suffered violence from the governing bodies who forced their exodus (Frye & D’Avanzo, 1994). Refugees are leaving one volatile and violent environment for a potentially safer but more unpredictable and foreign one. They are subject to the additional emotional and physical demands of flight and uncertainties encountered in an alien country. 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, the least likely population to take advantage of necessary and available health care systems.

*Health Providers’ Role in Establishing Culturally Appropriate Communication*

It is because of these emotional, educational and economic obstacles faced by refugees that public health activists and educators should not attempt to add the additional burdens of changing refugee etiologies of illness and require conformation to Western health care models. Cultural barriers experienced by refugees in relation to their health care are expansive and result in increased stress on an already overstressed community. Ultimately, health programs and interventions targeted at refugee populations require greater expense for and demands upon local health care systems (Kemp, 1985). Interventions and programs aimed at health care professionals are considered most likely to effect change since it is providers that exert more primary control over the health provision and care process (Horner et al., 2004). Approaching patients within a relevant cultural framework will actually aid the process of diagnosis and treatment, since symptomology and treatment regimens can be better understood by patients, who must describe and comply with such measures, and practitioners, who must interpret such symptoms and provide treatment (Hamilton, 1996; Kreps & Sparks, 2008). It has been argued that more effort should be put into provider-focused interventions than focusing on change in patients for these reasons (Horner et al., 2004). Providers who obtain detailed information about patients’ cultural perspectives will have a greater insight into patients’ health beliefs than if they only identify a patient by ethnicity (Andrulis & Brach, 2007). Because failure to consider patient cultural issues can result in incorrect medical histories, non-compliance, and low likelihood of effective treatment (Flores, 2000), culturally appropriate health communication targeted at health care
providers or agencies is thus necessary to limit health disparities in non-native and refugee populations.

METHODS

This ethnographic study focused on the subsection of Montagnard refugees in the Greensboro area, as well as community members who have worked extensively with the population and took place from September 2008 to February 2010. 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 my questioning, as it regarded health-related information, made introductions through acquaintances beneficial in securing source confidence. Because there is very little current literature about the Montagnards in general, much less about those living in North Carolina, I 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, I established a familiarity with the community and recruited interviewees, most of who suggested other family members or friends as potential interviewees.

Eleven female and three male Montagnards were interviewed, all between the ages of 20 and 60. Interviewees had been born in Vietnam but now lived in the United States for at least three years and were proficient English speakers. 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. Interviewees are not identified in the paper, unless their position is relevant to the quoted information. Analyzing techniques I used 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. Use of these types of scrutiny-based techniques have been deemed more appropriate for longer, richer narratives and the contrast-compare methods allow a broader exploration of a previously unexplored health culture (Ryan & Bernard, 2003). Such comparisons were made after the interviews by identifying key concepts discussed by informants and then matching these patterns to other interviewee statements and relevant literature. Seven primary motifs were identified and further literature was sought to expand specific themes not fully described in the initial literature review.

RESULTS/DISCUSSION

Patterns found among Montagnard refugees included misunderstandings between patient and provider due to differences in defining illness, passive obedience, reliance on traditional medicine and false perceptions of Western medicine. In addition, the introduction of American fast food is leading to the formation of new dietary habits by refugees, forecasting the possibility of new health concerns brought on by an unbalanced diet. These patterns were devised
posteriori by separating observations, interviews and applicable literature analyses into comparable thematic categories.

**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). Because health culture shapes the way in which sickness is defined and the interpretation of its severity, 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. “[The Montagnards] 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 is 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 doctors visits (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 can also play a role in the refusal of many routine procedures by Montagnard patients. “Circumcision [the doctors] explain is cleanliness, for a better health,” one interviewee said.
“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 doctors’ 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.

**Seeking health care**

Health-seeking behavior is constrained in many refugee Southeast Asian populations due to beliefs in the naturalness of suffering and reticence about seeking treatment for asymptomatic diseases. Southeast Asians beliefs concerning the inevitability of suffering and acceptance of the time of death as predetermined inhibit some from seeking medical services (Uba, 1992). Members of a Vietnamese population of rural origin studied in Victoria, British Columbia appeared to base many decisions around the traditional concept of causation, and the notion of individual destiny (Stephenson, 1995). Stigmas associated with disease and illness can lead many to not seek care for serious conditions out of fear of family or community judgment. “They can’t
afford to be here and to be an outcast from their society, their community because they have no one, nothing, this is it and they can’t go back to their homeland,” said one interviewee from the county health board. “So what do they do? They just accept it and die.” This belief is still very strong in older generations of Montagnard refugees. “It’s so hard to get them to go see a doctor because they always believe if you have cancer it’s a curse because your mom did bad things or your dad owe me 50 cents,” said one Montagnard refugee, who also works as a hospital translator.” Just to face the community alone is not easy. People start looking at you like ‘Your mom is a bad mom.’ For a certain symptom of a disease that you have [the thought] is you deserve it.” Similarly, Cambodians are slow to seek help because some accept symptoms as fate, which is related to certain religious beliefs and varying definitions of what it means to be healthy (Kemp, 1985).

Southeast Asian populations also can have different standards than Americans about how significant a health threat has to be to seek professional care. For example, the majority of Cambodian refugees are unaware of basic hygiene, principles of disease transmissions and many have lived under conditions in which high levels of disease are tolerated (Kemp, 1985). Many Montagnards lived in the jungle to escape governmental persecution and spent years treating injuries and sicknesses with herbal remedies since qualified health care was not an option. Even though professional health services are now available to Montagnards in the United States, many do not take advantage of them because they are not used to the idea of seeking out such services.

Collectivism and importance of family

Although collectivism and kinship are not inherently health related, these factors have a significant influence on health behaviors and outcomes (Kreuter & McClure, 2004; Ito, 1999). Because family and peers are often the source of accepted and trusted information, inclusion of
family, especially decision-makers within the family who may not be actual blood relatives, is an important factor in facilitating compliance (Ito, 1999). Montagnard refugees rely on elders, husbands and most importantly, their community’s religious leader to assist in or make the actual decision about care and the acceptance of treatment plans. “The oldest, normally one person makes a decision for you. If that person were not around in an urgent situation that you need to make a decision in five minutes then religious leader is the second person that make a decision on your spouse behalf. It normally whether you should have anymore baby or not, whether you should go on birth control or not,” said an interviewee. “A lot of health care providers ask, ‘What is your relationship with the patient?’ and the preacher will say ‘I’m her pastor’ and they still won’t get it because they have no idea. We honor God and we honor the person who delivers the message who is the preacher or the pastor.” The grouping of Montagnard communities and the many extended and immediate family members that crowd households illustrate the importance of “togetherness” many feel. “[Montagnards] don’t seek out the private space that [Americans] do,” one interviewee said. “You want to be with your family, you don’t want to be separated, in a way.” If Montagnards are willing to sacrifice personal boundaries and comfort to be with family members, they will certainly reject health professionals and institutions that don’t understand or allow family members to be included in the medical decision-making process.

The impact of specific family members (usually a husband or other male figure) and their importance as decision-makers is essential in gaining client cooperation and aiding in effective treatment and diagnosis (Ito, 1999). “The culture is always the husband make decisions. The problem like…to give birth control they have to ask husband to decide,” said one interviewee. Many Southeast Asians find being alone frightening. One woman did not want to leave Vietnam but came to America to be with her father who was living all by himself. “When I came here the
first time I think I don’t want to come here,” she said. “My dad call my family in Vietnam on the phone and I feel so sad for my Dad, he can’t speak English and work hard and I just feel sorry for him. I miss him too [so because of] that I just come over too.” Involving a patient’s family as much as possible during a doctor’s visit, even possibly simultaneously scheduling an entire family to be seen can put patients at ease (Muecke, 1983). “Over there in Vietnamese or Montagnard culture, family is to be honored, you got to respect that,” one interviewee said. “Rather listen to parents than listen to yourself.” Inviting family members and friends to participate in the clinical encounter and even assist with asking questions and recalling instructions is essential since many Southeast Asian cultures require family member approval or participation in the decision-making process (Andrulis & Brach 2007).

**Passive obedience**

Even though a Southeast Asian refugee patient may not understand or agree with a given diagnosis or the reason for a prescription regimen, many will not express their disquiet. Many Southeast Asian cultural traditions emphasize that authority figures or experts should not be questioned or opposed directly but only discreetly disobeyed later on (Muecke, 1983). This passive obedience also leads to non-compliance for Montagnard patients. “The trick is they are so polite they wouldn’t respond, they wouldn’t say no, they hardly say no because health care provider is like the goddess or something to them but they won’t do it when they go home,” said one hospital translator. This type of passive obedience is culturally adaptive and Southeast Asian refugee patients use this strategy to cope with uncertainty and authority as well as avoidance of shame (Muecke, 1983). The cultural values that emphasize this unmitigated politeness and obedience to authority figures is frustrating and confusing for medical personnel who do not
understand why patients fail to return for medical services after a seemingly smooth encounter (Uba, 1992). “That is the culture itself,” said a hospital translator. “Whether they like you or not they won’t let you know, the only way you know is if you never see them come back for their follow up, that’s when you know something was wrong.” Cultural norms regarding respect of clinicians’ authority may prevent patients from being active in their care (Andrulis & Brach, 2007). Winning a patient’s confidence is difficult for doctors who must contend with the many cultural variations in attitudes toward medical professionals.

Unfamiliarity and misunderstandings of Western health care systems

United States citizens 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 have 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
thirty 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 checkboxes 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 female 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 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 the 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.

Reliance on traditional medicine

The perception that Western medicine is inappropriate for non-Westerners can contribute to Southeast Asian patients’ refusal to seek Western healthcare or, once being prescribed a medication, not taking it (Uba, 1992). “I guess like my family have used the root of the tree but I don’t know what that called,” one interviewee said. “My brother sent it over here but we don’t keep it no more we use it all.” When asked about antibiotics many interviewees seemed confused
and asked what antibiotics were. Many did admit using Tylenol and Aleve but couldn’t think of any American medicine besides those name brands.

Southeast Asians put more emphasis on self-care and self-medication and both are often practiced longer than with Western patients before professional care is sought (Muecke, 1983). “In Vietnam only if the life’s threat, then you go to hospital,” one interviewee said. “If you flu you try to use herb medicine. We treat flu from earth, from mother earth medicine. They give birth also we have herb medicine. And vitamin we take from the jungle. I been 17 year in jungle I learn myself, I do all that I learn and use in the jungle 17 years. If you have wounded you put honey inside and clean all pus and clean pus go fast to heal. That is what we used to do.” Montagnards do believe there are limitations to even what herbal remedies can cure so Western medicines are still sought out. “Herb medicine to treat one only [symptom],” one interviewee said. “The body only one diagnosis and symptom can be gone only one and if you have two or three you can’t have herb medicine.” When medication is dispensed, dosing instructions are often misunderstood or not received at all. “We have make sure they understand medicines, how to take it,” said one Montagnard community leader. “They said okay one day I take three times a day. Three time how much? How many hour?” When a prescription or medication is received, a lack of knowledge about medicines in pill form still can lead to confusion. “The concept of needles they’ve heard of because they have experience because of the flu shot annually but they’re not really a big fan of pills because normally when you go to the doctor you usually get out with a shot. [In Vietnam] whether you have stomach ache they give you shot. Over here they expecting [a shot] but all you have is prescription you can’t even buy there,” said one hospital translator. “That’s when it gets lost, the pills never get taken. The prescription is ended up in their wallet for many years.” In this case, even though the patient does receive care from a
physician, the necessary steps to begin effective treatment i.e. filling the prescription, are never taken.

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 bad American 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 thirty Montagnard die in America. Same cause from stroke because of high blood pressure, and they never heard that in Vietnam.”

CONCLUSION

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, use of passive obedience, reliance on traditional medicine 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. For instance, patient ignorance, due to distrust of Western medicine and misunderstandings about its functions, is not always apparent since Montagnard cultural values emphasize feigning understanding rather than questioning authority figures or admitting a lack of knowledge. Culturally aware clinicians can navigate such cultural nuances through engagement and implementation of tailored communication techniques.

Future studies looking at the ways in which second and third generation Montagnards are experiencing dissonance with Western medicine are needed as the population continues to grow. Studying Montagnard communities outside of one specific geographic area and in other regions of North Carolina such as Raleigh and Charlotte could provide information about how location impacts health barriers, in terms of access and cultural incongruities. A more quantitative study using measurable data like that achieved by surveys could also be employed in future research. Such findings could potentially determine the significance of one barrier compared to another.
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and establish a more detailed plan by which providers and educators could develop cultural competency.

Because it is the engaged, non-judgmental clinicians who can learn about a patients’ belief system and practices, they are also the ones who can replace harmful or ineffective remedies with harmless ones that are consistent with individual beliefs (Flores, 2000). This can be accomplished in several ways, on both a micro and macro scale. At a provider-patient level, physicians and nurses can modify their messages so they are more digestible to refugee patients unfamiliar with health care commonalities. Allowing patients use their own words to describe their culture and language and adopting less formal assessment strategies will also limit misunderstandings between patient and provider (Andrulis & Brach, 2007). Clear communication can be facilitated by providers that deliver simple messages to patients and are taking an active interest in a patient’s understanding of their instruction. Providers that do not bombard patients with several messages at once, speak in uncomplicated and jargon-free language often have more success with patient compliance and improved trust (Andrulis & Brach, 2007). The teach-back or teach-to-goal method is also another successful strategy of having patients explain what they have been told. Patients should be asked to repeat information to make sure comprehension has occurred. Clinicians can learn more about their patients’ health culture and beliefs by asking questions that explore patients own unique concept of health, such as: What do you think has caused the illness? What do you think the illness does? (Andrulis & Brach, 2007) Providers who accommodate folk illness beliefs and practices and who are able to integrate them into suggestions for appropriate care will be better able to explain the rationale behind a particular 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).

It is important to remember that health communicators, providers and allied professionals are all at an early age of understanding the scope of health literacy and culture as it relates to minority populations, especially those isolated from majority populations by cultural boundaries (Andrulis & Brach, 2007). The scope of methods employed to evoke positive health change can be as large as instituting new training programs or as small as assuring understanding in a single patient encounter. On a grander scale, 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 can help address certain health barriers. Studies have suggested training in cultural competence when dealing with such multicultural and diverse patient perspectives, but this training is a complex mix of specific types of knowledge and self-awareness (Horner et al., 2004). Furthermore, creativity and flexibility is needed to apply these cultural competencies to the treatment and clinical decision-making and it is unlikely to be achieved by a one-time-only study course (Horner et al., 2004).

A merger of programs that seek to improve health professionals’ communication skills across culture and language and training to improve provider ability to serve low-health literacy populations is necessary (Andrulis & Brach, 2007). Training programs should take advantage of known effective learning methods such as role-playing, specific case presentations and the inclusion of outside consultants such as indigenous healers and community leaders (Horner et al.,
2004). Opportunities to include cultural training in health provider education may include courses offered in medical schools, lecture series during residency and continuing medical education courses (Flores, 2000). Patient and clinical care, however, is not just between physician and patient—the receptionists taking appointments and hospital administrators who make their facilities more or less accessible to minority populations are also involved in the health care process (Horner et al., 2004). If such advances are made and those working in a patient-care, health provider setting are able to move beyond their own personal perceptions of lack of care coordination, racial and ethnic prejudices and assumed patient ignorance, the cultural competency process can begin and the length and quality of refugee lives can be improved and brought up to par with majority members of the population (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.

WORKS CITED


