

Contemporary Perspectives on Vietnamese Medicine among Resettled Vietnamese Refugees in
Victoria, Canada.

by

Jessica Ly
B.A. University of Victoria, 2011

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Supervisory Committee

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Abstract

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This thesis is a qualitative study of health practices of resettled Vietnamese refugees in Victoria, B.C. This thesis looks at the past and present sociocultural and political experiences of forced migration and resettlement which have influenced definitions, understandings and practices of medicine among refugees today. Previous studies of Vietnamese refugee groups have identified traditional Chinese medicine and biomedicine as complementary healing systems which are used. These studies report that Vietnamese refugee groups still experience sociocultural barriers to care after resettlement to their host country. This research found that resettled Vietnamese refugees in Victoria, B.C. still demonstrate a syncretic approach to medical practice which is also inclusive of traditional Vietnamese medicine (TVM). Using semi-structured interviews and participant observation methods to collect materials and gain a detailed understanding of how medicine is understood and used by resettled Vietnamese refugees, this study is based on interviews from a sample of 7 resettled Vietnamese refugees, six female and one male. I demonstrate that medicine is much more complex than simply practicing different forms of medicine. There are underlying sociocultural and political issues that continue to shape how medicine is defined and represented by resettled Vietnamese refugees today. This thesis identifies TVM as a recognized healing system and shows how perceptions of medicine and health have changed over the course of resettlement. Although forced migration and long term resettlement has resulted in the internalization of certain socio-cultural and political norms and expectations regarding medical practice, some of these changes have been beneficial for resettled Vietnamese refugees in Victoria, B.C.

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Dedication

For my parents, my respondents, and all Vietnamese refugees who inspired this research and made this project possible.

Chapter One:

Introduction: Why Refugee Medicine isn't Just About Medicine

When I get it sick, it depends how sick I am. What is it? Like a flu, headache, or stomach ache? [W]hen you get a headache, depends on what it is to [find a] cure for it. For Vietnamese, when you have the flu you scratch it – you buy the oil and scratch. For a headache you have some herb from Vietnam, or you can take Tylenol or Advil. Or, also you can [steam]...you know – cook some ginger and lemongrass and put a blanket on your body and you steam – takes a few days. Or, it depends, if the medication doesn't help you, you can go see a [Western] doctor or a Chinese doctor. (Duc, resettled Vietnamese refugee)

Why Vietnamese medicine?

Across the world, responses to sickness vary considerably depending on social and cultural conditions. While many communities have access to a known system of treatment which they use with confidence, such as a traditional healing system or biomedicine, there are others where decisions about healing are not made so easily. For Vietnamese refugees in Canada, decision-making about how to treat illness is complex. Illness is defined cross-culturally as the somatic experiences of being unwell (Ember and Ember 2004, p.26). As the above quote made by a resettled Vietnamese refugee notes, many different medicinal options are available for treating illnesses and often the practices are applied based on ideas of how they affect the illness. The statement was in response to the most basic of questions that I posed in my interviews with resettled Vietnamese refugees in Victoria, B.C. – “When you are sick what medicines do you use?” The multifaceted and confusing nature of the answer indicates the complexities of contemporary decision making about medicines among resettled Vietnamese refugees in Canada, and is the focus of this study.

This thesis explores the use and understanding of medical practices among the local Vietnamese Refugee community in Victoria, British Columbia, through insider research. As a second generation Vietnamese myself, I have experienced first-hand the myriad use of remedies

or drugs for treating health problems similar to what my informant described above. My interest in health and medicine was piqued over the years of seeing how my family, and the Vietnamese refugee community I spend time with in Victoria, interacted with medicine. Over the course of my childhood I observed and used a syncretic approach to treating illness; that is, I and my family used medicines ranging from traditional home remedies to prescription medicines. For my parents, steaming, coining and Tylenol were all equally reasonable treatment options if I was sick with cold or flu. Although, all means available were tried, explanations around why we used a particular treatment were rarely provided. The use of various medical practices, as well as contradictory explanations of causes and treatments left me with many questions about illness, treatment and how medicine is understood among my family and other Vietnamese-Canadian families.

There were two features in particular which I observed in the interaction with medicine that I explore in this thesis. The first feature was the stark contradictions that seemed to be present in the syncretic approach to medicine particularly in how resettled Vietnamese refugees explained, understood, and justified each choice. Second was the low level of recognition of any practices referred to as “Vietnamese medicine,” the transfer of knowledge around aspects of Vietnamese medicine, and the limited scholarly literature addressing medical practices by resettled Vietnamese refugees in Canada, the U.S. or elsewhere.¹ The ambiguities and omissions led me to see if there was indeed a “Vietnamese” medicine, what it was in terms of definitions, treatments, and efficacy; what it meant for Vietnamese refugees who no longer lived in Vietnam, and to explore how and why it could be compared to other traditional healing systems, specifically traditional Chinese medicine. This research was initially driven by questions about

¹ Donnelly (2006), McKeary and Newbold (2010), and Stephenson (1995) represent the main contribution to academic work on Vietnamese refugee communities in Canada.

what medicine means and what practices or remedies were commonly used by Vietnamese refugees and why. What were the recipes and where did they come from? How have these practices been preserved or transformed throughout the forced migration and resettlement process? Why and how could syncretic approaches to healing be so common? And finally what was “Vietnamese” medicine? What does it mean to the Vietnamese refugee population today?

I chose this topic specifically because of my personal background and family history. My parents were boat people who immigrated here at the end of the Vietnam War in 1979. The term “boat people” is used to identify those who leave their homelands by sea during political upheaval or economic crisis. As used today, the term refers specifically to groups of people who leave home in small fishing boats and sometimes makeshift rafts, seeking asylum abroad² (Schaefer, 2008). The impact of the American-Vietnam war drastically altered the socio-political development of Vietnam. The American involvement in Vietnam escalated the intense struggles of nationalism in the country driving a greater rift between the North and South. When the Americans withdrew Vietnam in 1973 rapid deterioration sent a shock through Vietnam. The destruction that followed made Vietnam inhabitable for most and when Saigon fell in 1975, millions fled the country. Of those trying to escape, 1.5 million fled by boat in the first wave of 1975, hence becoming known as the “boat people” (Hall 2000). Millions, including my parents, were forced to flee their country in search of a new life. The physical, emotional, and cultural trauma that they experienced during the war, forced migration, and resettlement process has and continues to shape how resettled Vietnamese refugees live in Canada today.

Research on resettled Vietnamese refugees in Canada revealed the many dimensions of medical healing and practice. This thesis argues that the answers given by my respondents,

² During the 20th century, the most significant movements of such ‘boat people’ - at least from an American perspective – began in the 1960’s, with Cubans, Haitians and Vietnamese (Schaefer 2008).

which were colored by the physical behaviours (i.e. hesitations and suspicions) exhibited towards me prior to and during the in-depth interviews, suggest that medicine is an important aspect of their lives, but that there are many underlying issues that have shaped and continue to influence their behaviours and understandings of not only medicine, but also of the social world that they live in. Why do they exhibit these particular mannerisms and to what extent do their subjective perceptions of medicine, as discussed in their interviews with me, reflect broader socio-cultural issues? Singer and Baer note that,

...understanding of health issues begins with an analysis of the impact of political and economic forces that pattern human relationships, shape social behaviours, condition collective experiences, re-order local ecologies, and generate cultural meanings, including forces of institutional, national and global scale (1995, p. 65).

How resettled Vietnamese refugees respond to questions regarding medical practice and how they understand illness and treatment in particular contexts demonstrates the subjective nature of the topic and of the individual. Accounts given by resettled Vietnamese refugees shows that their past experiences continue to influence how they live their lives today, how they relate to medicine and make decisions about healing, and how they respond to questions about medical practices. This relationship between refugee history and medical experiences is a main finding of this research.

This thesis describes which socio-cultural and political meanings are represented through the use of certain medical practices. In interviews with resettled Vietnamese refugees who now live in Victoria, B.C.³, I explored if and in what ways Vietnamese medicine was its own coherent medical system by showing how resettled Vietnamese refugees identify and work with healing

³ One respondent resides in Vancouver, B.C.

systems and how they came to understand them. I explored issues around efficacy, cultural beliefs, and politics, and argue that the terms and distinctions resettled Vietnamese refugees used to identify medicines illustrate an established historical opposition between “traditional”⁴ medicine and biomedicine that has been embedded into the cultural and political lives of these refugees even today. By traditional medicine I mean, “the broad range of non-biomedical systems of medicine and medical therapies as they are used in countries where those practices originated” (Alter 2005, p. 90); and by biomedicine I mean the “dominant medical tradition of the Western industrialized societies,” such as Canada (Leslie and Young 1992, p. 6) The ways that respondents classify and understand medicines expressed underlying political connotations that I explore in this thesis. How resettled Vietnamese refugees described their relationships with medicine appeared to be directly related to the forced migration and resettlement process. Thus, rather than highlighting what “Vietnamese medicine” is and what specific Vietnamese remedies⁵ are, I discuss the circumstances and conditions that define the parameters of medicine, and how healing is discussed by Vietnamese refugees who have resettled in Victoria, B.C.

This thesis is the first to analyze contemporary Vietnamese medical practices of Vietnamese refugees in Victoria, B.C. after long term resettlement. Through respondent definitions and their practices surrounding medicine this study investigates the underlying impact of forced migration and resettlement both on perceptions of health and how medicine is used. It also illustrates how the personal, social and political characteristics of both Vietnamese and Canadian cultures are represented in everyday medical practice. I will demonstrate how the

⁴ The World Health Organization (WHO) defines traditional medicine as, the sum total of all knowledge, skills and practices based on the theories, beliefs and experiences of indigenous to different cultures that are used to maintain health, as well as to prevent, diagnose, improve or treat physical and mental illness.

⁵ Initially, one goal of this research was to collect and catalogue recipes for traditional Vietnamese remedies; however, due to lack of knowledge transfer, my respondents did not have the detailed knowledge for this. I will discuss this in more detail in the following chapter.

social and political experiences with sickness, treatment, and well-being of first generation Vietnamese refugees are subjective. In particular, the language, presentation, and understanding of medicine, as well as the conditions surrounding its use will illustrate how politically charged the topic of medicine and health is for the Vietnamese refugee. I argue that internalized social and political perceptions of “Canadian” and “Vietnamese” culture are what shape their everyday practices of medicine and self-reported health status. In particular, I show how the internalization of political tensions occasionally manifest themselves in the refugees’ choice of language, willingness to share experiences, and their understanding of medicine.

Another aspect this thesis will explore is the political undertones that shape medical practice for resettled Vietnamese refugees by identifying how respondents define medicine. It will explore the subjective nature of medicine and its rationalization for refugees, by presenting when and why respondents chose to employ particular practices. Finally, this thesis will examine how medicine is used as a navigational tool for personal, social and political identities through public and private representations of health.

Comparative Perspectives on Refugee Medicines

The use of different medical practices is a key factor in identifying how medicine is understood in Canada. Refugee groups develop particular ways of using and presenting their perspectives of traditional healing systems and Western biomedical practices after migration and resettlement. Many studies show the use of traditional healing practices among immigrant and refugee populations still persists after resettlement in the host country (Anh et al., 2006; Barimah, and van Teijlingen 2008; Buchwald, Panwala, and Hooton 1992; Ma, 1999; Stephenson, 1995). Anh et al.’s (2006) study of Chinese and Vietnamese-Americans show that

these populations have a high use of complementary and alternative medical (CAM)⁶ therapies. CAM therapies are defined as “the non-prescription, traditional Asian therapies,” that are used most commonly by ethnic minority groups (Anh et al 2006, p. 647). For example, some of these therapies include herbs, acupuncture, and cupping. In another study of Ghanaian refugees in Canada, Barimah and van Teijlingen (2008) illustrate that a mix-and-match approach to health seeking behaviours is common and is integrated with biomedical practices. Although Ghanaian refugees did utilize some traditional medicines they tended to denigrate those practices and expressed a preference for biomedicine, reinforcing a binary between the two systems. Of particular interest in Barimah and van Teijlingen’s findings is that “the reasons given by Ghanaians for any changes in their attitude towards Ghanaian traditional medicine (TRM) was negative” (2008, p. 7). Ghanaian refugees felt that their traditional medicine could not provide the same level of assurance in comparison to the technological advances and scientific evidence of biomedicine. They demonstrated concerns about trust and efficacy of more traditional remedies and this was a reason that deterred them from using Ghanaian traditional medicine after arrival to Canada. These studies by Anh et al. (2006) and Barimah and van Teijlingen (2008) present the medical practices of other immigrant and refugee communities and raise the question of whether Vietnamese refugees have the same perspective or if the causes are beyond this commonality and are a result of the refugee experience.

The majority of studies on the Vietnamese are from the United States and Australia. Hoang and Erickson (1985) and D’Avanzo (1992) show that newly arrived Vietnamese refugees to the United States also use a dual system of medicine but have a tendency to underutilize health services due to cultural and linguistic barriers. Furthermore, the inability to find a primary care

⁶ This term is often used in the literature to identify traditional practices of ethnic minority groups; however I will not be using this term as it tends to generalize the medical systems.

physician and lack of health coverage⁷ exacerbates the situation of low health service usage (D'Avanzo 1992). O'Callaghan and Quine show that cultural influences, both before and after resettlement, have had an impact on how Vietnamese Australian women utilize and understand health and medicine. O'Callaghan and Quine's study of Vietnamese women in Australia found that:

[Their] long experience of using Chinese and Vietnamese medicine strongly influenced their perception of problems taking medicine... They showed an understanding of how each of these modes of treatment (Chinese, Vietnamese, and Western medicines) were quite different and discussed strategies they used that combined their different types of knowledge to treat illnesses and maintain their health (2007, p. 411).

This finding among Vietnamese refugees in Australia illustrates how complex and multifaceted the use of medicine becomes with the introduction of an alternate system of healing.

Socio-cultural barriers to health care and services have also been highlighted in the few studies done on Vietnamese refugee communities in Canada as well (Donnelly, 2006; McKeary and Newbold, 2010; Stephenson, 1995). Stephenson's (1995) study of the Vietnamese refugee population in Victoria, B.C. found that traditional medical practices were consistent for the new refugee community. He describes a community that sought treatment from traditional Chinese and Vietnamese herbal remedies and relied on herbalists in Chinatown for these. Stephenson's study also supports other studies which found language and cultural beliefs were barriers to care. Donnelly's two studies of Vietnamese women and cancer screenings in Vancouver, B.C. and Calgary, A.B. indicated that although health services were available, Vietnamese women were

⁷ Given the different health care systems of United States, Australia and Canada, these studies cannot be used as a comparison to the experiences with health services of immigrant and refugee groups in Canada.

still reluctant to use them due to socio-cultural and economic barriers (2006; 2007). Donnelly argued that the small size of the Vietnamese community in Canada requires more attention to recognize the health care needs specific to this group. Donnelly states that “unless Vietnamese immigrants...are visible enough in Canadian society and unless their concerns are heard, there will be limited healthcare services or institutional government support for them” (2006, p. 9). Newbold and McKeary’s study of refugees in Hamilton, O.N. reflects this awareness as well, “while the need for cultural competency clearly extends to the larger immigrant and ethnic communities, it is in critical demand in order to address and care for the special needs that refugees bring to the health care system” (2010, p. 532). This thesis on resettled Vietnamese refugees could provide new data that can assist in understanding long term health care needs and medical practices.

Although these studies have provided substantial data on the health practices of refugee groups there are some limitations to these studies. For instance, they only address socio-cultural differences and acculturative processes, such as language difficulty and lack of access or misinformation due to cultural misunderstandings, as the reason for treatment choices. Anh (2006), Ma (1999) and Stephenson (1995) highlighted cultural or spiritual beliefs, horoscopy, and presumed efficacy as some of the common reasons for the continued use of traditional medicine. These studies discuss cultural beliefs and perceptions of illness and causation such as yin and yang⁸ and holism (Ma, 1999; Stephenson, 1995). Stephenson states that, “very traditional ideas are held by some Victoria Vietnamese people and appear even to motivate their use of ‘western’ medicine” (1995, p.1637). This is an aspect that I explore in order to explain how

⁸ Two fundamental concepts of Chinese medical philosophy, these are two opposing concepts that account for changes in the universe and human body. Yin is the internal region and Yang is the external region. When the two are not in balance sickness occurs, in terms of treatment, striking a balance between the two is required; ‘A hot disease should be treated by cold herbs; a cold disease should be treated by hot herbs... Yin should be treated in a yang disease, yang should be treated in a yin disease’ (Lu 2005, p. 11).

cultural beliefs have persisted or been transformed, and to what extent. This thesis argues that immigrant and refugee groups demonstrate myriad forms of utilization and rationalize their chosen practices in complex ways which need to be explored further. Additionally, the results which indicate that health professionals need to be more aware of different cultural beliefs and traditional health practices (Anh,2006; Stephenson, 1995; Jenkins et al., 1996; Newbold and McKeary, 2010) do not reflect any changes or improvements that have taken place since resettlement.

Another limitation of past studies is that they often do not distinguish between immigrants or refugees.⁹ The terms are often used interchangeably, or as in studies by Beiser (2005), Laroche (2000) and Newbold and Filice (2006), refugees are identified merely as a subgroup of immigrants and no further reference is made. This is problematic because it assumes that refugees and immigrants come from similar circumstances¹⁰ or do not require the same level of distinction. The term immigrant is defined as: “a person who comes to a country to take up permanent residence,” whereas refugee is defined as: “a person who flees to a foreign country or power to escape danger or persecution” (Feller 2005, p. 28). The former indicates that migration and relocation is a decision of personal choice and freedoms, whereas the latter have not had that option. Another problematic categorization used within these studies, particularly those on Southeast Asian (SEA) refugees, is that they are classified under the SEA umbrella¹¹; there is no distinction between Lao, Mein, Cambodian, or Vietnamese populations¹². Although these ethnic

⁹ Studies that do distinguish between the two or that were done specifically on refugee groups include: Buchwald, Panwala and Hooton (1992), Chung and Lin (1994), Donnelly et al. (2009), Donnelly and McKellin (2007), Hoang and Erickson (1985), and Stephenson (1995).

¹⁰ Because of their precarious security situation and because of the absence of national protection in their own countries, refugees are the recognized beneficiaries of internally endorsed rights....Migrants are different [and] there are a wide range of agreements of various sorts relating to the management of migration (Feller 2005, p. 28).

¹¹ This is presumably due to their limited numbers.

¹² Total Vietnamese population (as identified by mother-tongue) is 141,630 (Statistics Canada 2006 Census)

groups share some similarities there are distinctions that should not be dismissed. For example, Chung and Lin (1994) found significant differences in health seeking behaviours among Southeast Asian refugees (Vietnamese, Cambodian, Lao, Hmong, and Chinese-Vietnamese) before and after resettlement to the United States. Another aspect of the literature that is missing is longitudinal research that tracks the changes in health-seeking behaviour among refugee groups after long term resettlement. Stephenson's (1995) study presents the case of the Vietnamese refugee community in Victoria eighteen years ago and highlights changes to health practices after initial resettlement. While comprehensive in its assessments, the time frame of the study does not allow for exploration on the long term impacts of the refugees' relationship with medicine and how it could be reflective of socio-political issues of forced migration, resettlement and re-socialization. This thesis provides follow-up to this earlier study, and seeks to identify if changes in healing practices and preferences have taken place and if so, why? This is a critical study as it helps to identify and understand how refugee groups adapt socially and culturally after long term resettlement. This thesis will present how the meaning and practice of medicine has changed for resettled Vietnamese refugees in Victoria, B.C. The following section will define medicine and address the critiques of medical classifications and why it is relevant for this study of Vietnamese refugees and medicine today.

Classifying Medical Systems: What's in a name?

Medicine, as Kleinman identifies it, is a, "cultural system, a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions...Illness, the responses to it, individuals experiencing it and treating it, and the social institutions relating to it are all systematically interconnected" (1980, p. 24). This definition of medicine is helpful in highlighting the cultural and symbolic meanings that encompass medicine

and health. It is these representations that make each medical system unique from one another and illustrate that medicine is more than just illness and treatment. The sociocultural environment is as important for identifying and treating an illness as is the stethoscope or prescription medication. As such, I will distinguish “Vietnamese medicine” from other diverse practices by highlighting its specific history and cultural background. I argue Vietnamese medicine is a distinctive practice and deserves recognition as a systematic formal medical system on par with Traditional Chinese medicine (TCM) or Ayurveda.¹³

Classifications of healing systems or medical practices are often viewed in comparison to one another and this shapes how medicine and health are understood and practiced. For example, biomedicine is defined as “a ‘sociocultural system,’ a complex cultural historical construction with a consistent set of internal beliefs, rules and practices” which has a non-spiritual, non-religious biotechnical approach (Gaines and Davis-Floyd 2004, p. 96). Biomedicine has a clinical and mechanistic focus in dealing with illness and medicine, with one of its main features being the separation of mind and body.

Biomedicine is firstly, a distinctive domain within a culture that features both specialized knowledge and distinct practices based on that knowledge; second, it exhibits a hierarchical division of labor as well as guides or rules for action in its social and clinical encounters; and third, as an internally cohesive system, biomedicine reproduces itself through studies that confirm its already-established practices (Gaines and Davis-Floyd, 2004, p. 97).

Biomedicine is clinical, regimented and scientifically grounded. Due to its institutionalized system, technological advances, and association with Western nations,

¹³ Indian Ayurveda is a system of traditional medicine; See Chopra and Doiphode (2002) for more information.

biomedicine is often seen as superior and the basis upon which to compare other medical traditions.

In contrast with biomedicine, other medical traditions are often simplified into terms such as “traditional,” “Eastern,” or “holistic.” These terms group diverse practices under the same umbrella and reinforce notions that they are one and the same (Earnst, 2002; Good, 1994). I move away from simple categorizations because each medical system has a different language, history, culture, and skill, which I argue should first be understood within its own context rather than as comparisons or generalizations. I show in this thesis the specific characteristics of Vietnamese medicine and explore, “the uniqueness of the Vietnamese approach [which] is...the incorporation of foreign influences carried out through an assimilation process which modifies and adapts them” (Hoang, et al., 1993, p. 15). As Good claims, “medicine is a cultural configuration...a functionally integrated system of cultural beliefs and practices, and must be analyzed within cultural context” (1994, p. 29). In providing a name for Vietnamese medicine, this thesis is addressing the classificatory system of medical practices; however, it will focus primarily on the contemporary medical practices of resettled Vietnamese refugees and their underlying meanings.

The way in which medicine is understood can show what underlying social, cultural and political tensions may be present. My research respondents consistently referred to the medical systems they spoke of in nationalistic terms – Vietnamese, Chinese and Canadian. They identified medicine as state systems and this is not surprising as, “...nationalism is, in some ways, concerned with the centering of medicine as medicine (Alter 2005, p.16). Resettled Vietnamese refugees seemed to identify medicine in nationalist terms in an effort to ground their understanding of certain practices. The confusion and complexities that my respondents

demonstrate in discussions about medical practices is illustrative of how, “transnationalism...either destabilizes medicine as a category or complicates its structure, function, and meaning” (Alter 2005, p. 16). The forced migration process experienced by Vietnamese refugees introduced biomedicine as a dominant practice and with that changed their initial understanding of medicine which now needs to be considered. In identifying medicine as a national system, in nationalistic terms, these individuals highlight the political bearing that medicine has on their personal identity and conception. Alter emphasizes how “the politics of nationalism does not just affect the practice of medicine...it has an effect on how practice is theorized” (2005, p. 22). Therefore, through medicine we can identify some of the political influences which have transformed the socio-cultural perceptions of resettled Vietnamese refugees since resettlement in Canada.

The changes that have taken place regarding medical practices following resettlement are demonstrative of the fluid and adaptive nature of medicine. Medicine is ever changing: “each medical system evolves to meet a people’s conception of their health needs” (Fabrega 1976, p. 143). Each system, be it folk, tradition, or contemporary has evolved and changed with the developments of new knowledge and interaction with other systems or individuals. Medicine “is all about life and death, and most certainly not just in a metaphorical sense...The paradox is that as medicine is more deeply implicated in the politics of culture that the act of politics often involves ever more elaborate claims about the organic, natural nature of medical truth and about the universal efficacy of one kind of medicine as against another” (Alter 2005, p. 13). Medicine is understood and represented through different personal, cultural, and political frames and this is demonstrated in the contemporary practices of resettled Vietnamese refugees. In this thesis, I will explore the ways in which medicine is subjectively experienced and defined by resettled

Vietnamese refugees in Canada, within a framework that incorporates their past and present socio-political conditions.

Subjectivity and the Internalization of Medical Practices

Addressing refugee experiences of medicine requires addressing issues around subjectivity. Subjectivity is “everyday modes of experience, the social and psychological dimensions of everyday lives, the psychological qualities of social life, the constitution of the subject, and forms of subjection found in diverse places” (Good et al., 2005, p. 1). This emphasis on subjectivity draws on the particularities of individual experience, practice, belief, and understanding. The forced migration and resettlement process experienced by resettled Vietnamese refugees has shaped the social and political conditions of medicine and its use, as well as how refugees feel about medicine today. Those experiences have forced refugees to learn how to navigate between two different worlds from the past and present, and not just in the context of medicine. To gain a better perspective of what Vietnamese refugees have experienced and how those experiences translate into their everyday lives we must understand that “the notion of intersubjectivity provides an important bridge to a more precise understanding of the interactions among cultural representations, collective processes, and subjectivity” (Jenkins and Hollifield 2005, p. 380). The subjective analysis of my approach draws on the argument that, “studies of subjectivity need to pay attention to that which is *not* said overtly, to that which is unspeakable and unspoken, to that which appears at the margins of formal speech and everyday presentations of self...” (Good et al., 2005, p. 14). The reason for exploring this is to provide a voice to resettled Vietnamese refugees about their health practices and the experiences they have had with medicine throughout the migration and resettlement process.

In illustrating the actual health practices of resettled Vietnamese refugees, this thesis provides a broader understanding of what influences medicine has on everyday life, in particular, how medicine is assumed to be understood and presented. After all, “medical systems may be understood not only in terms of what they do as therapeutic interventions, but also in terms of what they allow people to say (Das 2007, p. 69).” This political characterization of medicine is not new, nor is its discussion in regards to refugee groups (Ong, 2003; Good et al, 2005; Foucault, 1973). For refugees, medicine, “is not only a medium of experience, a mode of engagement with the world; it is a dialogical medium, one of encounter, interpretation, conflict and...transformation” (Good 1994, p. 86). Ong clarifies this,

Refugees learn within the first few months of arrival the steps to becoming a well-adjusted subject; the clinics and health care regimes that are/were put in place specifically for the screening of refugee patients teaches them what they need to know in terms of living amongst North Americans so as to reduce the harm to “others” (2003, p. 95).

At the outset, the refugee is problematized and viewed as an individual that needs to be taught, to be re-educated in order to successfully and appropriately adapt. This socialization process is internalized and I argue that this affects how Vietnamese refugees understand medicine in the Canadian context as well, even after nearly thirty years.

The refugee experience with medicine has particularly political undertones since most refugees pass through refugee camps where medical screenings were regular and mandatory, and this experience has impacted how they view medical practices today. Refugee camps¹⁴ are the site where many refugees first became introduced to the systematic and clinical nature of

¹⁴ The location of the refugee camps were Malaysia, Singapore, Thailand, Hong Kong and the Philippines, they housed over 350,000 refugees (Mortland 1987, p. 381).

biomedicine in order to reinforce social and political power dynamics. As traditional Vietnamese medicine was dominant in Vietnam, many refugees fleeing Vietnam had little or no experience with biomedicine when they left (Craig, 2002; Dung, 2001). There is no place for, or access to, any form of traditional, ethnic, or cultural practices in the refugee camp because these camps are locations where refugees are educated for their new “Western” lives abroad: “the purpose of the [refugee camp] ... is to prepare refugees for life in the country in which they will be resettled. In a very real sense, the purpose...is to ‘change’ refugees from what they were before to what they need to be, in the country of resettlement” (Mortland 1987, p. 385). Through medical assessments, refugees were classified based on their level of health and acculturative factors which would identify whether or not they were eligible for transfer.¹⁵

The rigorous screening processes that Vietnamese refugees¹⁶ were put through to ascertain their suitability for placement is an example of the political nature of medical practice. In her study of Cambodian refugees in the United States, for example, Ong highlights how instructions given to new refugees for “healthy living” had an emphasis on odor, “While offensive bodies can be physically contained, smells cannot. The focus on offensive smells, those ‘invasive’ and invisible forces, highlighted anxiety over regulating refugee bodies in social space” (2003, p. 97). The focus on minute personal details, such as odor, represents the extent to which the control over these individuals and bodies was desired. It is an example of how deeply the state wants these refugees to internalize the basic requirements to becoming an accepted civilian in their host country.

¹⁵ Refugees are chosen both for factors they exhibit (e.g., possessing relatives already living in the country of resettlement, previous employment with western organizations) and for factors they do not exhibit (e.g., Communist affiliations, ability to be repatriated, contagious physical conditions) (Mortland 1987, p. 387).

¹⁶ For the purposes of this study I identify Vietnamese refugees, but all refugees are put through screening processes as well prior to receiving entry into a host country.

Vietnamese refugees who arrived in Canada at the close of the Vietnam War 1975 marked the beginning of refugees seeking asylum, yet Canada was not immediately welcoming. The social and political reception of the refugees who arrived was one of mixed indifference, fear, hostility and compassion and greatly reflected the sentiments and consequences of war. In Canada, Vietnamese refugees arrived to two military barracks set up as staging areas in Montreal and Edmonton¹⁷. At these centres, Vietnamese refugees were processed; filling in paperwork, undergoing a medical exam, and receiving a crash course on Canadian culture.¹⁸ Canada took in approximately 137,000¹⁹ refugees between 1975 and 1989; however this was only due to Prime Minister Pierre Trudeau's Liberal government adopting Multiculturalism²⁰ in 1971 to promote the importance of immigration and diversity in Canada. Canada's immigration policies have changed consistently over the past three decades, with conditions for acceptance varying drastically.²¹ I suggest given the similarities in reception in both the U.S. and Canada, that similar measures were employed by Canada to test refugee health. By accepting the regulations of biomedicine and publicly suppressing their own healing systems, refugees are seen to be able to adapt and become part of their new country, part of a new citizenry.

The message of belonging is strongly reinforced at refugee camps, and biomedicine plays a critical role in this process. The experience of being filtered and processed in refugee camps and staging areas creates a space where "biomedicine...attempts to maintain its modern scientific status by co-opting and redefining knowledge, therapies, or therapeutic agents found in other

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http://www.lyhuong.net/viet/index.php?option=com_content&view=article&id=172:172&catid=51:thuyennhan&Itemid=64

¹⁸ <http://www.cbc.ca/archives/categories/society/immigration/boat-people-a-refugee-crisis/welcome-to-canada.html>

¹⁹ Bloemraad 2006, 71

²⁰ This was a shift from the Official Languages Act of 1969 which declared Bilingualism and Biculturalism as the official representation of French and English language and culture in Canada (Katz).

²¹ For example, the implementation of the point system greatly limited those able to enter the country due to more stringent screening and application requirements. For more information of the requirement visit <http://www.workpermit.com/canada/individual/skilled.htm>

traditions, professional or popular” (Gaines and Davis-Floyd 2004, p. 104). The refugee camps were sites for this type of reproduction. Ong (2003) demonstrated in her study of Cambodian refugees in the United States that democratic sensibility was introduced as a notion that refugees need to acquire and maintain; Vietnamese refugees in Canada were no exception. Therefore the nationalistic characterization of medicine that my respondents have consistently referenced, consciously or not, highlight how this attempt at political internalization by way of medical practice has been successful. This thesis argues that the re-education process that took place in refugee camps still influences resettled Vietnamese refugees today. Not only that, the acculturative process that has taken place since migration and resettlement also affected refugees, and are both present in the interviews I held in 2012. The responses provided on the understanding and use particular medical practices reveal how these refugees interpret the politics of medicine in their everyday lives – in other words, it presents the political subjectivities of medicine for resettled Vietnamese refugees in Victoria, B.C.

Summary of Thesis

In documenting the experiences resettled Vietnamese refugees have with medicine, this thesis will identify and address the impact of past socio-political conditions on the medical practices and subjective experiences around healing. It speaks to the socio-cultural conditions that evoke feelings of hope and fear in the context of everyday medical practice among resettled Vietnamese refugees in Victoria, B.C. This thesis will illustrate how resettled Vietnamese refugees define and understand medicine today and the contextual nature of each chosen practice. It will then highlight the complexities involved in the relationship and perception of Vietnamese refugees in regard to traditional Vietnamese medicine and biomedical practice. The following summarizes the main arguments of each of the chapters in the thesis.

Chapter Two – Methodological Approaches: What is Insider Research? – will present the methodological approaches taken in this research. I will describe my role as a researcher, with particular reference to my role as a Vietnamese-Canadian “insider” and what this meant to me, my respondents and my research. Reflections and challenges on project design and participant recruitment will be discussed and demographics of my respondents will also be provided.

Chapter Three – Is there a Vietnamese medicine? – will identify what traditional Vietnamese medicine is and how it is presented as a distinct practice through scholarly literature as well as respondent definitions. Attention will be brought to classifications of medicines and to how traditional Vietnamese medicine compares to other medical practices, such as traditional Chinese medicine and biomedicine. Through case studies, I will highlight what traditional Vietnamese medicine is and what it is not for respondents, with particular focus on issues around efficacy, trust, and knowledge transfer. The varied definitions and understanding of the practices will show how subjective the topic of medicine can be for refugees.

Chapter Four – Medical Syncretism: When and Why Certain Medicines are used – will discuss the context of medical practice for each respondent. Respondents’ mixed medical practices will be explored and analyzed through different case studies. This chapter will present respondent understandings about when traditional Vietnamese medicine and biomedicine should be used as treatment. The absence of conflict between the medical practices used will be discussed as it reflects changes in practice since resettlement to Canada. Furthermore, contradictory accounts of use will be analyzed in order to understand how and why medicine is discussed in this way.

Chapter Five – Language and Luck: The Projection of a “Healthy” Vietnamese Refugee – will focus on the perceptions of sickness and medicine as it relates, or seemingly does not, to

the everyday refugee life. Self-perceived health status will be discussed as it is contingent upon the migration and resettlement process to Canada. This chapter will address respondent subjectivities regarding their refugee status and identity; what the implications are for self-perceived health status and the use of traditional Vietnamese medicine. Changes in previous socio-cultural barriers to health care services will also be discussed to show how the acculturation process has impacted resettled Vietnamese refugees' access to health care services and their relationship with primary care physicians.

Chapter Six – Conclusions and Recommendations – summarizes research findings and states limitations to the study; it also suggests further research on resettled Vietnamese refugees and the implications to long term medical practices. Reflections on the sensitive and challenging nature of this research are also provided on the basis of this research experience.

Chapter Two: Methodological Approaches: What is Insider Research?

Research of vulnerable populations, such as refugees, has been notoriously difficult since refugees are identified as people who can be seen as, “impoverished, disenfranchised, and/or subject to discrimination, intolerance, subordination, and stigma” (Liamputtong 2007, p. 3). Given their social and political statuses, it is often difficult to engage refugee populations in study. The difficulties in research can stem from a myriad of emotional, social or political conditions. Issues of accessibility and lack of trust are commonly cited reasons for reaching refugee groups (Dunbar et al., 2002; Jacobsen and Landau, 2003; Liamputtong, 2007) and occurred in this research. Furthermore, research concerning refugees is often sensitive in nature. This study is particularly sensitive because it discusses issues surrounding medicine and health of a refugee population. Research is deemed sensitive, “if it requires disclosure of behaviours or attitudes which would normally be kept private or personal, which might result in offence or lead to social censure or disapproval, and/or might cause the respondent discomfort to express” (Liamputtong 2007, p. 5). As such, sensitivity is required by the researcher and in their methods when undertaking studies of this nature, particularly with vulnerable groups.

Studies on immigrant and refugee groups that explore medicine and health often use qualitative methods; prominent examples are Anh, 2006; Barimah and van Teijlingen, 2008; Ngo-Metzger, 2008; O’Callaghan, 2003; and Stephenson, 1995. Qualitative research is especially appropriate for studying vulnerable people because the methods are “flexible and fluid, and therefore, are suited to understanding the meanings, interpretations and subjective experiences of vulnerable groups” (Liamputtong 2007, p. 7). The nature of qualitative research methods can allow respondents to present their perspectives in a form that gives greatest

expression of their views. In studying first generation Vietnamese refugee practices of medicine, a qualitative approach can thus provide a richer, in-depth, understanding of the respondent and the research.

Methodological Approaches to Data Collection

This chapter will present and highlight the processes and challenges of fieldwork methods that I undertook during my research of the Vietnamese refugee community in Victoria, B.C. in 2013. In this chapter, I review specific qualitative research and analytical methods such as in-depth interviews and participant observation which were integral to understanding the experiences and perspectives of resettled Vietnamese refugees and their use of medicines. I will discuss challenges and ethical considerations that occurred prior to and during this research process. It also will provide an overview of respondent demographics. The description of research methods in this chapter provides the reader with an introduction to the participants that made this project possible. It will also highlight some of the complexities of the research conditions and the reasons why this research process was challenging. The data collection process for this research study was much more difficult than initially presumed. In order to gain access to the Vietnamese refugee community in Victoria, B.C. several different strategies were required such as identifying my ethnic background as a second generation Vietnamese and revising my initial research methods and protocol. My identity as an “insider” proved integral to the success of this research and will be explored in-depth in this chapter along with the methodological approaches used.

The methodological techniques used adhere to the guidelines of ethnographic research (Hammersley and Atkinson 2007, p.3). What I argue in this chapter is that although the guides of research protocol are pragmatic, in some cases they are not effective or suitable when in the

field. The concept of insider and outsider research (Hammersley and Atkinson 2007; Hellowell, 2006; Liamputtong, 2006) in particular, plays a significant role in this study because of how my identity as a Vietnamese, a Canadian, and a student researcher affected all aspects of the field research process from respondent recruitment, level of access and data collection. How my respondents identified me affected the approach and the execution of research methods. I argue the behaviours and reactions of resettled Vietnamese refugees during the recruitment and interview processes seemed to not only echo their perceptions and use of medicines but also highlighted underlying socio-political issues of trust in a more general sense.

To collect the necessary data for this 2012 study on resettled Vietnamese refugees in Victoria, BC., I chose a qualitative approach because its methods “emphasize the processes underpinning social activity through detailed descriptions of the participants’ behaviours, beliefs, and the contexts within which they occur” (Green and Thorogood 2004, p. 21). The method is appropriate because I am seeking to identify how and why the local Vietnamese refugee population in Victoria, B.C. understand and utilize medical practices. Furthermore, an ethno-medical inquiry is appropriate because as Fabrega states, “it is the study of how members of different cultures think about disease and organize themselves toward medical treatment and the social organization of treatment itself” (1975, p. 969). This is important for my study because I am seeking to identify how resettled Vietnamese refugees understand and utilize different medicines. As such the qualitative approach seemed to be best suited for this project as it is centered on the health practices of a refugee community. A qualitative approach enables me to identify and analyze the complex relationship that these individuals have in defining and using medicine (Joralemon, 1999). The relatively small sample size does not enable much generalization to the larger population. Descriptive measures such as simple frequency counts

(Green and Thorogood 2004) and hierarchy of resort (Schwartz 1969) also are used within this thesis to highlight the patterns, and suggest the significance of particular findings. Hierarchy of resort refers to the order and range of treatments that are used, this provides insight to how illness and medicine is understood and chosen.

I initially chose several different qualitative methods for my research. These were: focus groups, in-depth interviews and participant observation. Focus group are, a method where “a group of people [are] brought together for a joint interview session” (Bernard 1988, p. 267). I included these in the initial research plan. The location I had chosen to hold the focus group interviews was the local Vietnamese temple. Generally, focus group interviews are used to identify common themes among the respondents regarding health beliefs and practices as noted by Bernard, 2006; Green and Thorogood, 2004; Krueger and Casey, 2009. However, this procedure was not successful because the initial recruitment process was met with suspicion by the local Vietnamese community and therefore they were hesitant to participate. In this circumstance, I experienced first-hand that, “field researchers are frequently suspected, initially at least, of being spies, tax inspectors, missionaries or of belonging to some other group that may be perceived as undesirable” (Hammersley and Atkinson 1998, p. 63). When I later tried introducing myself as a second generation Vietnamese, I proved to be more successful in recruiting respondents as they were more willing to accept me knowing I was one of them. This behaviour demonstrated a lack of trust towards outsiders.

The sensitive nature of this research made individual interviews ideal for gathering the rich information because of their personal and private nature. The in-depth, face to face,

interviews²² with individual respondents are the primary source of data for this project; they provided great insight about the personal experiences and concerns that each respondent had. This method allowed access to individual views and sometimes hidden opinions. In total, seven interviews were conducted out of 23 attempts to recruit respondents. The difficulty in recruiting respondents was partly reflective of the initial suspicions and hesitation that highlighted issues of trust in myself as a researcher and the sensitive nature of the study of medicine and health.²³ The difficulty also arose because of the political issue of medical care and past experiences in refugee camps for these respondents. Given the history of resettled Vietnamese refugees, “in-depth interviews are particularly valuable for ‘accessing subjugated voices and getting at subjugated knowledge;’ [because] they are suitable for collecting stories from vulnerable or marginalized people” (Liamputtong 2007, p. 97). While the sample size was small, the respondents’ answers were rich and detailed. The ethnographic interviews were adequate for grasping a sense of the meanings and practices of resettled Vietnamese refugee medicine in the current era.

The locations of the interviews were chosen by the respondents to ensure their comfort. These locations ranged from their homes, local coffee shops, and their workplaces. Hammersley and Atkinson note that, “with many people, interviewing them on their own territory, and allowing them to organize the context in the way they wish, is the best strategy” (1998, p. 116). In allowing my respondents to choose the location and times for the interviews they seemed more relaxed and willing to participate. Given the limited time that some respondents had (interviews ranged from 20 minutes to 2 hours) the semi-structured interviews I conducted with

²² This process involves a meaning-making effort which starts out as a partnership between the researchers and their participants. In-depth interviews aim to elicit rich information from the perspective of a particular person and on a selected topic under investigation (Liamputtong 2007, p. 192).

²³ The majority of refugees may never have experienced a nonthreatening interview in their lives. If some refugees have had previous experience being interviewed, it has almost certainly been within the context of recruitment to fight in wars, being hounded for their previous activities in various military operations, or being persecuted for their political involvement or religious or ethnic affiliations (Pernice 1994, p. 208).

the use of an interview guide²⁴ (see Appendix 1) proved to be quite efficient and effective for ensuring all the topics and questions that I needed were covered. The data collected from respondents show that similar views and practices were shared among the sample. Common themes were highlighted and continuously repeated in all individual interviews. The Victoria Vietnamese community exhibits a high degree of fragmentation suggesting that minimal contact occurs. Respondent interviews show that there is a tendency for people to isolate themselves²⁵ from one another, which is surprising given that similar statements arose during the interview process.

An additional method used was some participant observation - studying and observing people's behaviours (Bernard 1988, Hammersley and Atkinson 2007). This method, "gives you an intuitive understanding of what's going on in a culture, and allows you to speak with confidence about the meaning of the data" (Bernard 1988, p. 151). I used this method during interviews, at visits to the local Chinese herbal store, and while visiting the local temple. My observations and analysis of the interview locations, body language, and respondent dialogue during the interviews provided me with more intimate knowledge and intuitive understanding about the individual in a particular context. In my visits to the local Chinese herbal store I was able to identify the clientele that frequented the store which enabled me to triangulate the responses by resettled Vietnamese refugees. Interviews that took place in respondent homes allowed me an opportunity to analyze their lifestyle, personal presentation, and behaviour in their own environment. These observations enabled me to gauge how and why respondents reacted as they did to particular questions. As Bernard states, "many research problems simply cannot be

²⁴ This is a written list of questions and topics that need to be covered in a particular order. The interview still maintains discretion to follow leads, but the interview guide is a set of clear instructions (Bernard 1998, p. 205).

²⁵ All respondents stated quite clearly that they try not to associate with other members of the Vietnamese community and try to keep to their own family units.

addressed adequately by anything except participant observation” (1988, p. 152). These observations provided a deeper level of analysis and a means to triangulate responses; that is, “to check inferences drawn from one set of data sources by collecting data from others”

(Hammersley and Atkinson 2007, p. 183). Respondent Demographics: Who are Resettled Vietnamese Refugees?

I did a fairly rigorous search for respondents between June and October 2012. Of the 23 potential respondents I initially contacted I managed to obtain 7 in-depth interviews. All participants reside in Victoria except for one, who resides in Vancouver. Each respondent has been given a pseudonym to protect their anonymity. Specific names of locations have either been changed or omitted throughout depending on relevance and necessity. All respondents were female except for one male. All respondents either work or have worked in the hospitality and service industry. Each respondent is resettled Vietnamese, left Vietnam between 1980 and 1995²⁶, and immigrated to Canada under refugee status. The ages of my respondents ranged from 41-65 years. They have been living in Canada between 18-33 years and each individual demonstrated competence in the English language. Only one of the respondents had completed high school, and that was the male respondent who did receive some post-secondary education before his family fled Vietnam.²⁷ All female respondents have family or extended family here and the seven respondents all stated that they had family residing back in Vietnam who they visit, some more regularly than others.

Participant Recruitment

I initially chose Victoria as the case study site for this research project because of its moderate size and the small size of the local Vietnamese community. The recruitment method I

²⁶ My initial research plan sought out Vietnamese refugees who arrived between 1975 and 1985, however, the respondents who arrived after 1985 still fall under the classification of “first generation” Vietnamese refugees.

²⁷ This is typical as men were more likely to be educated during this time.

chose for this research was snowball sampling.²⁸ This is where you “locate one or more key individuals and ask them to name others who would be likely candidates for the research” (Bernard 1988, p. 98). I recruited my participants in Victoria and Vancouver, British Columbia between June-October 2012. However, the smaller community proved to be difficult to access in the beginning of my recruitment process. Trust seemed to be the main concern for most individuals in the community that I approached. They were initially reluctant to participate because I am not part of the local Vietnamese community here.²⁹ Because of that, I expanded my search to include Vancouver³⁰ as a secondary site for recruitment.

My ideal respondents were resettled Vietnamese refugees who were born in Vietnam and migrated to Canada between 1975 and 1985. This generation of Vietnamese refugees was ideal because they would have experience or be familiar with healing practices in Vietnam prior to coming to Canada. Finding these individuals was not hard. To say that I had difficulty finding respondents to participate however is an understatement. I began my recruitment process with flyers that described my research topic and provided my contact information, as approved by the ethics committee. In Victoria, I distributed these flyers in and around Chinatown, at the local Vietnamese temple and visited nail salons³¹ and Vietnamese restaurants where I introduced myself and left my contact information. In Vancouver, I went to different Vietnamese grocers and restaurants. These flyers did not produce any respondents. Everyone I approached stated quite frankly they were not interested in participating or speaking with me in anyway.

²⁸ In practice, most research studies with forced migrants employ some form of non-probability sampling (Sulaiman-Hill 1969).

²⁹ I grew up a few hours north of Victoria, B.C. so do not know many people in the local Vietnamese community. As my parents are not part of this community many people were suspicious and hesitant to engage with me because they do not know my history.

³⁰ My temporary placement in Vancouver was also a factor in choosing it as a secondary site.

³¹ The majority of smaller nail salons are owned and operated by individuals of the local Vietnamese community

My initial assumption that the moderate size of Victoria would allow easier access to the local Vietnamese refugee community was not realized. British Columbia has the second smallest Vietnamese population at 21, 695³² with the majority residing in Vancouver. In Victoria, the total population of Vietnamese is approximately 870.³³ Regardless of the small population the local Vietnamese refugees my respondents repeatedly stated that this was not a close-knit community; this echoes Stephenson's 1995 finding of a fragmented community.³⁴ Furthermore, individuals of the community were difficult to locate and identify. For example, all of my respondents told me that they had minimal to little contact with other Vietnamese in the community and in almost all cases stated that they did not know the majority of the Vietnamese community here at all. My hopes of finding a gatekeeper, "an individual in the community...with control over key sources and avenues of opportunity" were dashed (Hammersley and Atkinson 2007, p. 27).

The initial discouraging stages of the recruitment process led me to re-evaluate my recruitment methods. After some reassessments, I went out again and reached out to my peers (friends and acquaintances) to ask about their networks. I began speaking more openly about my research project and the initial failed search for respondents. This ultimately produced results as I was put into contact with several respondents through peer networks and was able to obtain successful interviews. The difficulty in accessing, or even finding, members of the local Vietnamese refugee community illustrated that this community did not want to be identified. Faugier and Sargeant state that, "in attempting to study hidden populations for whom adequate lists and consequently sampling frames are not readily available, snowball sampling

³² Statistics Canada, 2011 Census

³³ Statistics Canada, 2011 Census

³⁴ Unlike other refugees and cities in Eastern Canada, the Victoria did not have an established Vietnamese community prior to 1979 as an alternate support system to government aid (Bong, 1980; Woon, 1987).

methodologies may be the only feasible methods available” (1997, p. 792). Other respondents were obtained by frequenting their work establishments³⁵; where during their quiet time and/or after work they became willing to speak with me. Liamputtong states that, “[h]anging out at services or sites commonly used by the hidden people for a period of time is a useful way of gaining access to these populations” (2006, p. 50). These particular experiences provided great insight into the recruitment process and particularly my role as an insider researcher. The concept of “hidden populations” as noted by Liamputtong is particularly relevant to my research because of the group of individuals I sought to study. As a refugee group they have experienced traumatic events and therefore the suspicions and lack of trust about me as a researcher, or any outsider, is not surprising, “as years of misrepresentation and misinterpretation have legitimated scepticism and distrust” (Dunbar et al., 2002, p. 291). This community seemed highly closed off and was difficult to access; this speaks volumes to how its members may perceive social and cultural relations here in Canada even decades after resettlement. The exclusiveness and suspicious nature of members of the local Vietnamese refugee community towards outsiders reflect socio-political issues that arose throughout this research.

Insider or Outsider Research: Who am I?

My background as a second generation Vietnamese had an impact on my research which I address through insider-outsider debate. This concept of insider-outsider refers to the social position the researcher has with the research respondents or community (Hammersley and Atkinson 2007, p. 86). This position or role of a researcher is important for my study because, “broadly speaking, those defined as insiders are likely to have immediate access to different sorts of information” (Hammersley and Atkinson 2007, p. 87). In contrast, the definition of an outsider

³⁵ The process of snowball sampling has been described as haphazard as it has the potential to be biased if respondents are only identified through one individual (Bernard 1988; Liamputtong 2006; Hammersley and Atkinson 2007). I want to note here that only 3 of my respondents were the results of this sampling method.

is where the “researcher is not a priori familiar with the setting and people s/he is researching” (Hellowell 2006, p. 485). I am second generation Vietnamese; my parents were some of the boat people that fled Vietnam in 1979 after the war. I was raised with Vietnamese customs, understand some Vietnamese language, and am familiar with most aspects and nuances of the culture from language, food, belief systems, etc. Although in that sense I am Vietnamese (and therefore an insider) I did not grow up as part of the local Victoria or Vancouver Vietnamese communities and this is one factor that I feel emphasized my role as an outsider. I grew up in a few hours north of Victoria and have only lived here for a few years so am not familiar with many people in the local Vietnamese community.

One of my initial problems with research recruitment and data collection was because the local community did not know who I was or who my parents were and therefore were reluctant to participate (Aguilar, 1981; Hellowell, 2006). Individuals that I approached often asked where I was from, referring to my ethnic background. Furthermore, although I am able to understand basic conversation in Vietnamese my vocabulary is not extensive enough for me to engage in lengthy dialogue with respondents, particularly on a topic as complex and diverse as medicine. My initial approach to find respondents was made in English and that was detrimental to my recruitment attempts. I was not seen as an “insider” because I did not speak Vietnamese during the recruitment process. Also, following strict research protocols increased the level of hesitation and suspicions of the study and my identity which emphasized their perception of myself as an “outsider”.

The second round of recruitment went much better. I utilized my role as an “insider,” making it more prominent in my initial contacts with potential respondents by stating my Vietnamese ethnicity. My physical attributes are slightly ambiguous as I could not be easily

identified as distinctly Vietnamese. Many people do not and cannot tell what my ethnicity is at first glance and many respondents thought that I was Chinese, Japanese, Korean, or mixed race. In this instance, self-disclosure was important for my respondents as it helped to facilitate trust and rapport. It is stated that in researching sensitive groups self-disclosure occurs, “when the researcher shares ideas, attitudes, and/or experiences concerning matters that might relate to the interview topic in order to encourage respondents to be more forthcoming” (Liamputtong 2006, p. 72) I made sure to introduce myself as Vietnamese in all initial contact efforts this time around. More than half of my respondents only agreed to speak with me after they found out I was Vietnamese, I was quite surprised at how their demeanor changed within seconds. That being said, when asked where in Vietnam I was from I specifically stated that I, or rather my parents, were from South Vietnam. Had we been from North Vietnam, I feel that the response and reception would have been different given the political context. For example, in one case my gatekeeper advised me that a respondent bluntly stated that if my parents were Northerners she would not participate in the study or have me in her home.

Establishing connections with peers within the local Vietnamese community provided me with a basis for connection as well as a level of validity in regards to my identity. Being referred by someone they knew greatly eased the tensions and skepticism about who I was and what my intentions were. My presentation about researching Vietnamese medicine did not change, however, the fact that I was known to someone in the community and also ethnically part of the community seemed to make it easier for them to open up to me and my research. The respondents were not only more open to discussing my work; they were willing to share information unprompted. In instances during the interviews my role as an insider were drawn on many times: respondents assumed that I was familiar with certain terms, particular histories,

cultural themes and more, which emphasized my insider role, not only to them but also to myself. Throughout the process it became quite apparent how greatly my insider status impacted this research. Being a second generation Vietnamese, I am familiar with certain aspects of the culture and nuances in language and behaviour. I chose to discuss particular topics that I was not familiar with rather than highlight those that I have knowledge of primarily because it is assumed knowledge among this community; this shaped the direction and progress of my research.

Without my status as a Vietnamese person the later work would not have been possible. This was quite a revelation; I had not been sure how I was going to approach the insider-outsider techniques throughout this research project, but the recruitment and interview processes introduced many avenues for me to do so.

Protocols for Ethical Research

Certain ethical procedures and protocols were required to begin this research study with human subjects. The standard protocol required of University of Victoria (UVic) graduate students for ethical research – introducing myself as a student researcher from the UVic and presenting consent forms and information on my research project – was followed for this research. My research proposal was submitted and approved by the Human Research Ethics Office at the UVic prior to beginning my field work. Research protocol requires that each respondent was briefed about the research and presented with consent form (approved by the Human Research Ethics Office at the UVic) which they signed and received a copy of prior to beginning the interview process. Each respondent was aware they could leave the interview at any time without penalty. Confidentiality and anonymity were confirmed and assured for each respondent and all interviews were voluntary.

The strict ethical protocol that I followed in the first round of recruitment however, alarmed respondents and led them to become suspicious of me and my research and therefore declined to participate. Presenting myself first as, and with, a member of the community, proved to be more beneficial in terms of recruitment and access than presenting myself as a student researcher. This is an example of where methodological approaches require some flexibility. By placing my insider role at the forefront of the recruitment process the initial stages of the interviewing process proved to be much less daunting and eased any apprehensions my respondents had because there was a certain level of trust and familiarity there.

The topics of health and medicine are extremely sensitive and this coupled with the respondents' refugee background highlighted concerns of trust. Potential psychological and emotional harm were one of the main concerns for me and the Research Ethics Office in doing this research so I tried my best to make sure that all my respondents were comfortable and at ease with the process from start to finish. In any cases where respondents were uncomfortable with questioning we took a break and I let them know that the interview could be stopped at any time and therefore the interview and data would not be used in my final submission. The thoroughness of the ethical concerns and protocol (consent forms³⁶) seemed to act as the initial deterrent for the majority of respondents. They either did not understand the concept fully or seemed to feel that the formality of the process meant much more than I let on; in those instances questions about who I "really" worked for arose. Overall, after I explained the research, each respondent shared their experiences with me even if they were hesitant to begin with, so I am

³⁶ A problem among refugees, who do agree to participate in studies and give accurate information, is the refusal to sign any document, including the informed consent form. Refugees felt confused and frightened that they had to give consent in writing before participation in a simple question-and-answer session. Furthermore, the assurance of anonymity appeared to be contradicted by the signature, which in turn contributed to distrust and anxiety on the part of the migrant (Pernice 1994, p. 209).

very thankful to all my respondents for their help. Each respondent was given a small gift as a token of thanks for their participation.

All interviews were conducted in English although respondents did speak in Vietnamese for parts of some interviews; those sections were translated to English afterwards. All interviews were tape recorded with permission and respondents agreed that if clarification was needed I could contact them afterwards. The interviews and hand-written notes were transcribed and coded for analysis after interviews were completed.

Assessment

The research plan that I began this study with was not the plan that I ended up using to complete the study. The difficulties I had in the field with recruitment were not expected and definitely put many things into perspective regarding methodologies, my role as a student, researcher, and as a “member” of the local Vietnamese community. The reluctance and skepticism of many of the respondents that I approached bring up many social and political issues regarding refugees and research that clearly still need to be addressed, albeit outside the scope of this study. Concerns around trust in a general sense were prominently shown and therefore research on refugee groups should take into consideration how experiences of forced migration and resettlement still have an impact on the sociocultural interaction of these groups today. The strict protocols that are used for research should be adapted to the sensitive nature of refugee groups so as to limit associations with negative past experiences of screening during the forced migration process. The underlying psycho-social issues that are part and parcel of the forced migration and resettlement process are important here and their wide ranging effects should be addressed in other research. The research data gathered here will provide a window into the complex nature of medicine from the perspectives of this particular group.

In summary, field research is hard. The experience of conducting research, from protocol to participant recruitment as an insider and outsider, was a lesson in itself and is demonstrative of this particular kind of research on sensitive issues and with sensitive groups. I am thankful for the experience which has taught me more than I could have imagined about the research process. I have learned that it is difficult to approach and engage respondents with a subject as sensitive as medicine. The complex nature of the relationships of the respondents with medicine made this project both challenging and alluring. My navigation of the research process highlighted the importance, and requirement, of flexibility, reflexivity and innovation in doing field work. The barriers and challenges that I experienced taught me about how I identify with resettled Vietnamese refugees and why.

Chapter Three: Is there a Vietnamese medicine?

Classifying Vietnamese Medicine

The initial research goal of this study is to see if traditional Vietnamese medicine (TVM) is its own distinct practice and to identify respondents' perspectives around medicine. In this chapter I describe and assess issues around TVM that were presented by resettled Vietnamese refugees during the interview process. There were several issues raised by respondents, the initial one was the lack of recognition of TVM as a healing system. Second, trust and efficacy of certain practices were highlighted as some of the factors that determined patterns of use. The last issue that arose during my interviews was how medicine was understood and contextualized, both now and in the past experiences of resettled Vietnamese refugees.

The confusion expressed by my respondents in attempting to identify and define TVM is a critical theme in my interviews and it is highlighted here because it raises issues about knowledge and information transfer for Vietnamese refugees in contemporary Canada. Furthermore, the ease and ability of resettled Vietnamese refugees to identify what TVM is not, rather than what it is, suggest that concerns around efficacy and trust were more prominent in their understandings of what is important in medicine than in identification with a particular Vietnamese form of healing. In this chapter, I argue that the recognition, identification and definition of medical practices have been impacted by the introduction of biomedicine through the forced migration and resettlement process for resettled Vietnamese refugees. The themes identified by my respondents around what TVM is illustrate how past experiences and present conditions determine how they define, understand and use medicine.

This chapter will address the various ways that TVM is recognized, identified, and understood in scholarly literature and by resettled Vietnamese refugees. In the first section, TVM

will be described as it is presented in scholarly literature, in order to highlight how it compares and contrasts to other healing systems, particularly traditional Chinese medicine. I suggest that TVM should be recognized as a distinct healing system that is on par with other medical systems. The next section will show how traditional Vietnamese medicine is defined and understood by resettled Vietnamese refugees. The recognition of TVM is highlighted; however respondent perspectives place an emphasis on what features TVM does not have, particularly in contrast to biomedicine. This demonstrates that the way in which medicine is characterized or classified is often dependent on comparisons to other medical systems.

What is Traditional Vietnamese Medicine?

Scholarly classifications of Asian medical traditions are often only inclusive of Ayurvedic, Unani, and Chinese medicine³⁷ (Leslie and Young, 1992). The overall assumption is that all Asian medical traditions share similar characteristics and fall under the same rubric of *Đông Y* (Eastern medicine) and TVM is no exception. TVM is perceived to have features of what scholars term “traditional medicine” and/or traditional Chinese medicine. This term “traditional medicine” is often used as a term to identify most *Đông Y* or herbal and natural remedies. The World Health Organization³⁸ (WHO) defines traditional medicine as:

The sum total of all knowledge, skills and practices based on the theories, beliefs and experiences of indigenous cultures, that are used to maintain health, as well as to prevent, diagnose, improve or treat physical and mental illness.³⁹

Traditional medicine is widely used as a form of healing practice specific to Eastern or Asian countries. Medical practices can include holistic and/or spiritual beliefs, herbal remedies containing roots and bark, acupuncture, coining and cupping etc. (Craig, 2002; Kleinman, 1978;

³⁷ See Leslie and Young 1992 for descriptions of these medical systems.

³⁸ As of December 2008

³⁹ <http://www.who.int/mediacentre/factsheets/fs134/en/> March 2012.

Lai and Chappell, 2007; Ma, 1999). Many of these practices are assumed to originate from the regionally powerful and influential traditions of Chinese medicine.

What is termed traditional Chinese medicine⁴⁰ by scholars typically is the study of human physiology and pathology, and the prevention, diagnosis, and treatment of diseases. Furthermore, traditional Chinese medicine is characterized as a practice based on cosmological principles, such as holism, yin/yang⁴¹, acupuncture⁴², and herbal remedies (Kleinman, 1980; Landy, 1977; Leslie and Young, 1992). The remedies⁴³ consist of mixtures of herbs and plants that vary in number, preparation, and consumption depending on the illness, symptoms, and the individual (Anh, 2006; Siow et al., 2005; Lu, 2005; Yuan and Lin, 2000). Traditional Chinese remedies, which can be brewed in the home, are also available from local herbalists and/or Chinese pharmacies (Lai and Chappell, 2007; Ma, 1999). The concepts behind traditional Chinese medicine centre on the balance of the body, internally and externally, with natural elements and spiritual beliefs, which is why the concept of yin and yang are often so prominently featured. The concept of internal and external balance comes from a long history of traditional beliefs centering on the five elements of nature as well as the concept of yin and yang. The imbalance of the elements affects the body and person and is what causes ill health, therefore restoring the balance, restores health.

This particular aspect of yin and yang is a feature shared by TVM as well. TVM features the use of natural remedies, which consist of herbs and roots, to treat illness and follows the beliefs of *am* (yin) and *duong* (yang) which balance the body internally and externally with the

⁴⁰ See p. 63-76 in Leslie (1979) for detailed history of traditional Chinese medicine (TCM).

⁴¹ The concept of internal and external balance comes from a long history of traditional belief about the five elements of nature as well as the concept of Ying and Yang. The imbalance of the elements affects the body and person and is what causes ill health – restoring the balance, restores health.

⁴² Acupuncture is a Chinese medical technique that inserts one or more small needles into the skin and underlying tissues at precise points on the body.

⁴³ Lu (2005) provides classifications of Chinese herbs and various formulas for corresponding illnesses and disease.

five elements. Looking strictly at these characteristics, it is easy to assume that traditional Vietnamese medicine and traditional Chinese medicine are one and the same. We cannot deny that traditional Chinese medicine has similar aspects of TVM⁴⁴, however, “the encounter between *thuốc nam* (Southern Vietnamese medicine) and *thuốc bắc* (Northern / Chinese Medicine)⁴⁵ was a much more two-way exchange than the standard historical trope presents” (Monnais et al. 2012, p. 45). Evidence for the period of Chinese domination over Vietnam from 179 BC to AD 938⁴⁶, and for several hundred years after that, points directly to materials, *material medica*, flowing in the both directions, from Vietnam-north, south, and centre-to China (Monnais 2012). During this time a number of Chinese practitioners came to Vietnam as doctors for the Chinese lords and “a large number of Vietnamese drugs were exported to China, and some of these (e.g. *Coix lachrymal job L.* and *Quisqualis Indica L.*) were selected and described in Chinese herbal manuscripts with references to the utilisation of the plants as practiced by [Vietnamese] people” (Nguyen 1995, p. 2010). A number of tropical plants were also introduced into China, these included water rice, summer rice, sweet potato and sugar cane.⁴⁷ Furthermore, trade of particular spices and ingredients, such as cinnamon, for medicinal recipes that were seen as rare and expensive by the Han Chinese [were] used quite regularly by the Vietnamese (Monnais et al. 2012). This shows that Vietnam is the source in this particular case, not the other way around. “The exchange of ideas and experiences brought about the integration of [Vietnamese] traditional medicine with the Chinese, which in turn led to the formation of a Vietnamese national traditional medicine” (Nguyen 1995, p. 210).

⁴⁴ French colonization (1887 – 1954) of Vietnam also had a large impact on how biomedicine was used and developed in the country.

⁴⁵ *Thuốc bắc* (Northern medicine) was historically referencing China – to the north of Vietnam (Craig, 2002; Monnais et al., 2012).

⁴⁶ Nguyen 1995, p. 210

⁴⁷ Nguyen 1995, p.210

There were three particular qualities of TVM that distinguish it from traditional Chinese medicine. First was the distinction within TVM itself; this practice has two systems *Thuốc nam* (Southern medicine) and *Thuốc bắc* (Northern medicine) that are distinguished from one another geographically and theoretically. The second characteristic of TVM is the belief in the metaphysical; that is, the different spiritual beliefs about illness and healing. The metaphysical beliefs of the Vietnamese influence how the third characteristic of TVM, the five units – the internal and external classification of the body and natural elements - are understood in relation to one another. These three features of TVM are elaborated upon below.

Characteristics of Traditional Vietnamese Medicine

Scholars, such as Craig (2002), Marr (1987), and Monnais et al. (2012) demonstrate that there are several features distinct to the practice of traditional Vietnamese medicine. The first characteristic of TVM is that within the system of TVM, there are two categorizations: *Thuốc nam* (Southern medicine)⁴⁸ and *Thuốc bắc* (Northern medicine).⁴⁹ *Thuốc nam*, or Southern medicine, is based on local ingredients, predominantly leaves, flowers, fruits, barks and woods⁵⁰, and premised on easy access and inexpensiveness: “it was the poor man’s medicine, generally using ingredients readily available nearby and involving a minimum of processing [and] most knowledge was passed unselfconsciously from one generation to the next” (Marr 1987, p. 169). *Thuốc nam*, or *thuốc ta* (our medicine) as it was also often called, is wholly indigenous to Vietnam:

⁴⁸ The Việt, an ethnic group who make up almost 90% of the total population of Vietnam, self-identify as being “of the South” with the term *nam* meaning south of China (Monnais et al. 2012).

⁴⁹ Partition of Vietnam in 1954 inevitably produced two very different health systems. In the South, the government extolled Western medicine and tried repeatedly to restrict the role and status of traditional practitioners. In the North, building on practical experience obtained during the anti-French Resistance, Hồ Chí Minh urged all medical cadres to study means of “harmonizing” Eastern and Western remedies. For the first time in Vietnamese history the government granted institutional legitimacy to Eastern medicine practitioners, while however pressing them to eschew “superstition.” Meanwhile, the advent of the Second Indochina War forced ordinary citizens in both regions to fall back on local initiatives and remedies. Popular attitudes became more complex than ever (Marr 1987, p. 183).

⁵⁰ Nguyen 1995, p.211

It derives from popular practices and dates back to time immemorial. Although it lacks a perfect theoretical system, it contain[s] a vast range of internal and external therapeutic treatments, and a set of methods for small scale surgery using a host of remedies handed down from generation to generation (Nguyen 1995, p. 211).

Thuốc nam practices are “simple, practical logics that can be easily understood and used at the household level”; thus *thuốc nam* is seen as essentially Vietnamese” (Craig 2002, p. 40).⁵¹

In contrast, *thuốc bắc*, that is Northern medicine, is seen as medicine for the elite and educated. In addition to the beliefs of *am* and *duong* and the five units, it incorporates established training and pharmaceutical aspects of medicine: “Northern medicine was the only form of disciplined medicine available, and it enjoyed (and in many ways continues to enjoy) prestige on a par with Western medical approaches” (Craig 2002, p. 41). The distinction between the two systems is still acknowledged in the scholarly literature and by my respondents today.

The second characteristic of traditional Vietnamese medicine is the metaphysical or spiritual beliefs and approaches to illness and healing. These are often identified as superstitions or *mê tín* however, I will shy away from this as it denigrates cultural and spiritual beliefs and practices. This aspect encompasses a myriad of sources for explaining illness and healing. Geomancy, astrology, spiritual healers and seers, Buddhist monks, Taoist priests, and spirits or ghosts⁵² are just some of the explanations of disease (Craig, 2002; Marr, 1987). The concept that humans possess three souls⁵³ (*hồn*) is one aspect of this:

⁵¹ Craig’s text notes that Southern medicine has been supported and encouraged by the state of Vietnam to develop into a popular medicine. Monnais et al.’s (2012) text shows that this has seemingly taken place in Northern Vietnam. The recognition and development of Southern medicine into an institutionalized healing practice has been supported.

⁵² The most likely ghosts involved with illness or misfortune are nomadic spirits of dead relatives or community members who lack afterlife or a satisfactory burial site (Craig 2002, p.95).

⁵³ Humans have three souls, whereas animals have two and plants only have one (Marr 1987, p. 173).

These could be attacked or lured out of the body. Death meant loss of all three souls, unconsciousness the loss of two, and various mental or physical disorders the loss of one. Although the departure of all three souls was irrevocable one or two could be located and retrieved” (Marr 1987, p. 173).

The Vietnamese beliefs in the metaphysical influence how the third characteristic of TVM, the five units, is understood and related to the body.

For the Vietnamese, the concept of units of five are central to the understanding the internal and external aspects of human physiology. The body is “intimately and constantly linked to external forces, so that good health depended in large part on tuning internal functions to the environment” (Marr 1987, p. 164). The elements of earth, wind, water, fire, and metal, are just one aspect of this concept. The flow of our body’s energies is thought to follow the same principles of these elements⁵⁴, depending on and regulating one another: “pathology is conceived in terms of dangerous imbalances affecting the body and its vital ‘organs’ as a result of blockages, weakness, or excess flow of the *khi* (life force) or thermal influence between them, or as a result of the effects of five external pernicious influences (wind, heat, cold, dampness, and dryness) or internal influences through the emotions (sadness, fear, anger, happiness, and worry)” (Craig 2002, p. 47). Figure 1 below shows the categories of the five units and which elements correspond with particular body parts, seasons, colors, planets, and vital essences:

⁵⁴ Marr, 1987; Craig, 2002

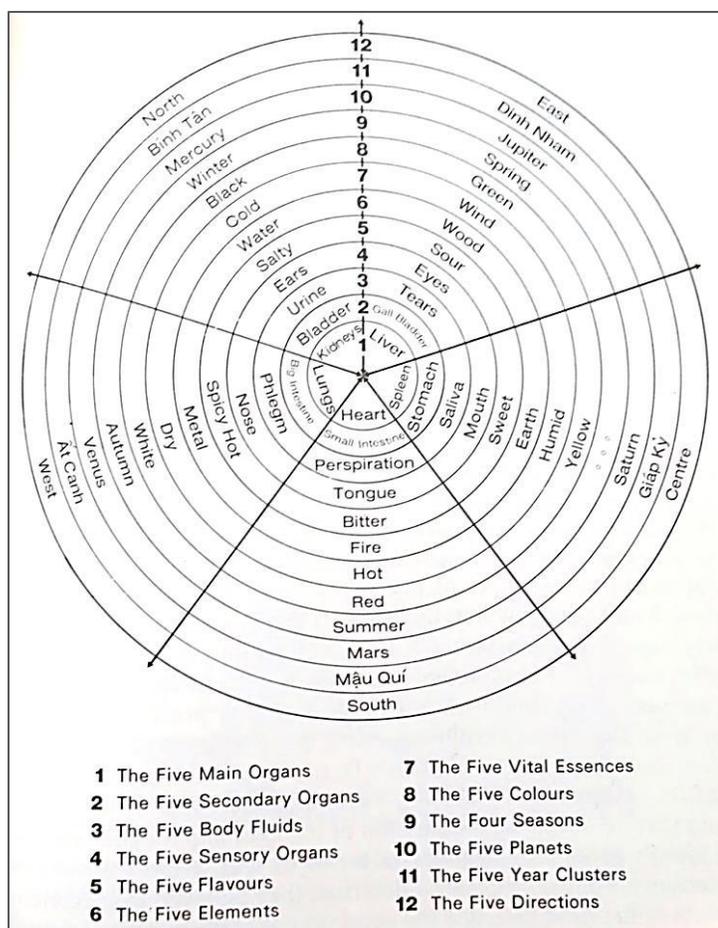


Figure 1: Sino-Vietnamese Conceptions of Man and the Universe (Marr 1987, p. 165)

The complexity of traditional Vietnamese medicine cannot be fully outlined here, but the combination of the three features provide a glimpse into how diverse this healing system is.

The above characteristics of traditional Vietnamese medicine provide a look at what it encompasses as a practice. TVM also has a deep, rich history that should be acknowledged by scholarly literature. Tuệ Tĩnh and Lãn Ông are two of the most famous historic figures of southern Vietnamese medicine (Dung and Bodeker, 2001; Huu, 2003; Marr, 1987; Monnais et al. 2012). Tuệ Tĩnh was a scholar and Buddhist monk⁵⁵ who was named the father of Vietnamese

⁵⁵ The exact date of his birth are unknown still to this day; scholars vary in their claims, with some placing him in the fourteenth century and others in the seventeenth century.

medicine and succeeded by Lãn Ông.⁵⁶ As Dung notes, “during a period when Chinese medicine and pharmacology were dominant, Tue Tinh propounded the view that the Vietnamese people were most likely influenced by the products of their own land, water, climate, plants, and animals” (2001, p. 402). Furthermore, the hot and humid tropical climate of Vietnam is very different to that of China and therefore different remedies are required because certain illness and treatments react differently to certain climates. This highlights the uniqueness of Vietnam and its environment⁵⁷ and reinforces the notion that traditional “Vietnamese medicine [is] profoundly embedded in the Vietnamese climate, the constitution and pathologies of the Vietnamese people, and, of course, Vietnamese explanatory models of disease” (Monnais 2012, p. 77).

Although the particularities of traditional Vietnamese medicine may not seem to be fully understood by first generation Vietnamese refugees today, they are still recognized. As the following results from my research interviews will demonstrate, the political history of Vietnam is apparent in how the nature, use, and meaning of TVM are uncertain, ambiguous, or not to be trusted for my respondents today in Canada. I would like to note that the clear distinction resettled Vietnamese refugees made between *thuốc nam* (Southern medicine) and *thuốc bắc* (Northern medicine) throughout my interviews highlights that they relate more closely to *thuốc nam*. This could be due to the elite nature of *thuốc bắc* as well as the fact that all but one of my respondents were from southern Vietnam. The consistent use and reference to *thuốc nam* by my respondents suggests that recognition of *thuốc nam* is still alive and well and makes Craig’s statement that, “the uniqueness of Southern medicine has long been a point of nationalist pride,”

⁵⁶ For detailed history see Huu, 2003, p. 29-39; Marr 1987, pg. 170-172.

⁵⁷ Tue Tinh’s work [eleven collected volumes] records more than 630 remedies of plant, animal, and mineral origin, of which more than 500 remedies are uniquely Vietnamese (Dung and Bodeker 2001).

still relevant today (2002, p. 50).⁵⁸ As such, instead of TVM, *thuốc nam*, or southern Vietnamese medicine (SVM), seems to be the appropriate term to use in reference to traditional healing practices of first generation Vietnamese refugees throughout this thesis. How then, do first generation Vietnamese refugees define and identify SVM?

How is Southern Vietnamese Medicine understood and practiced?

One of the key questions in the interviews I carried out with resettled Vietnamese refugees asked, “What is traditional ‘Vietnamese’ medicine?” This question proved to be one of the most difficult questions for my respondents to answer. As indicated above, the history of traditional Vietnamese medicine is present but the literature is sparse and information not readily accessible. The concepts of biomedicine or traditional Chinese medicine are much more prominent in scholarly literature (Alter, 2005; Kleinman, 1978; Landy, 1977; Leslie and Young, 1992) and in every day practice. These two practices are recognized on an international level and are also distinguishable from one another; they have specific characteristics that most anyone could describe, if even only at the most basic level. My respondents had nearly identical, simple classifications for both practices; traditional Chinese medicine is more natural, consists of herbs, whereas biomedicine is based on science and technology. Traditional Vietnamese medicine however, proved to be extremely complex, confusing and difficult to define, let alone identify, for my respondents.

I found that most respondents were aware of *thuốc nam*, southern Vietnamese medicine (SVM); however the levels of recognition, understanding and practice varied. For the respondents, SVM was either recognized as its own practice or seen to be the same as traditional Chinese Medicine.

⁵⁸ Craig’s (2005) study on traditional Vietnamese medicine was conducted in Vietnam, yet it highlights that the distinction between *thuốc nam* and *thuốc bắc* is recognized in both Vietnam proper and within Vietnamese émigré communities.

“I know it’s different, Vietnamese and Chinese, it’s different.” (Tracy)

“No, there is not Vietnamese medicine. It’s the same as Chinese medicine, comes from China. There is western medicine...but nothing called ‘Vietnamese medicine’” (Anh)

Although identifying and cataloguing SVM and its remedies was part of initial research goals, the respondents had limited or no knowledge of recipes or ingredients that they could share. As for utilization, in all cases, the respondents claimed they did not practice SVM since resettlement to Canada. However, as each interview progressed it became quite apparent that each respondent has practiced SVM on occasion, if not regularly, since relocation. This contradiction illustrates deeper underlying socio-political concerns which will be addressed in Chapter Four.

For each respondent, the use of SVM and/or biomedicine is contingent upon circumstance. Each situation is perceived differently and thus requires different methods of treatment. Concerns around trust and efficacy were prominent themes for the respondents and surfaced in how they approached the topic of medicine, utilization and justification of certain practices. There were several healing strategies that were highlighted by all respondents. This use of remedies supports previous literature on Vietnamese refugee medical practices in Canada and the United States (Anh et al., 2006; Bushwald et al., 1992; Purnell, 1998; Stephenson, 1995). Table 1 lists the treatments respondents used to treat certain symptoms.

Table 1: Symptoms and corresponding treatments

Symptoms	Vietnamese Practices
<i>Sốt / lạnh</i> (Fever/Cold)	<i>Cạo gió</i> (Coining); <i>Xong</i> (Steaming); <i>Ngải cứu</i> (Moxibustion)
<i>Đau bụng</i> (Stomach aches)	<i>Gừng</i> (Ginger); <i>Cháo</i> (Congee)
<i>Đau đầu</i> (Headache)	<i>Cạo gió</i> (Coining)
<i>Nhức / đau</i> (Soreness/aches)	<i>Châm cứu</i> (Acupuncture)
<i>Thu giữ</i> (Seizures)	Rhinoceros Horn/Bear's Gallbladder
Varied (mild – extreme)	Rhinoceros Horn/Bear's Gallbladder

Adapted from: Marr, D. G. (1987). Vietnamese attitudes regarding illness and healing. In N. G. Owen (Ed.), *Death and disease in Southeast Asia: Explorations in social, medical and demographic history* (pp. 162-186). Singapore: Oxford University Press.; Nguyen, V.T. (1995). Traditional medicine in Vietnam. In J. Van Alpen & A. Aris (Eds.), *Oriental Medicine*. University of Michigan: Shambhala.

For mild ailments such as colds, flu, or headaches the most common treatments were *cạo gió* (coining) and *xong* (steaming). *Cạo gió*, which literally means ‘rubbing out the wind’ is where warmed mentholated oil is rubbed on the affected area and then diagonally scratched with silver (usually a coin) to release the toxins in the body. *Xong* is where *xa* (lemongrass) is placed in a pot of boiling water, the individual then sits with the pot at his/her feet and covers their body with a blanket to steam. *Ngải cứu* (moxibustion) was also referenced by two respondents as a method for treating basic symptoms of the common cold. Moxibustion is where a small bundle of herbs is burnt and the heat is held close to the affected area to alleviate symptoms or effect cures (Marr 1987, p. 168-169).

My respondents noted that for extreme cases of illness such as seizures, either the rhinoceros horn⁵⁹ or bear gallbladder⁶⁰ can be used for treatment⁶¹. Most respondents noted that

⁵⁹ The rhinoceros horn has been used as an ingredient in traditional Asian medicine for the past 2000 years (Still 2003, p. 119).

both the rhinoceros horn and bear gallbladder were perceived as cure-alls for most types of illness. Rhinoceros horn⁶² has been used as an ingredient in traditional Asian medicine for the past 2000 years. Virtually every part of the rhinoceros is used: the horn for alleviating fever, the skin for treating skin disease, the penis as an aphrodisiac, the bone to treat bone disorders, and the blood (Still 2003, p.119) The bear's gallbladder, "is reputed among ordinary people to have miraculous curative virtues" (Hoang et al. 1993, p. 148). The preparation of both the rhinoceros horn and bear gallbladder is similar. First they are ground down to fine powder by mortar and then mixed with water and given as a drink.⁶³ For mild ailments such as a cold or flu, *cao giò* or *xong* were tried first. Lin confirms this, "I do the steam and you get the smell of the lemongrass and the heat helps...If you have a cold or flu, they help." If symptoms progressed, then a physician was seen. For more serious or acute illnesses, a physician and biomedicine was always the first choice for all respondents. May's situation demonstrates this, she states that she uses biomedicine, "because I have the thyroid [problem] I don't use Vietnamese medicine, I see my doctor...for the thyroid pills."

Treatments with SVM are dependent upon ideas of illness and causation. The cause of sickness or illness for the Vietnamese is seen as an imbalance of *âm* (yin) or *duong* (yang). When

⁶⁰ *Bear's gall* is very valuable commercially because of its special therapeutic properties. There are two species of bear whose *gall* has the necessary properties: the tall *Sole arctos thibetanus*, recognizable by the V-shape crescent on its chest, and the smaller *Ursos arctos listotus*. The gall-bladder is dried in the shade and afterwards kept in a hermetically sealed container with some quicklime as a desiccant. People have long used bear's gall to treat gastric and muscular pains, indigestion, jaundice, poisoning and other ailments. But because of the high price of the medicine a family will normally only have a small piece for treating sprains, wrenches and ecchymosis. A small quantity of the gall (about the size of a grain of rice) diluted in purified water is used as an eye-lotion to bath conjunctivitis and other external eye inflammations (extemporaneous preparation). A tincture, five percent bear's gall in alcohol, is used as an ointment for pains and sprains and to reduce ecchymosis (Hoang et al. 1993, p. 149).

⁶¹ The use of rhinoceros horn or bear's gallbladder (and other animals such as tiger) in "traditional" healing practices has become very controversial in recent years because of ethical and population concerns. Certain species of rhinoceros, for example, are now endangered and / or being farmed for these specific purposes.

⁶² Asian rhino horns are more highly prized than African rhino horns; consumers believe that their smaller size means that they are more concentrated, and therefore more potent (Still 2003, p. 119).

⁶³ Preparation of this was described to me by Lin during informal conversation after the interview.

an individual is sick it should first be decided if the illness is *nội thương*, emanating from within the body due to poor physical maintenance of emotional strain, or *ngoại cảm*, resulting from external forces and disrupting the body's systemic harmony. Then 'hot' and 'cold' components have to be delineated to assess treatment (Marr 1987, p. 168). The multitudes of factors that can be attributed to one's illness vary from weather, food, religious beliefs, and superstitions. Kim recounts a story about her friend who was a new immigrant that had not acclimatized to Canadian weather yet, "[he] first come to Canada he very weak. His body not get used to the weather here and always weak....[his wife] buy him Chinese medicine which she cook for him every day for a couple years. After a couple of years...he was strong. For "...Vietnamese of rural origin, [the] most important among the traditional concepts of causation (for all things, including illness) are probably horoscopy and the notion of individual destiny" (Stephenson, 1995, p. 1636). Although metaphysical beliefs and explanations for causation and illness are very prominent in Vietnamese approach illness and healing, and were found by Hoang (1993), Marr (1987) and Stephenson (1995), none of my respondents discussed this in-depth during the interviews. The complex nature of the Vietnamese belief system of cause and illness however, cannot be overlooked when discussing their current medical practices. As the following results show, although refugee experiences and relocation may have affected some medical practices, the underlying beliefs are still there and greatly influence how medicine is understood and used today for several respondents.

Respondent Perspectives 1: There is no Vietnamese Medicine

Given the difficulty I myself had had in trying to identify southern Vietnamese medicine, one of my central questions was whether or not my respondents could define, or recognize it as a

systematic practice. What I found was that there were conflicting answers from all respondents and they ranged all over the spectrum. The first respondent perspective is that there is no SVM.

Initially, the question “Is there a Vietnamese medicine?” was met with confusion and denial. However, with prodding, answers began to surface. In answer to this question the respondents’ answers fell into two opposing camps: “No, there is no Vietnamese medicine” and “Yes, there is Vietnamese medicine, but I don’t know what it is.” I discuss each of these responses here.

The first response, “No, there is no Vietnamese medicine” indicates that these respondents do not recognize Vietnamese medicine as a practice. The answers provided in this context were direct and blatantly assured me that SVM does not exist. For instance, Anh claims,

No, there is not Vietnamese medicine. It’s the same as Chinese medicine; comes from China. There is Western medicine you can buy, pills, in Vietnam then and more now. But nothing called “Vietnamese medicine”.

Her sentiments are supported below by several other respondents:

No, it all comes from Chinese medicine from before. Vietnamese use Chinese medicine. The herbs are from China, never Vietnam. We don’t have it. (Mary)

Oh no, there is no Vietnamese medicine. There is Chinese medicine (May).

When I asked Lin if she uses any traditional Vietnamese medicine she actually corrected me:

“Hmmm...you mean Chinese medicine? No, never. Thirty years I’ve never touched it.”

Each respondent does not just claim that SVM is not a practice; they are adamant that it simply does not exist as its own medical tradition. This is in striking contrast to the scholarly literature by Craig (2002), Dung and Bodeker (2001), Huu (2003), and Monnais et al. (2012) who show the historical roots and contemporary legitimacy of SVM within Vietnam. For several respondents in Victoria however, it would seem that traditional Chinese medicine is the only form of traditional regional medicine that they recognize.

The second set of responses to the question of “Is there Vietnamese medicine?” is encapsulated as, “Yes, there is Vietnamese medicine, but I don’t know what it is.” This response took two forms. As the textual statements from sources given will show, the first response clearly recognized that SVM is its own medical practice. The second response suggested a loss of knowledge due to migration and resettlement or the replacement of earlier practices with new ones. Either way, their responses indicate they recognize SVM as a tradition and that prior knowledge of it as a practice is present, although it is now limited or lost. I describe their responses below.

Respondent Perspectives 2: There is SVM

The second respondent perspective is to admit that SVM exists. However, several respondents said that while it existed, they did not practice it anymore. For several respondents, they said the resettlement process has changed the socio-cultural environment and as a result once common Vietnamese medical practices are no longer so. For example, Tracy states that she has not practiced SVM since her relocation to Victoria: “I don’t know very much about Vietnamese medicine because I haven’t used it since I came here.” In this instance, Tracy has a recollection and recognition of using the practices; however, she does not practice them now. This shows that particular methods have either been transformed or lost over time. Thirty

decades have passed since she came to Canada and over the course of time certain concepts, ideas, and practices have decreased.

Another respondent not only acknowledges Vietnamese medicine, he feels that it is clearly distinguishable from traditional Chinese medicine.

Duc feels that SVM is from and for the Vietnamese people. He does recognize that certain practices have been learned from the Chinese but is adamant that there is indeed a distinction between Vietnamese and Chinese medical practices. When asked to identify a specific practice he says,

Yes, lots of differences...but they do learn from Chinese. [...]Oh! Yea...For example, if you have the flu or something – you put the lemongrass and ginger to steam your body – that is Vietnamese way. It's inside.

As Duc claims here, there are certain practices, such as *xong* (steaming), that originates from Vietnam and thus validates it as a medical practice. His claims are supported by Tracy who states,

I know it's different, Vietnamese and Chinese, it's different. I don't know Chinese medicine a lot, I know more Vietnamese... it does treat different things. I just don't know too much about it.

The assertiveness each respondent exhibited when providing these answers indicated to me that the distinction between the two forms of medicine, Vietnamese and Chinese, was of the utmost importance. Each respondent was quite concise and unyielding when making these statements ensuring that I knew that these two practices should not be assumed to be the same. This reaction was not surprising given the specific distinctions of *thuốc nam* and *thuốc bắc* also found in the literature. The distinctions made illustrate that there is indeed recognition of SVM as

a practice; and although traditional characteristics were unknown, first generation Vietnamese refugees were very clear on how they characterized SVM today.

Contemporary Characteristics of SVM in Canada

This section identifies what respondents believe SVM to be. There were two common sentiments shared by all respondents about SVM. First they asserted that it is natural and easier on the body. Second, they assert that it is expensive.

First, each respondent described SVM as natural, but not immediately effective. It is perceived that traditional remedies, being more natural, take a considerable amount of time to work and show improved health. Mary shares her sentiment about the length of time it takes in comparison to biomedicine.

They are different. [SVM] takes time, like 6 months to feel better and it takes time to make. Like the drink I made took 5 hours, so long and Western medicine works right away. It helps more right away. If you need to feel better soon then you take Western medicine. [Our] medicine takes a long time to work and you can't tell right away that it is working.

Second, Mary also describes SVM as costly. Here she comments on why SVM is so expensive:

Medicine prescribed by the doctor, if you need it, is usually covered right...
[Vietnamese] medicine costs more; like the ginseng I bought cost me \$40.00!
And other things you might need you have to get shipped in from China or Vietnam, you have to order it...

Mary's statement about cost is supported by Duc as well. Duc spent thousands of dollars to order and ship his sister's treatment in from Vietnam. In contrast, other respondents noted that prescription drugs or simple pain killers such as Advil or Tylenol seem to reduce or eliminate the

pain right away and they were not as costly.⁶⁴ Here, the high cost coupled with the perceived “slow” natural process of SVM is seen as detrimental to its utilization and effectiveness. SVM and other traditional medicines (traditional Chinese medicine and Ayurveda) are on the whole more expensive than biomedicine due to the limited availability here in Canada. The price of SVM ingredients and remedies varies greatly. The cost for any single ingredient is noted to be approximately \$40.00; one prescribed package of herbs starts at \$60.00⁶⁵ and can range into the thousands depending on illness, as Duc’s case highlights. The emphasis on high cost that Duc notes above was mentioned by all respondents and is also one deterrent for use. As most of the ingredients are shipped in from Vietnam or China, the difficulty of access raises the cost significantly. Duc’s case of spending thousands to treat his sister is illustrative of how expensive some treatments can actually be.

There was limited information and knowledge available about what the actual costs, remedies, and practices of SVM were by resettled Vietnamese refugees. This led my respondents to lean towards identifying what they felt or knew SVM wasn’t. In particular, there were three dominant negative themes that they identified with SVM that arose throughout the interviews. These are: efficacy; trust; and lack of knowledge transfer.

Efficacy: “There is no proof that it will work!”

One of the most striking sentiments that all respondent shared was skepticism regarding the efficacy of SVM. Even the respondents who did use SVM stated quite clearly that trust was one of their main concerns. These concerns were centered upon: lack of trust in the ingredients, the practitioner, and themselves. This demonstrates that the concerns are multifaceted. It is not

⁶⁴ This is partly due to health care coverage in Canada. Depending on the individual’s medical plan, most prescriptions are covered to a certain degree; this is not the case in Vietnam. Furthermore, over the counter medicines, such as Advil or Tylenol are reasonably priced and easily accessible.

⁶⁵ Price provided by the Chinese Herbal store owner in the Chinatown, in Victoria, October 18, 2012.

just the social or cultural facets that they are worried about; SVM creates a level of uncertainty and insecurity on the personal level. The case study of Anh illustrates concerns around efficacy.

Case Study - Anh

Anh is a middle aged woman who arrived to Canada in 1993. She and her husband own a restaurant here in Victoria, where she works six days of the week. She is close to her extended family as they have all settled in Victoria as well. She is a petite woman with an extremely bubbly and inviting personality. Her English is near perfect and I would say that she has adopted a “Canadian” perspective in terms of how she views medicine. Anh is a firm believer in the science and efficacy of biomedicine. She has gotten her annual flu shot since her arrival to Canada, which she attributes to keeping her healthy and sickness free for almost 20 years. She has been educated about biomedicine, such as the flu shot, by the local news on television⁶⁶ and by her Canadian physician. Although she will occasionally use SVM, such as lemongrass to steam, her first choice is always to see her physician if she is experiencing any kind of illness.

Anh’s introduction to biomedicine and Canadian culture has influenced her perspectives on health and medicine. She did not express any particularly good or bad past experiences with SVM which would have deterred her from SVM, however she is adamant that it is not a practice that should be trusted. When asked why she no longer uses SVM she states:

There is no proof that it will work! You take it but it takes so long for it to work, you don’t know for sure if it is what helped you. Western medicine has check-ups; you go to the doctor regularly and they know what the body needs, it is science, they know the body and what is sick in the body and how to treat

⁶⁶ Here, Anh is referencing the television ads that appear during flu season that remind everyone to get their flu shots, she states that she receives some of her information from television ads like these about when and where to get them and about how you can get sick if you do not get your flu shot. She attributes her good health to getting her annual flu shot since she arrived to Canada.

it. There is...how you say...evidence! I don't use Vietnamese medicine or any medicine really because I'm not sick ever! I don't get sick, haven't been sick since I got to Canada. My family is very lucky.

The language that she uses in her statement is quite particular. For Anh science is the basis of effective medicine; the proof that science is able to provide, the knowledge that science has about the body and how it functions shows her what medicine should be. She comments later on in the interview about the use of x-rays and scans that can show you what is wrong. The evidence that biomedicine can provide, the basic facts and data, appears to be the driving factor for Anh in terms of justification and rationalization for using this particular form of medicine. She has adopted and adapted to the Canadian culture in the context of health and medicine, discarding any traditional practices that she may have used before her arrival.

She elaborates on the level of trust she has placed onto physicians and biomedicine particularly when it comes to children:

...Because you don't know what is wrong or what they are feeling because they are little and can't tell you. You take them to the doctors and they can do tests and check-ups to find out what is wrong and give them the right medicines. We can't be sure and you don't want to give them something wrong or something that is too strong for kids. A lot of Vietnamese medicines – you don't know what it is or how much – it can be dangerous because there is no dosage for kids. Even in Vietnam they always give you the wrong amount and you can't be sure. It's hard, can't risk the kids getting sick or sicker.

Anh became very heated during this discussion. She feels that the health and welfare of children are things that physicians practicing biomedicine should address. She makes it very clear on how

important it is to trust your physician, particularly when it comes to children. The “proof” that the physician is able to provide, the technology and science that is used is the evidence that this method is effective, unlike SVM:

We don't know medicine or enough about sickness or how to describe what is wrong so we can't tell them what to take. Doctors here know much more about medicine. It is different for kids and it is scary because we don't know what is wrong and we are not doctors so we can't tell. The doctors here you can trust because they do all the tests to find out. Vietnamese and Chinese medicine, what do they do? They take pulse? More important for kids and making sure what is wrong.

For Anh, it seems that the maternal instincts that come with being a parent are sidelined in this case. The care of the child is placed into the hands of the physician and the parental input appears to be insufficient or invalid here. Anh expresses a lack of knowledge in diagnosing a child's sickness and thus is unable to diagnose or treat the child. She states that the physician is more knowledgeable and therefore more capable of assessing the child and illness in a much more comprehensive fashion, particularly with the aid of technology and science. This illustrates to me that the refugee mother, in Canada, feels insecure in her ability to provide appropriate care for her child in the new social and cultural environment⁶⁷. Furthermore, in discussing the use of SVM Anh expresses feelings of fear and distrust; therefore its use in caring for a child's illness is not an option. The “proof” that biomedicine can provide and the consistent information available and supported by the media and her family physician makes it not surprising that Anh would choose biomedicine over the use of SVM for the care of herself and her family. Anh's case

⁶⁷ The concerns regarding adequate parenting and care for children among refugee groups is important however is not an issue that I will be covering in this thesis. Rather, I introduce this issue to highlight the emotional expressions felt by Anh in discussing adequate care and the choice between biomedicine and traditional practices in Canada.

highlights the importance of efficacy and proof in choosing care and indicates a deeper level of mistrust for SVM.

Trust: “I don’t trust the Vietnamese potion”

The concerns around efficacy of SVM also raised issues of trust. Trust is the second theme that arose in my discussions of what medicine is or is not with resettled Vietnamese refugees. The concept that SVM should not be trusted, in comparison to biomedicine, was common among several of my respondents and is highlighted below in the case of May.

Case Study: May

May is from Northern Vietnam and has been in Canada since 1993. She has lived in Victoria for the majority of her past twenty years. She owns one of the local Vietnamese restaurants here in Victoria and works six to seven days a week. She is not married, and has no children; her family are all in Vancouver so she tries to go there as much as she can to spend time with them. May has a thyroid problem and is on prescribed medication from her physician which she takes daily. She has been fortunate enough not to have surgery. She only takes the medication prescribed by her physician and does not take any type of SVM because she is afraid of mixing and possible reactions. Her physician did not advise her against this, it was a self-imposed decision that she made when she found out she had a thyroid problem.

The socio-cultural pressures that were apparent in Anh’s decisions arise in May’s discussion about trust in medicine as well:

I trust Canadian medicine more. I don’t understand the Chinese language and I don’t trust the Vietnamese potion...All the world, we use Canadian medicine right? And in Vietnam...I don’t know how to say...but I trust Canadian

medicine more than I trust Vietnam medicine and Chinese medicine – I don't trust that.

She states that “Canadian medicine” is the global practice, and her inquiring statement highlights her uncertainty about the issue. When I asked May about what impacted her choice to use biomedicine and why she does not trust Vietnamese medicine she relays a story about a family friend.

My friend, who died in Vancouver, [went] to a Vietnamese doctor. He went, he cough, he just had a cough right, so the doctor just gave him medicine for the cough, right. And one week he still cough so he go back and he gave another prescription for the cough and about one month later he still coughing. He ask “Why I cough for so long?!” So he go to a white doctor. You know what the white doctor said? Go home, enjoy your life – go home and enjoy your life. And he just passed away last week...Only three months, July. He still young, he 48. He is sick...I'm sorry, you ask about Vietnamese medicine and doctor so I start to tell the story. I just tell you. I want to say why I don't trust. I have a reason why I don't trust.

May feels that had her friend gone to the “white doctor” at the outset of the cough then the proper screening and treatment would have been done and her friend's sickness could have been treated. The story that May shared is similar to several others that I will discuss in the following chapters where I discuss the reasons and circumstances that influence individual decisions. Here, trust in the ability of biomedicine to not only treat, but also diagnose illness, and to provide the evidence of this is what matters. The issue of trust is critical, particularly in regards to ingredients used in SVM.

Like May, Tracy has a lack of trust. Tracy explains that trust in the ingredients' origins is why she does not purchase or use SVM. When asked if she is aware of any locations that sell such ingredients she replies:

From here? No, I saw another in the herbal store I think you can get some. I don't know though because I don't buy. Some people I know get it from Vancouver. I don't know. [The] medicine is no good! It's scary! I hear about it...I don't know...It is scary medicine, you don't know what it is or if it works. Where is it from?? It isn't right, I don't trust it. And me and my family only use medicine from here anyway so it's better."

As you can see from her statement, the distrust she has is because she does not know where the product is coming from and therefore chooses not to use it. The concerns about origin were shared by every respondent I spoke to; about where the herbs and roots were being sent from as well as authenticity of the ingredients. For instance, May warns that "...you know, here the Chinese they can make the money but we don't trust them because they put so many things in there to fool us." All respondents stated that the herbs and roots for most SVM are sent from China and that due to the high rates of counterfeit products in China many people are becoming much more cautious. Furthermore, as Lin states, "...you know the truth is because it's long time ago everything is good, it's honest like the root and everything. Long time ago we use in Vietnam, we believe it. But it is getting harder and harder to find the root[s]..." With the increasing levels of environmental damage and limited agricultural land there is skepticism about how and where certain herbs and roots are harvested.

Lack of knowledge transfer: “Before I used to know more about [SVM]...”

Respondents present concerns around efficacy and trust as two important identifiers for ways Southern Vietnamese medicine falls short. The third negative factor associated with SVM is that information and knowledge transfer is not present. The inability of my respondents to relay details or provide recipes of remedies is an example of a lack of transmission of knowledge. The basics of *cao giò* or *xong* were known by all respondents but as for actual ingredients and remedies, no one knew or could not remember. This was striking because given the age and generation of the respondents I had expected they would have the knowledge. Several of them mentioned that they knew of older individuals using remedies but they could not identify specific practices themselves. Kim mentions that her mother no longer practices SVM:

My mom used to believe something about Vietnamese medicine, about Vietnamese way but when she come here she doesn't do it anymore. Because [she] don't know what it is.

In this instance, the impact of migration and resettlement on the practice of SVM for this family has touched three generations. Kim's mother stopped using SVM upon her arrival to Canada, which in turn limited Kim's use. This lack of practice means limited knowledge or loss of knowledge. The knowledge that Kim's mother had has not been passed on to Kim, nor will it be passed on to her children. She stated that none of her 4 children use any form of SVM. Craig notes that,

“one of the most striking characteristics of [traditional] practices, that must be noted, is that they are oral traditions that are passed on through families. The recipes are necessarily mnemonic, relying entirely on memory for accurate transmission. As such, they are rhythmic and formulaic, formally and linguistically structured to be easily learned through repetition” (2002, p. 107).

This oral tradition enables easy transmission and was particularly important because many of these communities were illiterate. Recipes and remedies are often kept private within family lines and therefore written texts would also mean they could be easily replicated or stolen (Hoang, 1993; Marr, 1987; Wahlberg, 2012). This does not seem to be the case here, however and although there is the possibility Kim and her family have information they were not willing to share with me, I presume that this is more a case of lost knowledge. The loss experienced during the forced migration and resettlement process includes traditions and cultural knowledge. The forced exposure to western biomedicine that occurred in refugee camps could have facilitated the use of biomedicine and thus limited, or restricted, the use of previous medicinal practices.⁶⁸ Since Kim's mother stopped using Vietnamese medicine upon arrival to Canada, this suggests that exposure to biomedical practices became the dominant form of medicine that she presumed should be practiced. Therefore, it is not surprising that any knowledge Kim's mother has or had would no longer be passed down and lost over time.

The overall expressions of fear and distrust that have been presented by respondents in this summary of SVM indicate to me that once common practices are no longer fully understood or regularly used within the community. This is a striking change from Stephenson's 1995 study of the community which showed that use and knowledge of SVM was quite prominent among following their initial resettlement in Victoria, B.C. This lack of understanding and use seems to be what is facilitating and reinforcing respondent's current definitions, perceptions, and beliefs surrounding medical practices. Furthermore, the limited scholarly literature on traditional Vietnamese medicine can also be seen as reflective of how as a medical practice, it is not

⁶⁸ The limited access of even basic necessities in camps and the dominance of biomedicine for treating refugees suggest that there was little, if any, access to traditional Vietnamese medicine.

acknowledged to the same standard or universality⁶⁹ as traditional Chinese medicine or biomedicine, and as a result of this, definitions and recognition of SVM are more difficult to obtain.

Assessment

This chapter set out to identify and define traditional Vietnamese medicine. It achieved this by reviewing scholarly literature and by presenting respondent knowledge. This chapter has shown that TVM is a recognized and distinct healing system with two different systems within, *thuốc bắc* and *thuốc nam*. Resettled Vietnamese refugees acknowledged both systems but seemed to identify more closely with *thuốc nam*, southern Vietnamese medicine. Respondent narratives illustrate, however, that SVM is known not by what it is, as defined in the literature by Craig (2002), Dung and Bodeker (2001), Marr (1987), and Monnais et al. (2012), rather it is known by what features it seemingly lacks, and in comparison with traditional Chinese medicine and biomedicine. Respondents gave varying definitions as to what SVM is, but ultimately the definition of SVM is characterized by individual respondent perspectives and experiences rather than by recognition of it as a medical tradition. This chapter has further argued that the concerns shared by resettled Vietnamese refugees surrounding efficacy, trust, and knowledge transfer are reflective of the limited information and literature that is available on traditional Vietnamese medicine compared to other healing systems.

The ambiguities and confusions respondents demonstrated show that the forced migration and resettlement process has had an impact on knowledge transfer and understanding about healing practices in Canada. Craig states that the, “choice of medical care is not a simple matter of complying with some universal rationality that prescribes precisely what needs to be done.

⁶⁹ Monnais et al., (2012) discusses in depth the historical and contemporary revival of traditional Vietnamese medicine in Vietnam. This text illustrates how most recently Vietnamese medicine has been gaining a foothold in the global medical field.

Rather, it is a complex negotiation between systemic biomedical knowledge (as accessed from doctors and pharmacists) and the family's own pool of knowledge, experience, and resources" (Craig 2000, p. 161). Here I would like to extend Craig's concept of negotiation to address the systemic socio-political factors that influence how medicine is understood and defined. The identification of medicine becomes much more complex after resettlement because of the changes in the refugees' socio-political environments. The examples of Anh, May, and Kim suggest resettlement has a strong impact on how different medical practices are defined and understood in relation to one another. The decisions these resettled Vietnamese refugees make regarding medicine reflect the complexities of their identities, past and present. In the next chapter I show why particular medical practices are chosen in specific situations and what the socio-cultural conditions and beliefs are that influence these decisions. It will show how the intersection of SVM and biomedicine is illustrative of resettled Vietnamese refugees' syncretic approach to illness and treatment.

Chapter Four: Medical syncretism: When and why certain medicines are used

The previous chapter demonstrated how complex it can be to define, describe and categorize a medical system. It showed that SVM exists but not all respondents recognized it or used it. This chapter will explore what medicines refugees use and how they use them. It will illustrate how the use of medicine is multifaceted. Resettled Vietnamese refugees showed used different medical practices for treating different types of sickness. In other words, they demonstrated a syncretic approach to medicine. The term syncretism is defined as “the combination of different forms of belief or practice...as a result of contact” (Ember and Ember 2004). Although this term is most often used in reference to religions, it is fitting in this case because of the complexity in medical practices among resettled Vietnamese refugees in Victoria, B.C. The term medical syncretism is used here to refer to the combination of different beliefs and practices regarding illness - somatic experiences of being unwell⁷⁰ - and treatment which are chosen. My respondents revealed that, despite their negative comments about SVM, both southern Vietnamese medicine (SVM) and biomedicine are actually regularly chosen as treatments for sickness. When are SVM and biomedicine chosen and to what extent are they used? This chapter will address these questions and provide insight into the complexities of refugee choices around using SVM and biomedicine to treat illness.

The overall theme among resettled Vietnamese refugees in Victoria is that a syncretic approach to medicine is the norm. Access and availability to different treatments are demonstrated in both case studies discussed below. This chapter will demonstrate that there are particular circumstances which require certain treatments for resettled Vietnamese refugees. The

⁷⁰ Ember and Ember 2004, p. 26

treatment choices my respondents made introduced two themes regarding the utilization of medicine. The first theme they introduce is the order in which available medical practices are used as treatment. The second theme discussed is the lack of conflict or blame towards chosen treatments when they do not work. For both trends, respondent statements about medical choice and treatment indicated that there are underlying social pressures that influence how medicine is discussed and used. A case study of Lin's decision-making highlights the inconsistencies in claims about medical use. These issues will be discussed in the sections below to illustrate the complexities of medical syncretism among refugees.

Mixing Medical Systems

Previous literature has shown that refugee groups practice complex systems of care after the resettlement process (Ahn, 2006; Ito, 1999; O'Callaghan and Quine, 2007; Ngo-Meltzer et al., 2003). This complex system of care is typically a syncretisation or integration of medical practices - using different systems in a complementary fashion. This is expected to some degree because with any introduction of new ideas and practices, interactions and changes are bound to take place in all spheres of life: "acculturation requires that two autonomous cultures come into contact. One of the two groups changes as a result of the contact. In practice, one group becomes dominant and less dominant culture takes culture elements from the dominant one" (Berry 1989, p. 2). For most refugee groups, they are often the less dominant culture and thus acquire certain cultural traits from the dominant culture; in this case it is the dominant practice of biomedicine. The syncretic approach to medicine that is demonstrated by refugee groups is a result of this acculturation process.

Culture contact is often presumed to be problematic due to the imbalanced interaction between dominant and subordinate cultures (Berry 1989).⁷¹ First generation Vietnamese refugees have shown that the common assumption that there is conflict between medical practices and that preference for one or the other poses barriers is not present. Several cross-cultural and trans-global studies have shown that in the past, language and cultural beliefs act as barriers to understanding health care and medicine (D'Avanzo, 1992; Gellert et al., 1995; Hoang and Erickson, 1985; Ito, 1999; Ngo-Meltzer, 2003). In contrast to some of these reports however, my results suggest those barriers are no longer present to the same degree. Resettled Vietnamese refugees have demonstrated the ability to negotiate between different medical practices to their benefit. The characterization that medical practices tend to be in opposition or conflict with one another was not present in these data. Rather, my respondents simply chose another available option if their first choice did not work. My respondents' decisions indicated that medical choices are complex and there are certain situations in which particular practices are more suitable as treatment.

This medical syncretism has proven to be common among many refugee and immigrant groups after they have acclimated to North American culture (Ahn, 2006; Chiu, 2006; Chung and Lin, 1994; Barimah and van Teijlingen, 2008). For example, The latter case is a study of Ghanaians in Canada, that highlights how refugees, "have adopted a mix-and-match approach of health seeking behaviour whereby the decision to use either traditional medicine (TRM) or modern medicine is based on the nature of the health problem" (2008, p. 7). The case studies I will present explain how this "mix-and-match" approach was typical for resettled Vietnamese refugees as well. As much of the literature on medicine and health presents, presuming that one particular medical practice is better than another is erroneous (Helman, 1985; Kleinman 1978;

⁷¹ See Berry 1986 for definitions and varying levels of acculturation.

Landy, 1977). My results will show that there does not seem to be a conflict between medical systems for resettled Vietnamese refugees. Each medical system has its advantages and disadvantages for an individual, group and illness and the decisions regarding treatment are influenced by the respondent's past experiences and current circumstances. The first section will describe which practices my respondents report are best for certain illnesses, the second section presents two case studies to highlight the complex nature of these decisions.

Which Medicines to Use First?

The choice of medicine for treatments varied depending on the sickness; if it was mild or acute; and on what services were available. My respondents provided two different answers when asked about their preferred treatments. First was that biomedicine or consult from their physician was always the best option, and the one that they used. For example Tracy's states, "I came here and it's different...different medicine. Medicine here works well...now I just use the medicine here that my doctor tells me to." With biomedicine being the dominant practice in Canada, it is not surprising that the respondents' initial answers reflected this trend. However, when my respondents were asked to elaborate further however, each stated Vietnamese medicine was the practice they would choose or try prior to seeking a physician's counsel. For example, Duc clarifies below when he chooses to see his physician:

You have to go [get a] check up every year, you have to go to the doctor. But, when I get sick here, like a flu, I don't go to see the doctor. ..If I have a sore throat for more than a week or like an ear infection, more serious, I go to the doctor.

Overall, my respondents reported using a syncretic approach to medicine, with a particular hierarchy of practice. Vietnamese medicine was often chosen first for mild ailments

such as cold or flu and the treatments used would be *cao giò* (coining) or *xong* (steaming). These two practices were identified as the most common home remedies used to treat colds and mild ailments. Similarly to Chinese immigrants, my Vietnamese respondents “believed that the Western medicine was more effective for acute diseases or a combination of acute and chronic diseases, such as heart diseases, TB, hepatitis, cancer, fractures and severe stomach problems, among others”(Ma 1999, p. 432). The concept of “wind” and an imbalance of *âm/duong* (yin/yang) were also noted by respondents as the causes for disease or sickness. Yin and yang are two concepts that account for changes in the universe, elements, and body and illness occurs when there is an imbalance of the two (Craig 2002, p. 46-47). For more serious illness, such as high blood pressure or thyroid, medication was used to treat symptoms as prescribed by the respondent’s physician. Concern about mixing different medical treatments was raised by several respondents and therefore did not occur often because of risk of danger. In cases where the illness is severe biomedicine was always identified as the practice that respondents sought for initial treatment⁷², given its immediacy and effectiveness.

For my respondents, it was common to try a home remedy first and then seek medicine or consult a physician. This finding supports those in studies conducted by Ma (1999), Nguyen (1985) and Stephenson (1995). Medicines such as Tylenol or Advil were cited by every respondent as being used to treat minor symptoms of aches, pains, or headaches. These were used after home remedies such as *xong* or *cao giò* were tried. I will note every respondent stated that although medicines such as Tylenol or Advil worked faster than Vietnamese medicine, the side effects were of high concern and thus regular use was not recommended. For example Kim notes that, “ibuprofen is not too good [...] they have side effects so I don’t take it [often].”

⁷² However, there are many cases reported where refugees will use home remedies to treat mild symptoms without knowing the severity of the illness, it is then that they seek biomedical treatment – when the illness has become “severe.”

Furthermore, other studies have indicated that many refugees are concerned about possible addictions as well so tend to limit their intake or adjust prescriptions to how they see fit (Bushwald et al., 1992; Ma, 1999; O’Callaghan and Quine, 2007). The general sense that prescription medicines are effective yet “too strong” for the body is common, therefore the use of Vietnamese medicine is often chosen because of its mild properties. Initially, I sought to identify if there was a general level of distinction between two options to test the general proposition that SVM was often chosen as the first treatment for mild ailments and biomedicine is sought out if that did not work or if the illness was severe. This was confirmed, however there were also slight inferences⁷³ made by my respondents that there were other factors that influenced decisions regarding medical practice which could propose a hierarchy of resort⁷⁴ to treatment.⁷⁵ Duc’s case below, illustrates a navigation between different medical treatments for a family members’ cancer.

Case Study: Duc - Cancer and Hope

Duc is a 62 year old male, single and no children. He escaped Vietnam in 1980 and his sponsor brought him to Victoria where he decided to settle. He works at two restaurants downtown, one Vietnamese and one Japanese, and hopes to retire in the next 3 years. He is well known in the local Vietnamese community and has good relations with everyone. He has only returned to Vietnam once since his resettlement. His family settled in California where he visits when he can. He is a practicing Buddhist and goes to the temple at least twice a week, more if he has time off work. His spirituality limits him from using certain practices of Vietnamese medicine, such

⁷³ Some respondents briefly noted on different occasions, the use of different practices to treating mild to severe illness – ranging from home remedies, exercise, over the counter medicines, to seeking physician’s aid.

⁷⁴ Schwartz, 1969

⁷⁵ Further research on medical choices should be done to identify what the hierarchy of resort is for the Vietnamese refugee population. The different aspects of TVM, such as metaphysical beliefs and the five units, indicates that there may be other ways in which illness is treated that may not include medical treatment.

as the bear's gallbladder.⁷⁶ However he firmly believes that Vietnamese medicine is better for the body and individual on the whole. He used to work in a pharmacy back in Vietnam. However his knowledge about herbs and remedies have significantly decreased over the years due to lack of practice. That being said, when he is not feeling well he always tries a home remedy before he seeks treatment from his physician.

Duc has experienced great loss in his life. His brother and two nephews passed away when their boat sank en route to Thailand in 1981 when they tried to escape. His mother passed away 12 years ago and his younger sister died of cancer. He talks in great length about his sister's passing; she was still fairly young, only 52 years old. The story he shares regarding his sister's cancer evoked many feelings of sadness and hope. His family used every resource and treatment they could to try and cure her. When the chemotherapy failed to cure her, Duc sought treatment from SVM. This case demonstrated the emotions that are involved in choosing medical treatment and how in difficult times any and all treatment options are often tried.

In the following section Duc discusses his sister's cancer treatment and the last attempt to cure her with SVM before she passed away.

Duc: Yes, she was sick, the doctor took care of her in America. When they find something in her bowel, the plum in her bowel, they do an operation and take it out. So hopefully she OK, but later we found out that she had cancer and it jumped to the liver. So she was sick total 3 years.

JL: When she found out she was sick, did the doctor give her treatment?

⁷⁶ The gall of certain animals is reputed among ordinary people to have miraculous curative virtues. (Hoang et al. 1993, p. 149).

Duc: Yes, they do everything, chemo – she lose her hair – she can't stand because it was too strong. She would throw up all the medicine because she can't take it so it doesn't stay in her body.

This is illustrative of how biomedicine is viewed as being too strong for the body. The physical reaction that his sister had to the chemotherapy legitimizes and validates the assumptions that Duc and his family have about Western treatments, which are that they are too strong and hard on the body. Given the difficulties Duc's sister had with the treatment, I asked if they tried any type of Vietnamese medicines to treat her:

Yes! She do, I bought for her – expensive – over thousands dollars for her. She try to drink it but it doesn't help so we return it to them. I lose money on that. She drink it and twenty minutes after, same her body can't handle it. So she go to hospital and American take care of her and she pass away three days later...I stayed with her, take care of her for 6 months. I quit my job and move to California to stay with her, she okay. She's happy, she know – in a few days she know she can't stay longer [...] It was special medicine from there for the cancer. It is a friend send it to us... there is nothing here like that. You have to go to Vietnam to get it.

In the case of Duc's sister, the use of SVM was only sought out after the initial treatments with biomedicine had failed⁷⁷. Surgery and chemotherapy were chosen by their family to treat the cancer. This is reflective of utilizing biomedical services for acute illness as it is seen to be more effective and immediate. The initial operation had helped her and so it seemed that she would be alright. However, after 3 years, the chemotherapy hadn't worked so they turned to a

⁷⁷ Duc did not state if they had tried Vietnamese medicine in the early stages of her sickness so I cannot confirm if biomedicine is the first practice that was used to diagnose and treat his sister's illness.

Vietnamese remedy as a last resort. Her body's unwillingness to accept biomedical treatment led the family to turn to SVM, hopeful that because it is seen as milder and easier for the body that it would work. Unfortunately for Duc's sister, neither of these medical practices helped. Duc's case shows how decisions regarding treatment options are circumstantial and highlights how certain traditional beliefs regarding the body and its reactions with medicine are reified.

Say versus Do: Which Practices are Really Used

The following case of Lin demonstrates how, like Duc, different types of medical treatment are used for illness. Her case is noteworthy because she initially denies using any forms of SVM, and stated emphatically that her and her family have only used biomedicine since resettlement to Canada. However, Lin is, in fact, actually a firm believer of SVM and continues to use certain practices to treat illness in her family, and this came out during her interview. As such, in this particular interview I will draw closely on the inconsistencies in statements about use made by respondents.

Case Study: Lin - Epilepsy and the Treasured Rhinoceros Horn

Lin is a 65 year old woman, married with 4 children and 3 grandchildren. She and her husband are retired; they live comfortably and travel back to Vietnam one to three times a year to visit family. She arrived to Victoria in 1981 with her husband and their three young children. They were among the group of boat people who fled Vietnam after 1979 -when asked where her boat landed, she stated Victoria, B.C.⁷⁸ Lin has high blood pressure and has to take medication every day to treat this. She is not on any other medication and claims that she does not and has not used

⁷⁸ Lin is adamant that her boat landed directly in Victoria. This is interesting as all the boats leaving Vietnam would and could not make such a voyage, they would have first been placed in one of the refugee camps in Thailand, Malaysia, Singapore, Hong Kong, Indonesia or Philippines. Furthermore, all Vietnamese refugees entering Canada would have been processed in one of two staging cities in Montreal or Edmonton. When asked what refugee camp she was placed in she would change the subject continue to do so every time I tried to come back to confirm this statement.

any traditional medical practices since her arrival to Canada. That being said, she tries to lead a healthy lifestyle and believes in a balanced life and home. She has a lovely home that is furnished with accents of Vietnam, numerous plants that she says is the source of the positive and healthy energy of her house and those in it. She gets most of her information on health and medicine from the internet. She searches various Vietnamese forums and websites that provide information from day to day activities to food to politics. Lin is very politically engaged – she keeps up to date on the political status of Vietnam even today. The last twenty minutes of our interview, she talked about human rights and shared her sentiments on the Vietnamese government, past and present. Lin supports Vietnamese youth, and anti-communist organizations that want to create a better Vietnam and support the global Vietnamese community. That being said, Lin states that she and her family are not close to any members of the Vietnamese community here in Victoria. Although the Vietnamese community is fairly small she says that she does not associate with any of them and therefore does not know very much about the community. Her children on the other hand are well known in the community and participate in many of the community events that take place.

The claims that Lin made in the initial stages of the interview were that she and her family do not use SVM at all and have only used biomedicine since arriving to Canada. However, Lin's tone changes quite drastically throughout the interview and the numerous contradictions that arise indicate to me that she does indeed practice Vietnamese medicine, and to quite a large extent. When asked why she takes medication she tells a story of her mother-in-law and experience with SVM:

Lin: Yes, medication for my blood pressure, I have to take it every morning.

But I don't use Chinese medicine at all. For the 30 years I've been here...I

don't use the Chinese medicine, just my mother in law. She go to a Chinese lady, the lady she half Vietnamese and Chinese and she know my mother in law. One day she drink the medicine, the western medicine, and the next day after 24 hours she take the Chinese medicine and then she die.

JL: Really?? Did they know why?

Lin: That's what the doctor ask when she die. My father threw the whole thing in the garbage – you know the package – that's where I found it... I know one thing, I learn, in the internet every time; you have to be careful with the Chinese medicine because it makes thin the blood. Even the medicine here they tell you, you have operation or anything they tell you, you cannot take the Tylenol or Aspirin or anything because it makes thin the blood.

Here she highlights the fear and mistrust she has regarding the use of different types of medicine because of her mother-in-law's passing. She continues on to reiterate the lack of trust she has for traditional medicine.

Yah, you know the truth is because it's a long time ago everything is good, its honest like the root and everything. Long time ago we use in Vietnam, we believe it. But it is getting harder and harder to find the root and everything can be fake, it make people don't believe, lose faith because don't believe it is the real thing...And the truth is the Chinese don't tell you the truth! Even when they tell anything it is not the truth, everything is the fake unless you know them they will sell you the real one. If you don't know them, they sell you the fake one and in your mind you think you have a good one, in your mind, and you drink it and you feel better but only in your mind. I believed it a long time

ago, same thing as Vietnam they have real root that they use but not anymore. I don't believe, everything can be fake.

The aversion Lin has expressed towards any form of SVM is quite clear and is legitimated by the uncertainty of ingredients and the unfortunate passing of her mother in law. However, as our discussion continues she shares with me stories about her son and grandson and their experience with seizures. What is of particular interest in her case is that in both circumstances she has used traditional remedies to treat them, despite her earlier comments that she does not use SVM. Her son had a seizure when he was an infant and she talks of how she used a bear gallbladder mixture to treat this in Vietnam.

...my son, drink another one – the gallbladder – he had seizure when he was baby and he drink it, just a little bit, and he have no more... That time, I make I mix it with water because he was just a baby, 1-2 years old. So I dry out and I keep it. That is good for that one.

Here Lin attributes her son's well-being to the treatment of the gallbladder mixture that she administered. Her initial claim that she does not use any kind of SVM is further contradicted in the story of her grandson here in Victoria. Her grandson, her son's son, has had seizures since he was born: below she describes the experience and treatment of his condition.

My son had [seizures] when he was a baby and then his son, my grandson had seizure. When he was very little baby, one day he had two, he was just like that and so blue face and almost die. I was so scared, but couple years now it's gone. Now he's four years old.... My oldest son, he is over 40 years old now, and the [seizures] never come back! That's it, so he have one seizure when he was a baby and that's it; and my grandson he had some seizures too but I

scratched some of [rhino horn] and steamed it, I let him drink for two years and it fade away. Slowly...but we don't know which one because he had [Western biomedicine] too, that one is just like water, you steam it but suddenly he doesn't need the medicine no more. That's all.

JL: When it happened, did they take him to the doctor right away?

Lin: Yes, they take him and then they give him the medicine at home, you have to give it every day before he has a seizure, every day. Then my daughter-in-law slowly day by day stop giving it to him, then couple months, then year and it go away. She keep the medicine and then tell the doctor the truth and he said, oh if you don't need to refill it then throw it away. So now he is four years old.

JL: And no seizure?

Lin: No, so far that's all I know...Yah, that's why my daughter-in-law slowly cut it. If he have a seizure they give it to him immediately but they don't want to give him every day. Slowly, it's gone. If that one affects him, I don't know but now the seizures are gone, they're no more.

This is another example of Lin's contradiction regarding her use of medicine. In a further example, Lin's description and extensive use of the rhinoceros horn demonstrate that she is clearly an avid believer in Vietnamese traditional medicine, yet claims that she is not. When Lin talks about the rhinoceros horn that she has she expresses great emotion and belief in its efficacy:

And I have a real one in my hand but I don't bring it here though, I keep it in Vietnam. But when I go home (Vietnam) I scratch a bit and bring it back here for my kids. My older son drink a lot, but not for everyone. It's just certain sickness like the heart you know. Then that's it, it's nothing else but it is very

expensive⁷⁹ ...I leave in Vietnam. Used to be this long but just keep cutting and cutting and now we have just a little left. You just mash it or scratch it like a powder and you steam and drink it like water.

Although Lin cannot be sure if the rhinoceros horn is the reason her grandson's seizures have stopped, her descriptions show that she wants to believe it. By leaving it in Vietnam, the difficulty of access seemingly makes it that much more effective and promising as a cure.

In cases of Duc and Lin, the high cost and transportation required in acquiring SVM was striking. Although biomedical practices were used by Duc's and Lin's families, SVM was sought out from the home country. The high cost that each case mentions has been noted by some respondents as being a barrier to use in the previous chapter. Duc's case is illustrative of how expensive some treatments can actually be. The difficulty in access appears to add to the belief, and legitimizes the effectiveness of SVM for these respondents here. In the case of the rhinoceros horn Lin's descriptions seem to characterize it as a form of prestige medicine, her repetitive claim that she "has the real one (rhinoceros horn)" indicates a sense of pride that she and her family have this in their possession. Duc expressed personal satisfaction in his ability to have an herbal remedy sent in from Vietnam, specific to the type of cancer his sister had. Overall, the access to secondary sources of treatment was valued by both respondents. These two case studies have highlighted how belief and hope in certain medical practices influence decisions on treatments. There was an effortless consistency in the transition between SVM and biomedicine in the circumstances presented by both respondents.

⁷⁹ Rhinoceros horns are very controversial due to the excessive poaching, efforts are being made to stop the trade of rhinoceros horns and preserve the species (Still, 2003).

Why Do Vietnamese Refugees Use What They Use?

The two case studies discussed above have demonstrated a complex, and surprisingly fluid, system of medical practice. Each family utilized SVM and biomedicine to treat the serious illnesses of cancer and epileptic seizures. Their past experiences and knowledge influenced how they chose medical treatment. The two themes addressed in more detail here were first, the order in which medicines were used and second, the absence of conflict or blame on medicine that was not effective.

First, for both respondents, Vietnamese medicine seemed to come second to biomedicine. As both cases are responses to acute illness, biomedicine was chosen as the initial treatment due to its immediacy and presumed efficacy. The uses of Vietnamese medicine seemed to come as a last resort for both Duc and Lin's families. Although biomedicine was chosen at the outset to treat the illnesses, ultimately each turned to Vietnamese medicine in hopes for final treatment. Duc and Lin demonstrate that in such circumstances, even in the case of Lin's mother-in-law, that they ultimately sought comfort and treatment in the practice that they were more familiar with or felt competent in administering themselves. In Duc's case, the treatment he sought out for his sister was sent in from a close family friend so there was trust in where it came from and what it was. For Lin, the preparation and use of the rhinoceros horn as a treatment method for her grandson is something she is familiar with because she has done the same for her son in Vietnam. Duc and Lin exhibited pride in their ability to provide a secondary source of treatment for their loved ones. Overall, they were able to utilize treatments in Canada and from Vietnam that were not only difficult to get but also specifically tailored to the illnesses they needed to treat.

The second theme that arose in the discussions about this was that there was no conflict or blame towards either practice that was used. The apparent ease of availability of both SVM

and biomedicine suggested options in care for both Duc and Lin. There was a lack of animosity and anger in both cases. Neither Duc nor Lin blamed biomedicine or SVM for not working. For Duc, although his sister passed, the sentiment was that the family and physicians all tried their best efforts to cure her and it was just not meant to be. For Lin, the break in seizures in her grandson could not be identified as the result one specific treatment, “I don’t know [which] one affect him, I don’t know...but now the seizures are gone.” Lin’s grandson had been inundated with medications since birth for twenty-four consecutive months, and during that time she also provided him with the rhinoceros horn mixture. Although she credits her son’s successful treatment to the gallbladder mixture, she cannot be certain if the prescription medications or rhinoceros horn is what helped her grandson. The neutral response of both cases was surprising given the accelerated discussions regarding trust and efficacy by all respondents in the previous chapter. In the case of Duc’s sister, although she was not cured, neither he nor his family blamed the medical approaches that were taken. And Lin is just grateful that her grandson is free of seizures. Duc and Lin show in their experiences the subjective nature of medicine and the decisions that that they have made regarding treatment.

Assessment

This chapter highlighted the circumstances which call for particular forms of medical treatment and the reasons why respondents chose each type. The case studies demonstrate that the relationship between medicine and illness is not always so consistent. There are situations where biomedicine is seen to not work and cases where SVM is seen to not work. This syncretic approach to medicine demonstrated by resettled Vietnamese refugees shows they utilize different forms of treatment which they have knowledge of and access to. Furthermore, the beliefs and understanding that Vietnamese have regarding illness and treatment introduces a basis for

identifying a hierarchy of resort to curative practices. Duc and Lin's experiences demonstrate that "health-producing behaviours are not necessarily done with explicit links to health in mind; it is also of particular salience when considering that oftentimes health strategies are governed not only by traditional belief systems" (Lewis 2007, p. 147). In both cases they utilized what they knew, and had access to, in efforts to treat members of their families. Although on the surface it seems they have adapted to accept biomedicine as their primary source of care, there remains that underlying belief in the cultural traditions of healing that they grew up with.

Every single respondent identified with biomedical practices at the outset, answering in extremely scripted formats only to later identify more deeply with Vietnamese medical practices. The contradictions that Lin demonstrated as well as the shift in dialogue by each respondent throughout the interviews illustrates that resettled Vietnamese refugees feel that they need to publicly identify with a particular practice. I argue the reason this pattern occurs is because of their past experiences in refugee camps and in initial stages of socialization, as described in Chapter One, where they were obliged to accept and practice biomedicine. The effect of migration and resettlement into a new place and new culture brings with it many pressures. The need to fit in and adapt to particular cultural norms and practices is part of the process, so assuming certain norms are expected of you appears to be part of that process: "A social desirability bias may also have influenced the findings, in that immigrants who want to adapt may feel that it is necessary to believe in (or to state that they believe in) and use Western medicine" (Gellert et al. 1995, p. 98). Highlighting biomedicine as the primary, or sometimes only, practice that they use is part of the regimented, assumed cultural role that these refugees have adopted.

The assumption that Western physicians do not want to discuss the use of other practices with their refugee patients may also be a reason for hiding the use of SVM. This point is illustrated with the example of May. When I asked May if it was her physician who suggested she shouldn't use SVM she replies, "Uh...that's the way 'I' think. But when you are one way (have thyroid problem⁸⁰) the doctor checking for me many ways and its better." This statement illustrates her reluctance to speak to her physician about the use of SVM, because May has just assumed that her physician would advocate against the its use. The presumed negative response that May thought she would receive from her doctor has been cited as common by many refugees in their interactions with health care physicians, particularly regarding the use of more traditional practices in studies by Lewis (2007), Ngo-Meltzer (2003), and O'Callaghan and Quine (2007). This type of scripted response, arising from presumed medical norms will be explored further in the following chapter about self-perceived health status and the patient-physician relationship nearly thirty years after resettlement. The following chapter will show how certain images and perceptions of being "healthy" have been internalized and maintained, as well as how certain sociocultural barriers to care have been bridged.

⁸⁰ May has a thyroid condition so is on medication prescribed by her physician. She uses some herbal remedies and has done *cao giò* and *xong* in the past. She is extremely careful about what she uses and never mixes any remedies with her medications because she is unsure of the reactions or possible side effects.

Chapter Five: Language and Luck: The Projection of a “Healthy” Resettled Vietnamese Refugee

In the previous chapter a syncretic approach to medicine was shown among resettled Vietnamese refugees. This syncretic approach occurred within a broader sociocultural context, in which this navigation of medicinal use demonstrated that SVM and biomedicine are equally legitimate healing practices for contemporary refugees in Victoria, B.C. This chapter will elaborate further on changes in perceptions of health and medicine which occur after the resettlement process. Resettlement is, “the selection and transfer of refugees from a State in which they have sought protection to a third State that has agreed to admit them – as refugees – with permanent residence status.”⁸¹ First-generation Vietnamese refugees were relocated to Canada and my respondents then settled here in Victoria, B.C. This process of resettlement has influenced how they understand health and represent their health status in Canada today. While in the previous chapter the use of medicines was discussed, here I describe the conditions that shape how changes have occurred in the way resettled Vietnamese refugees understand and talk about their health status and the health care services they use in Canada.

In this chapter, I discuss two dominant themes so as to highlight changes that have occurred in perceptions of and access to health and medicine since resettlement in Victoria, B.C. nearly thirty years ago. The two themes identified are self-perceived health status and language. First, this chapter will explore how the forced migration and resettlement process has shaped refugees’ self-perceived health status. Second, it will discuss to what extent the acculturative process has influenced changes in sociocultural barriers to care, in particular English language

⁸¹ UNHCR <http://www.unhcr.org/4ac0873d6.html>

competence. This chapter will first show how resettled Vietnamese refugees' reported good health status is linked to their experiences at medical screenings during the forced migration process to Canada. I will show how my respondents have internalized particular cultural norms and ideas about what "healthy" is and how this image is maintained. Then I will explore English language competence as it seems to be one of the central factors that have bridged certain sociocultural barriers to care, specifically allowing for a satisfying and workable patient-physician relationship. The themes addressed will ultimately demonstrate that perceptions and projections of health among resettled Vietnamese refugees have changed since resettlement in Victoria, B.C.

Refugee Health Status in Canada

In each interview that was conducted, resettled Vietnamese refugees reported good health status since their arrival in Canada. Medicine was deemed unnecessary because of their presumed good health, most respondents said. They attribute their good health to their time living in Canada. Why is this so? How is this aging group of individuals so healthy, and why has this happened since their arrival in Canada? This is quite striking and particularly curious because past studies, such as Newbold and Danforth (2003) on immigrant and refugee populations, show a decline in health status with increased duration of residence in Canada. Dunn and Dyck have also found that, "...those who originated in Asia, Africa or South America were more likely to report poorer health, as were those immigrants who had been in Canada more than 10 years" (2000, p. 1582). A study by Dean (2010) of the immigrant community⁸² in the Greater Toronto Area (GTA) shows that although immigrants initially felt that their health had improved due to the environment here in Canada and because of easier access to resources,

⁸² Although this study has been done on the immigrant community and does not include refugees, I have used this study as comparison because long term immigrants do face some similar socio-cultural barriers to care and access to health services as refugees.

such as food and health services, their self-reported health status worsened after time. My findings seemingly contradict these studies. My respondents consistently said that they were in great health, particularly since their arrival in Canada.

As discussed in the previous chapter, the experiences of refugees have great impact on how they understand and utilize medicine. Their past experiences have also influenced how they define and present their health and wellbeing. The notion that sickness, or being ill, has social or cultural repercussions is not a far-fetched assumption to make as resettled Vietnamese refugees have experienced this firsthand. Their experiences in refugee camps created a specific identity, an identity where, “Southeast Asian refugees were constructed as carriers of exotic and mysterious diseases” (Ong 2003, p. 1245). To be a refugee meant being labeled as diseased and sick and therefore needing to be cleansed before being received in a host country. The intense screening processes were done to ensure that those who carried diseases, or who were not deemed appropriate for relocation or placement, knew that and knew why. As is thoroughly covered by Mortland (1987) and Ong (2003) in studies in the United States, refugees are screened and then re-socialized so as to learn how to maintain cleanliness and good health and be model citizens in their host country. Canada is no exception, Tan and Tan⁸³ emphasize that in the initial screening, “Vietnamese refugees should be viewed as non-immunized persons and complete immunization should be given. [...] Any vaccine given prior to arrival in Canada might well have been outdated or attenuated by the lack of proper storage” (1980, p. 407). These processes reinforce, “popular metaphors of warfare and machismo [that] help structure explanations...[W]hether in science or health education, these figures also ‘serve as a powerful patriarchal instrument by reinforcing assumptions about who gets sick or ill’ (Good 1994, p. 45).

⁸³ See Tan and Tan pages 407- 408 for proposed outline of tests required upon initial medical visit of recent Vietnamese refugees to Canada.

After having to endure such traumatic experiences of war, forced migration and then internment in refugee camps, the trauma of being a refugee is further exacerbated when initial reception to the host country begins with physicians assuming that refugees are diseased.⁸⁴ This is an example of how, “political and psychological meanings projected onto disease are...turned onto the sufferer” (Good 1994, p. 45). Therefore, it is not surprising that the projection of a particular image – one that is the farthest from a diseased refugee body – should appear here in my interviews given the constant assumptions made during their initial arrival. I argue the negative connotations of the refugee bodies have been internalized from the onset of their forced migration process through to their placement and resettlement in their host country. Therefore projecting an image of a healthy citizen could be presumed by resettled Vietnamese refugees to be one of the most important public displays to maintain.

Statements that my respondents made during the interviews shed light on political undertones influencing representations of health. This chapter will show how presentations of health status are reflective of deeper socio-political constructions which have been internalized by resettled Vietnamese refugees.

Self-perceived Health Status

As noted above, the respondents uniformly all reported in good health after nearly thirty years in Canada. This finding is interesting as it contradicts past studies on immigrant and refugee health status (Dean and Wilson, 2010; Dunn and Dyck, 2000; Newbold and Danforth, 2003). For example in their study, Newbold and Danforth found that among immigrants and refugees, “there is a near continuous decline in health status...with increasing duration of residence within Canada” (2003, p. 1985). Furthermore, “long-term immigrants reported a

⁸⁴ Erickson and Hoang provide a list of certain illnesses and infections that should be screened for among Vietnamese refugees arriving in the United States (1980, 1005).

decline in physical health status based on the natural processes in the life course, such as aging and child-bearing” (Dean and Wilson 2010, p. 1223). The average years of living in Canada for my respondents was 27.3, with a range from 17-33 years; that is nearly 30 years of living in Canada in which they claim they lived without falling sick.⁸⁵ Furthermore, my respondents range from 41-65 years old. This is an aging group and therefore some complications to health are bound to arise over time. How then, do resettled Vietnamese refugees perceive their health status and why conditions or experiences explain this?

“I don’t get sick, haven’t been sick since I got to Canada.”

A self-presentation of being a “healthy” person was consistently voiced in my interviews with resettled Vietnamese refugees. Respondents viewed the use of southern Vietnamese medicine (SVM) or biomedicine as unnecessary because they were very rarely, if ever, sick. Furthermore, the discussions about medicine were met with confusion primarily because they did not feel they were relevant. This was a dominant trend among all my respondents. Each person initially claimed that they were not sick at the outset of each interview and therefore felt that they did not ever need to use medicine.⁸⁶ For example, claims by my respondents such as these emphasize the idea of a “healthy refugee”:

I don’t use traditional medicine or any medicine really because I am not sick ever! I don’t get sick, haven’t been sick since I got to Canada. My family is very lucky. (Anh)

My husband and I don’t get sick very often because we are healthy [...] we don’t get sick very much so I don’t know [about medicine]. (Mary)

⁸⁵ This is aside from the occasional cold or headache that has been reported.

⁸⁶ These statements were all made at the beginning of the interviews. Discussions about the use of different types of medicines, and medical conditions that my respondents have (eg: thyroid problem, high blood pressure) that were discussed in the previous chapters come later in the interviews.

I'm not very much sick – I'm very strong! I am lucky! (Tracy)

Sentiments such as those above were common among all respondents; self-reported health status was basically excellent. None of my respondents seemed to ever get sick and so the use and discussions about medicine seemed irrelevant to them. What I would like to point out is that in the previous chapters it has been identified that May in fact has a thyroid problem, Lin has high blood pressure, and Kim and Mary have high sugar levels which places them at risk for diabetes. Although these individuals describe themselves as healthy they do have conditions that require them to take medications daily. The statements above about their healthy status and their luck were made near the beginning of the interviews and their conditions were only revealed later on. The contradictions in my respondents' narratives reinforce my previous chapter's discussion about scripted responses by refugees and the apparent necessity to present a healthy public image.

There are two issues which arise from this trend of excellent self-reported health status that will be discussed in the following section. The first is the place of Canada in their narrative of well-being. Both, Anh and Tracy both claim they haven't been sick since arrival to Canada. The second issue is the consistent use of the term "lucky" when respondents described their well-being. Both these trends suggest that the relocation to Canada is a key factor in why and how they reported a positive health status.

"Lucky" in Canada

The timing of these refugees' good health and the use of the term "lucky" are themes I explore particularly because of the individuals that I interviewed. Given my respondents' refugee status the term "lucky" may have much more bearing than simply being free of a cold or flu. The sentiments that were shared above are quite telling. For example Anh's statement extended to

her family as a whole and that leads me to posit that her feelings extend past issues of health. These refugees are living in Canada not by choice; they have had to flee their home country due to the socio-political conditions that put their lives at risk. The use of the term “lucky” could be seen as representative of how my respondents feel in an overall general sense; that they are lucky to be in Canada. Each respondent spoke highly of the comfort and ease of access to resources that are not available in Vietnam, particularly with regards to health and medicine. A study by Donnelly et al. on Vietnamese women in Canada reveals similar feelings:

Although these Vietnamese...lived with a very restricted income and encountered many difficulties because of language and culture differences, they were very glad to be living in Canada. The emotional burdens, stress and limitations...was relieved, in part, when compared with their present living conditions, with life prior to migration, and with what they imagined their lives would be if they were living in Vietnam (2009, p. 462).

The comparison of life in Canada to what could have been in Vietnam is a particular point respondents touched on. In regards to health care May prefers being in Canada because of the options that are available to her and the level of care that is provided. She makes a sad and angry comparison of this to her family in Vietnam:

In Vietnam you have no choice. My family in Vietnam they have no choice...
[in Vietnam] it's not right.

Her sentiments are shared by Kim below.

The Canadian, they are very exact, very careful. If you're sick they always take the time and send you to blood tests. They don't give you medication right away until they find out what is wrong with you. My mom is 82 years old and she has

diabetes, if she was in Vietnam she may die. But she lives here and she has a good doctor who gives her medicine for diabetes so she is OK.

Kim's comparison shows that she is aware that if her mom was still in Vietnam, she may not be here today and for that she is grateful. Duc elaborates further on the difficulty of being sick in Vietnam as compared to Canada:

If you get sick and have to go to the hospital or have an operation it's very expensive and the government does not take care of it. You have to pay 100%. If you have or bought [health] insurance in Vietnam, or if you're really poor you can get some discount. Some people don't have money so they die. In Canada it doesn't matter if you have no money, you don't have to worry if you're poor, [Medical Services Plan⁸⁷] will take care of it. You don't have to worry about how you pay like in Vietnam.

The gratitude that Donnelly et al.'s respondents expressed is illustrated in the discussions of health services by my respondents. Although it would initially seem that my results contradict studies such as Dean and Wilson (2010), Dunn and Dyck (2000), and Newbold and Danforth (2003), regarding the poor health status of refugees, deeper analysis of the past socio-political experiences of resettlement shows otherwise. In the larger picture, it would seem that whatever health problems these resettled Vietnamese refugees may have, they are in circumstances where they can be treated with ease and therefore complaints may not feel warranted when compared to conditions back in Vietnam. Furthermore, as discussed above, there is a certain public image that resettled Vietnamese refugees have internalized and therefore feel they are required to maintain.

The claims made by resettled Vietnamese refugees that they were healthy were all made during the initial stages of the interview process. The answers were given when they were still

⁸⁷ Medical Services Plan (MSP) is the health care provided in British Columbia (B.C.), Canada.

suspicious about who I was and why I wanted to discuss matters of health and medicine. In this particular context, the statements highlight the political nature of the discussion of health status for my respondents. Unsure of who I was and who I worked for their immediate responses were very specific and regimented statements about health status and medicine. Furthermore, their claims of good health were all made leading into, or following, discussions of their prominent use of biomedicine. This suggests that for resettled Vietnamese refugees good health is directly correlated with the use of a particular medical system, the biomedical system. Their answers and the context under which they provided them are reflective of how they feel the need to present a particular image and understanding of health.

The ability of resettled Vietnamese refugees to discuss their health status as they do shows that they have acquired a deeper understanding, or knowledge, of what health and medicine means for them in Canada. The socio-cultural skills that were consistently demonstrated by my respondents show that they have adapted particular qualities which have aided in reducing previous barriers to care. The following section describes how certain barriers to care have been bridged.

Changing Barriers to Care

Previous literature on patient-physician relationships with refugees has indicated that language and cultural barriers were often the sources of discontent and misunderstanding in care situations (D'Avanzo, 1992; Gellert, 1995; Hoang and Erickson, 1985; Ito, 1999; Ngo-Meltzer, 2003). These barriers resulted in a lack of communication and often misinformation about available services or treatments, which led to a low level of usage of Canadian health care. As Stephenson's study highlighted, "many physicians serving the Vietnamese felt that their patients underutilized the available system" (1995, p. 1640). This is often due to the limited English

language skills that refugees have which makes it difficult to communicate or understand information. This process can be fairly intimidating and many refugees do not want to go through that experience. Cultural and linguistic barriers are further aggravated when refugees do not have a primary care physician. Asanin and Wilson's study on immigrants in Ontario indicated that on top of the geographic, sociocultural and economic barriers to health care there was also lack of access to a primary care physician. This study found that, "although the shortage of physicians is a barrier that affects all residents of Canada, the impacts on accessibility may be accentuated among immigrant populations" (2008, p. 1279). This finding is supported by Newbold and McKeary, "while services catering to refugees have been created 'by demand' within [Hamilton, Ontario], a lack of appropriate services remains...leaving many refugees...lacking access to individual family physicians" (2010, p. 533). Although these studies may still be relevant for new refugees they do not seem to apply to my study of resettled Vietnamese refugees.

The above mentioned barriers are not present for my respondents. My results show resettled Vietnamese refugees demonstrate ease in accessing health care services, medicine, and a primary care provider. This trend of increased ease of clinical use could be due to several factors, such as dispersal of health information, increased English language competence and physician's cultural respect and understanding. In terms of access to health information, in cities with larger refugee populations, information on health services are made readily available for ethnic populations in their respective languages. For example, Woodall's (2006) study of Vietnamese American men in Seattle found that Vietnamese newspapers/magazines⁸⁸ and

⁸⁸ Vietnamese magazines and newspapers are fairly widely distributed among Vietnamese communities in Canada and the United States.

Vietnamese radio⁸⁹ were reported as main sources for health information. In Vancouver, B.C. Vietnamese magazines and the newspapers *Thời Báo* and *Vina Báo*⁹⁰ are printed weekly which contain daily news stories, adverts, etc. Although these resources are not printed in Victoria, these magazines and newspapers are either picked up and brought here or sent over from family or friends regularly. In terms of accessing health services, my respondents arrived to Canada between 1980 and 1996 when services were put in place specifically to aid the incoming Vietnamese refugees. Lin speaks to the help her and her family received when they first arrived to Victoria in 1981:

At that time we have a lot of help. There was Emily, who was half Chinese and half Vietnamese. She worked in the government. They helped the refugees coming and they translate and they help us go to the doctor and she helped me choose a doctor.

Lin's case is demonstrative of the resources that were in place to support the community's needs⁹¹ during their initial resettlement.

Furthermore the cultural barriers that were apparent thirty years ago are no longer present to the same degree. Resettled Vietnamese refugees have demonstrated their ability to adapt to certain Canadian cultural norms, primarily through language. My respondents also highlighted how their health care physicians have also become more aware of and recognize Vietnamese cultural traits. As Gushulak et al. states "the linguistic and cultural needs of many immigrant communities have been recognized by health practitioners working with new immigrants, and

⁸⁹ Donnelly and McKellin's study on Vietnamese refugees in Canada also found that for more than eight years, a group of Vietnamese women have been volunteering their time to broadcast a radio program specifically to provide healthcare information to members of the community (2007, 7-8).

⁹⁰ *Thời Báo* and *Vina Báo* are Vietnamese newspapers that are published in Canada and the United States. *Thời Báo* is also available online at www.thoibao.com.

⁹¹ With Victoria, B.C. being a fairly small-sized city access to particular resources is much easier given the smaller community.

the amount of health information available in different languages and alternative media has grown” (2011, p. E956). These positive changes in health care access and services are clearly expressed by my respondents. For example, when I asked Kim if she discussed practices such as *xong* (steaming) or *cao giò* (coining) with her physician she replied:

At the beginning, yes. She think I get bruised⁹² when I first came to Canada but now it's better. You see...they do it here now. They OK now, at the beginning they say it is strange and black, so no good right, but now I explain and they OK. They say if I feel good then OK because nothing wrong right? They can see it, I'm OK. Now, more Chinese, more Vietnamese, more Asians come to Canada now...they know that now, it's a traditional medicine.

Kim's account shows how discussions about certain medical practices with her physician have helped in terms of knowledge sharing and learning to understand different healing systems.

Another issue that has been highlighted in previous studies is the inability to find a primary care provider among refugee groups. This problem was not noted among resettled Vietnamese refugees in Victoria, B.C. All of my respondents stated that it was quite easy to find a family physician when they arrived.⁹³ That being said, May does acknowledge that it is harder now to find a doctor, and so she assisted her friend in finding a new physician when hers retired:

Before when I first came here it was easy. My family helped me and introduced me to their doctor and it was easy to do. A couple of years ago now are very hard. If your family doctor retires now they don't send you to another doctor. You have to find one on your own, like the girl who was just here, her

⁹² Studies in the past such as Golden (1977) and Yeatman and Dang (1980) have shown that bruising from *cao giò* treatment was suspected as abuse against children and other family members.

⁹³ This does not speak to the quality of care that the physicians provide; that is beyond the scope of this thesis and research.

doctor retire and she can't find a doctor so I asked my doctor, said I have a friend like that and he said bring her here so she is lucky. A year she had to wait!

Each of my respondents has a Canadian family physician which they have had for many years now, some since their arrival to Victoria. Below, respondents discuss the relationships with their physicians and the ease of interactions, primarily focusing on language⁹⁴. I will note that there are no Vietnamese physicians⁹⁵ in Victoria⁹⁶, however all respondents did claim they would prefer to see a Vietnamese doctor if there was one in the area. Although there are no Vietnamese physicians in Victoria, this was not a problem for resettled Vietnamese refugees given their improved competence in English language. My respondents prided themselves in their ability to speak and understand English better than they did when they first arrived as a primary factor for improved relations with their physicians.

“He doesn't speak Vietnamese but that's okay because I speak English!”

One of the most striking findings in this research was the linguistic competence of my respondents⁹⁷. Gellert (1995) and D'Avanzo (1992) found that among Vietnamese Americans language remains a barrier to health care. Stephenson's study on the Vietnamese community in Victoria in 1995 found that, “all additional problems associated with cultural misunderstanding were found to be rooted in the failure to communicate accurately, and meaningfully, through

⁹⁴ Although there are other factors that may attribute to the improved patient-physician relationship, language is the most common theme and factor discussed among my respondents. Further study into changes in sociocultural barriers to care would provide more insight into this aspect of the research findings.

⁹⁵ When I say Vietnamese physicians/doctors as my respondents have, I mean physicians of Vietnamese ethnic background who practice biomedicine, not Vietnamese physicians that practice traditional Vietnamese medicine.

⁹⁶ Mary is the one respondent that resides in Vancouver and she states that “there are no Vietnamese doctors here.” To my knowledge there are Vietnamese physicians in Vancouver that practice biomedicine so I am not sure why she has made this statement or if she truly believes that there are none in Vancouver. Her later comment suggesting that she is not close to the Vietnamese community in Vancouver could be why she is unaware of this; however this is just my speculation.

⁹⁷ I acknowledge that because each of my respondents were competent in English this may have created a bias and cannot be used to generalize or represent the greater Vietnamese refugee population here in Victoria

language” (p. 1636). This is supported by Gellert’s data which indicates that, “language ability per se may not be as critical to effective and satisfactory utilization of health care as the ability to communicate, which may be related more to organizational and cultural issues than linguistic problems per se” (1995, p. 97). My findings show that these “organizational and cultural issues” have been overcome to a certain degree by Vietnamese refugees here in Victoria. My respondents state that relations with their physicians are no longer as difficult because of improved language skills, and I would add to that because of a mutual cultural understanding by both parties. These findings indicate an improvement between refugee patients and physicians and it would seem that the sociocultural divide has been somewhat bridged among my respondents.

When Anh speaks of her doctor below she notes that her improved English skills are what help in making the process easier:

He is a Canadian doctor. There are no Vietnamese doctors here I don’t think?

He is a good doctor and is helpful. He doesn’t speak Vietnamese but that’s okay because I speak English!

Her views are shared by Tracy and Mary below when asked if they had Canadian or Vietnamese physicians.

My family doctor? He’s a Canadian doctor. No, no translator. I can speak English. If I don’t understand he can talk slowly, slowly and I understand [...]
 Yes, the doctor is very good. He is so nice. He is good at listening and helping me understand [...] He doesn’t know Vietnamese but he is a good doctor. He talks slow so I can understand. (Tracy)

Yes...he is a Canadian doctor; there are no Vietnamese doctors here. I've had a Canadian doctor since I came here, my kids have a Canadian doctor [...] He's good. He knows us better now so I think it is easier, and we know English more too now. If there were more Vietnamese doctors I think it is better but there isn't much. (Mary)

I would like to note that in each of these three cases it is the improved English language skills of the respondents that are seen as the key factor for improved patient-physician relations⁹⁸. They illustrate that it is the refugee respondent that has adapted to the Canadian medical culture (language and practice); it is the refugee that has had to learn English to discuss their health matters with physicians, not the other way around. Their statements indicate that they are proud that their English language skills have improved and attribute their good relations with their physicians to this. What is also worth mentioning is that all respondents stated that their physicians are very helpful and make an effort to ensure that they understand what is being discussed. This is reflected in Tracy's statement that her doctor speaks slower so that she can understand better.⁹⁹ This is reflective of how physicians are more aware of the difficulties that refugee groups face in terms of language. The trust and assurance that my respondents highlighted in a previous chapter is fitting here; the comfort that they feel with their physicians indicate that past barriers are no longer present to the same degree and highlight how changes have taken place both by the Vietnamese refugee community and health care providers. Improved English language skills seem to have had an impact on respondents' confidence in

⁹⁸ One respondent did note after her physician retired she was not comfortable with his replacement and when the opportunity arose, she chose a female physician and now feels much more comfortable.

⁹⁹ Although I cannot speak to the experiences of the health care providers with Vietnamese refugees now as it compares to thirty years ago because it is out of the scope of this study, it would be beneficial to both parties and to the improvement of the health care system to see how the patient-physician relationship has changed for the physicians as well.

discussing matters of health and medicine with their physicians, resulting in a better patient-physician relationship and more importantly mutual understanding between them.

Assessment

The results above have indicated that there are many factors that influence how health status is understood and represented by refugee respondents. The ways in which resettled Vietnamese refugees have presented their health status show to what degree the forced migration and acculturation processes impact, not only their perceptions of health and medicine, but also their lives in general. The themes of language discussed here show that health and medicine is not just about health and medicine, particularly for refugees. There are underlying issues from past experiences that are consistently reflected in how health and medicine are discussed, understood and represented. More importantly, this chapter shows that changes in perceptions of health status as well as in health care access and services have occurred following resettlement.

This chapter demonstrates how deeply internalized certain aspects of the forced migration and resettlement process is, and how it shapes how refugees talk about their health status. The scripted responses that I discuss here are a recurring theme in all my chapters. The experiences in the refugee camp and the identification of refugee body as ‘diseased and sick’ still resonates for these individuals today. My respondents’ adamant and consistent claims that they are not sick or unhealthy suggested to me that they do not want to be viewed as they were nearly thirty years ago; they wanted to change that social perception. Furthermore, the timing in which my respondents became ‘healthy’ individuals was conveniently noted as when they arrived to Canada. The opinion that medicine is only for those who are ill is illuminated here in the politically charged representation of the refugee body. My respondents demonstrated in their use of the term “lucky” in relation with resettlement in Canada that good health is perceived to be

associated with life in Canada and therefore should be publicly displayed. My respondents have shown that this image is one that must be presented and constantly maintained.

My results have indicated that resettled Vietnamese refugee seemed to be more accommodating in terms of learning English and moulding to biomedical practices. Socio-cultural barriers seemed to be bridged to a certain degree because of this and therefore are no longer as explicit. Furthermore, their overall self-rated health status was good which presents a new perspective on the long term health of resettled refugees. Overall, my respondents seemed satisfied with the relationship with their physicians. The ease through which resettled Vietnamese refugees are able to access health services here in Victoria show that cultural changes, and maybe changes to the health care system, have occurred since they have arrived. The recording of accounts and discussion of results in this chapter has presented new data on perceptions of health status and services of the Vietnamese refugee community here in Victoria, BC. The changes observed in my research in 2012 contrasts past literature on the topics discussed, it presents changes that have taken place among the Vietnamese refugee community and their health care providers. Foremost among these changes have been the reported self-perceived health status and the bridging of certain sociocultural barriers to care among resettled Vietnamese refugees and their physicians.

Chapter Six: Conclusions and Recommendations

What do the Medical Practices of Resettled Vietnamese Refugees Mean?

At the beginning of this project I set out to find out what Vietnamese medicine is and what it means to resettled Vietnamese refugees today in Victoria, B.C. I found very limited literature on traditional Vietnamese medicine, and hoped my respondents could provide more detailed information. I had expected resettled Vietnamese refugees to be able to pass on knowledge about Vietnamese healing systems relating to causation and treatment and I also expected to find scores of recipes for different remedies which I could then catalogue and return to the local community. As my field research progressed however, it became quite apparent that this knowledge was not known by my respondents. The lack of scholarly literature on Vietnamese medicine was mirrored by resettled Vietnamese refugees' limited knowledge. Clear distinctions and definitions about what Vietnamese medicine was, proved in general difficult to come by. Given the profile of my respondents, I had expected that they would have retained knowledge about SVM practices; the absence of this was unanticipated and deserves further exploration. Moreover, there were constant contradictions about the definitions and use of medicines. What I found, was that the identification of medicine, both southern Vietnamese medicine and biomedicine, revealed underlying socio-political issues that seemed to be consequences of the forced migration and resettlement process experienced by resettled Vietnamese refugees.

The study of how medicine is understood and used among resettled Vietnamese refugees provided a critical analysis of how respondent identities are shaped and represented. Resettled Vietnamese refugees demonstrated a sophisticated ability to navigate between complex healing systems and medical practices. The care in how my respondents presented themselves, their

understanding of medicines, and their use of medicines reflected underlying socio-political issues. The scripted responses that each respondent provided during the initial stages of the interviews showed that they felt that a medicine should be presented and represented in a certain way. Resettled Vietnamese refugees illustrated how subjective medicine can be and how past and present day experiences continually shape every day practice. The ways in which my respondents understand and respond to illness and medicine varied greatly. This thesis has shown that the subjective nature of medicine is underscored with socio-political definitions and identities that have been placed on the refugee body. Resettled Vietnamese refugees have internalized definitions about medicine and themselves as “refugees,” and their specific claims and representations about medicine show that they have a particular identity they are trying to maintain.

Summary of Findings

This thesis has shown that the past refugee experience of forced migration and resettlement has impacted how medicine is used and understood. My respondents have shown the complexities of medicine and the changes that have taken place over the course of resettlement in Victoria, B.C. over the past thirty years. This thesis has shown that a traditional classification of medicine and its practices among refugees is insufficient because of the changing socio-cultural environments and the political nature of the resettlement process.

In Chapter Three I showed that traditional Vietnamese medicine (TVM) is a recognized healing system. It is distinguishable in the scholarly literature from other medical systems such as traditional Chinese medicine, Ayurveda, and Biomedicine. The chapter demonstrated that although traditional Vietnamese medicine is recognized by resettled Vietnamese refugees it is not fully understood. Furthermore, particular reference was made to Southern Vietnamese

medicine (SVM), one distinction within TVM, as the practice that resettled Vietnamese refugees identified with. The limited scope of my respondents' understanding of the practice was due in part to the lack of knowledge transfer upon arrival and resettlement to Canada. Furthermore the increased use and promotion of biomedicine in Canada raised concerns of trust and efficacy in practicing Southern Vietnamese medicine. The lack of knowledge and comparison to biomedical practice resulted in resettled Vietnamese refugees defining Southern Vietnamese medicine by what they felt it was not rather than what it actually is. Southern Vietnamese medicine, although recognized, proved to be extremely complex and difficult to define.

In Chapter Four, I showed that the use of different medical systems is extremely complex and contingent upon circumstance. Medical syncretism was shown to be fairly common practice among resettled Vietnamese refugees in Victoria, B.C. The use of a particular healing system varied depending on the illness, and where necessary travel or transport of remedies took place. This chapter highlighted the syncretic use of medicine for refugees; it demonstrated that previous claims of opposition or conflict between different healing and medical systems were not present. Rather, resettled Vietnamese refugees have demonstrated that the practice of medicine is negotiable and dependent upon various social and cultural perspectives of illness and healing.

In Chapter Five, I showed that changes have taken place among the resettled Vietnamese refugee community regarding health care in Victoria, B.C. Sociocultural barriers that were apparent upon first arrival to Canada are no longer present to the same degree. Improved English language skills, on part of the refugee community, and mutual cultural understanding between refugee patient and their physicians has bridged previous barriers to health care access and services. Furthermore, resettled Vietnamese refugees' comparisons of health services in Canada to services in Vietnam have shown a degree of gratitude for the services and

conveniences available to them now. This gratitude was reflected in the self-perceived health status of resettled Vietnamese refugees. Rather than complain about their illnesses, all respondents reported good health since arrival to Canada. This finding proved to have deeper socio-political implications about the refugee body, in particular how important a “healthy” public image is perceived by refugees for sociocultural acceptance and integration.

Overall, the findings in this research demonstrate that although traditional Vietnamese medicine is recognized in the scholarly literature and among respondents, there is a surprisingly low level of retained knowledge among resettled Vietnamese refugees. Furthermore, the level to which sociocultural and political experiences still impact respondents’ lives, not just their understanding of health and medicine, nearly thirty years after resettlement was striking. My respondents have demonstrated that they have adapted to certain sociocultural changes which proved to be beneficial in terms of health care access, however there are still underlying issues that need to be addressed regarding the implications of long-term resettlement for refugees.

Contribution to Knowledge

This research has provided an updated contribution about how resettled Vietnamese Canadian refugees understand medicine. This study is the first to explore aspects of Vietnamese medicine in Canada. This research provides data on Southern Vietnamese medicine as practiced by resettled Vietnamese refugees nearly thirty decades after resettlement to Victoria, B.C. In addition, it contributes to the scholarly literature on Vietnamese medicine as well as to the general literature on traditional healing systems. Furthermore, it can be viewed as a follow-up to a previous study on the local Vietnamese refugee community by Peter Stephenson in 1995.

In a broader sense, this study has contributed insights into the relationship between resettled Vietnamese refugees and their medicines after long term resettlement. This study raises

the possibility that similar practices and perceptions about health and medicine could be found among other resettled refugee groups. It introduces potential implications for other refugee groups regarding long term impacts on socio-cultural, political and personal issues surrounding resettlement. In particular, this thesis suggests that other refugee groups in Canada may experience perpetual concerns of trust and feel the need to demonstrate certain cultural norms regarding health and medicine... Outside of Canada, general patterns from this study such as the lack of traditional medical knowledge transfer, syncretic approaches to medicine and bridging of cultural and linguistic barriers to care might also be found among other long term resettled refugees. This thesis also provides new knowledge for physicians and health care professionals regarding long term refugee health practices that can be used towards their work with new and resettled refugees. In a broader sense this study has contributed insights into the relationship between resettled Vietnamese refugees and their medicines after long term resettlement.

Limitations of the Study

There are a number of limitations to this study. First, the sample size was small, which may limit the extent to which the results of this study can be generalized to the larger Vietnamese refugee population. Furthermore, the majority of respondents were women so the perspectives presented may not reflect the perspectives of men in the community. Second, only respondents who were competent in English language participated in this study. Resettled Vietnamese refugees who did not speak English could not be reached or did not want to participate. Third, this study did not include interviews with representatives of Canadian health care system used by resettled Vietnamese refugees and therefore in-depth accounts and insights on physician care and services are not part of the source materials.

Recommendations for Future Research

There are several aspects of the practice of medicine among resettled Vietnamese refugees that can be further explored in future research. First, this study has only provided a general description of what traditional Vietnamese medicine is, from the scholarly literature. Future research could be conducted among larger resettled Vietnamese refugee communities to gather recipes and knowledge which could be catalogued for Vietnamese communities in Canada. That research could provide a comparison against the historical works which cite hundreds of Vietnamese remedies. This would allow future researchers an in-depth look what practices have been preserved or transformed over the course of time and migration.

Second, while my discussions primarily focused on the identification and utilization of Southern Vietnamese medicine, there were more issues that influenced how my respondents viewed and understood medicine that were beyond the scope of this thesis. Future research should aim to conduct longitudinal studies on resettled immigrant and refugee communities to compare past and present experiences with the Canadian health care system. For Anh et al. (2006) Donnelly (2006, 2007), McKeary and Newbold (2010), and Stephenson (1995) have provided substantial data on the health practices of Vietnamese refugee communities in Canada, follow-up research on these communities would be beneficial to understanding how perceptions and practices of medicine change after long term resettlement. Discussing past and present experiences with health care services and physicians in Canada would provide a greater picture of what socio-cultural and political changes have taken place for refugees within the health care system. Longitudinal research on refugee communities would provide new knowledge and a better understanding about the long term sociocultural impacts of migration and resettlement.

Lastly, this study was conducted using primarily female respondents so cannot be generalized to the reflect perspectives of male Vietnamese refugees in this community. A study

directed towards the health practices and perspectives of men would provide data which could be used to supplement these findings and see if there are differences in practice. These recommendations are only reflective of some of the aspects of medicine and health care that affect the lives of refugees.

Personal Reflection

In conducting this research, my understanding of the complexities of medicine and health was heightened. I feel that I gained a better understanding of what the impact of forced migration and resettlement can have, not only on an individual's perceptions of medicine, but also on their larger social, cultural, and political lives. Although resettled Vietnamese refugees migrated to Canada nearly thirty years ago the members of this community are still affected by the conditions of their past.

The knowledge and awareness that I gained through this research project has led me to view the forced migration and resettlement process in a different light. When I began this project, I felt that the implications of forced migration and resettlement were primarily negative. My respondents have shown me that although there are underlying issues that can never truly be expunged; there are also positive changes that have been made towards personal and social health and well-being. This research has shown me how resettled Vietnamese refugees have used medicine as a tool for bridging the gap between their past and present day lives.

In sum, this research project has demonstrated that medicine is highly subjective for resettled Vietnamese refugees. In particular, in this population there are clear political undertones that impact how medicines are used, understood, and represented, as substantiated in the accounts of my respondents. Resettled Vietnamese refugees demonstrated some particular ways where in, medicine is an extremely complex domain and is not just limited to issues concerning

health and wellbeing. Medicine, in this context, is a marker for identity, personal and cultural history, as well as past and present socio-political conditions for resettled Vietnamese refugees in Victoria, B.C.

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Appendix A

Interview Questions

- 1) Could you please state your name just for record keeping purposes? Your name will not be used in the research.
- 2) What is your profession/what do you do for work?
- 3) Where were you born?
 - i) Can you tell me about when you came to Canada?
 - ii) Who did you come here with?
- 4) Where do you first live when you arrived to Canada?
 - i) How often did you move before settling here?
 - ii) How long have you lived on the island?
 - iii) Can you tell me about settling down on the island? What happened on your arrival here?
- 5) Where does your have family live?
 - i) What family do you have here? (Names of family members are not required, this is general question pertaining to size of family and relation in terms of resettlement)
 - ii) Who did you come here with/settle here with?
- 6) Do you live on your own? How close in proximity to your siblings/children?
- 7) What languages do/can you speak?
 - i) What language did you speak at home/growing up?
 - ii) What language do your children speak?
 - iii) In what language do you communicate with your children/family? Friends? Co-workers?
- 8) Could you describe your life in terms of sickness and health?
- 9) How would define “well-being” in your own words?
 - i) What do you do to stay healthy?
 - ii) What does that mean for you?
- 10) When you think about your identity, how does health, medicine, wellness relate?
- 11) Could you tell me about the last time you were sick?
 - i) Could you tell me about how you felt? What did you do you do about it?
- 12) Are you familiar with “traditional” medicine?
 - i) Is there another name for ‘traditional medicine’? What is it called in Vietnamese? In Chinese?
 - ii) What does it include?
 - iii) How would you define holistic medicine?

- iv) Where can you get the ingredients?
- 13) Could you tell me about your first experience with traditional medicine?
- i) Can you tell me about the last time you used it?
 - ii) What was it for?
 - iii) How would you describe the quality of care? Can you give an example of personal experience?
- 14) Can you recall your first experience with western medicine/health care? How was it?
- i) Could you tell me about your last visit to the doctor office?
 - ii) What was it for?
 - iii) How did you feel about the visit? The doctor/clinic?
 - iv) How often do you go to the clinic?
 - v) Does anyone accompany you to the clinic?
- 15) What language do you speak to your physician?
- i) Does he/she talk about holistic medicine?
 - ii) Do you know what he practices?
 - iii) Could you tell me about your experiences speaking with him/her about health and medicine?
- 16) How do you feel about the Canadian health care system?
- i) Is it easy to access?
 - ii) How would you describe the quality of care? Can you give an example of personal experience?
- 17) What would you go to the clinic for? How come?
- 18) How do you compare holistic medicine to “western” medicine?
- i) Do you see any differences in terms of costs?
 - ii) What sort of differences are there in quality and care?
- 19) How does your spouse/family feel about holistic medicines?
- i) Does your family use these methods too?
 - ii) Where do you think your community stands on your use of holistic medicine?
- 20) How do you think your physician feels about holistic medicine?
- i) Does he/she know what it is? What it is used for?
 - ii) Do you know if they have tried it?
- 21) Have you been back to Vietnam recently?
- i) How do you keep in touch with your family there?
- 22) Do you have any questions for me?
- 23) Is there anything you would like to discuss further?**