

Promoting Cultural Sensitivity

A Practical Guide for Tuberculosis Programs That Provide Services to Persons from Vietnam



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION



*Suc khoe la vang.
“Health is gold.”
–Vietnamese Proverb*

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A newborn sleeps next to his mother
at the Tinh Gia District Health Center.
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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION**

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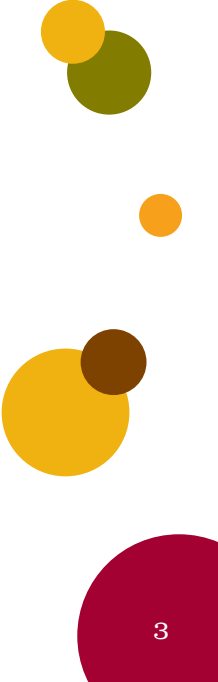
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Introduction

Promoting Cultural Sensitivity: A Practical Guide for Tuberculosis Programs That Provide Services to Persons from Vietnam is one guide in a series that aims to help tuberculosis (TB) program staff provide culturally competent TB care to some of our highest priority foreign-born populations. Other guides in the series focus on persons from China, Mexico, Somalia, and Laos.

Intended Audience

This guide is intended for health care providers, community-based workers, program planners, administrators, health educators, and resettlement agencies that work with Vietnamese communities. This guide is designed to increase the knowledge and cultural sensitivity of health care providers, program planners, and any others serving persons from Vietnam. The ultimate aim is to foster culturally competent TB care and services for Vietnamese in the United States.

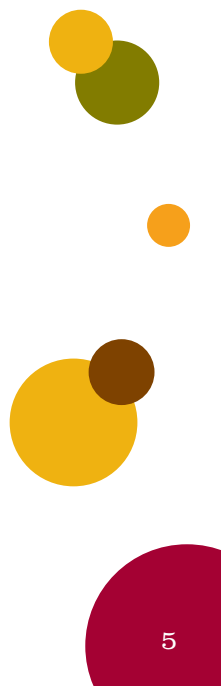
About the Guides

Each guide in this series includes the following:

- A two-page summary of program tips.
- Chapters on history and immigration; culture; health issues; and common perceptions, attitudes, and beliefs about TB.
- A concluding summary.
- Appendices, including additional resources for working with TB patients and interpreters.
- Useful resources.
- References.

Some of the information in the guides, such as the practical tips, can be applied directly, while other sections are more informative and will help providers better understand the background and sociocultural context of the population. A deeper understanding of pertinent issues will heighten the cultural sensitivity of TB care providers, enhance communication, and improve the overall effectiveness of organizations and staff in cross-cultural settings.

The content of these guides was gathered in two ways. First, an in-depth review of TB-related epidemiologic, behavioral, and ethnographic literature on Vietnamese in the United States was performed. Secondly, in 2003, the Division of Tuberculosis Elimination (DTBE) at the Centers for Disease Control and Prevention (CDC) undertook a qualitative study to describe ethnographic aspects of the increasing burden of TB among five foreign-born populations. Selected major findings from this study are presented in each of the guides.





How to Use This Guide

- The tips section at the front of the guide provides a summary of practical suggestions, which are also interspersed throughout the guide in textboxes. Keep these tips readily accessible and refer to them as often as necessary.
- The chapters on history, immigration, and cultural issues (Chapters 1 and 2) provide important background information on the cultural group. Depending on your needs and interests, you will want to read in depth or skim.
- Chapter 3 begins with “Health Statistics at a Glance,” which highlights TB and related health issues. The remainder of the chapter expands upon this information. If you provide direct health services, you may wish to read this section in depth.
- Chapter 4 contains findings from the CDC study on common TB perceptions, attitudes, and beliefs. If you work directly with TB patients, you will want to read this section thoroughly.
- Appendix A presents a set of questions that can be used to elicit a patient’s understanding or perception of his or her own health problems. You may wish to use these questions or slightly modified questions to begin a conversation with a new TB patient.
- Appendix B provides suggestions for working with interpreters. Refer to these suggestions when working with people with limited English proficiency.
- Appendix C provides a list of resources for both patients and providers. These resources include culture-specific educational materials and fact sheets. Use them to enhance communication with patients of different cultures.
- Refer to the other appendices as needed.

Background

Worldwide, tuberculosis (TB) is one of the most deadly infectious diseases. Although it is curable and preventable, TB claims the lives of more than 5,000 people every day (nearly 2 million deaths per year) (World Health Organization [WHO], 2006c). TB disproportionately affects poor and marginalized groups of society who are often at higher risk for TB, both around the world and in the United States (Dubos & Dubos, 1952; Mitnick, Furin, Henry, & Ross, 1998; Sepkowitz, 2001).

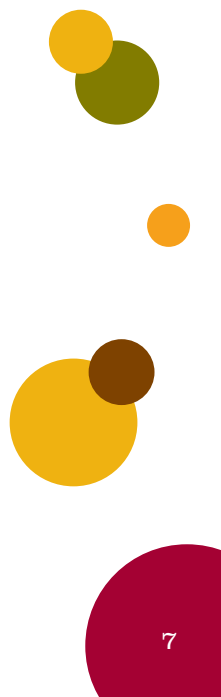
Domestically, the number of TB cases has decreased steadily since 1992, but this reduction has not affected all populations equally. In 2005, the TB case rate among foreign-born persons was almost nine times that of persons born in the United States (21.9/100,000 compared with 2.5/100,000). The same year, 55% of all TB cases in the United States were among foreign-born persons (Centers for Disease Control and Prevention [CDC], 2006d). Most cases among this group result from reactivation of latent TB infection (LTBI) acquired in countries of birth with high TB prevalence (Zuber, McKenna, Binkin, Onorato, & Castro, 1997).

The high incidence of TB in the United States among foreign-born persons poses challenges to public health programs across the country (CDC, 2006d). Although disparities between U.S.-born and foreign-born TB patients are caused by multiple factors, persons born outside the United States often face challenges related to personal or cultural beliefs, behaviors, and needs when accessing TB services. Attempts to control TB in foreign-born populations have sometimes been hindered by cultural and linguistic barriers, as well as by challenges related to resettlement, employment, and socioeconomic position. Understanding these issues is crucial to the prevention and control of TB among foreign-born populations.

Cultural Competency in Tuberculosis Service Delivery

Cultural competence is an essential element of quality health care and can help improve health outcomes, increase clinic efficiency, and produce greater patient satisfaction (Brach & Fraser, 2000). Although there is no universally accepted definition of cultural competence, it may generally be understood to be a set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations. Furthermore, it reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices, and communication patterns of patients and their families in order to improve services, strengthen programs, increase community participation, and close the gaps in health status among diverse population groups (U.S. Office of Minority Health, 2006). Linguistically appropriate services are a key component of culturally competent health systems. In 2001, the U.S. Office of Minority Health issued Culturally and Linguistically Appropriate Service (CLAS) standards to help health care organizations move toward cultural competence (see Appendix C). Several of these standards are federal mandates supported by Title VI of the Civil Rights Act (1964), which prohibits discrimination on the basis of national origin and language. In summary, these standards aim to ensure that all federally funded health facilities provide services in a language understood by patients.

To move towards cultural competence, health care providers and other program staff should understand the ethnic and cultural needs of the populations they serve. Providing effective care involves taking the time to learn from patients what is important to them in the experience of illness and treatment. According to medical anthropologist Arthur Kleinman, finding out “what is at stake” for the individual will provide crucial information to use in communication and in tailoring a treatment plan (Kleinman & Benson, 2006). Culture does matter in the clinic, and providers must remember that they too bring a cultural perspective to the patient-provider relationship. Increasing staff knowledge of the cultural and ethnic backgrounds of populations served is one important aspect of the CLAS standards.





Considerations When Using This Guide

Although the information in this publication was gathered from many sources, it will not apply to all Vietnamese in the United States. Vietnamese culture, as all others, is dynamic. Cultural perspectives may vary depending upon a person's age, sex, education, social class, or degree of acculturation. To ensure that TB services are both sensitive and appropriate, users of this guide are encouraged to use an approach grounded in an understanding of the cultural background of those served, while also appreciating each patient's individuality and uniqueness.

Further, providers must also recognize their own beliefs and biases, as these may inadvertently be communicated to patients and families. Awareness of one's own verbal and nonverbal communication styles will help avoid social gaffes that may offend others and adversely affect the relationship. Good patient-provider relationships are built on trust and respect; therefore, providers wishing to care effectively for their patients should heighten their sensitivities to both differences and similarities and use knowledge to guide their practice (Lipson & Dibble, 2005).

Clarification of Terms

In 2000, the U.S. Census instituted a change to the race category in which Asian Americans and Pacific Islanders were included. This change divided the "Asian/Pacific Islander" (API) category into two separate groups: "Asians" and "Native Hawaiian or Other Pacific Islanders." "Asian" is used to refer to people having origins in the Far East, Southeast Asia, or Indian Subcontinent (Grieco & Cassidy, 2001). Despite this change and the implications for collecting group-specific health data, much of the health statistics literature continues to use the overarching category API. As a result, the terms API and Asian are used throughout this guide as they are in the original source.

Tips for Providing Culturally Competent Tuberculosis Services to Persons from Vietnam

Below are practical suggestions presented in *Promoting Cultural Sensitivity: A Practical Guide for Tuberculosis Programs That Provide Services to Persons from Vietnam*. These tips are intended for tuberculosis (TB) program staff, including program planners, managers, and providers who work with persons from Vietnam. For additional background and resources, please consult the full version of the guide.

Interactions with Vietnamese Patients and Family Members

- To meet the needs of Vietnamese patients and comply with national standards in health care, provide materials and services in Vietnamese, including interpretation services by bilingual staff or phone interpreters.
- In Vietnamese culture, the traditional family is valued highly, and elders are greatly respected. To show respect, address elderly patients and family members with a slight bow of the head.

Communication Styles

- To foster a personable relationship, ask the patient for the correct pronunciation of his or her name.
- When speaking to a patient, avoid using medical jargon. Use simple terms and phrases.
- To avoid confrontation or signaling disrespect, Vietnamese may not express disagreement. Do not assume that nodding or responding “yes” to questions means that a person agrees or understands. It may mean that a person is listening or wants to show respect to the speaker.
- To elicit a patient’s understanding of diagnosis, treatment, or other health issues, avoid asking “yes or no” questions; instead, ask open-ended questions that call for more than a simple one-word response.
- To confirm understanding, have patients repeat back information in their own words.
- Vietnamese convey respect and other traditional values through nonverbal gestures such as gentle bows, smiles, nods, and avoiding direct eye contact. Be aware of physical gestures that may be offensive, such as winking, beckoning someone with the index finger, placing hands on hips while speaking, patting a person’s back, pointing to other people while talking, or touching a person’s head.
- Before performing a clinical examination, inform the patient of your intention and seek permission before making physical contact. Ask female patients if they would prefer to have a female family member or friend present during an examination or consultation.

Mental Health

- Carefully inquire about symptoms that may signal a psychological problem. Assure the patient that psychological concerns are not uncommon among people who have had similar experiences.
- Emphasize that consultation and treatment for mental health concerns are available.
- Consider using a holistic approach to address health concerns with physical and psychological symptoms.

Tuberculosis Symptoms, Transmission, and Prevention

- So that information can be tailored appropriately, ask questions to understand the patient's ideas about TB symptoms, transmission, and prevention. Recognize that a two-way exchange of information offers an opportunity to understand the patient's preconceptions, dispel inaccurate notions, and highlight pertinent messages.
- Address concerns and confusion about the differences between TB disease and LTBI. Clarify that a person with LTBI does not need to be isolated and cannot spread TB germs.
- Provide education about sources of TB risk, emphasizing that risk is increased by spending time in places where TB is prevalent, and not by personal hygiene.

Social Stigma

- Some Vietnamese consider TB to be a highly stigmatizing disease that would result in rejection and ostracism. To allay fears, emphasize the need for only short-term isolation during active TB treatment.
- When promoting TB services, emphasize confidentiality. Ensure privacy by conducting consultations in private settings.

Tuberculosis Diagnosis and Treatment

- Some Vietnamese attribute illness to hot or cold body imbalances and view Western medications as hot. Ask about traditional medicines or herbs, changes in diet and nutrition, or other practices used to counterbalance the hot TB medicines. When appropriate, discuss ways to incorporate traditional remedies into treatment.
- Emphasize that services and treatment for TB are free and that other TB-related services, such as LTBI medicines and chest X-rays, are often free or offered at reduced cost at health departments.
- Some Vietnamese may have difficulty remembering to take TB medications. Aid patients in developing a reminder system that might involve a family member or friend or other measures, such as keeping pill bottles next to a toothbrush, refrigerator, or car keys, but safely out of reach of children.
- Vietnamese may discontinue Western medications if symptoms are lacking, or they may self-adjust to smaller dosages because of the belief that Western medicine is too potent. Emphasize the importance of taking medications as prescribed, even if symptoms abate.
- Extend clinic hours to include Saturdays or one or two weekday evenings.

Tuberculosis Education and Outreach

- When possible, provide TB information in an oral or written format that is appropriate to the age, literacy level, and preferences of the patient.
- To increase awareness of TB programs and resources, conduct community presentations, publish articles in local newspapers and magazines, or sponsor public service announcements on local television and radio stations.

Chapter 1. Vietnamese History and Immigration to the United States

Vietnamese Geography and History

Vietnam is located on the eastern rim of the Indochina peninsula in Southeast Asia and is bordered by China to the north, Laos and Cambodia to the west, and the Pacific Ocean to the south and east. Major cities include the capital city of Hanoi, Ho Chi Minh City (formerly Saigon), Hai Phong, and Da Nang. About 75% of Vietnam's 82.1 million people reside in rural areas (General Statistics Office of Vietnam, 2005; U.S. Department of State, 2006). Vietnam's population is approximately 90% ethnic Vietnamese and 10% minority groups, such as ethnic Chinese, Montagnards (also known as "mountain people"), Khmer Krom (Cambodians), Cham, Hmong, and Thai (U.S. Department of State, 2006).



Vietnam's history is marked by foreign invasions and civil warfare. The first known invaders, the Chinese, ruled Vietnam for over 1000 years, from 111 BCE–939 CE. During this time, Vietnam absorbed many of China's philosophies, including Buddhism, Confucianism, and Taoism (Gold, 1992b; Hunt, 2002). In the early 1500s, Western explorers, including the Portuguese, Dutch, and English, arrived in Vietnam and established trade offices (Gold, 1992b). The French arrived in 1858 and by 1885 had conquered the entire country, ruling for the next 60 years. In 1945, Japan invaded Vietnam. With the French out of power, Vietnamese communist leader Ho Chi Minh was able to declare independence (Hunt, 2002). However, the French refused to relinquish control of Vietnam until 1954, when the communist-led Viet Minh (later renamed the Viet Cong) defeated them at Dien Bien Phu. Vietnam then split into the communist North and the nationalist South (anti-communist Vietnamese who sided with the French).

In 1955, South Vietnam declared itself the Republic of Vietnam, and in 1961, the South Vietnamese requested help with a Viet Cong uprising. In response, the United States sent military advisors then troops to fight in what became the Vietnam War (Hunt, 2002; U.S. Department of State, 2006). During 1969–1973, peace talks were held in Paris where the Paris Peace Accords were signed by North and South Vietnamese leaders. On April 30, 1975, the communist North gained control over South Vietnam and reunified the country to form the Socialist Republic of Vietnam. Warfare continued into the late 1970s and early 1980s over border conflicts with Cambodia and China (Gold, 1992b; Hunt, 2002; U.S. Department of State, 2006).

As a result of weak governmental infrastructure, poor agricultural production, and reduced aid from the Soviet Union, Vietnam faced economic ruin in the late 1980s. To promote economic growth, Vietnam adopted capitalism to allow private enterprise and foreign investment. In the 1990s, Vietnam became one of the fastest growing economies in the world (Hunt, 2002). In 1994, the United States ended its 19-year trade embargo against Vietnam and in 1995 resumed full diplomatic relations (U.S. Department of State, 2006; Wright, 2005). In 2001, the Vietnamese reaffirmed their

commitment to economic liberalization and international integration by becoming a member in the Association of Southeast Asian Nations Free Trade Area and by entering into a trade agreement with the United States (Central Intelligence Agency, 2005; Wright, 2005). In January 2007, Vietnam became the 150th member of the World Trade Organization (World Trade Organization, 2006).

Immigration and Resettlement to the United States

Since the fall of Saigon in 1975, hundreds of thousands of Vietnamese have fled to various countries to escape war and persecution and possible loss of life (Nowak, 1998). Three distinct waves of Vietnamese have entered the United States: the 1975-era refugees; the “boat people;” and lastly, minority groups, including Amerasians and ethnic Chinese-Vietnamese (Gold, 1992b).

First Wave

The first wave of Vietnamese refugees, numbering about 175,000, entered the United States during 1975–1977. This group was mostly U.S. military and government employees; members of the South Vietnamese military and government; and educated, urban professionals and their families (Gold, 1992b; Hunt, 2002). Many spoke English, were familiar with American culture, and adjusted rapidly to the United States (Gold, 1992b).

Second Wave

Vietnamese refugees who arrived in 1978 were known as “boat people,” because they fled by boat to refugee camps in Thailand, Malaysia, Indochina, the Philippines, and Hong Kong (Hunt, 2002). Typically, they were less educated and from rural areas and included farmers, fishermen, and soldiers. Many were attacked by pirates and military forces, and roughly half died. Survivors eventually entered the United States, but were disadvantaged by a lack of education and English-language ability. As a result, this wave has had more difficulty adapting to the West (Gold, 1992b).

Third Wave

A third wave of Vietnamese, primarily immigrants but also refugees, continues to arrive in the United States (Niedzwiecki & Duong, 2004; U.S. Department of State, U.S. Department of Homeland Security, & U.S. Department of Health and Human Services, 2006). They include Amerasians (often offspring of Vietnamese women and U.S. soldiers), political prisoners (former South Vietnamese government workers, military personnel, and intellectuals sent to “reeducation camps”), and ethnic Chinese-Vietnamese (an entrepreneurial class of Chinese living in Vietnam) (Gold, 1992b; Hunt, 2002). The Chinese-Vietnamese, in particular, are similar to the boat people in that their adjustment to the United States has been slower (Gold, 1992b). In 2001, according to the Southeast Asian Resource Action Center, 25,180 Vietnamese immigrants settled in the United States (Niedzwiecki & Duong, 2004). The same year, 3,108 Vietnamese refugees and Amerasians were resettled in the United States (U.S. Office of Refugee Resettlement, 2001).

Overall, hundreds of thousands of Vietnamese have relocated to the United States, most settling in southern California; Texas; Pennsylvania; Minnesota; Massachusetts; New York; Illinois; Washington state; and Washington, DC (Hunt, 2002). Many are at high risk for having infectious diseases such as TB, hepatitis B, and parasitism. Over time, they may develop higher risks for chronic diseases, including hypertension, heart disease, cancer, and diabetes (LaBorde, 1996; Lee, 2003). Mental health issues, such as post-traumatic stress disorder, depression, anxiety, psychosis, and adjustment reactions, are also common. Because mental illness is highly stigmatized and rarely discussed in the Vietnamese culture, mental illness may manifest as somatic complaints (LaBorde, 1996).

Chapter 2. Overview of Vietnamese Culture

This chapter provides an overview of Vietnamese culture in terms of language, literacy, socioeconomic position, social structure, family, gender, religion, communication styles, traditional health care beliefs and practices, and health care-seeking behaviors. Readers are cautioned to avoid stereotyping Vietnamese on the basis of these broad generalizations. Vietnamese culture, as all others, is dynamic and expressed in various ways, owing to individual life experience and personality. Some Vietnamese living in the United States may be more or less acculturated to mainstream U.S. culture.

Language and Literacy

The official language in Vietnam is Vietnamese, which has Thai, Khmer, and Chinese influences. In the 20th century, the French introduced the Romanized script, which replaced Chinese characters and indigenous phonetic script (U.S. Department of State, 2006). Other languages spoken in Vietnam include English, French, Chinese, Khmer, and mountain-area languages (U.S. Department of State, 2006).

The Vietnamese language has three mutually intelligible dialects: Northern, Central, and Southern. The dialects often vary in tone and pronunciation. For example, the Vietnamese word *day* (meaning “to teach”) is pronounced “zigh” (as in “high”) in the Northern dialect and “yigh” in the Southern dialect. Although most Vietnamese in the United States come from South Vietnam and speak the same dialect as interpreters, challenges may arise. Differing pronunciations can convey slightly different nuances. In addition, though Vietnamese words may be spelled alike, their meaning depends on the accent. Vietnamese vowels have six tones, five of which are indicated by an accent mark above or below the vowel. For an unaccented vowel, the voice remains unchanged (Tung, 1998). Table 2-1 provides an example of six meanings for one spelling, depending upon the vowel tone. Refer to Appendix E for a glossary of Vietnamese terms and phrases.



Farmers in An Giang Province prepare for the new harvest.
© 2006 Le Thai Son. Courtesy of Photoshare.

Table 2-1. Tones in the Vietnamese language*

Tone	Vietnamese word	Accent mark	Word meaning
No tone	ma		Ghost
Raising	má	ˊ	Mother
Falling	mà	ˋ	That
Questioning	mả	ˆ	Tomb
Falling then raising	mã	ˊˋ	Horse
Weighing	mạ	˘	New rice plant

* From Vietnamese Online, n.d.

In Vietnamese culture, education is valued highly. In 2002, Vietnam's literacy rate was 91% (Hunt, 2002; U.S. Department of State, 2006). According to the U.S. Census Bureau (2000), 95% of Vietnamese spoke a language besides English in the home. Furthermore, 30% reported they spoke English "very well."

Suggestion



- To meet the needs of Vietnamese patients and comply with national standards in health care, provide materials and services in Vietnamese, including interpretation services by bilingual staff or phone interpreters.
- Because most Vietnamese come from South Vietnam, interpreters and patients will likely speak the same dialect. However, be aware that challenges can arise when interpreting different dialects.

Socioeconomic Position in the United States

The first wave of Vietnamese, mostly educated professionals and former military personnel, experienced fewer difficulties adapting to life in the United States compared with the "boat people" who followed. During the 1980s, many Vietnamese refugees experienced high levels of poverty, unemployment, and welfare dependency (Gold, 1992b). According to the U.S. Census Bureau (2000), 7% of Vietnamese families had an annual income less than \$10,000, while the median income (\$47,000) was closer to that of the general U.S. population (\$50,000). About 14% (compared with 9.2% among the general U.S. population) of Vietnamese families lived below the 1999 poverty line. In addition, Vietnamese were less likely to have finished high school: 61% were high school graduates or higher compared with 80.4% of the general U.S. population.



A man transports pigs on his motor scooter near Hanoi.
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A newborn is weighed prior to vaccination at a communal health center in Ha Tinh Province.

© 2004 Philippe Blanc. Courtesy of Photoshare.

Social Structure, Family, and Gender

Among the Vietnamese, family is valued highly and plays a central role in the culture. The family is often extended and includes married sons and daughters-in-law, unmarried adult daughters, and grandchildren (Gold, 1992b; Healy, 1997; Nowak, 1998). In 2000, the average Vietnamese household in the United States was 3.7 persons (Reeves & Bennett, 2004). Traditional family structure is patriarchal, with the eldest male as the decision maker and family spokesman. Within traditional Vietnamese families, husbands make

decisions on issues outside the home, while wives care for the home and make family health care decisions (Healy, 1997; Nowak, 1998). Elders are highly respected and honored, and children are expected to obey them (Lindsay, Narayan, & Rea, 1998). Obligations are met and decisions are made based on the common good, usually under the guidance of the eldest male (Gold, 1992b). Generally, individualism is discouraged in favor of family responsibilities that promote interdependence, belonging, and support (Nowak, 1998).

As the Vietnamese assimilated to the United States, gender roles in Vietnamese families slowly reversed. Because of the availability of jobs in Western society, women gained economic independence outside the home (Fox, 1991). In addition, children could become interpreters for their families because of their ability to speak English and their familiarity with American customs (Nowak, 2005). Women and children who adapt to Western society more quickly than men can increase their authority in the family and thus rise in position (Gold, 1992b; Nowak, 1998). These role changes can leave men and older family members feeling alienated and without the respect and honor to which they are culturally accustomed (Gold, 1992b; Nowak, 1998).

Suggestion



- Address elderly patients and family members with a slight bow of the head to show respect.
- Be aware that some health care decisions may be made on a collective basis and under the guidance of an elder male.
- When speaking to a patient, avoid using medical jargon. Use simple terms and phrases.



The Huc Bridge to the Ngoc Son Temple. Hanoi is cloaked with heavy smog even at noon.

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2006). Christianity, mainly Catholicism, is practiced in Southern Vietnam. Islam is practiced by the Cham communities in the Central Coastal Plain and the Mekong Delta, and Hinduism is practiced by Indian communities in Ho Chi Minh City (U.S. Department of State, 2006). Two newer indigenous religions practiced mainly in the South, Hoa Hao and Cao Dai, incorporate teachings from Buddhism, Christianity, and Confucianism (Hunt, 2002). In the United States, about one-third of Vietnamese are Catholics and the remainder are Buddhist (Nowak, 2005).

Religion

The Vietnamese have diverse religious beliefs that influence their way of life, including decisions concerning health care and end-of-life issues (McLaughlin & Braun, 1998). Most Vietnamese practice Buddhism, which posits that people live a virtuous life by suppressing personal desire. Other beliefs may include elements of ancestor worship, animism, and the philosophical principles of Confucianism and Taoism that emphasize the importance of family life, social virtues, and harmony (Hunt, 2002; McLaughlin & Braun, 1998; U.S. Department of State,



A street vendor in Halong wears a face mask to block air pollution.

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Communication Styles

Communication styles can reflect Vietnamese cultural values, and these values may influence how Vietnamese interact and communicate with one another and with people from different cultures, including health care providers. Effective verbal and nonverbal communication can influence positively the quality of the health care-seeking experience as well as treatment acceptance and adherence, just as ineffective communication can negatively affect the quality of care. Providers should treat patients as individuals and avoid making assumptions about patients on the basis of certain characteristics or places of origin. Even providers and patients who speak Vietnamese may not necessarily share the same cultural values or communication styles.

Verbal Communication

Formality, respect, and interpersonal harmony are cultural values evident in verbal communication among Vietnamese. To avoid confrontation or signs of disrespect, especially with persons of higher status, Vietnamese may not express disagreement. Instead, they may not answer a question directly, or they may remain silent (LaBorde, 1996). Though Vietnamese

may nod and use the word “yes” or “ya” to show respect and convey that they are listening, this does not necessarily indicate understanding or agreement (Stauffer, 1995). Misunderstanding nonverbal cues to questions about diagnosis and treatment has been mistakenly linked with treatment noncompliance (Hunt, 2002; Lindsay et al., 1998).

Suggestion



- Do not assume that nodding or responding “yes” to questions means that a person agrees or understands. It may mean that a person is listening or wants to show respect to the speaker.
- To elicit a patient’s understanding of diagnosis, treatment, or other health issues, avoid asking “yes or no” questions; instead, ask open-ended questions that call for more than a simple one-word response.

Nonverbal Communication

Vietnamese convey respect and other traditional values through nonverbal gestures such as gentle bows, smiles, nods, and by avoiding direct eye contact. Vietnamese are taught at an early age to avoid eye contact, especially with older people and those of higher status (Hunt, 2002; Lindsay et al., 1998). Some gestures that Vietnamese may view as inappropriate or offensive include winking (especially when directed at the opposite sex), beckoning someone with the index finger, placing hands in pockets or on hips while talking, patting a person’s back, and pointing to other people while talking (Hunt, 2002).

Vietnamese seldom use touch as a means of communication, especially with elderly people, members of the opposite sex, and those of higher status. Additionally, it is considered disrespectful to touch a person’s head, which is regarded as a sacred part of the body. Only elders may touch the head of a child (LaBorde, 1996). Unless absolutely necessary, male health care providers should avoid touching female patients and, even then, only in the presence of a female friend or relative (Nowak, 2005).

Suggestion



- Before performing a clinical examination, inform the patient of your intention and seek permission before making physical contact.
- Ask female patients if they would prefer to have a female family member or friend present during an examination or consultation.
- To confirm understanding, have patients repeat back information in their own words.

Naming Conventions

Vietnamese names consist of a family (last), a middle, and a given name, in that order. For example, if the name is Nguyễn Thị Lan, Nguyễn is the last name, Thị is the middle name, and Lan is the person's given name (Nowak, 2005). In a health care setting, it would be appropriate and respectful to address this female by using a title (Mrs. or Miss) before her last name, Nguyễn. Within their families, Vietnamese use different forms of address, depending on a person's age, sex, maternal or paternal lineage, and marital status. Also, Vietnamese use different terms to address relatives and strangers.

Suggestion



- To foster a personable relationship, ask the patient for the correct pronunciation of his or her name.
- Be aware of physical gestures that may be offensive, such as winking, beckoning someone with the index finger, placing hands on hips while speaking, patting a person's back, pointing to other people while talking, or touching a person's head.



Housing on the Vietnam-China border.
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Traditional Health Beliefs and Practices

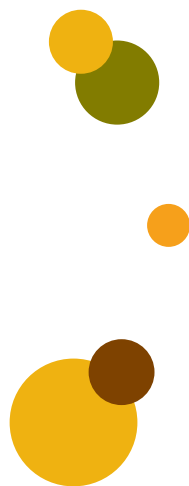
Vietnamese may attribute illness to spiritual causes, disruption of balance and harmony, biomedical causes as defined by Western medicine, or to any combination of these. Supernatural or spiritual causes include curses, sorcery, or violations of religious or moral principles (LaBorde, 1996). In addition, illness may be seen as punishment for offending a god, spirit, or demon (Nowak, 1998). For illnesses thought to have a spiritual or supernatural cause, Vietnamese may seek assistance from traditional practitioners or Buddhist monks (Hunt, 2002).

Some Vietnamese consider illness the result of an imbalance within a person's body of two opposing forces, âm (cold, dark, female) and dương (hot, light, male). Illnesses, foods, medications, and herbs are classified as either hot or cold (though the concepts do not refer to temperature), and good health results from a balance between the two. Cold foods include tea, water, rice, flour, potatoes, most fruits and vegetables, fish, duck, and plants that grow in water. Hot foods include fish sauce, eggs, spices, peppers, onions, sweets, coffee, ice, and most meats (Nowak, 2005). Fever, ulcers, and infections are usually deemed hot, but some febrile illnesses are considered cold (Stauffer, 1995; Thai, 2003). In general, Western medicines are considered hot, and traditional (e.g., Chinese) herbs, cold (Stauffer, 1995). To restore balance, people may change their diet, use Western or traditional medicines or practices, or try a combination of approaches (Hunt, 2002; Nowak, 1998; Thai, 2003).

The following are examples of traditional practices and medications (Hunt, 2002; Nowak, 1998, 2005).

- **Coining (Cạo Gió):** Literally meaning “rubbing out the wind,” this practice is used to restore balance by releasing the excess force (wind) from the body. Ointments or mentholated oils are rubbed across the skin (usually the back, chest, or shoulders) with the edge of a coin. The firm strokes bring blood under the skin and result in mild dermabrasion. This technique is used to treat colds, sore throats, flu, sinusitis, and similar ailments.
- **Cupping (Giác):** Used to relieve stress, headaches, and joint and muscle pain, cupping involves pressing small, heated glasses against the skin to draw unwanted hot energy through the skin into the cup. This technique leaves red marks similar to large bruises.
- **Pinching (Bắt Gió):** Pinching is thought to release force from the body and is used to treat headaches or sore throats. Pinching often results in dermabrasion on the treated area.
- **Steaming (Xông):** The steam from a boiled mixture of medicinal herbs is either inhaled or used for bathing and is most often used to relieve motion sickness or cold-related problems.
- **Balm:** Medicated balms or oils are rubbed on the body to relieve muscle ache, skin rashes, small abrasions, cold, and flu.
- **Acupuncture:** Specialized practitioners insert small needles into vital energy points of the body that correspond to specific organs. This practice is used for healing or to restore balance and increase energy flow.
- **Acupressure or massage:** Similar to acupuncture, vital energy points are stimulated by pressing or massaging to maximize their therapeutic effects.
- **Herbs:** Medicinal herbs are boiled in water or mixed with wine and consumed to restore balance and to treat a variety of maladies.
- **Packaged medicines:** These herbal medicines come in a variety of traditionally prepared pills or liquids and are taken for prescribed ailments.

Vietnamese may also explain illness using Western concepts and use Western medicines, such as antibiotics, to treat illnesses or relieve symptoms. However, the concept of preventive medicine is not generally recognized, especially if a condition is not accompanied by symptoms. If symptoms are lacking, Vietnamese may discontinue Western medications or self-adjust to smaller dosages because Western medications are believed to be extremely potent (Lindsay et al., 1998; S. J. McPhee, 2002).



Health Care-seeking Behaviors

In Vietnam, people often consult one or more traditional practitioners to alleviate illness. Traditional practitioners include spiritual healers, physicians who employ herbal medication and acupuncture, informal folk healers who use natural and pragmatic approaches such as special herbs and diets, and magicians or sorcerers (Nowak, 1998). In the United States, Vietnamese may use a combination of traditional and Western health care practices.



People in the highlands attend a health communication program.
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Some Vietnamese, especially new arrivals, may treat illness with self-care, self-medication, and herbal medicines. Some may choose traditional and natural remedies because of affordability and seek Western health care services only if traditional methods fail (Healy, 1997; LaBorde, 1996; Nowak, 1998, 2005). Other research has shown that the use of traditional methods could also be associated with living in rural areas prior to immigration rather than length of time in the United States. People from rural areas in Vietnam have had less exposure to Western medicine than people from urban areas and therefore may distrust Western medicine (LaBorde, 1996; Queensland Health, 2003).

Suggestion



- Some Vietnamese attribute illness to hot or cold body imbalances and view Western medications as hot. Ask about traditional medicines or herbs, changes in diet and nutrition, or other practices used to counterbalance the hot TB medicines.
- When appropriate, discuss ways to incorporate traditional remedies into treatment.
- Emphasize the importance of taking medications as prescribed, even if symptoms abate.

Chapter 3. The Health of the Vietnamese

Health Statistics at a Glance

Tuberculosis

In Vietnam

- In 2004, tuberculosis (TB) incidence in Vietnam was 176 per 100,000 (WHO, 2006a).
- An estimated 22,000 TB-related deaths occur annually in Vietnam (Do, Huong, Tawfik, & Church-Balin, 2004; WHO, 2004, 2005b).

In the United States

- In 2005, 8% of TB cases among foreign-born persons in the United States occurred in persons from Vietnam (CDC, 2006d).

HIV/AIDS

- In 2005, Vietnam reported an estimated 263,000 HIV infections and 13,000 AIDS deaths (WHO, 2006b).
- In Vietnam, the HIV epidemic is based largely on injection drug use and sexual transmission (Joint United Nations Programme on HIV/AIDS, 2005).

Substance Use

- Southeast Asians (including Vietnamese) have considerably higher cigarette smoking rates than other Asian populations (American Lung Association, 2006).
- Among the Vietnamese, men are much more likely to smoke than women (U.S. Department of Health and Human Services, 1998).

Diabetes Mellitus

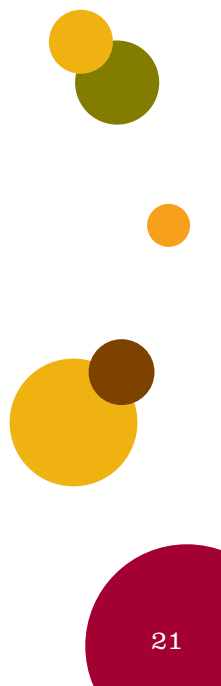
- Due to changes in lifestyle, diet, and physical activity, the risk of developing diabetes increases significantly for Asians who immigrate to the United States (Fushimoto, 1995).

End-stage Renal Disease

- In the United States, Asians are almost twice as likely to have end-stage renal disease (ESRD) as non-Hispanic whites (Karter et al., 2002).
- New ESRD cases are increasing at a rate of 11% per year for Asian/Pacific Islanders (APIs) compared with 6% per year for non-Hispanic whites (U.S. Department of Health and Human Services, 2000).

Cancer

- In 2001, APIs showed a higher incidence (2.5 per 100,000) of nasopharyngeal cancer than all other racial groups (Yee, 2005).



Tuberculosis Among the Vietnamese

In Vietnam

In 2004, Vietnam's TB burden was ranked the 13th highest worldwide (WHO, 2006a). The estimated TB incidence in Vietnam is 176 cases per 100,000; the estimated percentage of new multidrug-resistant TB cases (resistant to at least isoniazid and rifampin) is 2.3 (WHO, 2006a). Although 98% of the population receives a Bacille Calmette-Guérin (BCG) vaccination at birth, an estimated 22,000 TB-related deaths occur annually (Do et al., 2004; WHO, 2004, 2005a). In 1995, Vietnam implemented directly observed treatment short-course (DOTS) for TB control and achieved nationwide DOTS coverage in 1999. In addition, Vietnam detected 82% of the estimated number of new infectious TB cases during 1997–2002 and cured 89% of those cases (Do et al., 2004).

In the United States

In the United States during 1995–2005, people from Vietnam had the third largest percentage of TB diagnoses among foreign-born persons, after people from Mexico and the Philippines (CDC, 2006d). In 2005, diagnoses among people from Vietnam accounted for 8% (n=577) of foreign-born TB cases in the United States; the TB case rate was 58 per 100,000 (Cain et al., 2007; CDC, 2006d). During 2001–2005, the total case count was 3,145. In 2005, 18% of adult TB cases among Vietnamese occurred among those who had been in the United States for less than 1 year, 9% for 1–4 years, and 57% for 5 or more years. For the remainder, the number of years in the United States prior to diagnosis was unknown (CDC, 2006d). Please see Appendix F for information about tuberculosis screening policies for persons overseas.

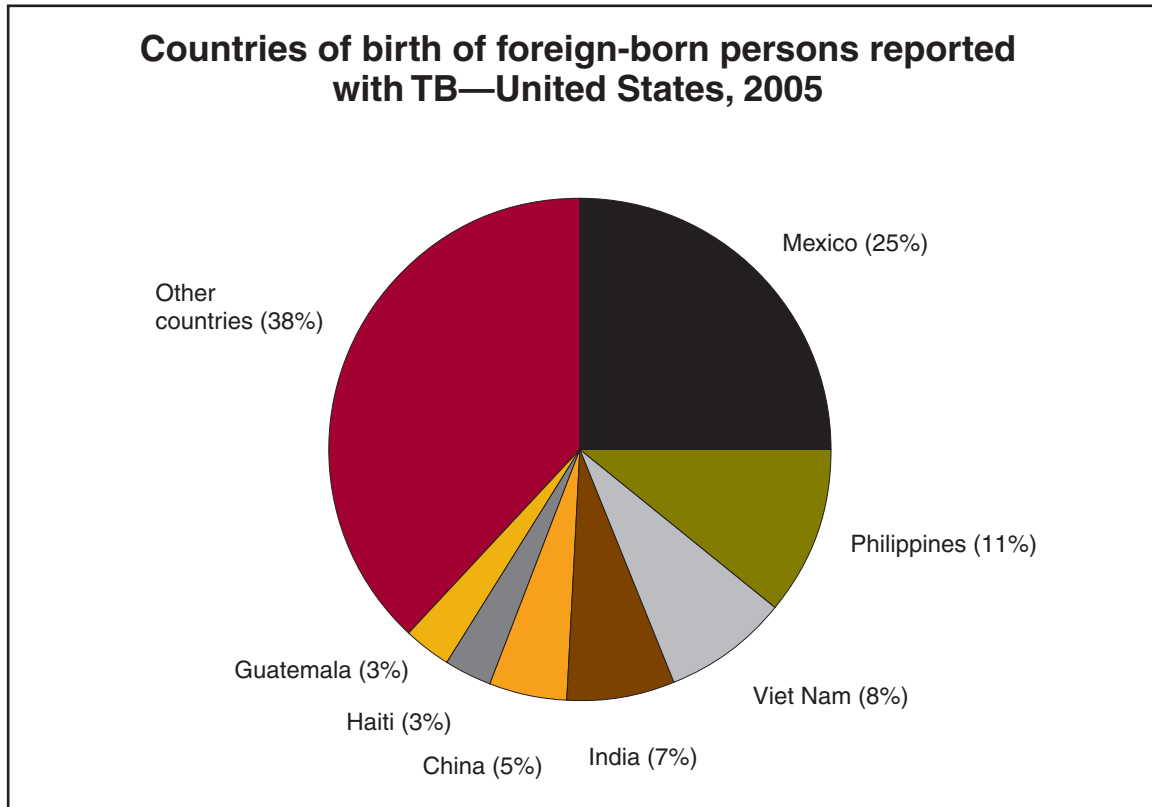
Bacille Calmette-Guérin

BCG vaccine is currently used in many parts of the world as a vaccine against TB. In Vietnam in 2006, BCG vaccine coverage at birth was 95% (WHO, 2007). Post-vaccination tuberculin reactivity is not an indicator of the protective efficacy of BCG vaccination, because it is not an indicator of immunity to *Mycobacterium tuberculosis*. Reaction to a tuberculin skin test (TST) caused by BCG vaccination wanes rapidly in individuals who receive the vaccine in the neonatal period and more slowly in those vaccinated at an older age (Menzies, 2000).

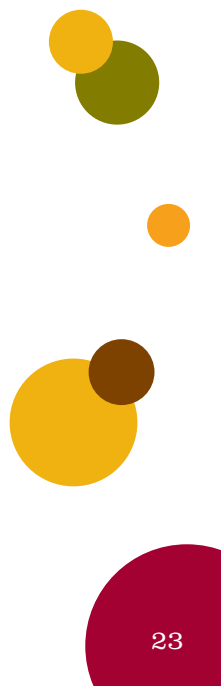
CDC's current TB testing guidelines state that a positive reaction to tuberculin in BCG-vaccinated persons indicates infection with *M. tuberculosis* when the person tested is at increased risk for recent infection or has medical conditions that increase the risk for disease. (See Table 7 in the June 09, 2000 MMWR for criteria for tuberculin positivity.)* Therefore, a history of BCG vaccination should not influence decisions about treatment of latent TB infection (LTBI) (CDC, 2000).

* Centers for Disease Control and Prevention. (2000). MMWR Weekly: Targeted tuberculin testing and treatment of latent tuberculosis infection. Retrieved November 8, 2007, from <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4906a1.htm>.

Figure 3-1.



Source: CDC Tuberculosis Surveillance Reports.



Tuberculosis-related Health Issues

Understanding other health issues affecting the lives of Vietnamese patients provides critical information for TB care providers. Conditions that can increase the risk of LTBI progressing to TB disease include the following (CDC, 2004):

- HIV/AIDS.
- Previous TB (in a person who received inadequate or no treatment) indicated by chest radiograph findings.
- Prolonged corticosteroid therapy and other immunosuppressive therapy.
- Recent infection with *M. tuberculosis* (within the past 2 years).
- Substance abuse (especially intravenous drug use).
- Silicosis.
- Diabetes mellitus.
- End-stage renal disease.
- Cancer of the head and neck.
- Hematologic and reticuloendothelial diseases.
- Intestinal bypass or gastrectomy.
- Chronic malabsorption syndromes.
- Low body weight (10% or more below ideal).

Of these conditions, those that are most relevant to people from Vietnam are further explored here.

HIV/AIDS

Once a person is infected with *M. tuberculosis*, HIV infection is the strongest known risk factor for developing TB disease. While the average probability of progressing from TB infection to disease is less than 10% over the lifetime of a person not infected with HIV, the risk is 5%–8% per year for those who are HIV-infected and not on Highly Active Anti-Retroviral Therapy (HAART) (Markowitz et al., 1997; Selwyn et al., 1989), a combined use of several antiretroviral drugs that inhibits the ability of the virus to multiply in the body (National Cancer Institute, n.d.).

The effect of HAART on the progression from TB infection to TB disease is not well understood (Markowitz et al., 1997; Selwyn et al., 1989), though some evidence indicates that it may have a protective effect on the risk of developing TB (Badri, Wilson, & Wood, 2002; Girardi et al., 2000; Girardi et al., 2004; Jones, Hanson, Dworkin, & DeCock, 2000; Santoro-Lopes, Felix de Pinho, Harrison, & Schechter, 2002). In addition, research suggests that active TB disease accelerates the course of untreated HIV infection, which may lead to more opportunistic infections and earlier death (Lopez-Gatell et al., 2007; Thomas, 2006; Whalen et al., 1995; Whalen et al., 2000; Zar et al., 2007).

In Vietnam, the prevalence of HIV among adults (15–49 years) with TB is estimated at 3.0% (WHO, 2006a). In 2005, Vietnam reported an estimated 263,000 HIV infections and 13,000 AIDS deaths (WHO, 2006b). The HIV epidemic in Vietnam has largely stemmed from injection drug use, although the number of infections resulting from sexual transmission is growing (Joint United Nations Programme on HIV/AIDS, 2005). The number of Vietnamese in the United States who are co-infected with TB and HIV is unknown.

The estimated number of annual AIDS cases diagnosed among APIs in the United States increased from 346 in 1998 to 497 in 2003. Through 2003, an estimated 7,166 APIs had been diagnosed with AIDS, 87% of whom were men (CDC, 2003). Although APIs represented less than 1% of HIV/AIDS cases in the United States during 2001–2004, they had the highest estimated annual percentage increase in HIV/AIDS diagnosis rates of all races/ethnicities (8.1% for males and 14.3% for females) (CDC, 2006c).

HIV transmission in API males occurs primarily among men who have sex with men (MSM), followed by those who have high-risk heterosexual contact or are injection drug users (IDUs). In 2005, MSM transmission accounted for 71% of AIDS diagnoses among API men to date (CDC, 2006a). Among API women, HIV transmission occurs most often among women who have sex with men who are at increased risk for HIV, followed by women who are IDUs (CDC, 2006a). Table 3-1 presents the estimated number of diagnosed AIDS cases in the United States in 2005 and cumulatively since the beginning of the epidemic. APIs comprise less than 1% of the total diagnosed AIDS cases (CDC, 2005).

Table 3-1. Total AIDS cases in the United States by race/ethnicity

Race/Ethnicity	Estimated AIDS cases in 2005	Cumulative estimated AIDS cases through 2005	Percentage of total AIDS cases	Rate per 100,000 population
White, non-Hispanic	11,780	385,537	39.1	5.9
Black, non-Hispanic	20,187	397,548	40.4	54.1
Hispanic	7,676	155,179	15.8	18.0
Asian/Pacific Islander	483	7,659	0.8	3.6
American Indian/Alaska Native	182	3,238	0.3	7.4

Substance Use

Both TB and substance use are prevalent in crowded, low-income areas. As a result, substance users are 2–6 times more likely to contract TB than nonusers (CDC, 2004). When compared with non-Hispanic whites, Asians generally have lower rates of substance use, including smoking. In 2004, only 11.3% of Asians smoked cigarettes compared with 22.2% of non-Hispanic whites (American Lung Association, 2006).

Despite a low overall prevalence of cigarette smoking among APIs in general, there are significant variations in smoking rates among different API groups. Cigarette smoking rates tend to be particularly high among the Vietnamese and other Southeast Asians (American Lung Association, 2006). Smoking is also much more common among Vietnamese American males than females (U.S. Department of Health and Human Services, 1998). Surveys conducted in California during 1987–1999 indicated that the estimated smoking prevalence ranged from 33%–56% among Vietnamese men and less than 1%–9% among Vietnamese women, with a trend toward a gradual decrease over time among males (S. McPhee & Nguyen, 2000). Smoking among Vietnamese men and exposure to second-hand smoke among Vietnamese women and children contribute to high cancer rates and increased risk of hypertension and cardiac problems (Yee, 2005).

In several U.S. studies that examine knowledge of TB, findings have shown that many Vietnamese believe TB is caused by smoking tobacco and by working excessively (Carey et al., 1997; Houston, Harada, & Makinodan, 2002; Long, Johansson, Diwan, & Winkvist, 1999). While smoking does not cause TB, a recent meta-analysis showed consistent evidence that smoking is associated with an increased risk of contracting tuberculosis (Lin, Ezzati, & Murray, 2007).

Diabetes Mellitus

People with diabetes are at a higher risk of progressing from LTBI to TB disease. TB occurs more frequently among diabetics and causes greater mortality (Guptan & Shah, 2000). Because of changes in lifestyle, diet, and physical activity, the risk of developing diabetes increases significantly when Asians immigrate to the United States (Fushimoto, 1995).

End-stage Renal Disease

End-stage renal disease (ESRD) occurs when the kidneys are no longer able to function at a level necessary to sustain life. Asians in the United States are almost twice as likely to develop ESRD as non-Hispanic whites (Karter et al., 2002). In addition, annual increases in ESRD rates are greater in APIs than in whites. New ESRD cases are increasing at a rate of 11% per year for APIs compared with 6% per year for non-Hispanic whites (U.S. Department of Health and Human Services, 2000).

Cancer

People who are diagnosed with cancer of the head or neck are at an increased risk of developing TB disease. In Vietnam, rates of head and neck cancer are steadily rising. Risk factors include consumption of salted fish and shrimp paste, poor oral hygiene, smoking, and alcohol consumption. In 2002, APIs showed a higher incidence (4.1 per 100,000) of nasopharyngeal cancer than all other racial groups (CDC, 2002).

Special Issue

Mental Health

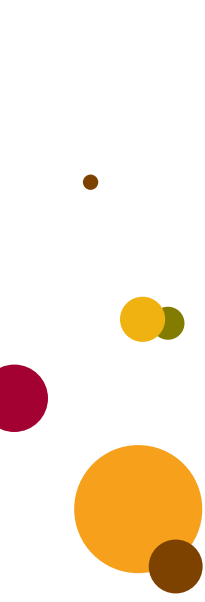
Vietnamese refugees have high rates of mental illness, including post-traumatic stress disorder (PTSD), depression, and panic disorders. These issues are associated with war experiences, military combat, political imprisonment, family separation, deaths of relatives and friends, and other harrowing experiences (Nowak, 2005). Research conducted in 1998 showed a 90% prevalence of PTSD in Vietnamese ex-political detainees and a 79% prevalence among non-detainees (Hinton et al., 2001).

Traditionally, Vietnamese view mental illness as highly stigmatizing and shameful. This view may result in fear or denial of any mental illness and reluctance to seek mental health care or services. Although Vietnamese may be familiar with severe forms of mental illness, the concept of mild or moderate psychiatric illness may not be recognized (Association of Asian Pacific Community Health Organizations, 2000). In general, Vietnamese tend to suppress negative experiences and the expression of emotions. Instead, Vietnamese may manifest psychological distress or negative emotions through physical symptoms and consider that such symptoms make it more acceptable to seek health care (Gold, 1992a; LaBorde, 1996).

Suggestion



- Consider using a holistic approach to address health concerns with physical and psychological symptoms.
- Carefully inquire about symptoms that may signal a psychological problem. Assure the patient that psychological concerns are not uncommon among people who have had similar experiences.
- Emphasize that consultation and treatment for mental health concerns are available.



Chapter 4. Common Perceptions, Attitudes, and Beliefs About Tuberculosis Among Vietnamese

Findings from Tuberculosis-specific Behavioral and Social Science Research

In 2003, the Centers for Disease Control and Prevention (CDC) conducted an ethnographic study of 48 Vietnamese-born persons in the United States to understand better the tuberculosis (TB)-related experiences, perceptions, and attitudes of the Vietnamese. In this chapter, this study is referred to as “the CDC study.” (See Appendix D for a description of the study design, methods, and study population.) The information presented in this chapter comes from both the CDC study and other TB-related behavioral and social science literature concerning the Vietnamese. It should be noted that the CDC study findings have limited generalizability because of the study’s small, non-randomly selected sample; thus, the information will not apply to all Vietnamese. Program staff should use discretion in determining how applicable the information may be for their specific context. However, taken as a whole, the research findings suggest several programmatic implications.

Vietnamese may not accurately understand TB symptoms, transmission, and prevention.

In the CDC study, one quarter of Vietnamese respondents were not aware that TB is an airborne disease that spreads from person to person, and many did not identify symptoms other than cough. About half of participants believed that TB spreads by sharing eating utensils or food or through dust and polluted air. Many participants held both accurate and inaccurate notions of transmission. One Vietnamese respondent said, “A person can pass TB on to others by coughing and sneezing at people, by eating and drinking with others, by sharing the same stuff with others.” Another noted that “a person gets TB by breathing polluted air, using polluted water, living with people who have TB, and not having good hygiene or lifestyle.” Others believed that TB is hereditary or results from hard work and not enough rest. Many believed that maintaining a healthy lifestyle or seeking proper treatment for TB disease were effective preventive measures. Some Vietnamese in the CDC study believed smoking caused TB. Although no causal link has been established, a 2006 meta-analysis demonstrated consistent evidence that smoking is associated with an increased risk of contracting tuberculosis (Lin et al., 2007).

Similar misconceptions have been described in the literature. In a study conducted in California of Vietnamese adults from community health centers, participants identified TB causation as malnutrition, excess stress, heredity, sharing eating utensils, and the supernatural (Nguyen, Yamada, Matsunaga, & Caballero, 2000). Participants in a qualitative study in New York State revealed similar perceived causes (Carey et al., 1997), including behaviors such as smoking, alcohol consumption, and poor nutrition. Participants also mentioned environmental factors such as exposure to others with TB, exposure to germs, living in unhygienic conditions, and breathing dirty air. Other factors noted were lack of sleep and hard manual labor (Carey et al., 1997).

Vietnamese may believe in different forms of TB. In a qualitative study of Vietnamese residents of Orange County, California, most Vietnamese participants mentioned “psychological TB” (lao tâm) and “physical TB” (lao lực) (Houston, 2002; Houston et al., 2002). Psychological TB was characterized by symptoms of fatigue, loss of appetite, and lethargy. This form of TB was thought to be caused by excessive anxiety, worrying, and depression, and was believed to be noninfectious. Strategies to cure psychological TB involved reducing worries, avoiding depression and anxiety, and using psychotherapy (Houston, 2002; Houston et al., 2002).

“Physical TB” more closely mirrored the biomedical definition of TB. Participants described it as a serious illness characterized by fever, chills, cold sweats, a persistent cough, heavy yellow sputum with blood, and a pale complexion. Physical TB was believed to be caused by working too much, having poor health, and smoking tobacco (Houston et al., 2002; Long et al., 1999). The majority of Vietnamese who understood the biomedical explanation of TB transmission believed that Western treatment was necessary to recover from physical TB and that a patient would need to maintain good mental and physical health (Houston, 2002).

Suggestion



- So that information can be tailored appropriately, ask questions to understand the patient’s ideas about TB symptoms, transmission, and prevention.
- Address concerns and confusion about the differences between TB disease and LTBI. Clarify that a person with LTBI does not need to be isolated and cannot spread TB germs.

Many Vietnamese may consider themselves at low risk for TB. In the CDC study, most respondents believed they were at low risk. This belief may reflect the low levels of knowledge about risk factors and transmission and can lead to delays in seeking care. For example, though Vietnamese participants in a study by Long et al. generally had good knowledge about risk factors for TB, they still maintained traditional beliefs about the different forms of TB. The authors noted that this belief could contribute to delayed care seeking and result in increased risk of transmission due to prolonged infectiousness (1999). Despite perceptions of low TB risk, many Vietnamese in the CDC study reported that TB would be more serious than other problems they may face in their lives and that death would be the outcome if a person did nothing at all. Among those who believed their risk for TB was low, about half stated that their friends and family worried about getting TB.

Suggestion



- Provide education about sources of TB risk, emphasizing that risk is increased by spending time in places where TB is prevalent, and not by personal hygiene.
- Recognize that a two-way exchange of information offers an opportunity to understand the patient’s preconceptions, dispel inaccurate notions, and highlight pertinent messages.

Vietnamese may be anxious about being ostracized by their friends and the community if they reveal their TB status. In the CDC study, many Vietnamese characterized TB as a stigmatizing and socially isolating disease and stated that it prevented them from sharing their TB status with others. One respondent reported, “TB is a dirty disease. It scared people away from me. People looked at me like I was a germ. That is why those who have TB are often afraid of telling people about their disease.” About half of respondents said they would disclose their TB status to others to prevent the spread of the disease. The other participants, however, said they would probably not disclose their TB status because they feared being ostracized or did not want to worry or scare others.

In Vietnam, TB is considered a social humiliation that isolates the person diagnosed with the disease and his or her family. As a result, individuals often endure significant stress and mental anguish, which is commonly expressed somatically through fatigue or body aches (Carey et al., 1997). In the United States, studies have found that Vietnamese believe that having TB causes significant stress and social isolation and negatively impacts one’s ability to work, perform family responsibilities, and maintain relationships with friends and community members (Houston, 2002; Houston et al., 2002).

Suggestion



- Some Vietnamese consider TB to be a highly stigmatizing disease that would result in rejection and ostracism. To allay fears, emphasize the need for only short-term isolation during active TB treatment.
- When promoting TB services, emphasize confidentiality. Ensure privacy by conducting consultations in private settings.

Vietnamese are likely to use Western biomedicine to treat TB and its symptoms. The CDC study found that, if they could afford the care, people in Vietnam who suspected TB would likely go to a doctor or clinic. Those who lacked resources might visit traditional health specialists for acupuncture or herbal medicines or use traditional remedies, such as coining (cạo gió). As one Vietnamese respondent reported, “If they do not have money, they do not go to the hospitals no matter how severe the disease is.”

The CDC study found that Vietnamese in the United States would seek TB information and treatment from medical doctors. Results from other studies also found that Vietnamese in the United States preferred Western medicine to treat TB over traditional Vietnamese remedies (Houston, 2002; Houston et al., 2002). Vietnamese in the United States may prefer biomedical approaches because many believe that biomedicine is more effective than traditional medicine. In the CDC study, many respondents believed that traditional remedies were not very helpful because “it is hard to kill the virus with herbal medicine,” and “[traditional remedies] only make people feel better or stronger.”

However, for Vietnamese in the United States who may want to use traditional health services, holding discussions in community settings about alternative remedies and practices demonstrates respect and strengthens relationships between patients and providers. Supporting the complementary use of traditional remedies, if not contraindicated, may help patients better cope with the illness. Providers can also use community opportunities to reinforce the benefits of biomedical treatment.

Suggestion



- Recognize that some Vietnamese may use traditional remedies before seeking health care from a clinic or doctor because of costs for medical care or preference for traditional treatments.
- Emphasize that services and treatment for TB are free and that other TB-related services, such as LTBI medicines and chest X-rays, are often free or offered at reduced cost at health departments.

Challenges with TB treatment may affect adherence and completion. In the CDC study, some Vietnamese had difficulties adhering to treatment because of pill size or side effects, including upset stomach, weight loss, nausea, and fatigue. A few reported that the recommended nine-month treatment regimen was too long, causing them to forget to take the medicines. Other challenges the Vietnamese faced included no access to transportation, clinic hours that did not accommodate work schedules, and long wait times for appointments.

Suggestion



- Some Vietnamese may have difficulty remembering to take TB medications. Aid patients in developing a reminder system that might involve a family member or friend or other measures, such as keeping pill bottles next to a toothbrush, refrigerator, or car keys, but safely out of reach of children.
- Extend clinic hours to include Saturdays or one or two weekday evenings.

Many Vietnamese want additional TB information in Vietnamese and English. In the CDC study, many participants requested general TB information, and some asked for specific information on TB pathology, transmission, and medications. Other suggestions included offering TB information in written formats, such as pamphlets and articles in Vietnamese newspapers and magazines, as well as in oral formats, including community and school presentations, videos, television and radio public service announcements, and talks with people in churches and temples. All of these may prove effective in reaching people of different ages and literacy levels. In addition, Vietnamese participants suggested hiring more bilingual staff familiar with Vietnamese culture.

Suggestion



- When possible, provide TB information in an oral or written format that is appropriate to the age, literacy level, and preferences of the patient.
- To increase awareness of TB programs and resources, conduct community presentations, publish articles in local newspapers and magazines, or sponsor public service announcements on local television and radio stations.

Conclusion

To meet the challenge of controlling tuberculosis in the United States, the care and treatment of all patients should be appropriate and effective, regardless of country of origin, language, or cultural factors. That entails not only addressing the linguistic and cultural needs of populations with or at risk for TB, but also focusing on the individual's perspective. This guide is intended to provide an understanding of the social and cultural setting from which some Vietnamese patients may come. It is not meant to stereotype or stigmatize; on the contrary, the authors of this guide fully recognize and appreciate the rich diversity of the myriad groups who have settled in the United States.

This guide aims to remind TB care providers that culture does matter in the clinic and that they too bring a cultural perspective to the patient-provider relationship. Providing effective TB care involves taking the time to learn from patients what is important to them personally in the experience of illness and treatment. In the words of Arthur Kleinman, ascertaining “what is at stake” for the individual will provide crucial information to use in tailoring the treatment plan. Being “Vietnamese” may not be a significant issue to a patient; being responsible for the care of multiple family members and juggling two part-time jobs without health insurance may. In short, focusing on the patient as an individual and maintaining open, two-way communication will foster effective TB care.

Appendix A. Using Kleinman's Questions to Understand Patients' Perceptions of Tuberculosis

While this guide encourages a broad understanding of Vietnamese culture, it is also essential to remember that each individual has personal beliefs. Several methods exist to help health care providers understand how an individual thinks about his or her own health problems. One method is to use a series of questions developed by medical anthropologist Arthur Kleinman (CDC, 1999; Kleinman, 1986). These questions, which have been tailored to tuberculosis (TB) here, can help providers see the illness from the patient's point of view by eliciting the patient's understanding of TB—its name, cause, timing, effects, severity, and treatment.

These questions also address the fears a patient may have, how TB may impact the patient, and the effects TB may have on his or her family or friends. Health care providers can use these questions to discuss TB with patients. The questions also can be adapted to address issues related to latent TB infection. These questions may be incorporated into an existing health assessment or an ongoing assessment of a patient's educational needs and treatment adherence. Questions can be reworded in accordance with a patient's cultural, linguistic, and educational backgrounds. The number and sequence of the questions also can be tailored to the circumstances.

Suggestion



Use Kleinman's questions to understand your patients' perceptions of TB.

- What do you call your illness (the problem)?
- What do you think causes TB?
- Why do you think you got sick when you did?
- What do you think TB does to your body?
- How severe is your sickness?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from this treatment?
- What are the main problems TB has caused?
- What do you fear most about TB?
- How do your family members or close friends feel about you having TB?



Appendix B. Tips for Working with Interpreters

A good interpreter is able to communicate effectively across cultures and convey important nuances. The most effective interpreters have been trained and assessed for active listening skills and for the ability to extract meaning and use descriptions when there are no language equivalents (CDC, 2006b). Whenever possible, make an effort to match the sex, general age, and social class of the patient and interpreter. In general, avoid using family members as interpreters, especially if sensitive topics are being discussed. An unknown third party may better be able to maintain confidentiality and provide unbiased communication (CDC, 2006b).

When communicating through an interpreter, speak slowly and clearly. Use a positive tone of voice that conveys your interest in the patient. Face the patient, not the interpreter. Speak in short units of speech, allowing sufficient time for the interpretation. Avoid medical terminology or professional jargon, as well as slang and idiomatic expressions. Clear, simple, lay language is generally most effective.

Encourage the interpreter to translate the patient's words as closely as possible and not to paraphrase, polish, or omit anything that may result in loss of the patient's true meaning. Be aware of nonverbal communication such as silence, distance between individuals, eye contact, emotional expressiveness, and body movements (CDC, 2006b). You may wish to ask the interpreter for clarification of the meaning of any nonverbal cues to be sure you have understood correctly any cross-cultural meaning. Above all, be patient: careful interpretation often takes considerable time.

Appendix C. Tuberculosis and Cultural Competence Resources

The following resources contain additional information on tuberculosis (TB) education and culturally competent care. See Appendix G for additional references used in the guide. Web site addresses for nonfederal organizations are provided solely as a service to the users of this guide; the Centers for Disease Control and Prevention (CDC) is not responsible for their content. Provision of these addresses does not constitute an endorsement of any organization by CDC or the federal government, and none should be inferred. At the time this guide went to press, all links were active.

General Tuberculosis Resources

Centers for Disease Control and Prevention, Division of Tuberculosis Elimination

<http://www.cdc.gov/tb>

This Web site is for health care professionals, patients, and the general public. The site can be used to search for TB guidelines, surveillance reports, education and training materials, and other TB-related Web links and resources.

Tuberculosis Education and Training Resources

<http://www.findtbresources.org>

This Web site is for health care professionals, patients, and the general public. The site can be used to search for TB education and training materials in various languages and to locate TB-related Web links.

Resources For Vietnamese Patients

Bạn Có Thể Chiến Thắng Bệnh Lao! (You Can Beat Tuberculosis!)

<http://www.findtbresources.org/scandocs/AD22721.pdf>

This pamphlet encourages readers to complete the full course of medical treatment to combat TB.

Bệnh Lao Là Bệnh Chữa Trị Được? Tôi Có Phải Đi Thử Xem Có Bị Bệnh Hay Không?

(What Is Tuberculosis? Should I Be Tested?)

http://www.sfdph.org/dph/files/TBdocs/TBbrochures/Screen_Vietnam05172005.pdf

This brochure differentiates between latent TB infection (LTBI) and TB disease. It discusses the symptoms of TB and who should be tested and lists TB test sites in the San Francisco area.

Healthy Roads Media

<http://www.healthyroadsmedia.org/vietnamese/index.htm>

This Web site contains free multimedia health education materials in a number of languages, including Vietnamese.

Những Câu Hỏi Và Giải Đáp Về Bệnh Lao (Questions and Answers About Tuberculosis)

<http://www.findtbresources.org/scandocs/AD31807.pdf>

This booklet discusses TB transmission, differentiates between LTBI and TB disease, and describes how multidrug-resistant TB develops.

San Francisco Tuberculosis Clinic

<http://www.sfdph.org/dph/comupg/oservices/medSvs/TB/default.asp>

The San Francisco TB clinic has brochures in several languages, including Vietnamese. The titles include “What Is Tuberculosis? Should I Be Tested?” and “I Have Been Exposed to Tuberculosis: What Do I Do Now?”

Stop TB!

http://www.hawaii.gov/health/family-child-health/contagious-disease/tb/contagious-disease/tb/educate/images/pdf/stop_tb.pdf

This poster presents the message “Stop TB!” in Chinese, English, Ilocano, Korean, Tagalog, and Vietnamese.

Tuberculosis: Are You at Risk?

<http://peelregion.ca/health/tb/other-languages.htm#videos>

This online video describes TB and how it spreads and explains that, although TB affects people worldwide, it can be prevented, treated, and cured. The video identifies at-risk individuals and emphasizes that they should take the TB skin test.

Thuốc Ngừa Lao Cho Bạn Và Gia Đình (Pills to Prevent Tuberculosis: For You and Your Family)

http://www.ethnomed.org/ethnomed/patient_ed/viet/aapcho_tbpills_viet.pdf

This pamphlet for immigrants and refugees who have been exposed to TB or who have LTBI explains the preventive therapy regimen using the drug isoniazid.

Toi Có Thể Bò Nhiễm Vi Trung Bệnh Lao. Làm Sao Tôi Có Thể Biết Chắc Được? (I May Be Infected with Tuberculosis. How Can I Know for Sure?)

<http://www2.sdcounty.ca.gov/hhsa/documents/TB-455vIMayBeInfectedwTBGerm.pdf>

This brochure provides information for people who may have been infected with TB.

Virginia Division of Tuberculosis Control

<http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/Tuberculosis/Patients/brochureLanguage.htm>

This multilingual Web site contains brochures about TB transmission, the TB skin test, the relationship between TB and HIV, the difference between LTBI and TB disease, and how multidrug-resistant TB develops.

Resources For Providers

The American Medical Association

<http://www.ama-assn.org>

<http://www.ama-assn.org/ama/pub/category/6759.html>

The American Medical Association offers a *Cultural Competence Compendium*, a 460-page resource guide, to help physicians and other health professionals communicate with patients and provide individualized, respectful, patient-centered care. Selected sections of the book are available at the Web site.

The Center for Cross-Cultural Health

<http://www.crosshealth.com>

The Center for Cross-Cultural Health has produced materials to guide communities faced with the challenge of providing culturally competent care. Sample language policies, guidelines for working with interpreters, instruments to help measure an organization's cultural competency, and lists of translated health education materials are available.

Cough It Up!

<http://www.dshs.state.tx.us/lab>

This videotape, available at the Texas Department of State Health Services' Web site, provides information about how to supply health care providers with a sputum sample.

Cross-Cultural Tuberculosis Guide: Cultural Influences on TB-related Beliefs and Practices of Filipinos, Vietnamese, Chinese, and Koreans

<http://www.findtbresources.org/scandocs/AD30408.pdf>

This book presents information about TB practices and beliefs of Asian Americans and makes recommendations on how to improve TB-related communication with Asian Americans.

Culturally and Linguistically Appropriate Services in Health Care

<http://www.omhrc.gov/clas>

The National Standards on Culturally and Linguistically Appropriate Services (CLAS), the CLAS Standards, makes recommendations for national standards for culturally and linguistically appropriate services in health care. Based on an analytical review of key laws, regulations, contracts, and standards currently in use by federal and state agencies and other national organizations, these standards were developed with input from a national advisory committee of policy makers, health care providers, and researchers. Each standard is accompanied by commentary that addresses the proposed guidelines' relationship to existing laws and standards and offers recommendations for implementation and oversight to providers, policy makers, and advocates.

CulturedMed

<http://culturedmed.sunyit.edu/index.html>

CulturedMed is a Web site promoting culturally competent health care for refugees and immigrants. The library also houses a research center containing relevant print materials. The bibliographies and links found on the Web site contain items that discuss health beliefs or ethnographic information about various ethnic groups.

DiversityRx

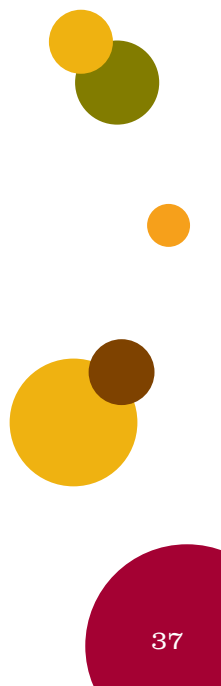
<http://www.diversityrx.org>

DiversityRx is a clearinghouse of information on how to meet the language and cultural needs of minority, immigrant, refugee, and other populations seeking health care.

EthnoMed

<http://www.ethnomed.org>

The EthnoMed Web site hosted by Harborview Medical Center, University of Washington, Seattle, contains information about cultural beliefs and medical issues pertinent to the health care of recent immigrants to Seattle, many of whom are refugees fleeing war-torn parts of the world.



Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons

<http://www.hhs.gov/ocr/lep/revisedlep.html>

This Web site offers guidance to help federally funded programs comply with regulations affecting people with limited English proficiency.

Linguistic and Cultural Aspects of Tuberculosis Screening and Management for Refugees and Immigrants

http://ethnomed.org/ethnomed/clin_topics/tb/tb.html

This site presents the transcript of a presentation that focused on TB screening, management of active cases, and linguistic and cultural differences between Western and non-Western approaches to medicine.

Tuberculosis and Cultural Competency: Notes from the Field

<http://www.umdnj.edu/globaltb/start.html>

This newsletter was developed to provide an ongoing educational forum for cultural competency training. The content includes a “teaching case” that reflects the experiential knowledge of health care providers working in TB, as well as relevant information and resources for culturally proficient skills development. The newsletters, which are published twice annually, are available on the Web site of the New Jersey Global Tuberculosis Institute under “Product List A–Z.”

Title VI of the Civil Rights Act of 1964

<http://www.hhs.gov/ocr/discrimrace.html>

This Web site provides information regarding the Civil Rights Act of 1964. The Office for Civil Rights (OCR) within the U.S. Department of Health and Human Services (HHS) is responsible for enforcing the nondiscrimination requirements of Title VI of the Civil Rights Act of 1964. It applies to covered entities under the jurisdiction of OCR. This jurisdiction includes entities that conduct programs or activities that receive federal financial assistance from HHS.

Tuberculosis Training and Education Network

<http://www.cdc.gov/tb/tbetn/default.htm>

The Tuberculosis Training and Education Network (TB ETN) was formed to bring TB professionals together to network, share resources, and build education and training skills. Members include representatives from TB programs, correctional facilities, hospitals, nursing homes, federal agencies, universities, the American Lung Association, Regional Training and Medical Consultation Centers, and other U.S. and international organizations interested in TB education and training issues. TB ETN’s Cultural Competency Subcommittee has developed a cultural competency resource list that is available to health care professionals.

Appendix D. Centers for Disease Control and Prevention Study Summary

A total of 48 persons born in Vietnam were selected to participate in the 2003 Centers for Disease Control and Prevention (CDC) study of tuberculosis (TB). These respondents were distributed among two study sites and involved public TB clinics administered by the state or local health department. The sites were recruited on the basis of local epidemiology, interest, and ability to participate. To elicit a range of responses, both TB patients and people recruited directly from the community (i.e., people who were not patients at the local TB clinic) were included.

In the CDC study, sites played an active role in choosing which foreign-born groups to recruit. In general, CDC aimed to include the same group in two sites to facilitate analysis of the influence of local context on participant responses. Although this guide focuses on data from the Vietnamese, four other groups included in the overall study were Mexicans, Somalis, Lao Hmong, and Chinese.

Study Population and Participant Recruitment

In Denver, Colorado, and Boston, Massachusetts, participants born in Vietnam were chosen by the study site staff to participate. This decision reflected the local epidemiological trends, as well as the need for TB-specific ethnographic information regarding this population.

This study used a convenience sampling strategy. In addition to country of birth, specific criteria and informal quotas for specific subgroups were identified, with local circumstances determining final sampling. The sample criteria were as follows:

- Persons aged 18 years or older.
- Persons residing within the area served by the local health department.
- Only one respondent per household.
- Approximately 50% of respondents with fewer than five years' residency in the United States.

Participants were recruited either through the community contacts of the bilingual, bicultural researchers (50%) or through recruitment of TB clinic patients by clinic staff (50%). The clinics recruited a balance of patients who 1) had a negative tuberculin skin test, 2) had received a diagnosis of latent TB infection (LTBI), or 3) had received a diagnosis of TB disease. The combination of quota and snowball sampling strategies was not random, but instead followed methodology appropriate to qualitative research. The demographics and TB status of the Vietnamese study group are presented in Tables D-1 and D-2.



Table D-1. Description of Vietnamese cohort

	N = 48, n (%)
Recruited from clinic/health department	20 (42)
Age at interview (mean, range)	40, 20–80
18–24	4 (8)
25–44	30 (63)
45–64	11 (23)
≥65	3 (6)
Years in United States (mean, range)	13, 1–35
1–4 years	6 (13)
≥5 years	42 (87)
Female	24 (50)
From urban area	23 (48)
Completed high school	36 (75)
English speaking	30 (63)
English literate	28 (58)
Any language literate	46 (96)

Table D-2. Tuberculosis (TB) status of Vietnamese cohort

	N = 48, n (%)
Screened*	43/48 (90)
TB disease diagnosis	4/43 (9)
Started TB treatment	4/4 (100)
Completed or currently on TB treatment	4/4 (100)
LTBI [†] diagnosis	16/43 (37)
Started LTBI treatment	13/16 (81)
Completed or currently on LTBI treatment	11/13 (85)

* Screened by one or more methods, such as tuberculin skin test, chest radiography, symptom screening, or sputum.

[†] Latent TB infection.

Appendix E. Glossary of Vietnamese Terms and Phrases

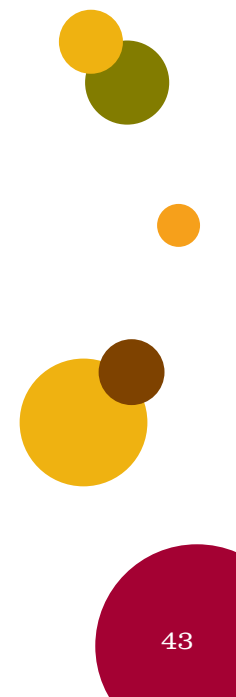
The Vietnamese language is extremely complex and includes numerous dialects and tones. The glossary includes tuberculosis (TB)-related terms and phrases and their Vietnamese translations. Health care professionals can facilitate communication by pointing to the Vietnamese word or phrase that they would like to communicate. The glossary is not meant to be used in lieu of interpretation services. Vietnamese language interpreters may also wish to refer to this table during consultations.

Terms and Phrases	Vietnamese Equivalent
Greetings	
Hello, my name is _____.	Xin chào, tên tôi là _____.
I'm sorry, I do not speak Vietnamese.	Xin lỗi, tôi không biết nói tiếng Việt-Nam.
We are waiting for an interpreter.	Chúng tôi đang chờ đợi thông dịch viên.
Symptoms of TB	
Cough	ho
Cough with blood	ho ra máu
Cough with phlegm	ho ra đờm
Chest pain	đau ngực khi quý vị ho
Fever	lên cơn sốt
Chills	ớn lạnh/lạnh run
Night sweats	đổ mồ hôi đêm
Appetite loss	biếng ăn
Weight loss	sụt cân
Fatigue/tiredness	mệt mỏi/sự mệt nhọc
TB Medications	
Isoniazid	Isotamine
Rifampin Rifampicin	Rifadin Rimactane, Rofact
Ethambutol	Myambutol, Etibi
Pyrazinamide	Tebrazid
Side Effects from TB Medications	
Are you experiencing any side effects from the TB medicine?	Bạn có đang bị những tác dụng phụ hay dị ứng gì khi uống thuốc trị bệnh lao không?
The following are possible side effects of TB medications (refer to list below). Please point to all the ones you are experiencing.	Sau đây là những triệu chứng có thể gây ra bởi tác dụng phụ hay là sự dị ứng của thuốc trị bệnh lao. Xin chỉ vào những triệu chứng mà quý vị đang có.

Skin rash	dị ứng da
Blurred or changed vision	mờ mắt/thị lực có thay đổi
Upset stomach	bao tử khó chịu
Abdominal pain	đau bụng
Fatigue/tiredness	mệt mỏi/sự mệt nhọc
Appetite loss	biếng ăn
Nausea	muốn ói/muốn mửa
Vomiting	ói
Yellowish skin or eyes	vàng da hay vàng mắt
Dark urine	nước tiểu có màu sẫm
Tingling sensation in hands and feet	tay chân có cảm giác bị tê
Joint aches	đau mỗi khớp xương
Balance problems	mất thăng bằng
Hearing loss	thính lực bị kém/điếc
ringing in the ears	ù tai
Easy bruising	da dễ bị bầm
Slow blood clotting	máu chậm đông lại
Traditional Health Beliefs	
Tuberculosis	bệnh lao
Physical TB	lao lực
Psychological TB	lao tâm
Hot, light, male force (yin)	đương
Cold, dark, female force (yang)	âm
Traditional Health Specialists	
Have you seen a (an) _____?	Bạn có đi khám (coi) _____ chưa?
Doctor?	bác sĩ?
Herbalist?	thầy thuốc nam hay thuốc tàu?
Acupuncturist?	thầy châm cứu?
Traditional Health Remedies	
Coining	cạo gió
Cupping	giác hơi
Pinching	bắt gió
Steaming	xông
Any over-the-counter drugs?	Thuốc không cần toa bác sĩ?

Useful Phrases	
It is important that you take all of your medicine even if you start feeling better.	Một điều rất quan trọng là bạn phải uống hết thuốc như lời bác sĩ căn dặn, tuy rằng bạn có thể đã bắt đầu cảm thấy khỏe hơn nhiều.
Do you understand what the doctor/nurse is telling you about TB?	Bạn có hiểu hết những lời bác sĩ/y tá đang nói với bạn về bệnh lao không?
Please repeat back to the doctor/nurse what he/she just told you about TB.	Xin bạn hãy lặp lại cho bác sĩ/y tá nghe những lời bác sĩ/y tá vừa mới nói với bạn về bệnh lao.
Do you have any questions about TB?	Bạn có câu hỏi hay thắc mắc gì về bệnh lao không?
Do you have any other questions?	Bạn có những câu hỏi hay thắc mắc về bất cứ điều gì khác không?

From Minnesota Department of Health, n.d.; The Canadian Lung Association & Capital Health, 2002.



Appendix F. Tuberculosis Screening Policies for Persons Overseas

This section is adapted from the 1991 “Technical Instructions for Medical Examination of Aliens” issued by the Immigrant, Refugee, and Migrant Health Branch of the Division of Global Migration and Quarantine (DGMQ), Centers for Disease Control and Prevention (CDC) (CDC, 1991). As new 2007 technical instructions are being applied to specific groups over time, please contact CDC’s Immigrant, Refugee, and Migrant Health Branch of DGMQ at 404-498-1600 for up-to-date information. You may also access <http://www.cdc.gov/ncidod/dq/technica.htm>.

Technical Instructions for Tuberculosis Screening

A medical examination, which includes screening for tuberculosis (TB), is mandatory for all refugees entering the United States and for all applicants outside the United States applying for an immigrant visa. Aliens in the United States who apply for adjustment of their status to permanent resident also require an examination. Aliens applying for nonimmigrant visas (temporary admission) may be required to undergo a medical examination at the discretion of the consular officer overseas or immigration officer at the U.S. port of entry if there is reason to suspect that an inadmissible health-related condition exists.

CDC’s DGMQ provides the technical instructions and guidance to panel physicians conducting the medical examination. If an immigrant or refugee has an inadmissible health-related condition, a waiver is required for the applicant to enter the United States. This also applies for an applicant who is in the United States and applying for adjustment of status to permanent resident. Section 212(g) of the Immigration and Nationality Act provides for the waiver of health-related grounds of inadmissibility.

Table F-1. Requirements for tuberculosis evaluation

Procedure	Required for
Review of history	All applicants.
Chest radiograph	All applicants 15 years of age or older. Applicants 15 years of age or younger whose skin test is positive (see below).
Tuberculin skin test	Applicants 15 years of age or younger who are suspected of having TB or who have a history of contact with a known TB case.
Sputum smear examination	Any applicant with a chest radiograph suggestive of clinically active pulmonary TB.

NOTE:

- Pregnant women with symptoms suggestive of active TB must receive a chest radiograph. If the radiograph is compatible with active tuberculosis, sputum smears must be obtained.
- Applicants whose chest radiographs show only calcified granuloma, calcified primary complex, calcified lymph node, or fibrosis, scarring, or pleural thickening with no radiologic or clinical evidence of active tuberculosis are not required to have sputum smears.


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