

# HEALTH NEEDS OF MIGRANT VIETNAMESE WOMEN IN SOUTH-WEST BRISBANE: AN EXPLORATORY STUDY

*Donald E. Stewart<sup>1</sup> and Bien Nam Do*

This study was conducted in the southwest area of Brisbane, Australia, and is designed to explore and assess the health needs of Vietnamese migrant women. The needs of this group are becoming increasingly urgent due to ageing of the original immigrant refugee community and decreased capacity for support from their children and families. The study used a qualitative research strategy involving focus groups and in-depth interviews with Vietnamese women between 18–65 years and interviews with Vietnamese health care providers. It shows that the women have had to deal with culture shock, low self-esteem, lack of friends and relatives, unrecognized professional skills and most importantly in health terms, low socioeconomic status. Significant barriers to access health services and to improved health and well-being were also identified, such as language difficulties, transportation, time, and knowledge about health education. Recognition of specific requirements of sub-populations as well as broader socio-economic and cultural determinants of health should be a guide to more effective planning and implementation of health promotion strategies. The changing needs, over time, of these sub-populations should also be recognized.

## Background

Over the last two decades and since the end of the war in Vietnam, the Vietnamese population has comprised the largest group of Asian-born migrants to Australia. In

---

<sup>1</sup> Donald Stewart is currently the Director of the Queensland Centre for Public Health and Assoc. Professor in the School of Public Health, Queensland University of Technology. He has been a World Health Organization consultant in Vietnam on several occasions in the area of health promotion and is currently involved in helping to develop the curriculum for an undergraduate public health degree at the Hanoi School of Public Health.

Bien Nam Do received his education and medical degree in Vietnam. He completed his Master of Public Health degree in 1997 at Queensland University of Technology.

the 1996 census, 151,053 Vietnamese were indicated as living in Australia with 75,247 males and 75,806 females. The annual rate of growth of this group is 6.5%. While the Vietnamese community in Australia is small, forming only 0.84% of the Australian population, by 1996 it comprised the fourth largest group of people born overseas, following Great Britain, New Zealand and Italy. In Queensland, from a group that was totally absent at the 1976 census, the Vietnamese population increased from 3,193 people at the 1981 census to 5,763 in 1986 and 11,966 in the 1996 census (ABS, 1997) with approximately half of this population female. This reflects a substantial increase in the number of Vietnamese people in Queensland over 15 years.

In the early years of migration, most Vietnamese arriving in Australia were refugees and when they resettled in Queensland, were housed in immigrant hostels and reception centres located in the southwest of Brisbane. The clustering of Vietnamese migrants in this area was encouraged by the availability of government housing and low rental accommodation. Furthermore, most new arrivals, knowing very little English, preferred living together in a small community to support one another and gain confidence (Do, 1998). Whatever their qualifications in Vietnam, it has been recognised that, with few exceptions, most immigrants enter blue collar jobs (Bottomley and de Lepervanche, 1990; Rice, 1999) and this area of Brisbane provided access to unskilled jobs in a variety of local factories, that did not require recognised qualifications. The vast majority (94.8%) of Vietnamese migrants in Queensland live in Brisbane and its surrounding suburbs, with the remainder (about 450) residing some distance from the state capital (Do, 1998).

Vietnamese migrant women, children and the elderly, in particular, have been identified as disadvantaged due to poor socio-economic status and low levels of formal education, compounded by a lack of English language and other cultural barriers (Jones, 1993; DIEA, 1995; Maltby, 1998; Kliever and Jones, 1997; Maltby, 1999). Women are often unable to make informed choices regarding their health due to a lack of knowledge about existing services (Bates and Linder-Plez, 1990; Plunkett and Quine, 1996; Women's Policy Development Unit, 1997) and health promotion (Do, 1998). For example, national figures indicate that 35.8% Vietnamese women have never used Pap smear services while only 19.25% Australian women have never used this service. Only 41% of Vietnamese women have had Pap smear tests within the last two years compared to 57.17% in Australian women (ABS, 1991).

There is evidence to indicate that elderly Vietnamese migrants suffer from loneliness and isolation to the extent that it causes chronic mental health problems (Thomas and Balnaves, 1993; Thomas, 1991; 1999). Although Vietnamese migrants generally

enjoy better health than people born in Australia (Donovan *et al.*, 1992), their health and well being appear to deteriorate gradually as the period of residence in Australia increases (Better Health Outcome of Australians, 1994).

At the national level, over the last decade there has been an increasing understanding of the social determinants of health with the National Health Strategy (1992), confirming that low socio-economic status is directly linked with poor health and that socio-economic issues are possibly the main factors impacting on health differentials in general. There is longstanding evidence to indicate that immigrants from lower socioeconomic backgrounds have higher rates of mental health problems than those from higher socio-economic groups (Krupinski, 1967; Minas, 1990).

Approximately 12% of the Australian female population was born overseas in a non- English speaking country. General figures indicate about one third of these have professional qualifications and around 20% have trade qualifications (Castles, 1991a). However, this is not necessarily true of the Vietnamese population, whose migration was less driven by qualifications and more by humanitarian and family reunion factors. Approximately eighty-four percent have an annual income of less than AU\$26,000 and are more likely to work as factory workers than other Australians (Castles, 1991b). So, in addition to being female and in a racial minority, women from non-English speaking backgrounds are also likely to be poor (Cath and Angie, 1998). Even when men and women have similar health problems, research indicates that effective service response needs to address women's differing attitudes, expectations and circumstances (Woods, 1985; Griffith, 1983). In the light of the above evidence, this project was designed to explore and assess the health needs of Vietnamese migrant women.

## The study sample

Three sources of data were used, namely (1) a set of focus groups with Vietnamese women across all ages from 18 to 65; (2) a series of in-depth interviews with individual women; and (3) a series of interviews with Vietnamese health service providers. All data collection was conducted in Vietnamese by a Vietnamese researcher. It was considered that this process would provide sufficient triangulation of views to allow the researchers to comment meaningfully on the circumstances of Vietnamese women immigrants in south-west Brisbane. The women were chosen on a non-random, convenience basis and informal networks were used in combination with 'accidental' sampling and snowballing methods (Pelto and Pelto, 1992; Harber, 1998).

The aims of the focus group discussions were to explore, in a broad sense, these women's health concepts, health needs, access to health services, and recommendations for a more appropriate health system. Eighteen women were invited to participate in three focus groups. Members of the groups were drawn from community groups such as the Christian Church, the Vietnamese Women's Association, or the Buddhist Temple and interviews were scheduled at weekends to suit the Mass service, or in break times during meetings or ceremonies. The duration of focus group meetings was around 90 minutes.

Twenty women were selected on a purposive basis for direct interview. Most of these women were engaged in home duties. As a specific aim of the project was to ascertain what circumstances were like for some of the most disadvantaged individuals in this group, selection criteria included that the women should have little or no English and were suffering from one or more long-term health condition(s). Informal, semi-structured interviews were conducted at the interviewee's own home. Each interview lasted for a minimum of half an hour.

In addition, a group of 10 Vietnamese health care providers were invited to participate in the study. The aim of these interviews was to explore, in-depth, Vietnamese women's health needs from the point of view of a professional health service provider, familiar with the Vietnamese cultural context. The sample consisted of 7 doctors (two of whom worked in local hospitals and 5 in general practice) two dentists both of whom worked in community health centres and one social worker whose employment was related to promoting ethnic women's health. Because of their work demands, the interviews were mainly conducted by phone during the evening, the duration of each interview was half an hour or more.

Data analysis was undertaken using content analysis based on the formulation of categories and themes from the data. The themes evolved from an iterative review of the three data sources: focus groups, individual interviews and health professional interviews. Significant statements were synthesised within these themes and categories and analysed to reveal common, supportive statements.

## Results

The main barriers these women faced when accessing health services were those associated with language difficulties, transportation, time and health literacy — broadly defined as knowledge about preserving and promoting their own health. Overlaying these problems, however, the focus group discussions and in-depth interviews identified a set of health concepts or beliefs which tended typically to

exacerbate these difficulties. These health concepts and beliefs indicate the need to examine the ways in which gender, race, class, culture, age/ageism, intersect to formulate women's experiences of health and illness. It is recognised, however, that the dis-aggregation of a person's life into abstract categories of, for example, gender, race and class may serve to conceal as much as it reveals since, in the everyday world of experience, concrete social relations are built on multifaceted interaction.

### ***Health concepts and beliefs***

Middle aged or older women clearly indicated that they believed their ill-health was due to their advancing age. The doctors in the study agreed that many of the local Vietnamese women seemed to confuse old age with poor health. Many of the women appeared to be satisfied with their present health, even though in some cases their condition was severe enough to require medical care. Chronic conditions may have caused pain and disability, but to a considerable degree they had decided that it was bearable. They asked their family doctor for relief but not radical treatment.

For example, one interviewee, aged in her late 40s, had been suffering arthritis for over 10 years. She appeared at the interview with marked deformity of both hands, which prevented her from performing basic functions, such as grasping and pinching. She attended the family doctor very regularly but all she asked for were analgesics for temporary pain relief, instead of a specialized check-up, physiotherapy or other specific therapy. She was quite happy with her present life (except when the pain presented), smiling during the interview, and her major concern was running her household jobs smoothly on behalf of her husband and children. Asked about the disease, she simply stated that it was the result of heavy labor required to make a living during her teenage years.

An additional feature of the belief system identified through the focus group sessions relates to the patient-doctor relationship, which was also associated with a sense of not wanting to cause trouble or make a nuisance of one self. There appeared to be a perception of a marked variation between Vietnamese and Australian beliefs in this regard as it emerged as a theme a number of times across the sample in focus group discussions.

The women reported that in Vietnam doctors are regarded as figures of authority and patients have no choice in the decision-making process about the provision of services. Illustrating this perspective, a young Vietnamese woman related her painful experience during labor in her first pregnancy at a hospital, as unbearable and devastating. When asked why she did not ask the doctor for something to relieve

the pain, she answered, without hesitation, that it was not fair to ask a doctor to do something for her and that her doctor may have been unhappy with her request. In Australia, participants suggested that doctors are perceived as both health providers and general confidants, who offer services and tailor health management to meet the patients' requirements in order to achieve optimal quality of service. Most Vietnamese women in the sample, however, indicated that they were afraid of expressing any extra need in front of an Australian doctor. They got confused when offered several different options of treatment and often chose the simplest, not for their own benefit, but (in their eyes) to make it easier for the doctor.

A number of women raised the issue of women's reproductive health and treatment from male doctors. Traditionally, it was said that women went to a female doctor to consult about women's problems. The women in the sample indicated that they felt uneasy and embarrassed when confronted by a male doctor for a vaginal examination, a gynecological sample, or an obstetric procedure. They hesitated to consult a male doctor about sexual health. In south-west Brisbane, however, the choice of doctor is limited and as there are insufficient numbers of Vietnamese female doctors for the needs of the community, some women had to choose Australian female doctors, but apparently with little satisfaction.

### ***Knowledge of the health system***

Most of the women in both the focus groups and the interviews revealed a limited understanding of mainstream health services, including how they work, what services are provided, how to access those services, or even where the services were located. Interviews clearly indicated that this lack of knowledge prevents those women accessing vital services, especially those that are essential to disease prevention, such as cancer screening programs. It comes as no surprise, therefore, that participation rates in these programs and services is very low for Vietnamese women. For example, discussion in the focus groups centred on two aspects of preventive health: breast and cervical cancer, with their high morbidity and mortality rates. Both can be adequately screened and effectively treated with early diagnosis. Interviews clearly supported national data indicating that awareness of the Pap smear test among Vietnamese women is markedly lower than that of Australian born women.

Most of the women in the study indicated that their health promotion knowledge came directly from their family doctor. In many cases the opportunity to gain this knowledge is limited, due to time constraints related to visiting a busy doctor's practice. Word-of-mouth from friends and family is another important source of information but, likewise, it is incomplete. Many women expressed concern that

they have no idea where to go for specific services. For therapeutic purposes, they can get most of the information they require from family doctors. However, preventive health is mainly advertised via media and brochures, which may or may not be appropriate, available and comprehensible — particularly for those unable to read Vietnamese. Many are completely dependent on Vietnamese family doctors who have little or no time to spend with them discussing health education and health promotion.

An interesting comment came from an elderly woman, a former midwife, who had had three operations in an Australian hospital over nine years. The impact of this experience had crystallized her views, as can be seen in her comment:

I criticize Australian doctors for putting their own legal responsibility ahead of patients' radical healing. Doctor dare not cure a patient radically by all of their ability or by all means because of legal responsibility. As a result, patients have to spend more time or resources to comply a full treatment (sic).

Whether she is right or not, or misjudges the processes required in any treatment, it is worth noting how this woman perceived her treatment and the role of the doctor.

Lack of recognition of the importance of complying with full treatment was raised as a concern by the health service providers. They indicated that a low compliance rate is common among Vietnamese women. A typical story was that they go to a family doctor, specialist or to hospital because of an acute health problem, however, when the acute illness regresses or is stabilized, they fail to comply with regular check ups. While recognising that 'compliance' is an issue in its own right, when asked, about half of the women interviewed admitted that they failed to complete the full course of treatment.

### ***English language issues***

Most of the women in this study expressed their concern regarding their communication skills. Even those who had good English skills indicated that they had continuing problems, as the English used in medical situations requires a high level of English proficiency.

Interviews indicated that communication in written form is even more troublesome. For example, language relating to consent forms and lengthy instructions can prove very confusing. To overcome the language barrier, participants, particularly the elderly, indicated that they have to rely on the translating and interpreting system

(TIS) or at least a friend or relative — and neither of these is always available or reliable. As a result, these data suggest that Vietnamese women are less likely to access the mainstream health system compared to their Australian counterparts. As one (Vietnamese) health care worker in a hospital commented:

Vietnamese women are probably one of the most highly disadvantaged groups requiring health support. Lacking English, they are unable to receive other health supportive programs like physiotherapy, speech therapy, occupational therapy, even social workers or regional nurses. In case of a severe disease, for example a stroke, they could not use such supportive treatments because of language barriers.

Lack of health education and information in culturally and linguistically appropriate material was frequently cited as preventing women from accessing appropriate preventive health services and programs, for example, pap smear screening and mammogram screening.

The reverse side of the picture was also presented in interviews. Most of the sample made use of a Vietnamese doctor when they had a health need. They indicated that this gave them increased confidence in terms of relating their concerns and feelings about the problems they were encountering and, most importantly, they were able to receive advice personally from the doctor rather than through the medium of an interpreter. Most of the women interviewed indicated that they felt great relief right after their consultations, as one commented “because we can expose everything we are thinking or concerned about in our own language”. Additional investigation is required to explore whether the use of linguistically and culturally familiar health service providers has an impact on broader health system problems.

Participants in the study indicated that there is a gap between daily language and the ability to describe medical complaints or to understand a doctor’s instructions completely. Health service providers commented that misconceptions often happen in daily medical practice. Interviews indicated that non-verbal cues can also hinder communication, as there are differing ways of communicating in different cultures.

It became apparent that a lack of health education often associated with a lack of English language, both spoken and written, has contributed to limitations amongst the women in understanding health risk factors and health hazards. It appears from this study that many health promotion campaigns undertaken by government agencies have not reached Vietnamese women, such as, for example, nutritional factors associated with diabetes, obesity, and cardio-vascular diseases. The main goals of preventive health programs such as cancer prevention programs, were



also not well understood. Although some women in the survey were interested in information about the Australian health system, the lack of culturally and linguistically appropriate resources was a major obstacle. It appeared that the lack of English skills has also led to inappropriate health information in a number of cases.

### ***Transportation problems***

Transportation was nominated as a major obstacle as few of the women could drive themselves and public transport is not easy to use especially for the elderly and those with little or no English skills. South-west Brisbane is not particularly well served with cheap local transport and frequently the women indicated that it was necessary to change buses or trains to arrive at their destination. Both the pressure to keep appointment times and the fear of using unfamiliar public transport were identified as extremely intimidating for these women.

Taxis are expensive and most often the women indicated that they relied on relatives for transport. This can prove difficult or inconvenient as car owners, typically younger people in employment, are usually at work during appointment times. The situation worsens for single women with no relatives, as they are totally reliant on the welfare system to get access to health services and as a consequence, have the poorest health status in comparison to other groups in the Vietnamese community. As the interviews indicated, women who cannot manage transportation themselves often break appointments or ignore medical treatment.

### ***Time***

Just as transportation is a major issue for the elderly, time is a main concern for the younger women in the paid work force. Factory workers and those working at offices have great difficulty in complying with medical appointments and long term treatment due to the time factor. Using medical centres would be their next option, but again due to language barriers, they are not completely comfortable or familiar with these after hours services. Associated with the desire to use Vietnamese health services is the issue of overcrowding. As one interviewee put it:

In a doctor's clinic I have to spend an hour or more to see the doctor and on the weekend it can take from two to three hours to complete the consultation — including the time waiting for medications in the pharmacy.

It appears that long waiting times coupled with time constraints, mean that many are discouraged from using health services. General criticism of 'waiting times' were

also made, for example in the hospital context, some women complained of a six-month wait for minor surgery or a full year waiting for a cataract operation for the elderly.

The following account illustrates on the one hand, how many women dismiss their health concerns, but on the other, the complexity of circumstances and attitudes surrounding the everyday world of decision-making and the balancing of working hard and “having everything” against appropriate health protection or an expected state of health. It is the story of a woman in her middle forties, who is a shopkeeper. She begins work at 6 a.m. and does not finish working until 6 p.m. every day. Her long-term health condition has persisted for nearly 10 years with severe pain in her lower abdominal region. Each bout lasts from 5 to 10 minutes and happens once every two or three days. The pain is severe and spasmodic, and she returns to normal after the crisis. She has been told that the disease is due to a genito-urinary disorder. She has never had a Pap smear test, a vaginal or breast examination or a mammogram during the 15 years she has lived in Australia. But she does not complain — quite the reverse she believes she “has everything” four children, cars and a relatively high income. The reason she gives for not having a definite diagnosis and a full treatment is mainly the lack of free time, but more importantly, it seemed that she also accepted the pain, not seeing it as something that was preventable or treatable.

## Conclusions and implications of the study

This study of the perceived health needs of migrant Vietnamese women in south-west Brisbane, using a combination of focus group discussions and interviews, identified some of the major concerns of the ageing Vietnamese community in this area. Key factors preventing Vietnamese women from accessing the health system, while frequently interconnected and multifaceted, consist of language barriers, knowledge of health promotion and prevention of disease, transport, and time. The study provides important information for those who develop health promotion programs, for example in terms of literacy and the usefulness of written materials.

This study included the views of Vietnamese health workers relating to the specific needs of migrant Vietnamese women in the South-West area of Brisbane. The views and observations of this group, with the insights provided from their unique perspective, were very important. It is suggested that in future research the views of migrant health workers can be explored in more depth. They are working in the field and may have clear opinions and ideas regarding more general policy needs.

Of increasing significance, noted in particular by the health service providers and due to both the migration of the elderly and the ageing of the group as a whole, was the need for additional discussion and planning regarding the needs of elderly migrants. Care of the elderly was identified as an increasingly pressing issue and, given the discrepancy in longevity between males and females, this is likely to be a growing problem for elderly Vietnamese women. In terms of health service provision, as the health service providers commented, geriatrics is a relatively new branch of medicine with limited appeal, particularly in terms of care for elderly Vietnamese. At the same time, the general provisions for the ageing Australian population, such as retirement villages, hostels and nursing homes were very clearly and emphatically not seen as being attractive either financially or culturally.

While alternative models of care may be required for ageing Vietnamese women, as the health service providers in this study also indicated, second generation immigrants or younger immigrants have important health issues which must not be forgotten. In general, the early period of migration raised specific issues and concerns related to women but as time moves on, post-resettlement issues become increasingly significant. The need for culturally appropriate planning continues within an evolving and dynamic context.

A small proportion of women in the study did not access the public health system because they disliked the system for a variety of reasons, including misunderstandings, feeling discriminated against and perceptions of unfriendly or poor patient-doctor relationships. Legislation, regulation and rules of practice have been generated to counter such concerns, but the evidence indicates that there is still some way to go in this regard.

The study underlined the importance of multiple strategies to improve health education and health promotion through a range of agencies, such as health providers, schools and government agencies. Family doctors, from whom over 90% of Vietnamese women seek help for example, play a major role in facilitating the issue (Do, 1998). Government agencies can assist by campaigning about health related programs using appropriate media on a regular basis, to raise awareness amongst Vietnamese women. Improvements in appropriate health communication could come about through better developed partnerships and collaboration between Government and relevant components of the private sector, particularly non-government organizations that are culturally familiar to Vietnamese women. This study, for example, found organizations such as the Christian Church, the Vietnamese Women's Association and the Buddhist Temple significant focuses of community life.

This study has indicated that there are still substantial real and perceived barriers inhibiting many migrant women both from benefiting from advances in health care and also from exercising their rights as consumers in an era of health care reform. One of the limitations of the research and why it should be seen as an exploratory study, however, is that the impact of health system reform pressures and broader economic, social and cultural changes on this population must also be investigated. For example, in terms of health care provision, the underlying pressure for reform over the last decade has been a shift from the welfare state, off-loading responsibility from the state to the individual, using the rationale of the dynamics of the market place (Twaddle, 2002). Research with poor migrant women in Canada and Australia (Anderson and Stewart, 2000) who must work outside the home to make ends meet, clearly documents the multiple demands on such women's lives. Caring for an ill family member is an additional demand on women who may not be able to access the resources available to alleviate the responsibilities of care taking.

The discourse of health care reform in Australia has focused on efficiency, better managed health systems, reorganization and new models of services. Research, building on this project should question the ways in which health care reform might in fact jeopardize the health of immigrant women, particularly those who are poor, non-English speaking, and who have few personal resources. Current reforms 'focus on cost containment and are expressed through economic and managerial changes at both a strategic and operational level' (Stewart and England, 2002). This project highlights the importance of recognizing the potential for disjuncture between official policy documents, reform initiatives, and the ways in which health care and social services are delivered at the local level, especially to immigrant or racialised groups.

## References

- Anderson, J. & Stewart, D.E. (2000) 'Migration, health and public policy — comparisons between Canada and Australia'. Paper presented at The 2<sup>nd</sup> Asia-Pacific Conference in Canadian Studies: *Renegotiating Identities: Canadian Studies in an Asia-Pacific Context*. University of Wollongong, 1–4 July.
- Australian Bureau of Statistics (1997) *1996 Census of Population and Housing*. Canberra: AGPS.
- Australian Bureau of Statistics (ABS) (1991) *1989–90 National Health Survey Summary of Results Australia*. Canberra: ABS.

- Bates, E. & Linder-Plez, S. (1990) *Health Care Issues*, Sydney, Allen and Unwin.
- Better Health Outcome of Australians (1994) *National Goals, Targets and Strategies for Better Health Outcomes into the Next Century*. Commonwealth Department of Human Services and Health. Canberra: AGPS.
- Bottomley, G. & de Lepervanche, M. (1990) 'The social context of immigrant health and illness'. In Reid, J. & Trompf, P. (eds.) *The Health of Immigrant Australia: A Social Perspective*. Sydney: Harcourt Brace Jovanovich, 39–76.
- Castles, I. (1991a) *Australia in Profile, Census of Population and Housing*. Canberra: ABS
- Castles, I. (1991b) *Multicultural Australia*. Canberra: ABS
- Cath, R.C. & Angie, S. (1998) *Women's Health: A Primary Health Care Approach*. Sydney, MacLennan & Petty Pty Ltd.
- Department of Immigration and Ethnic Affairs (DIEA) (1995) *Western Australia State Settlement Plan*. Perth, Department of Immigration and Ethnic Affairs.
- Do, B.N. (1998) 'A needs assessment of Vietnamese women's health in South West Brisbane'. Unpublished MPH dissertation, Queensland University of Technology.
- Donovan, J., D'Espaignet, E.T., Merton, C., & Van Ommeren, M. (eds) (1992) *Immigrants in Australia: A Health Profile*. Australian Institute of Health and Welfare: Ethnic Health Series No. 1. Canberra, AGPS.
- Griffith, J. (1983) 'Women's stress responses and coping patterns according to age groups.' *Issues in Health Care of Women*, 6, 327–340.
- Harber, J. (1998) 'Sampling'. In: Lo-Biondo-Wood G. & Harber, G. (eds) *Nursing Research*. St Louis, Mosby, 247–273.

- Jones, F.M. (1993) 'Women's health status in Australia'. In McElmurry, B.J., Norr, K.F. & Parker, R.S. (eds.) *Women's Health and Development: A Global Challenge*. London, Jones and Bartlett, 239–252.
- Kliwer, E. & Jones, R. (1997) *Immigrant Health and the Use of Medical Services. Results from the Longitudinal Survey of Immigrants to Australia*. Canberra, Department of Immigration and Multicultural Affairs.
- Krupinski, J. (1967) 'Sociological aspects of mental ill-health in immigrants', *Social Science and Medicine* 1, 267–281.
- Maltby, H. (1998) 'A comparison of health care practices of Vietnamese and Anglo-Australian women'. PhD Thesis, Curtin University of Technology.
- Maltby, H. (1999) 'Is it possible to ensure equality of access to health care for migrants to a new country?' In Rice, P.L. (ed.) *Living in a New Country: Understanding Migrants' Health*, Victoria, Ausmed Publications, 245–260.
- Minas, I.H. (1990) 'Mental health in a culturally diverse society'. In Reid, J. & Trompf, P. (eds.) *The Health of Immigrant Australia: A Social Perspective*. Sydney, Harcourt Brace Jovanovich, 250–287.
- Pelto, P.J. & Pelto, G.H. (1992) *Anthropological Research: The Structure of Inquiry*. New York, Cambridge University Press.
- Plunkett, A. & Quine, S. (1996) Difficulties experienced by carers from non-English speaking backgrounds in using health and other support services. *Australian and New Zealand Journal of Public Health*. 20 (1): 27–32
- Rice, P.L. (ed.) (1999) *Living in a New Country: Understanding Migrants' Health*. Victoria, Ausmed Publications.
- Stewart, D.E. and England, I. (2002) 'Reform of the Australian health care landscape: the contested terrain of development and innovation'. In Twaddle, A.C. (ed) *Health Care Reform Around the World*, Auburn House, Westport CT, USA, Greenwood Publishing Group, pp282–302.
- Thomas, T. & Balnaves, M. (1993) *New Land, Last Home: The Vietnamese Elderly and the Family Migration Program*. Canberra, AGPS.

- Thomas, T. (1991) 'Mental health issues and Vietnamese elderly women'. *Migration Monitor*, 23 & 24: 16–20.
- Thomas, T. (1999) 'Migrating in old age, Is it a good idea?: the mental health of Vietnamese older migrants'. In Rice, P.L. (ed.) *Living in a New Country: Understanding Migrants' Health*, Victoria, Ausmed Publications, 105–120
- Twaddle, A.C. (ed) (2002) *Health Care Reform Around the World*, Auburn House, Westport CT, USA, Greenwood Publishing Group.
- Women's Policy Development Unit, (1997) *Government Two Year Plan for Women 1996–1998*. Perth, Women's Policy Development Office, Government of Western Australia.
- Woods, N.F. (1985) 'Employment, family roles, and mental ill-health in young married women'. *Nursing Research* 34(1), 4–9.