Anthropology & Aging Quarterly

August 2008
Volume 29, Number 3

Anthropology & Aging Quarterly (ISSN: 1559-6680)
The official publication of the Association for Anthropology & Gerontology

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Anthropology & Aging Quarterly

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Volume 29, Number 3

Contents

Columns

From the AAGE President
Robert Schrauf ••••••

President's Column

Bob Schrauf

Last November during the AAGE official business meetings at the American Anthropological Association and the Gerontological Society of America, we talked about the possibility of enlisting a web service to host the AAGE website. In particular, we wanted to target a service that would allow us to keep track of the membership and pay dues on-line. Most of us are familiar with such websites from the other organizations to which we belong. Over the course of the past year, the Board has explored a variety of options, and we have finally settled on a company—Club Express—that seems to offer us the appropriate services at reasonable cost. We contacted other organizations that use this service to gather additional data, and we've run a pilot website over the last three months. Our conversations with other groups using the Club Express service have convinced us that the company maintains secure and safe servers, that their technical support is readily available and quick, and that there are no hidden costs going forward. Further, we were quite pleased with the pilot site that we set up. Therefore, sometime within the next couple of months we expect to 'go live' with a new AAGE website that will include some of the following features.

First, the website will present essential information about our organization, its mission, and history in an attractive, accessible, and publically available format. A link on the homepage will allow individuals who are interested in joining AAGE to do so on-line.

Second, the website will include a password-protected "Members Only" section with secure information that will include (a) a directory of members, (b) a link facilitating on-line payment of dues (via credit card), and (c) a document base that will include pdf's of the *Anthroplogy and Aging Quarterly*.

Third, the company managing the website will take care of sending out reminders about dues payment (and 'overdue dues') twice prior to the annual due date. We've re-set the annual due date to December 1 so that individuals who do not want to pay by credit card on-line can still pay in person at the AAGE booths at AAA and GSA. Sending reminders and managing on-line collection of dues will be a tremendous benefit for us.

Fourth, the management company offers a number of expansion modules that we can add to the site (at no extra cost) as needs arise. For instance, it will be possible to advertise our Workshops and take registrations for them on-line.

To cover the costs of the website and management the Board has also approved an increase in dues, so that regular and student members (the vast majority of us) will see an increase of $6.00 per year. Thus, dues for regular members will be $28 per year, and dues for student members will be $18.00 per year. Given the functionality, versatility, and organizational benefits of the site, these costs seem reasonable to us. (Also, I can't help but note that $6.00 will barely buy two cups of coffee at Starbucks).

It is my fondest hope that having a more dynamic and interactive website will free up some of our time and energies for increased growth as an academic association, attraction of new members, and more fruitful networking as anthropologists and social scientists devoted to issues of culture and aging. I'm hoping that all goes well (though there will inevitably be a few bugs to work out). Please feel free to email me with any questions or concerns that you may have.

Contextual Factors Influencing Dietary Practices of Chinese Canadian Seniors: An Overview and Synthesis

Xianmei Meng, BN, MN, University of Calgary
Tam Truong Donnelly, PhD, University of Calgary
Carol Ewashen, PhD, University of Calgary

Abstract: With the continuing increase in Canada's elderly Chinese population, a better understanding of contextual factors influencing their dietary practices is warranted as this may be directly linked to specific nutrition, health, and wellness issues. The purpose of this article is to review and synthesize relevant research related to Chinese Canadian seniors' dietary practices, and identify the current state of knowledge as well as research gaps. The areas of literature specifically examined are: (1) traditional Chinese culture and dietary practices, (2) dietary acculturation, (3) dietary practices of North American Chinese immigrants, and (4) contemporary health care availability for ethnic groups. Examination of the literature suggests there is a dearth of research exploring the contextual factors influencing elderly Chinese Canadians' dietary practices and their decisions regarding food choices. Chinese elderly immigrants seldom access health care services to obtain health information. Therefore, culturally appropriate and effective health care programs for Chinese Canadian seniors require further conceptualization, development, and promotion in order to further improve the diets and health status of elderly Chinese immigrants.

Keywords: diet, Chinese, elderly, acculturation, immigrants

Introduction

With more and more people of different ages and ethnic backgrounds choosing Canada as their new home, health care professionals in Canada are increasingly responsible for quality care across a diverse population. Furthermore, the Chinese make up the largest minority group in Canada, with a continuing increase in its elders in recent years (Lai 2004; Statistics Canada 2001). Health issues and needs of the minority elderly Chinese have changed due to migration. Compared to their Caucasian counterparts, elderly Chinese Americans are at greater risk for some health issues, including physical problems (Yu 1986), emotional problems, and poorer mental health (Ren and Chang 1998). Also, among the Chinese Canadian elderly, there is a 10% greater occurrence of depression and poorer overall mental health compared to the general Canadian elderly population (Lai 2000, 2004). Depression can lead to poor nutrition for seniors as a result of not eating regularly ("Growing older" 1996; Tsai et al. 2004), while inadequate dietary intake may result in compromised health, both physical and mental (Health Canada 2001; Suriah et al. 1998). Furthermore, compared to the Chinese living in their home countries, elderly Chinese Americans have higher morbidity from diabetes and some forms of cancer (e.g., colon cancer, rectum cancer) due to consumption of more high-fat and low-fibre foods (Le Marchand et al. 1997; Yu et al. 1991). All this suggests that some specific health issues occur within the Chinese elderly immigrants and dietary practices may play a dominant role in these health issues. In this article, a review and synthesis of research studies in the health care literature relating to the dietary practices of Chinese elderly immigrants reveals the current state of knowledge, including research gaps and recommendations for future research.

Review and Synthesis of Health Care Literature

An extensive literature review was conducted. However, only two citations were found in the literature that addressed the dietary practices of elderly Chinese immigrants (Chau et al. 1990; Newman and Ludman 1984), which were conducted over 15 years ago. A two-step approach was used to gather research pertaining to dietary practices of Chinese Canadian seniors. First, several online databases (Cumulative Index to Nursing and Allied Health Literature [CINAHL] from 1982, HealthSTAR from 1966, MEDLINE from 1966, and Anthropology Plus from 1993) as well as a website (www. scholar.google.com) were searched for research articles. The key words diet/food/nutrition, immigrant/Asian/Chinese, and senior/elder/old guided the initial search. As few references were found, the key terms 'senior/elder/old' were deleted, resulting in more studies. Since Canadian research on Chinese seniors' dietary practices is limited, studies from the United States, the United Kingdom, and Australia were also included. English articles are included in this review. Although the term 'senior' was commonly used in the research, definitions of 'senior' varied across different studies and included those as young as 50 years of age. The term 'Chinese' was also not defined clearly in the research studies; 'Chinese' referred to a very inclusive ethnic category not a national category, specifically including Chinese in Mainland China, Hong Kong, and Taiwan who vary with languages, cultural backgrounds,

and economic status. The majority of the participants in the reviewed studies were in the host countries first-generation Chinese who had not married outside their ethnic group.

Analysis of the literature suggests four main categories of contextual factors influencing health and dietary practices of Chinese Canadian seniors: traditional Chinese culture and dietary practices; dietary acculturation; dietary practices of North American Chinese immigrants; and contemporary health care availability for ethnic groups. A synthesis of key information in each of the categories is provided in subsequent sections. A comprehensive synthesis of the literature in this area might help to increase health care professionals' awareness and understanding regarding how to provide culturally appropriate and effective health care services that meet North American Chinese elderly dietary needs.

Traditional Chinese Culture and Dietary Practices

Food has a significant place in Chinese culture and has a close relationship with people's health that results in Chinese keeping traditional dietary practices even in host countries (Diehl et al. 1998). Compared with younger Chinese immigrants, Chinese elderly immigrants depend more on the traditional culture, such as Yin and Yang (Satia et al. 2001). In order to promote healthy dietary practices in Chinese Canadian seniors, it is essential to further understand the influence of Chinese culture on diet. Chinese culture is one of the oldest and most diverse cultures in the world and is influenced by several philosophies, including Yin and Yang, Taoism, Buddhism, Confucianism, Legalism, and Mohism (Rodgers and Yen 2002). Many of these philosophies guide the Chinese in daily dietary practices, and Yin and Yang, Taoism, Buddhism, and Confucianism are mostly addressed (Chen 2001). How these philosophies relate to dietary practices is provided below.

Yin and Yang. Yin and Yang is the most prevalent philosophy in Chinese culture, having a close relationship with Chinese dietary practices (Shih 1996). In Chinese culture, yin means feminine and yang means masculine. Yin and Yang philosophy suggests that all phenomena appear as pairs of opposites, which are interdependent and harmonious (e.g., hot and cold, dark and light) (Shih 1996). There are several principles essential to Yin and Yang philosophy that relate to dietary practices, with consideration of medicinal values of food being addressed. First, Yin and Yang philosophy values diet as a means to healthy living and also advocates for dietary modifications, especially during illness (Koo 1984; Shih 1996; Suzanne and Chan 1985). Prescriptive and proscriptive rules of diet are well known within middle-aged Chinese women (Koo 1984). Prescriptive rules refer to eating certain foods to improve poor physical status caused by inadequate nutrients during illness. In contrast, proscriptive rules recommend avoiding certain foods when people are sick (Koo 1984). Therefore, eating calcium-rich foods is prevalent in China when people break their bones, while people with cancer would be told to avoid drinking alcohol (Koo 1984). Second, there are two essential principles in dietary therapy in terms of Yin and Yang philosophy: 'like helps like' and 'using poison to fight poison' (Koo 1984). For example, the Chinese tend to believe that consumption of walnuts helps nourish the brain because a walnut resembles a brain, while scorpions are eaten for their 'anti-poison' properties. Foods and herbs are divided into 'hot,' 'cold,' and 'tonic,' rather than Western terms like 'calcium-rich' or 'vitamin-rich' foods (Koo 1984; Shih 1996). Maintaining the balance of hot and cold is considered vital to healthy Chinese life (Chan 1995; Koo 1984).

Taoism (Daoism). Taoism, the only indigenous religion in modern China, influences Chinese people's lives significantly, including basic principles such as worship of nature, striving for inner purity, and the control of personal desire (Wang 2006). Schipper (1993) explains, "The first meaning of the character *tao* is 'way': something underlying the change and transformation of all beings, the spontaneous process regulating the natural cycle of the universe" (p. 3). Nonaction (*wuwei*) and naturalness (*ziran*) are addressed in Taoism (Kohn 2001). In particular, the principles of "treatment before illness" and "consolidating life foundation" in Taoism are commonly used in Chinese medicine (Wang 2006). With respect to diet, there are several diet principles in Taoism. First, there are special foods required in different festivals, such as eating moon cakes on the Fifteenth of the Eighth (i.e., Mid-Autumn Festival) (Schipper 1993). Second, simplicity is addressed in Taoism and fancy and tasty foods should be limited in daily life (Kohn 2001). Finally, Taoism emphasizes moderation and flexibility. Taoism addresses a balanced diet in life, which is similar to Yin and Yang. Different from Yin and Yang, which categorizes foods into 'hot' and 'cold', Taoism classifies foods into 'five flavours' (i.e., bitter, sour, sweet, spicy, and salty) (The Great Tao 2004). In addition, flexibility is also addressed in Taoism and there are very few diet prohibitions (e.g., alcohol is permitted) (Kohn 2001). Festivals therefore provide opportunities to eat a lot of rich food and drink alcohol (Schipper 1993).

Buddhism. A third philosophy within the Chinese culture is Buddhism. Buddhists believe that life is a process involving the end of suffering and the search for enlightenment (Brooks 2004). There are four noble truths in Buddhism: "Suffering, concept of re-birth with suffering, correcting faults through meditation, and following the true spiritual path" (Brooks 2004: p. 15). Out

of respect for life and for all living things, and in order to achieve a higher standing in the next life, most Chinese Buddhists are vegetarian. They do not kill animals or eat meat.

Confucianism. There are two main principles in Confucianism: the generational hierarchy (paternalism) and the gender hierarchy (masculinism). The former principle means that "the elders have more authority than the young, the parents have more authority than the children, [and] the teachers have more authority than the students" (Cheng 1997: p. 39). Health care professionals are also in a position of authority according to Confucian philosophy. Thus, Chinese elderly clients who follow Confucianism may feel too humble to discuss their dietary issues with health care professionals. The latter principle means that a Chinese father and husband would have more power compared to a Chinese mother and wife (Cheng 1997). Chinese women often follow their husbands' or eldest sons' decisions rather than making their own decisions because of the influences of Confucian philosophy. For example, Chinese women often follow the food choices of their husbands, children, and elder relatives when preparing meals (Lv and Cason 2003; Satia et al. 2000; Satia et al. 2002).

The Chinese may share similar followers of Confucius' health attitudes and beliefs. Traditionally, the Chinese would seek Chinese medicine and traditional beliefs for mild physical problems (e.g., cold and chronic diseases) without harmful side effects, while they would prefer Western medicine for emergency or serious conditions (Holroyd 2002; Ren and Chang 1998). However, these traditional beliefs may vary due to other factors including age, socioeconomic status, and educational level (Satia et al. 2001; Satia et al. 2002).

Dietary Acculturation

Compared with the mainstream elderly population in Canada, Chinese Canadian seniors face a specific challenge in their dietary practices—dietary acculturation. Redfield et al. (1936) purport that, "Acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups" (p. 149). As a subcategory of acculturation, dietary acculturation is defined as the process by which minority groups adopt the food choices/patterns of the host country (Satia et al. 2001). Based on the literature review, dietary acculturation among Chinese immigrants may be characterized by increased consumption of meats and dairy products and decreased consumption of grains. In addition, dietary acculturation is multidimensional, affected by factors such as age, length of residency, gender, and educational level (Berry 1997; Chau et al. 1990; Satia et al. 2000).

Age. The younger the person entering the host country, the smoother the process of acculturation (Berry 1997). Older Chinese immigrants adhere to a traditional diet more readily than younger ones (Satia et al. 2002). Although it is not clear why age influences the process of acculturation (Berry 1997), some studies reveal that language barriers may be a significant factor influencing dietary acculturation among elderly immigrants due to their limited ability to speak the language of the host country (Netland and Brownstein 1984).

Length of residency. Length of residency is a factor commonly used when evaluating the degree of acculturation (Lv and Cason 2003; Newman and Linke 1982). However, current studies are inconclusive regarding the relationship between length of residency and dietary acculturation. For example, Newman and Linke (1982) state that Chinese participants living in the U.S. over 5 years have fewer changes in food habits than those living in the U.S. less than 5 years. In comparison, Lv and Cason (2003) report that there is no significant relationship between the length of time living in the U.S. and dietary patterns. This may be due to the time at which these studies were conducted, with the availability of ethnic foods likely changing over these years.

Gender. Gender importantly affects dietary acculturation as well. Women are more often recruited as participants when investigating Chinese immigrants' nutrition and diet because they are considered to generally be the gatekeepers of foods and food preparation (Newman and Linke 1982; Satia et al. 2000; Satia et al. 2001; Satia et al. 2002). As a result, Chinese immigrant women tend to be much more aware of the availability (or lack, thereof) of traditional Chinese food products in the host country (Newman and Ludman 1984). Also, Chinese senior women have decreased health status (Lai 2004; Suriah et al. 1998), less English ability, and poorer financial support than male Chinese seniors in the host country (Lai 2004), all of which may relate to poorer nutritional dietary habits.

Education. Education may also influence dietary beliefs and the process of acculturation. Suzanne and Chan (1985) found that Chinese participants with lower educational status hold more traditional dietary beliefs than those with higher education. Satia et al. (2002) also reported that Chinese immigrants with a higher level of education pay less attention to traditional beliefs about diet. Furthermore, level of education is considered to be directly linked to other factors influencing dietary practices such as socioeconomic status and employment

status (Berry 1997).

Social environment. Social environmental variables relevant to immigrants' dietary practices and acculturation include the availability and accessibility of ethnic foods, the development of ethnic communities, and health policies and programs particular to ethnic group differences. For instance, current healthcare services (e.g., Calgary Health Region) can play a significant role by providing Canada's Food Guide in different languages and also supplying information regarding the characteristics of minority groups.

Dietary acculturation is changeable and not a simple one-way process. Dietary practices can incorporate both traditional and acculturated. For example, individuals living in the U.S. over 5 years were found to revert to traditional dietary patterns (Newman and Linke 1982). Dietary acculturation can also bring both healthy and unhealthy dietary change. Chinese women with higher Western dietary acculturation scores were found to consume more high-fat foods (Satia et al. 2001). However, a healthy change was also observed with these same women eating more fruit and vegetables. Finally, dietary acculturation reveals the interconnectedness of personal and ethnic preference with environmental conditions. For example, the fact that it is time-consuming and expensive to prepare traditional Chinese food in Canada is a main reason for Chinese immigrants preferring Western food, plus Western food is, in comparison, cheaper and more readily available (Satia et al. 2000).

Dietary Practices of North American Chinese Immigrants

A systematic review and analysis of research studies related to the dietary practices of Chinese immigrants in North America potentially offers a valid and reliable knowledge base from which to conduct further research on the health of the Chinese elderly population in Canada.

The Newman and Linke 1982 study, one of the earliest relevant research studies examined the changes in food habits of 102 Chinese American women in terms of location and length of residency. Respondents living in New York City's Chinatown changed their food habits less than those living in Queens due to availability and accessibility of traditional Chinese foods. However, the majority of participants in this study were middle-aged women who may not accurately reflect the specific nutritional status of Chinese elderly women because of potential differences in physical status, socioeconomic status, educational level, and cultural beliefs.

In another study, Newman and Ludman (1984) distributed questionnaires to Chinese adults living in Beijing, Shanghai, and Guangzhou in the People's Republic of China (P.R.C.) and in New York City. The return rate was most impressive, with 90% of usable questionnaires completed (337 participants) and almost half of the participants being 50 years of age or older. Most participants followed traditional Chinese dietary habits in both countries with no difficulty in obtaining the necessary foods. In addition, most of them prepared special foods for seniors in both countries, with higher-protein foods being the first choice. Comparably, participants in the U.S. ate alone more often than those in the P.R.C. This study provides some detailed quantitative information about the dietary practices of the Chinese elderly, and explored some significant dietary issues among Chinese elderly participants in the U. S. (e.g., eat alone), which may influence them on keeping nutritional intake. However, what is missing is rich qualitative data that could provide descriptive information about dietary practices and issues from the Chinese seniors' perspective.

Comparably, Chau et al. (1990) examined the dietary practices of 45 elderly female Chinese over 60 years of age living in the San Francisco Bay area. Using an interviewer-administered questionnaire, the researchers gathered information regarding the food habits, food frequency, food accessibility, and traditional health beliefs of these elderly women. They obtained results similar to those of Newman and Ludman 1984. In addition, Chau et al. (1990) found that there is a significant positive correlation between subjects' consumption of American food and their English reading level, which may influence Chinese Canadian seniors' food choices as well. Similarly, the dietary practices of 399 first-generation adult Chinese Americans in Pennsylvania were explored through a self-administered questionnaire (Lv and Cason 2003). The participants with better English proficiency consumed more fruits and beverages than others, while those with a higher number of Caucasian friends consumed more meats, fats/sweets, and beverages. Although this research does not specifically address the dietary practices of Chinese seniors, two specific acculturation indicators (English proficiency and number of non-immigrant American friends) were investigated. This suggests a potentially significant relationship between Chinese seniors' dietary change and their degree of acculturation.

The Chinese Women's Health Project (Satia et al. 2000; Satia et al. 2001; Satia et al. 2002) offers another crucial beginning for systematic research on dietary practices, nutrition, and health among Chinese immigrants, as well as factors influencing Chinese women's dietary practices. Since Chinese women often prepare foods for the whole family, Satia et al. (2000) pilot study used qualitative research methods to explore information related to the dietary practices of 30 female Chinese Americans living in Seattle. Research results

indicate that breakfast is the first meal to reflect changes after immigration; few participants access Western media or health programs to obtain dietary information; and that health beliefs, costs, food quality, and availability are important factors influencing food choices after immigration. In another further study exploring the dietary practices of 244 Chinese women living in Seattle, U.S. and Vancouver, Canada, Satia et al. (2001) found that most participants incorporate some Western dietary practices. Women with higher Western dietary acculturation scores are generally younger, have a higher educational level, are employed outside the home, and consume more higher-fat foods as well as fruits and vegetables as compared to those with lower acculturation scores.

Building upon their prior work Satia et al. (2002) obtained information on the psychosocial predictors of diet and acculturation among 244 Chinese women. The researchers found that older and less-educated Chinese women do not believe that a relationship exists between diet and chronic disease, and also believe that the Chinese diet is healthier than the Western diet. In addition, these women experienced more difficulty in accessing Chinese food stores and in affording fresh foods compared with their younger and higher-educated counterparts. The participants stated that their older Chinese relatives prefer a traditional Chinese diet, with over half of the elderly relatives of participants influenced the family eating patterns, resulting in consumption of a more traditional Chinese diet.

Although the majority of the participants in Satia et al.'s studies are middle-aged Chinese women with dietary practices that may not represent all Chinese elderly immigrants, this research provides fundamental information about contextual factors affecting the dietary practices of Chinese immigrants. The contextual factors, such as age, educational level, living arrangement, and health beliefs, should be included in studies of the dietary practices of Chinese Canadian seniors.

There are also a number of significant anthropology research studies that address specific dietary behaviors and the factors influencing the dietary behaviors among Chinese seniors in North America. Lew-ting (1997) conducted a research study comparing egg-consumption behaviors among Chinese elderly of retirement homes in Los Angeles, U.S. and Taipei, Taiwan. There were 203 Chinese seniors participating in this research, 89 in Taipei and 114 in Los Angeles. Both males and females participated, with a mean age of 76 years. The research results revealed that many participants in both locations had egg-restriction at some level. In addition, health care providers, family members, peer groups, and mass media were significantly addressed in influencing practices of egg-consumption among the Chinese elderly. Although this research investigated only egg-restrictive behaviors among Chinese elderly rather than exploring their complete dietary practices, the factors discussed by Lew-ting 1997 may be relevant for further research as well, such as influences of family members, peers, media, and health care providers. Similarly, Liou and Contento (2006) explored the psychosocial predictors of fat-related dietary behaviors in first- and second-generation Chinese Americans in New York City. This study involved participants completing a questionnaire, with 743 useable surveys being returned, comprising a 55% response rate. The participants ranged from 21 to 73 years of age. Attitude, perceived barriers, self-efficacy, and overall health concerns were major predictors influencing participants' dietary practices. In addition, older participants have higher frequencies of dietary fat-reduction practices in the first-generation group due to having more health concerns. The influences of family members and others, health concerns, cultural believes and values were addressed in these two studies, which may influence Chinese Canadian seniors on choosing appropriate foods as well.

Contemporary Health Care Availability for Ethnic Groups

In recent years, more and more Western health care professionals realize the inadequacy of health programs to address the health concerns of an increasingly diverse ethnic population within Western cultures. Sekhon (1996) reviewed the food and nutrition values of the South Asian population in North America and explored effective strategies used in counselling South Asian clients, including dietary information that could be suitable to Chinese immigrants. Brown (2003) also reviewed meal-planning strategies used in ethnic populations, addressing the importance of health care professionals' cultural competency when communicating with ethnic clients. Browne et al. (1997) explored seniors' nutritional risk factors from the health care professionals' perspective. Among the six major risk factors for malnutrition (i.e., living alone, recent bereavement, denture problems, mobility problems, psychiatric morbidity, and multiple medication use), they identified psychiatric morbidity as most important. In addition, the researchers found inconsistent understanding between general practitioners and public health nurses regarding these major risk factors (Browne, et al 1997). This suggests that there may be a greater difference in understanding between health care professionals and their elderly clients regarding what constitutes a healthy diet, especially for the elderly with traditional Chinese beliefs (e.g., Yin and Yang, Confucianism).

To promote the nutritional health of Canadians, Canada's Food Guide (see Figure 1) was designed as a

healthy dietary guideline (Health Canada 2007). Canada's Food Guide is presented as a rainbow, consisting of four parts (from outer to inner): vegetables and fruit (4-10 servings), grain products (3-8 servings), milk and alternatives (2-4 servings), and meat and alternatives (1-3 servings). According to Canada's Food Guide, people need foods from all four groups; however, the amount of food from each group varies. Canada's Food Guide was adapted in an attempt to better meet the needs of minorities such as the Chinese, Portuguese, East Indian, and Vietnamese populations (Nutrition Research Centre n.d.). Unfortunately, the contemporary modifications of Canada's Food Guide may be insufficient in guiding ethnic seniors to achieve a healthy diet. For example, when introducing grain products, only rice and the Hong Kong style bun are shown as examples in the Chinese adaptation (see Figure 2), while other traditional favorites such as noodles, dumplings, and steamed buns are not suggested. In addition, the traditional Chinese diet has 'fan' (i.e., cooked grain products or starch portion) and 'ts'ai' (i.e., vegetables and meat consumed in mixed dishes), and people share ts'ai together (Simoons 1991). Calculating the exact number of food servings per person would be difficult when attempting to measure the Chinese diet (Satia et al. 2001). Therefore, designing a culturally appropriate and convenient food guide that include some of the common and preferred traditional foods would be necessary among ethnic groups, especially for the elderly population.

Another major health service issue is that Chinese elderly immigrants seldom access support from health care services. Ying and Miller (1992) reported that Chinese seniors in the U.S. seldom use the health care system, and language barriers may be an important reason, compared to younger Chinese. Instead, they tend to obtain health information from Chinese newspapers as well as their friends (Satia et al. 2000). Therefore, developing a systematic, dynamic, and culturally appropriate health care support system that reaches out to the Chinese elderly population is crucial in Canada.

Summary and Conclusion

Dietary practices of Chinese elderly immigrants are specific, varying with gender, health status, educational background, English proficiency, socioeconomic status, living arrangement, cultural beliefs, health concerns, and influences of family members and others. Most current research studies focus on epidemiological analysis of dietary practices in the young and middle aged female, with limited discussion of specific factors influencing Chinese seniors' dietary practices. Although some research addresses differences in food choices among the Chinese elderly varying with age, education, acculturation, and other factors, the dissemination of this information to health care professionals is limited. Consequently, two main knowledge gaps exist. First, although the dietary practices of Chinese Canadian seniors occur in complicated contexts, there is a paucity of systematic research focusing on the effects of contextual factors on their dietary practices. Second, although Canadian health care professionals are beginning to address health issues specific to the Chinese population, few Chinese Canadians and especially the Chinese elderly access the health information currently available. In order to bridge the knowledge gaps and better address the dietary needs of the Chinese elderly clients, further research is required to explore how contextual factors (such as cultural, social, historical, economic, and political factors) shape Chinese Canadian seniors' dietary practices from their perspective. It may assist health care professionals in providing culturally appropriate and effective nutritional consultations to improve Chinese Canadian seniors' diets in both communities and health institutions. In addition, it may help health care institutions with updating guidelines for health care professionals who work with elderly Chinese immigrants. Furthermore, it is significant for the development of cultural competency among health care professionals by understanding the contextual factors. This includes the importance of gaining an understanding of how Chinese Canadian seniors' cultural beliefs and values shape their expectations of a healthy diet and determining factors in the context of their daily lives. Finally, it may provide a basic foundation to develop culturally appropriate and effective health education programs and services which may, in turn, further improve the health status of elderly Chinese immigrants.

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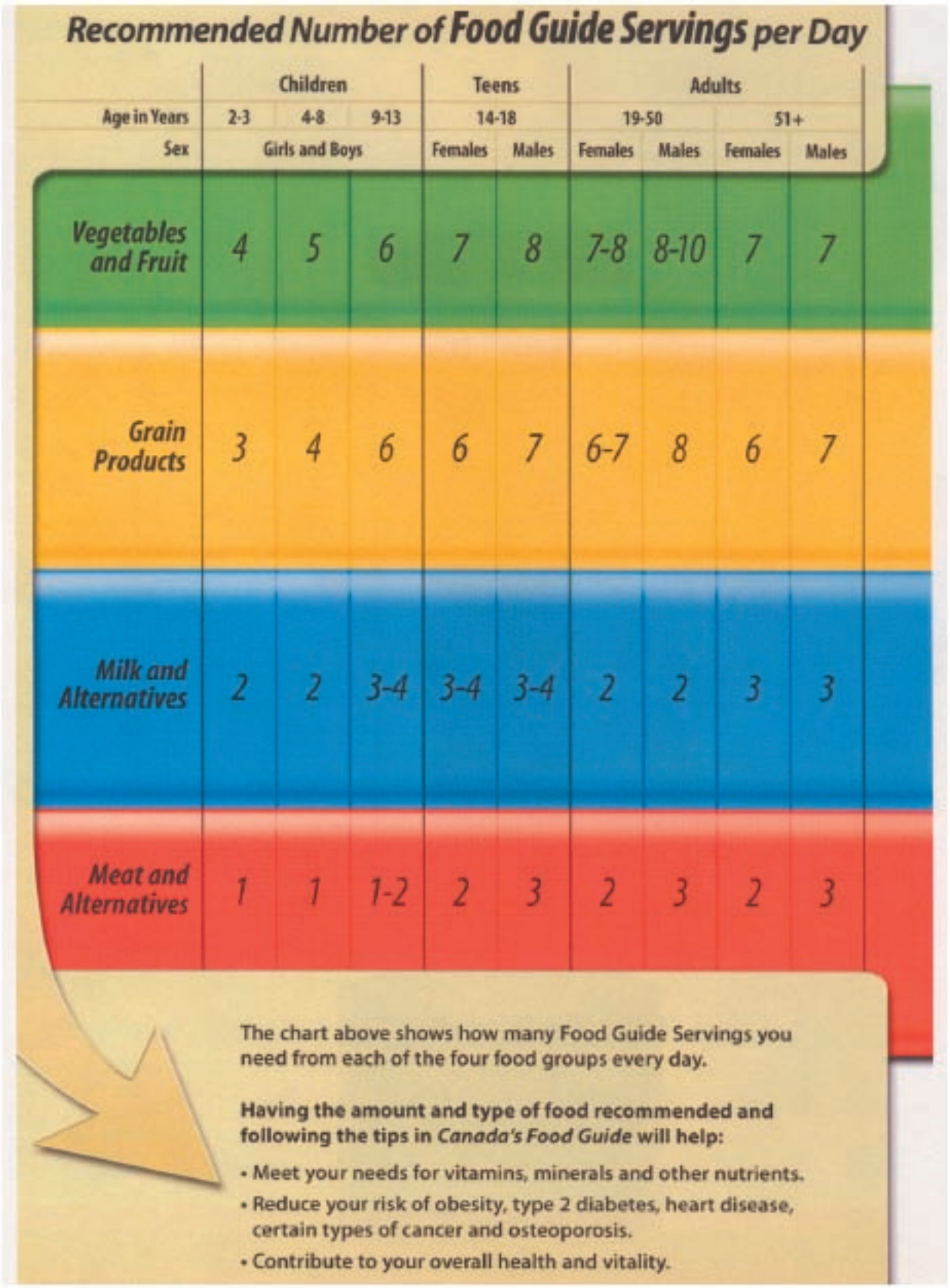
Figure 1: Canada's Food Guide



Recommended Number of Food Guide Servings per Day

	Children			Teens		Adults			
Age in Years	2-3	4-8	9-13	14-18		19-50		51+	
Sex	Girls and Boys			Females	Males	Females	Males	Females	Males
Vegetables and Fruit	4	5	6	7	8	7-8	8-10	7	7
Grain Products	3	4	6	6	7	6-7	8	6	7
Milk and Alternatives	2	2	3-4	3-4	3-4	2	2	3	3
Meat and Alternatives	1	1	1-2	2	3	2	3	2	3

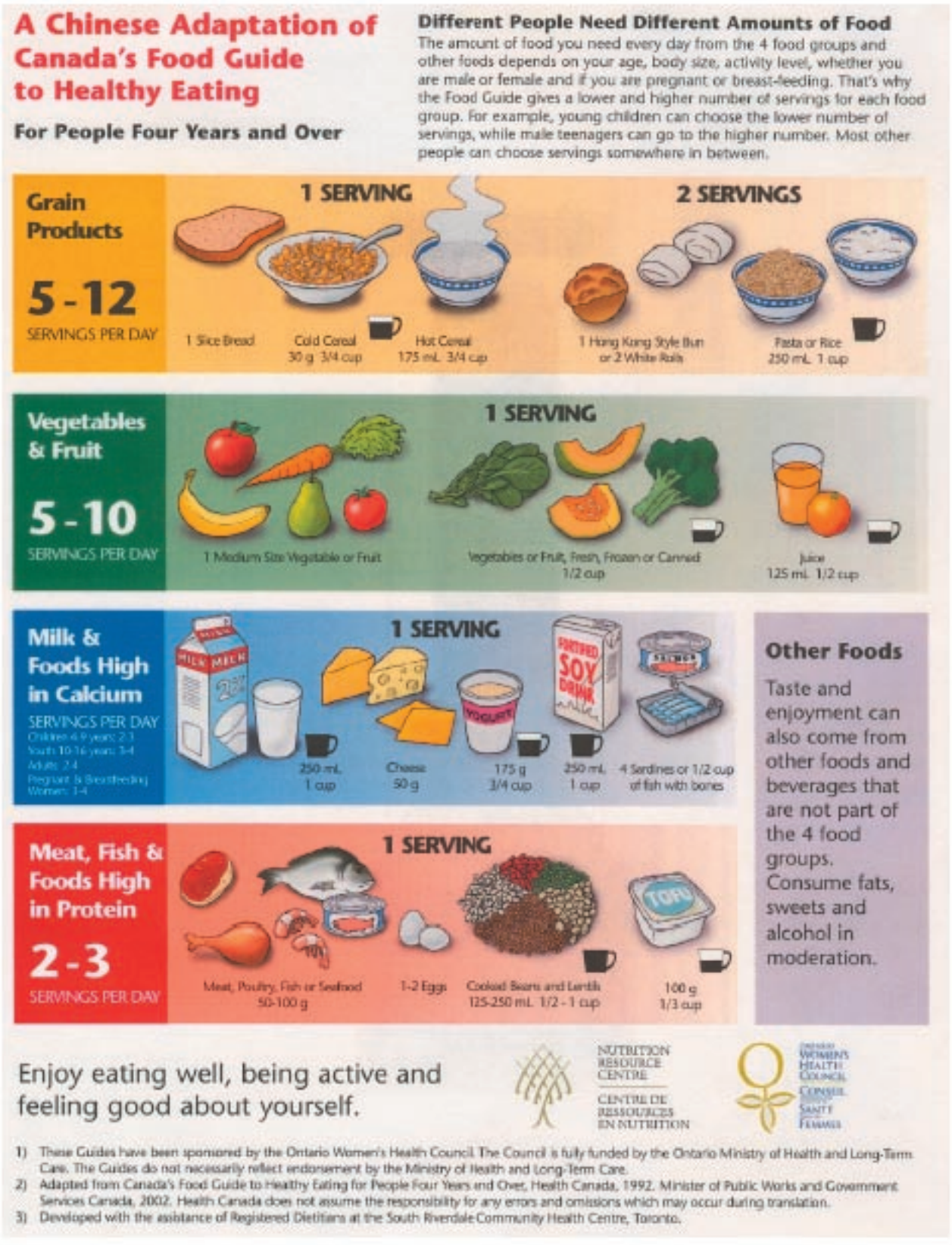
The chart above shows how many Food Guide Servings you need from each of the four food groups every day.

Having the amount and type of food recommended and following the tips in *Canada's Food Guide* will help:

- Meet your needs for vitamins, minerals and other nutrients.
- Reduce your risk of obesity, type 2 diabetes, heart disease, certain types of cancer and osteoporosis.
- Contribute to your overall health and vitality.

From http://www.hc-sc.gc.ca/fn-an/alt_formats/hpfb-dgpsa/pdf/food-guide-aliment/print_eatwell_bienmang_e.pdf

Figure 2: A Chinese Adaptation of Canada's Food Guide to Healthy Eating



From http://www.opha.on.ca/resources/foodguides/chinese_eng.pdf
Note: There is no 2007 update to the Chinese adaptation of Canada's Food Guide.

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Vietnamese Canadian Women's Breast Cancer and Cervical Cancer Screening: The Influence of Gendered Roles and Expectations

Donnelly, Tam Truong, RN, PhD.
Faculty of Nursing, University of Calgary, Canada.
William McKellin, PhD.
Department of Anthropology, University of British Columbia, Canada.

Abstract

There are approximately 76,585 Vietnamese women living in Canada. Breast cancer and cervical cancer are major contributors to morbidity and mortality among these women. Vietnamese women are at risk due to their low participation rate in these cancer preventative screening programs.

Informed by postcolonial feminism, this qualitative study explores (a) how Vietnamese women participate in breast cancer and cervical screening, (b) the appropriateness of current preventative cancer services for Vietnamese women, and (c) how Vietnamese women's cancer screening practices are influenced by social, cultural, political, historical, and economic factors which are shaped by race, gender, and class.

Fifteen Vietnamese women and 6 health care providers were interviewed. Analysis of these interviews reveals that several factors influence women's participation in cancer screening programs. This paper reports on the process by which gendered roles and expectations contributed to underutilization of cancer screening services. We make recommendations for the promotion of breast cancer and cervical cancer screening amongst Vietnamese women.

Key words: Vietnamese Canadian women's breast cancer and cervical cancer screening; immigrant women health care practices, Vietnamese women cancer preventive care.

Introduction

Vietnam began its new era with the march of the North Vietnamese troops to Saigon (now called Ho Chi Minh City) on April 30th, 1975. The downfall of the South Vietnamese government and withdrawal of the American troops from Vietnam marked a new period of Vietnamese history. With the fall of South Vietnamese government, thousands of Vietnamese left Vietnam to seek asylum in the West. Between 1979 and 1985, many of them arrived in Canada as refugees. "Refugees" as defined by the Citizenship and Immigration Canada (CIC) and following the UN Convention on Refugees (UNHCR 1951), are people in or outside Canada who fear returning to their country of nationality or habitual residence. These are persons needing protection. Canada, through its refugee protection system, aims to provide a safe environment to those with a well-founded fear of persecution, or are at risk of torture or cruel and unusual treatment or punishment (Citizenship and Immigration Canada, 2006). A large portion of these refugees came without their immediate and extended family. Many of them had suffered hardship, extreme violence, and cruelty prior to leaving their homeland and during their flight. In particular, many Vietnamese refugee women suffered from exposure to direct combat, and were victims of sexual assault and violence (Compton & Chechile, 1999, p. 191).

Despite the long history of suppression and centuries of struggle including colonial hegemony, frequent warfare, and economic domination, the majority of these refugee Vietnamese women, were able to resettle and adapt relatively successfully to a new life (Beiser, 1999; Johnson, 1999). However, the impact of cultural, social, economic, and family changes had diverse effects on women's ability to seek health care, in particular, preventative care for breast and cervical cancer.

Cervical cancer is among the most common cancers for women in the countries where Papanicolaou smears (Pap test) are not routinely performed (BC Cancer Agency, 2000), and Vietnamese-born women have a significantly higher incidence of cervical cancer (Cheek, Fuller, Gilchrist, Maddock, & Ballantyne, 1999; Lesjak, Hua, & Ward, 1999). Even though breast cancer is less common among Vietnamese women who are over 50 year old, they are more likely to be diagnosed at the late stages than women in the general population (Pham & McPhee, 1992).

Vietnamese Canadian women's cancer prevention practices are poorly understood (Statistics Canada, 2001) even though it is known that breast cancer and cervical cancer are major contributors to these women's cancer morbidity and mortality (Cheek, Fuller, & Ballantyne, 1999; King County Public Health, 2004; Lesjak, Hua, & Ward, 1999; Pham & McPhee, 1992). Early detection of breast cancer and cervical cancer through screening programs can significantly reduce mortality rates (British Columbia Cancer Agency, 2004). However, data suggest that Vietnamese women do not fully utilize breast and cervical cancer screening services (Cheek, Fuller, & Ballantyne, 1999; Jenkins, McPhee, Bird, & Bonilla,

1990; Jenkins, Le, McPhee, Stewart, & Ha, 1996; King County Public Health, 2004; Sadler, Dong, Ko, Luu, & Nguyen, 2001; Yi, 1994, 1995), putting them at significant risk due to the lack of early diagnosis and treatment for these diseases. Consequently, more Vietnamese women are diagnosed at advanced stages of breast and cervical cancer than women in the general population (Pham & McPhee, 1992; Yi, 1994a, 1995).

In Canada's 1994/1995 National Population Health Survey (NPHS), Asian women in Canada were less likely to participate in gynecological cancer prevention programs than their Anglo-Canadian counterparts. The number of Asian-born women who never had a Pap test is almost nine times higher than those of Canadian-born women (Gentleman, Lee, & Parsons, 1998). In 1996, the Pap test screening rate among Canadian immigrant women was 67% compared to 90% of non-immigrant women (Black & Zsoldos, 2003). Furthermore, Asian women who migrate to the U.S. have a six fold increase in breast cancer risk compared to the women in their native countries. Their breast cancer rates approach those of white women in the US (National Asian Women's Health Organization, 2004).

Sparse Canadian data on the Asian women's cancer screening (Black & Zsoldos, 2003; Gentleman, Lee, & Parsons, 1998), and studies from the U.S. indicate that Vietnamese women are less likely to have had cancer screening tests when compared to the general population of American women (Jenkins, Le, McPhee, Stewart, & Ha, 1996; Sadler, Dong, Ko, Luu, & Nguyen, 2001; Vo, Nguyen, Nguyen et al., 2004; Yi, 1994). A study conducted in Seattle and adjoining King County, in Washington State U.S. shows only 18% of Vietnamese women reported having had breast cancer screening in the last two years, compared to a rate of 67% of the women in the general population (King County Public Health, 2004). This study also reveals a startling figure that only 7% of the Vietnamese women participants reported having a Pap test in the last three years, compared to an overall rate of 86% in the county (King County Public Health, 2004). Another study shows that 37% of the Vietnamese women did not know that a breast lump could be cancerous (Pham & McPhee, 1992). The result from a telephone survey of 933 Vietnamese women living in California shows that 70% of these women had at least one clinical breast examination, while only 30% had a mammogram, and 53% had a Pap test (McPhee et al., 1997). Furthermore, in Australia, a questionnaire survey of 355 Vietnamese-born women by Lesjak, Hua, and Ward (1999) and an interview survey of 199 Vietnamese-born women by Cheek et al.(1999) revealed that Vietnamese women had a lower level of participation in cancer screening than that of the general population of Australian women.

In Canada, Vietnamese generally underutilize the existent health care services (Stephenson, 1995). This finding suggests that Vietnamese Canadian women might be less likely to follow cancer screening guidelines and use preventative cancer screening procedures when compared to women in the general Canadian population. Clinical guidelines in Canada recommend that:

- Women over 20 should have regular annual clinical breast examination (CBE) by doctors or other qualified health professionals and practice breast self examination (BSE) regularly (BC Cancer Agency, 2004) even though recently, it has been argued that BSE might not reduce mortality from breast cancer and may increase women chances of having a benign breast biopsy (Baxter, 2001, Thomas et al., 2002).
- Women have regular mammography according to their age/risk group or at least every two years after the age 50 (British Columbia Cancer Agency, 2004).
- All sexually active women have Pap tests at least every two years until age 69.
- Women over 69 may stop having regular Pap test if all their previous tests have been normal (British Columbia Cancer Agency, 2004).

Vietnamese health care practice is affected by cultural assumptions about gender and the body, beliefs about health, and the sources of illness (Donnelly, 2006; Stephenson, 1995; Uba, 1992) as well as the socioeconomic dynamics of immigrant women's lives (Donnelly, 2004: Donnelly et al. , in press). In the U.S. Vietnamese social values contributed to some extent to women's breast and cervical cancer screening practices (McPhee et al., 1997). Studies of Vietnamese women's screening have reported a number of barriers: low socioeconomic status, lack of health care insurance, low level of education, poverty, and never being married (Yi 1994a, 1994b). In addition, Lesjak et al. (1999) and Cheek et al. (1999) found the length of residence in the adopted country affects participation in cancer screening with recent immigrants being less likely to be screened. Surprisingly, having a Vietnamese physician (McPhee et al. 1997) and especially a male physician (Taylor, Schwartz, Yasui, Y et al., 2004) contributed to the lower participation rate of these women's cancer screening practices.

In summary, data from the U.S. and Australia indicated that Vietnamese women's low participation rate in breast cancer and cervical cancer screening programs is the result of different cultural beliefs and values, low level of education, poverty, never being married, recently

migration, and having a male physician. There is very limited information on Vietnamese Canadian women's health practices, particularly regarding cancer prevention and screening, and care seeking. Furthermore, there is very little research concerning the role of gender in shaping women's expectations and social relationships that may affect Vietnamese Canadian women's breast cancer and cervical cancer screening.

Postcolonial Feminist Perspective

These gender, cultural, and social considerations suggest that a postcolonial feminist theoretical model is appropriate to frame the research questions and methodology of our study of Vietnamese women in Canada. Furthermore, because this research is with Vietnamese women who come from a colonized society, postcolonial feminism, with its theoretical lens, issues, and debates provide valuable insights that guide the way we address and incorporate the effect of historical and gendering processes into the analysis of Vietnamese Canadian women's breast and cervical cancer screening practices (Donnelly et al., in-press).

Postcolonial feminist perspectives, generated through the convergence of post-colonial and black feminist scholarship have informed nursing scholarship in recent years (Anderson, 2002; Anderson & Kirkham, 2002; Anderson, Perry, Blue et al., 2003; Guruge & Khanlou, 2004; Racine, 2003). As Anderson (2002) points out, "[f]rom a post-colonial vantage point, we might come to understand that the difficulties people face in accessing and utilizing health care may be due …to historical processes that have produced systemic inequities and oppression" (p. 15). Whereas, black feminism provides a conceptual framework from which to examine social phenomena from the women's perspectives. Black feminism pushes us to use the everyday experiences of Vietnamese women as the sources for researching their cancer preventive behaviors. Together, postcolonialism and black feminism have directed us to incorporate not only 'race' and class relations, but also gender into our analysis to examine factors that influence Vietnamese Canadian women's utilization of breast and cervical cancer screening services. These above theoretical perspectives have directed us towards the development of the study's research questions and the semi-structured questions which we asked of our participants. Together, postcolonialism and black feminism have led us to a research methodology that "[lays] the groundwork for the analysis of gender, 'race' and class relations as simultaneous, contextualized and historicized" (Anderson, 2002. p. 19).

Postcolonial feminism aims to "shed light on the complex issues at the intersection of gender, race, class relations and culture, and further our understanding of how material existence, shaped by history, influences health and well-being for those who… have 'suffered the sentence of history…[of] diaspora, [and] displacement'" (Anderson, 2002, p. 11). Thus, postcolonial feminism serves as a theoretical lens to examine issues of equity and social justice. This is particularly significant in studies of health care, at the time when global migration, health care reform, and increase aging population are taking place in many countries. Postcolonial feminism can shed a unique perspective on issues such as equity in health and accessibility in health care services (Anderson, 2002).

Adopting postcolonial feminism, we posit that voices of Vietnamese women are legitimate and should be used as a direction for health care actions. Central to postcolonial feminism is the understanding that research should be responsive to women's specific social locations within a society, and consequently, women's health care experiences are shaped at individual and institutional interconnecting levels (Anderson, 2002).

This research on the experiences of Vietnamese women brings together two colonial and immigrant histories: that of Canada, a nation founded largely on immigration and colonization, and the national and personal histories of colonialism and immigration experienced by the Vietnamese women who participated in this study. Postcolonial feminist perspectives provide valuable insights into the development of the study's research questions and especially the analysis of the gendered marginalization that shapes Vietnamese Canadian women's health care experiences and preventive cancer practices. Thus, our study's results illuminate the difficulties Vietnamese women face in accessing and utilizing health care by revealing the historical, cultural, social, and political processes that have produced complex gendered social relationships, which in turn, influence the ways in which Vietnamese women participate in breast and cervical cancer screenings.

By employing a postcolonial feminist perspective, this research valued Vietnamese women's everyday life situations and provided a means of identifying factors that promote or impede their cancer preventive care experiences. Informed by the postcolonial feminist perspective, we investigated the processes through which gender and social relations have organized these women's lives and have shaped the division of labor between men and women, which in turn, has influenced how women participate in breast cancer and cervical cancer screenings. Details of the theoretical perspectives that guided the study were also reported in previous publications

(Donnelly, 2004; Donnelly, 2006a, b; Donnelly, 2008; Donnelly & McKellin, 2007).

Our study was conducted in one of the Western Canada metropolitan cities where the immigrant population makes up roughly 38% of its population of approximately two million. The estimated number of Vietnamese immigrants living in the whole province was 25,675 (Statistics Canada, 2001 Census). Our goal, through qualitative research, was to obtain detailed contextual information, and to capture the diversity, structural complexity, and challenges that Vietnamese women and their health care providers attribute to their thoughts, actions, and health-related behaviors towards breast cancer and cervical cancer screening. Informed by postcolonial feminism, the study addressed the following research questions: (1) How do Vietnamese-Canadian women participate in breast and cervical cancer screening programs? (2) What is the process by which they decide to engage in regular breast cancer and cervical cancer screening, and what are the key factors that influence this decision-making process? (3) How do contextual factors such as social, cultural, political, historical, and economic at the intersection of race, gender, and class affect Vietnamese-Canadian women's breast cancer and cervical cancer screenings? (Donnelly, 2004)

This paper is a report on the process by which gendered roles and expectations influence Vietnamese women's decisions regarding participation in breast cancer and cervical cancer screening, while the cultural and socioeconomic factors are examined elsewhere (Donnelly, 2004; Donnelly, 2006a, b; Donnelly, 2008; Donnelly & McKellin, 2007; Donnelly et al., in-press). All participants' names used in this paper are pseudonyms. Ethical approval was obtained from the University's Ethics Board where the study was conducted.

Research Design

Participants

This exploratory qualitative study used a maximum variation purposive sampling, which is "the process of deliberately selecting a heterogeneous sample and observing commonalties in their experiences" (Morse, 1994, p. 229). Gaining access through Vietnamese community gatekeepers and health care organizations was the main recruitment approach of this study. Recruitment of Vietnamese women was made through Vietnamese Community based organizations such as MOSAIC—a multilingual multicultural non-profit organization, Vietnamese Senior Association, Vietnamese Senior Support Groups, Protestant Church and Women's Support group, and by personal referral from the Vietnamese community workers and the women participants. Letters specifying the study's purpose, objectives, research questions, and recruitment criteria were provided to community agencies. The primary researcher made several presentations about the research project to community agencies. Participants and personnel from community agencies were asked to contact potential participants who fit the study criteria, to inform them about the study, and to ask their permission for the primary researcher to contact them. Once she received permission to make contact, she then talked to potential participants via telephone. During the initial telephone conversation, the primary researcher explained the study to potential participants in Vietnamese, answered any questions, and invited them to participate in the study before scheduling an interview. No incentive was offered to participants.

Fifteen Vietnamese immigrant women participated in this study. See Table 1. The Vietnamese women had diverse backgrounds. Their ages ranged from 46 to 78, they came from both the North and the South of Vietnam, and had lived in Canada an average of 22.7 years. Their educational backgrounds ranged from grade 2 to university graduates from Vietnam, with one third having grade 2-3 education, and nearly half of the women had less than a high school level education.

Recruitment of health care professionals was done by referral from community workers, community health nurses, and by personal referral from physicians who also participated in this study. Four Vietnamese speaking family physicians and two community health nurses participated in this study. Although an effort was made to recruit Vietnamese female physicians as participants, the only two female physicians available were too busy to participate. The Vietnamese physicians interviewed had worked in Canada from 4 to 21 years. One community health nurse had worked with Vietnamese women for 4 years, while the other nurse worked with Vietnamese women for more than 15 years.

Method of Data Collection

Individual in-depth interviews using a semi-structured questionnaire were conducted in the language that was preferred by the participant. Interviews were conducted with the women participants in Vietnamese. The physicians were also interviewed in Vietnamese while the interviews with 2 community health nurses were conducted in English. Interviews with the women participants lasted between 3 to 4 hours. Interviews with health care providers range from ½ hour to one hour. Each participant was interviewed once, except for six participants whom we went back to validate our preliminary results. With the participants' permission, all the interviews were audiotape recorded. Women

Table 1: Vietnamese-Canadian Women Participants' Profiles

(N = 15)

Variable	Range	*f*	%
Age	40 – 49	1	7%
	50 – 59	5	33%
	60 – 69	3	20%
	70 – 79	6	40%
Years living in Canada	5 – 9 years	1	7%
	10 – 14	3	20%
	15 – 19	1	7%
	20 – 24	5	33%
	25 – 30	5	33%
English speaking	Not at all	3	20%
	Poorly	5	33%
	So-so	4	27%
	Well	2	13%
	Fluently	1	7%
Education	University or college	4	27%
	Some University or college	2	13%
	High school	3	20%
	Grade 4-11	2	13%

participants' demographic data were also collected to gain more insight on other factors that might influence their ability to participate in breast and cervical cancer screening. The primary researcher, who conducted the interviews, is a Vietnamese woman who had immigrated as an adult to Canada during the same time period as many of the women she interviewed. Fluency in Vietnamese gave her the ability to conduct interviews in Vietnamese and to understand the participants' narratives.

Data Coding and Analysis

Data collection and analysis occurred concurrently. As data were obtained, they were transcribed in Vietnamese. To ensure accuracy, the transcripts were first rechecked against audiotape tapes before a hard copy was prepared for preliminary data analysis. In the early stages of analysis, transcripts were coded line-by-line and a list of preliminary code categories was formulated. These code categories were refined as subsequent data were gathered and analyzed. Data coded in one category was examined for its relevance to other categories. This process of analysis involved a systematic and rigorous development of code categories and subcategories, which were flexible, evolving, and used for the coding of subsequent transcripts. The final outcome of this analysis is a statement about a set of complicated interrelated concepts and themes. Themes and concepts were then compared within and across transcripts in individual's accounts and across participants in the data set. From this, a higher level of data conceptualization and broader theoretical formulations were generated. To ensure the study's rigor, preliminary results of the analysis were discussed with six participants whom the researcher believed could give insightful and reflective responses. These included two Vietnamese women, three physicians, and one community health nurse. This process enabled the researcher to clarify, expand, and discuss with participants the emergent themes, ideas, and concepts. It also allowed the researcher to validate findings and develop a more comprehensive understanding of the data and the social processes and structures that influenced these Vietnamese women's breast cancer and cervical cancer screening practices.

Findings

During the interviews, the women reported the frequency of their use of screening practices. Five or 33% of women participants had Pap smears regularly once a year (the screening practice recommended by the British Columbia Cancer Agency). Seven or 47% have mammography regularly every 2 years. Three or 20% have clinical breast examination regularly once a year. Only 1 or 6.6% practice breast-self examination regularly once a month. Analysis of the interview data revealed that traditional gender roles and expectations influenced women's educational opportunities and shaped women's family relationships and domestic activities, which in turn affected the ways in which these Vietnamese women participated in breast cancer and cervical cancer screening programs.

The Influence of Traditional Gender Roles and Expectations on Women's Education

Under the influence of traditional Confucian educational values women were excluded from education and administrative positions (Nguyen Khac Vien, 1974). Although many changes occurred during the later half of the 20th century, women's education is still very often regarded as secondary to that of men. Some older women participants, who did not have educational opportunities in either Vietnamese or French when they were young, are experiencing more difficulty in Canada as a direct result of their lack of education and language abilities. Coming to a new country and adjusting to new ways of living is hard enough; mastering a new language is even more difficult for them. Several women participants speak of this difficulty.

> *Mrs.. Mai: I don't understand what they say at all. If they ask me "how are you?" I say "thank you." If they ask me another question, I cannot say thank you then I would say "so so." Just that, only a few sentences. I cannot learn any English. It doesn't go into my head. My tongue cannot say the words. It is very frustrating.*

Although she has lived in Canada for more than 10 years, Mrs. Mai cannot speak English. She thinks she cannot learn English because she had very little education as a child.

> *Mrs. Mai: I did not go to English classes. Only my husband went. He understands more. My tongue would not speak … Because I have a very low education, I was afraid that I could not learn what they wanted me to learn. I only have grade three education. What can I do with grade three education?… Back then, my husband had time and his family gave him opportunity to study.*

Similarly, Ms. Lyn has lived in Canada for 14 years. She was one of the most articulate of the women participants. Yet, Ms. Lyn feels that she does not have the capacity to learn English due to her lack of education.

> *Mrs. Lyn: It is very difficult for me to learn English because I don't have the necessary education. Even in Vietnam, my education was very low… I was not allowed to learn much. My parents told me that girls should only need to learn how to read and write. Too much education would make them bad because they would just use it to write letters to boys. They did not let me go to school. That was why I don't know much. I only know how to read and write in Vietnamese … So you see, because my education is very low, I cannot learn English. I cannot remember.*

Because much of information about breast cancer, cervical cancer, and its screening are written in English, this information is inaccessible to these women. Furthermore, their inability to speak the host language, coupled with their unfamiliarity with the society's organizational structure and services have made it very difficult for older women to access the available health care services and institutionalized support networks. Mrs.. Hai who has been living in Canada for 22 years describes (Donnelly & McKellin, 2007, page 7):

> *I still don't know much about the health care system. I just go to the doctor. Some time, we go to the hospital if it is an emergency… I don't know about other things. Also, any social resource or support, social organizations, I don't know.*

The influence of Traditional Gender Roles and Expectations on Family Dynamic Relationships

Some Vietnamese women participants found it difficult to persistently struggle against the domination by traditional gender roles founded upon an ancient ideology. Although some women felt that equality between men and women has improved, some men have resisted changing their ideas about Vietnamese women's roles, and their struggle toward social equality. For example, although the practice of polygamy was abandoned many years ago, some men choose to continue this practice by having mistresses or simply by being promiscuous. When this happens, a wife is often the one who feels more shame, rather than the man, and she rather than he is likely to be criticized and blamed for the man's behavior. The husband's misconduct is often looked upon as the wife's

weakness. She is held responsible for her inability to make her husband happy. Thus she must not be a good wife or a desirable woman. She is a woman who is *vo phuoc*, a woman who does not inherit any good luck from her ancestors' good deeds and a very unlucky woman.

> *Mrs.. Le: For Vietnamese women, we have learned to accept things since we were born. Everything was our doing. If our husbands are unfaithful, we say it is our destiny to have such husbands and because it is our destiny, we just accept it…. There are many women who would not say anything about their husbands because if they do, it is like you are talking bad about your husband, you are 'vo phuoc' to have such husband…. So it is more embarrassing for a woman to admit that her husband is not good to her. Everything has to be covered.*

This ideology and discourse of saving face for one's husband and oneself, coupled with the language barriers, which may create the need for a translator, has a direct influence on how Vietnamese women think of and participate in cervical cancer screening program. Because having problems "down there" is often associated with husband's unfaithfulness, social stigma and the potential lost of face may present barriers for some women to engage in frequent Pap testing.

Mrs. Phi: The language is a barrier, because each time they go, they have to find a translator. And they just can't find a translator anytime they want. Finding a translator is difficult. They are not even comfortable with the translator. If I have a headache or a runny nose then it's okay, translate for me, but [voice lower] if I have white discharge, or if I have got an infection from someone, I would not dare saying anything about it. If you have STD, of course you don't want anybody to know. It's embarrassed because they will question why you have that disease. Is it because of her husband is running around? For a woman to say that her husband is running around, it is a big embarrassment. Beside that, if the woman is single, oh, she must have many partners, etc. So, I think all that prevent Vietnamese women from going to the doctor for this kind of things. For Asian women, this kind of things is difficult to talk about. They might not even talk to their own husband that they have pain there, let alone talking to another man about it.

The influence of Traditional Gender Roles and Expectations on Women's Domestic Activities

Even though some studies have found that Vietnamese living in contemporary Vietnamese society might not necessarily follow traditional family practices and expectations (Luong, 1984; Hirschman & Loi, 1996), traditional attitudes still persist, even if they are not practiced consistently. Very often Vietnamese women were expected not only to take care of their children and spouse, but also members of the extended family (Maltby, 1998; Dinh, Ganeson, & Waxler-Morrison, 2005). A comment by Mrs.. Hai, one of the study's participants, illuminates this ideology at work:

> *Mrs. Hai: I am most concerned about my children... I think about the family situation for my children. I am concerned with looking after the family, eating, and cooking. Because I am a woman, I have to pay attention to those things…Vietnamese women, we go to the market, we cook. We organize our family. We take care of the family financial situation, how to spend, making sure we don't have too much debt… We are concerned with our children's future. We are also concerned with our parent from both sides [the wife and the husband sides]. We are concerned with our sisters and brothers. We are also concerned with our friends, people around us, and the people at the church. (pause). That's it.*

Several women participants found that in Canada, it is difficult to meet these expectations. Added to the pressure of performing these caregiver's roles, was the difficulty of adjusting to the new life, different living arrangements, and busy working schedules.

> *Mrs. Phi: At home, the parents don't need their children as much because they have friends. Here, in Canada, many parents feel insecure because they can not speak English. So they have to rely on their children more. Having their children with them make them feel more secure. So, here, performing the children's role is much more difficult. They have to take care of their husbands, their children, and also their parents. The main person is a woman.*

An important virtue that is instilled within many Vietnamese women is that one should always put the family and group interests before one's own self-interest. The pursuit of individual goals is frowned upon as selfishness. Thus, putting oneself second to family and husband is looked on as a great virtue of Vietnamese

women by some Vietnamese women participants. When asked about how Vietnamese women's gendered roles and expectations affected the ways they took care of themselves by participating in preventative cancer screening, a 50-year- old woman who has lived in Canada for 23 years said:

> *Mrs. Le: Because the family is considered as most important, they tend to forget about themselves. They worry about their families too much. Vietnamese women think about their families too much so they don't think about themselves… Because we are women, we are bounded to our duties.*

Caring for children comes before caring for one's self as Ms Minh recounted:

> *Mrs. Minh: For us, as a family, the first priority is our children. The children should have enough, then we are second… For Vietnamese, the parent's needs are second. For the woman, not only the children, but also the husband come first and she is second. That's Vietnamese way … Yes, it is a Vietnamese thinking … We brought all that with us here. We still think the same way.*

Individuals who exhibit self-negation, self-sacrifice, and modesty are considered to have good moral character. These values are reinforced and supported within the Vietnamese community by the high regard that is given to these women as "good mothers," "good daughters," and "good women." These qualities can be the bases for community support networks for women. These cultural values and expectations have led some Vietnamese women to view additional responsibilities and hardship as opportunities to demonstrate their moral courage given the circumstances and "the way things are." When asked if she ever thinks about herself, Mrs. Hai responses:

> *Mrs. Hai: Yes I do. But when I think about myself, I think that I have to stay healthy so that I can look after my family. Yes. I do… I do think about myself but I don't consider that as important... If I think about myself, I just think about going to work. Even when I am sick, I go to work instead of staying at home or going to the doctor… That is just the way it is.*

Although many Vietnamese still retain many of their values and beliefs, adaptation to this new way of life and integration into Canadian society have changed their social roles and relationships. Economic adaptation has also necessitated role changes for men and women within the family structure. As with many Western families, to make ends meet, both husband and wife need to enter the labour force. In the traditional Vietnamese family, the husband should be the breadwinner, whereas the woman's economic contribution is viewed as secondary to that of the husband (although, in reality women often end up being the breadwinner of the family).

> *Mrs. Minh: For Vietnamese, the husband might be the main breadwinner. But the wife is the one who looks after the spending and family financial situation. She also looks after meals and family activities. The wife has all that responsibilities … The Vietnamese women have more responsibilities. How a woman runs the family results in a "bad" or a "good" family.*

Thus, working conditions and dedication to family responsibilities over concern for themselves, in the view of women participants, are indirect barriers for women to participate in breast cancer and cervical cancer screening programs.

> *Ms. Lyn: Many Vietnamese women have a very difficult life because they don't have anyone to give them support. Not only that they have to look after their children, they have to make a living as well. They have to work very hard. It is very difficult [to think about cancer screening].*

Even health care providers recognized that concerns for family income and care-giving supplanted participation in preventative screening for beast and cervical cancer. As one of the physicians has said:

> *Dr.. Dau: There are other issues. Their jobs and other things, so even they (Vietnamese women) see that health care is important. Other daily things take priority. This new society has too many issues that they have to deal with. Many issues that are important to the Western women, are not necessarily important issues for these Vietnamese refugee women. It is not that they don't know about it (breast and cervical cancer screening programs), but there are just too many other things that they have to deal with.*

Discussion and Conclusion

Gendered roles and expectations influence the ways that Vietnamese women manage their health and participate in health care practices. It is important to acknowledge that although Vietnamese women's social relationships, their roles and expectations were shaped for many decades by traditional cultural practices and Confucian teachings that are integrated into many aspects of their lives, the present society's social and political

natures play an important role in constructing the ways in which these women live and practice health care.

For older Vietnamese women, limited English skills and perceived inability to learn the host country's language due to low educational levels is a direct barrier for them to participate in cancer prevention programs. Because much of the information on the prevention of breast and cervical cancer is in the host country's official languages (in Canada, it is English and French), this information is inaccessible to these women. As indicated by the women participants, this is one of the main reasons why Vietnamese women underutilize breast and cervical cancer screening services. Thus, to promote women's participation in breast cancer screening and Pap testing, information about these diseases should be made accessible to the women in Vietnamese. To increase community awareness about these diseases, both formal (i.e., workshops, teaching sessions, distribution of pamphlets, and books) and informal (i.e., word of mouth, discussions among friends) routes should be taken. Health care seminars and workshops about breast and cervical cancer prevention should be provided to the women by the Vietnamese speaking personnel who understand and respect the women's hesitations and addresses these issues in culturally sensitive and appropriate ways. Institutional funding should be made available for the training and hiring of Vietnamese community outreach workers and the translation of information into Vietnamese that can be understood by the women.

Congruent with the postcolonial feminist perspectives, this study found that the difficulties Vietnamese women face in accessing and utilizing breast and cervical cancer care are due to their 'culture', but also to historical processes that have produced gendered roles and expectations, which in turn, influence how women receive health care and cope with illness. Anderson, Blue, Holbrook, and Ng (1993) found that non-English-speaking immigrant women were unable to obtain health care services that they needed because of the position and condition in which these women worked and lived. Thus, it is imperative to examine the effect of unequal gender relations. Examining gender inequality in relation to women's roles and expectations social class, education, and economic opportunities, can illuminate factors that influence women's everyday life and how it impedes immigrant women's ability to access cancer preventive care services.

Many elderly Vietnamese women cannot speak, read, or understand English. In addition, traditionally, Vietnamese health care education and practices often involves informal oral teaching where one learns how to take care of one's health by listening to each other. Grandmother, mother, and aunts are instrumental in relaying health care information to the younger generations. With the influence of biomedicine health care and education, younger generations have now acquired health care knowledge through the formal school system. However, the practice of oral tradition still exists and remains an important way of distributing health care information among the Vietnamese community members, especially among the elderly. As such health care providers should consider women's different ways of knowing when promoting breast cancer and cervical cancer screening.

To have a person who has a disease to share her experience with other members of the community is a powerful strategy. However, finding a suitable volunteer might be very difficult because of the privacy issue, the social stigma, and the moral assumptions that are associated with these diseases, especially, cervical cancer. Because cervical cancer has been associated with the infection of human papilloma virus (HPV), a history of sexually transmitted diseases, multiple male sex partners, and early age of first intercourse, for a Vietnamese woman to admit that she has cervical cancer is equivalent to admitting that she might have one or all of the above mentioned risk factors. It might also mean that she is not a "good" woman or that she is *vo phuoc* to have a husband who "runs around" and gave her the disease. This will prevent women from talking about the problem, and might even prevent them from going for a Pap test due to the "fear of knowing."

The high rate of cervical cancer among Vietnamese immigrant women revealed by the U.S. National Cancer Institute should not be construed as the result of the women's sexual practices because the majority of Vietnamese women value and practice monogamy. Many of them have placed great emphasis on virginity before marriage. Therefore, more research is needed to investigate what causes Vietnamese women's high incidence rate of cervical cancer. This high incidence of cervical cancer might be the result of low Pap testing among the Vietnamese women, hence the precursor lesions are not detected and treated before progression to cancer. Furthermore, because the racial/ethnic differences in cervical cancer rates are also the negative effect of socioeconomic status and access to health care (Lawson, Henson, Bobo, & Kaeser, 2000), information that is being provided to the Vietnamese women regarding the etiology of cervical cancer should emphasize this fact to reduce social stigma associated cervical cancer.

Living in Canada, some women participants found that they are still living under the ideology and practices that denied them independence. The traditional value

placed on their roles as family care takers manifest itself as a barrier in Canada that undercut their status within the family and community, and deterred them from seeking health care. These practices coupled with traditional ideology requiring Vietnamese women to honor, obey, and be loyal to those who are in a higher status, made it difficult for these women to voice their dissatisfaction with health care services. As a result, they may choose to remain silent, and the government has consequently overlooked their health care needs.

Because putting the family before one's self-interest is still considered an important virtue by many Vietnamese women and their communities, women face adverse conditions with patience, silent suffering, and perseverance. This behavior is related not only to a long history of struggle against Confucian ideology, harsh, feudal systems, and colonial regimes, but also to the fact that patience and courage are valued as moral virtues and rewarded within the community. However, health care professionals should be aware that by focusing and praising these women's gendered roles and expectations, we might, in fact, participate in the reproduction of the unequal social relations between men and women, and create circumstances that interfere with women's involvement in health care programs.

It is also important for health care providers to recognize that although superficially the Vietnamese appear to have some commonality, there is also diversity among Vietnamese Canadian women. They come from different backgrounds, have different experiences, and encounter different obstacles. Thus, although some women take pride in how they put their families and children before themselves, others might resent the expectation that their needs must be considered as second to everyone else.

Given that many Vietnamese women have considered family and children as priorities, health promotion and disease prevention strategies should address issues within the family context. A health promotion discourse that capitalizes on individual interests, on doing good for oneself, might not be an effective message. The Western value of individualism which these strategies take for granted is contrary to the norms of Vietnamese women's communities. Focusing on the interest of both the individual and the family's, or presenting them as congruent, might be a more culturally appropriate and effective in promoting health care among immigrant women. Because an individual's health care practices often become a family's practice, promoting women's health care, particularly breast and cervical cancer screening programs, should make all female family members as its target population. Information on breast cancer and cervical cancer should be made accessible to all family members, which include elderly, women, men, and children (Donnelly, 2006).

Difficult working conditions; diminished support from family members, friends, and limited language skills are barriers for immigrant women to form a solid social support network, which in turn, affect women's ability to access the available cancer screening programs. Health promotion and disease prevention programs need to take into account not only the very different world-views of the women whom they aim to serve, but also their lived actualities.

In conclusion, providing effective high quality health care that is culturally appropriate and acceptable to immigrant women, and understanding their lived experiences, are essential to foster women's participation in cancer preventive screening programs. Gendered roles and expectations developed from both their colonial histories and immigration experiences influence how Vietnamese women use health care services and participate in breast and cervical cancer screening programs. This study also confirms that older Vietnamese women's low educational level due to limited educational opportunities, family relationships, and daily domestic activities are major deterrents to the ways in which they access health care and contributed to these Vietnamese women participants' underutilization of breast and cervical examinations. It is equally important to recognize that although traditional ideologies have had many negative effects on the lives of Vietnamese women, history has proved that even though Vietnamese women have suffered extreme hardship, they are capable adapting well to life in Canada.

Finally, to provide quality and equitable health care to immigrant women, an alternative approach is needed that is not only culturally sensitive, but one that also considers the many factors that affect their lives. Health care services ought to move beyond the treatment of diseases. It must recognize the occupational, educational, linguistic, and family dynamics that affect women's access to health care services are the reflection of the intersection of colonialism, gender, and class. These social and historical forces shape an individual's multiple social positions and create unequal social relations, which in turn affect health and health care practices.

Acknowledgements: *We are grateful to all the women and men who participated in this research and the National Cancer Institute of Canada for the PhD Research Studentship Award, which provided Tam Truong Donnelly with funding from the Canadian Cancer Society. She also gives special thanks to Dr.. Joan Anderson, Dr. Bonnie Long, and Dr. Nancy Waxler-Morrison of University of British Columbia and Dr. Gregory Hislop of the British Columbia Cancer Agency for their mentorship.*

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Book Reviews

Bamford, Sandara. Biology Unmoored: Melanesian Reflections on Life and Biotechnology. Berkeley, CA: University of California Press, 2007. ISBN 978-0-520-24713-0. 245 pp. $21.95 (Paperback)

Following Schneider's critique on the anthropological study of kinship, Sandra Bamford writes an excellent account of "what it means to live in a world that is not structured in terms of biological thinking" (Bamford 2007:5). In Bamford's discussion, she presents an account of a non-biological kinship system in order to leverage an argument about the possibility of biological thinking being a new form of Western imperialism. In *Biology Unmoored*, Bamford demonstrates how firmly the biological framework shapes Westerners' views of reproduction, kinship, and the life course. To better understand the ways in which Westerners view these relationships, Bamford exemplifies the views of Kamea persons who understand reproduction and relationships through nonbiological means. Bamford intertwines three years of ethnographic fieldwork in Papua New Guinea with discussions of ongoing reproductive issues in the United States. She then compares how certain assumptions regarding reproduction are formed and influence the social, political and economical landscapes in which United States citizens live. The use of these recent reproductive events in her analysis enforces her argument that Westerns live and think in a biological framework that depends on physiology. Then, switching back to her rich ethnographic data, she further demonstrates that this biological framework is not a universal way of thinking. As such, she examines and challenges the past and current Western social science theories and paradigms of kinship calling for theories that are not grounded in biological concepts now embedded into Western thought.

In the first part of the book, Bamford discusses both the relationships between people and the organic world and the relationships between groups of people. Her examples include genetically modified organisms and fertility clinics, which demonstrate the connection of parent and child through substance that persists in Western thought. To halt this notion, Bamford illustrates how the Kamean perceive the link between mother and child through only maternal links. She next focuses on the human body and the debates surrounding the moment when a fetus becomes a human. Recently, in Western thought, a fetus begins to have personhood and legal rights at conception. To counter this biological mentality, Bamford discuses the ritual processes in which a young man becomes an autonomous agent in their society, but not until adolescence. Bamford then discusses death in both Western and Kamean views, emphasizing the differences in notions of individuality. In conclusion, Bamford examines the implications of global biologicalization and how a universal worldview with a biological backing would change how certain people view birth, life, and death.

Bamford incorporates three main themes in *Biology Unmoored*. The first theme is the fact the majority of the current social science theories utilizes a biological framework as their grounding. In studying a culture where biology is not part of their reproductive thinking, these theories are not adequate to explain the kinship systems occurring within the Kamean tribe. Therefore, other ways to explain Kamean practices and thoughts are necessary. The second theme integrated throughout the book is in regards to kinship studies and human-environmental relationship studies and the need to combine these thoughts together to create a comprehensive understanding of the Kamean views of the connectedness between humans and other species. Finally, Bamford discusses the implications of "biological imperialism" (2007:12) on indigenous peoples' views of personhood and life in general.

One shortcoming that the author readily admits within the book is the dualisms that she relies on to state her objectives. Her ethnography is a comparative work and the dualism of Americans versus Kamean is not that transparent. These two cultures are not exact opposites and the individuals within these cultures do not all share the same assumptions, therefore some of the comparative information and some of the generalizations regarding both groups should be viewed with vigilance.

Biology Unmoored is an important work that emphasizes and makes obvious how entrenched in biology Western theory has become as the scientific technologies advance. One way to recognize this entrenchment is to examine thoughts that are not doused with biological notions. This work sheds a light on truisms that appear to be not so true in all settings and also cautions Westerners about the harms that could be encountered by populations who do not regard life in the same manner. This book is an important addition to life course studies and will enhance our understanding of the influences of technology on the life course of various populations.

Jennifer Van Nuil, M.A.
Department of Anthropology
Wayne State University

AAGE Member News

Margaret Perkinson, Ph.D.
St. Louis University

Athena McLean, PhD, continues her amazing productivity. She shared a detailed account of her recent work in Ireland:

"I am doing a few different things here in Ireland. I am based at the Irish Centre for Social Gerontology, the National University of Ireland, Galway (NUIG), as the Senior Researcher heading the Ethnography Research Unit of the TRIL (Technology Research for Independent Living) Centre. TRIL is an initially 3-year, 30 million euro project co-funded by the Industrial Development Agency (IDA) of Ireland -- the most economically successful global development agency -- along with the INTEL Corporation. The project involves an academic-industry partnership, with St. James Hospital in Dublin and three universities (though this is likely to expand) -- NUIG, Trinity College, Dublin, and University College, Dublin. This is a multi- and increasingly inter-disciplinary venture that involves geriatricians, including specialists in geriatric psychiatry and epidemiology, academic engineers, designers, social and behavioral scientists, cognitive and neurological researchers from the universities as well as engineers, designers and social scientists from INTEL. The research begins with 600 volunteers who come in to St. James Hospital for many hours of physical, social and cognitive assessments. This pool of volunteers serves as the base for other substudies in which they may have interest within general ethnography, or the three strands of research I describe below.

The stimulus for the research has been the awareness of the changing demographic of ageing in Ireland in light of a shrinking number of family and domestic caregivers, along with the desire of many people to continue to remain at home or in the community. The goal, then, was to target areas to help facilitate independent living through the use of technologies. The areas targeted include the three strands of the research -- Falls, Cognitive, and Social Connections. The thinking here is that there are three major areas (although certainly others as well) that are major impediments to independent living -- falls and incapacitating injuries they may entail, cognitive impairments, and social isolation. We have three sets of researchers targeting each area, each supported by at least one ethnographer from my team and engineers/designers. Together, we are working on developing technologies that might prevent falls, provide early detection of cognitive impairment, while developing possible ways to bolster attention, and finding ways of getting people more connected through technologies in the home or community. Of course, this means attending to macrostructural needs (e.g., transportation) as well as microstructural issues in the home.

My own work has three components. First, it begins (like that of the two ethnographers on my team) with baseline ethnographies with older people in their homes and communities to begin to get some understanding of the experience of ageing in a rapidly changing Irish society. That has meant anything from spending time with people in the clinic, church, their homes, shopping, or other places that are part of their daily lives. This could range from 1-6+ meetings depending on the length, issues raised, etc., although contact continues with all participants.

Second, I have been involved working with researchers on the Cognitive strand who are developing research projects to "engineer alertness" and develop early biomarkers of cognitive decline, using speech samples. My focus has been on helping to make the research user friendly, and bring in the user perspective to refine the research instruments, but also to determine the actual interest and relevance of the research and eventual interventions that might result. This part is just starting for me, but it has involved regular meetings with the researchers and designers, and as the research progresses, older users will have a direct involvement in discussing ideas with us to consider viability, interest, and ways to improve design.

Finally, through the Irish Centre for Social Gerontology at NUIG, I have also been involved in policy work, bringing in my US perspective about long term care, while meeting with policy makers about developments in policy. I have met with countless researchers, practitioners and policy makers who are trying to find ways of providing care people want during in an economically difficult period, where the Health Services Executive in undergoing pressures and severe dissatisfaction. I have also been fortunate in having been able to participate in European conferences on dementia, e.g., as an invited speaker at the Journal of Dementia Care, at Alzheimer's Europe and at an new initiative in the EU of the Senior Project, that is exploring a roadmap for e-inclusion of elders in the future of Europe and considers such timely issues as the ethics of monitoring of older people, through the use of sensor technologies. At the Senior Confer-

continued on page 91

AAGE Business

Candidate Biosketch and Statement

Bo Xie
Ph.D., Science and Technology Studies, Rensselaer Polytechnic Institute, 2006
Assistant Professor, College of Information Studies, University of Maryland, College Park, MD

Research: My research focuses on the intersection of older adults, information technology, and health. Specific areas include: older adults' learning and use of information technology; computer literacy; senior-friendly computer design and training; lifelong learning; civic engagement; volunteering; social relationships; social support; online communities; psychological well-being; health literacy.

Recent Publications: Xie B. in press. The mutual shaping of online and offline social relationships. *Information Research*; Jaeger PT, Xie B. in press. Developing online community accessibility guidelines for persons with disabilities and older adults. *Journal of Disability Policy Studies*; Xie B, Jaeger PT. in press. Designing public library computer training programs for older adults to promote technical skills and personal well-being. *Public Libraries*; Xie B, Jaeger PT. 2008. Older adults and political participation on the Internet: A cross-cultural comparison of the United States and China. *Journal of Cross-Cultural Gerontology* 23:1-15; Xie B. 2008. Civic engagement among older Chinese Internet users. *Journal of Applied Gerontology* 27:424-45; Xie B. 2008. Multimodal Computer-Mediated Communication and Social Support among Older Chinese. *Journal of Computer-Mediated Communication* 13:728-50; Kazmer MM, Xie B. 2008. Qualitative interviewing in Internet studies: playing with the media, playing with the method. *Information, Communication and Society* 11:115-36; Xie B. 2007. Older Chinese, the Internet, and well-being. *Care Management Journals: Journal of Long Term Home Health Car*e 8:33-8; Xie B. 2007. Using the Internet for offline relationship formation. Social Science Computer Review 25:396-404; Xie B. 2007. Information technology education for older adults as a continuing peer-learning process: A Chinese case study. *Educational Gerontology* 33:429-50; Xie B. 2006. Perceptions of computer learning among older Americans and older Chinese. *First Monday 11:URL: http://www.firstmonday.org/issues/issue11_10/xie/index.html*; Xie B. 2005. Getting older adults online: The experiences of SeniorNet (USA) and OldKids (China). In *Young Technologies in Old Hands - An International View on Senior Citizens' Utilization of ICT*, ed. B Jaeger, pp. 175-204. Copenhagen, Denmark: DJOF Publishing; Xie B. 2003. Older adults, computers, and the Internet: Future directions. *Gerontechnology* 2:289-305.

Statement: As society moves forward into the information age, older adults are at risk of being left behind, since their adoption of computer technology, including use of the Internet for health information, lags significantly behind other age groups. To narrow the generational digital divide and to facilitate the use of the Internet to address health disparities, it is essential to design senior- friendly computer interfaces and systems and to develop and provide effective health-oriented computer training programs for older adults. In my research I strive to explore design and training interventions to help to promote older adults' adoption of information technology. I hope to have the opportunity to contribute to the continued growth of AAGE by helping to share the goals and objectives of this association with other groups.

Member News, continued from page 90

ence, bringing in our work at TRIL, as well as other relevant research, I recently spoke on the issue of Homeliness in its multiple dimensions of meaning, technologization, social consequences of shifts of care from the institution to the home and the fears of substituting technologies for people. This was an exceptional opportunity to participate on a forum that seriously examined ethical issues in the future of technologies with older people in Europe.

Congratulations to Samantha Solimeo, PhD, who was recently elected to the Committee on the Status of Women in Anthropology, Undesignated Seat #1! Her term begins at the conclusion of this year's AAA conference.

AAGE ELECTIONS
For SECRETARY
Term starts November 2008

The elections committee certifies that the following candidate has agreed to stand for election for the position of Secretary. Please read the candidate statement in this issue of AAQ and place a check next to the candidate's name to indicate your vote.

Secretary:

Bo Xie _____

(Unopposed)

Return your completed ballot to:

Rebecca Berman
626 Florence Ave
Evanston IL 60202

OR

rlhberman@comcast.net

AAGE Business

NEW EDITION OF *THE CULTURAL CONTEXT OF AGING IN PRESS*.

The new edition (3rd) of *The Cultural Context of Aging: World-Wide Perspectives* (Greenwood) should be available for classroom use Spring 2009. Teachers can contact Jay if they are teaching in the fall about getting some pre-publication chapters for use in class.

This edited text is completely revised with over twenty new original works covering China, Japan, India, Indonesia, Peru, indigenous Amazonia, rural Italy and a variety of ethnic groups in the U.S.. A new feature of the book includes a web section of classic articles integrated into the table of contents and on the book's web site (http://www.stpt.usf.edu/jsokolov). Among the new subjects included are: The Okinawa Centenarian Study; menopause and aging; world cities and environments for aging; Matrilineality and late life; the age-friendly community movement; special Alzheimers' units and the Green House model; Conscious Aging; culture and the lifecourse; globalization and the risks of Aging; elderly in suburbs; custodial grandparenting from a comparative perspective; Denmark's "Flexsecurity" long-term care system.

NEW INTEREST GROUP "ANTHROPOLOGY OF AGING AND THE LIFE COURSE" FORMED WITHIN THE AMERICAN ANTHROPOLOGICAL ASSOCIATION – 1st meeting at AAA Thursday, 11/20/2008; TIME: 12:15:00PM - 01:30:00PM; ROOM: Sutter B

In April 2008 the AAA executive board approved the new Interest Group "Anthropology of Aging and the Life Course." There will be a formal initial meeting of this group at the upcoming AAA meetings in November – details of time and place will be posted on the AAGE website when it becomes known. This group was initiated by the work of Jay Sokolovsky, Maria Cattell and Peggy Perkinson. The working description for the Interest Group is as follows:

> The consequences of global aging will influence virtually every topic studied by anthropologists, including the biological limits of the human life span, demography, generational exchange and kinship, household and community formations, symbolic, representations of the life course, gender, discourse on the body, caregiving and attitudes toward disability and death. A major goal of this interest group is to bring together anthropologists whose work addresses such issues both in and outside of academia.

Interest Groups: (1) may hold one special event at the AAA Annual Meeting, for substantive and/or business discussion; (2) may submit volunteered annual meeting sessions for review and acceptance/rejection by the AAA Program Committee; (3) having 100 members for three consecutive years will qualify to present a substantive session for one full-time slot on the Annual Meeting program.

To facilitate development of the Interest Group, please:

1) If you are a AAA member and wish to be counted as an interest group member or have any ideas for activities of this group, contact Jay Sokolovsky at jsoko@earthlink.net

2) If you have a new book that has just come out or will be out in the next year, could you send me the bibliography reference. At the initial meeting of the group we hope to put out a short guide to the new publications in the area.

30th Anniversary of AAGE to be celebrated at AAA Meetings in San Francisco (Nov 19-23, 2008):

With the overlap of the AAA and GSA meetings this year, it will again be a chore for getting to both meetings, but we really do have something to celebrate – the 30th year of our organization. Could you please let Jay Sokolovsky jsoko@earthlink.net know if you have sessions or papers related to aging so we can get out the word about them and also ask that they not be scheduled in competition with each other. Details about our annual dinner will be forthcoming.

Major Session on Aging

At AAA in San Francisco we already have a wonderful session accepted, GLOBAL COMINGS OF AGE: ELDERS, GENERATIONS, AND LATE LIFE IN THE 21st CENTURY (organized by Roger Sanjek) - this includes papers by

sholars who have published ethnographic books about aging which are about to be published (such as Roger Sanjek's forthcoming book on the Grey Panters) and others which have come out since 2000. See you there.

WHEN: Friday, November 21, 10:15 am to 12 pm
PLACE: Franciscan A

RETHINKING THE GENERATION GAP: AGE AND AGENCY IN MIDDLE-CLASS KOLKATA, Sarah Lamb (Brandeis University**)**

AGING, AGENCY AND GETTING BY IN THE GWEMBE VALLEY, ZAMBIA, Lisa Cliggett (University of Kentucky)

DISPLACING AGING? NORTHERN EUROPEAN RETIREMENT MIGRATION TO SPAIN, Caroline Oliver (University of Cambridge, UK)

THE GRAY PANTHER CONCEPT OF THE PERSON, Roger Sanjek (Queens CUNY)

THE ANTHROPOLOGIST AS CAREGIVING DAUGHTER: LESSONS FROM THE WORLD OF THE FRAIL ELDERLY, Luisa Margolies (Universidad Central de Venezuela)

DISCUSSANT: Jay Sokolovsky (Univ of S. Florida St. Petersburg)

Anthropology & Aging Quarterly
The official publication of the Association for Anthropology & Gerontology

Information and Submission Guidelines

Anthropology & Aging Quarterly is the official publication of the Association for Anthropology & Gerontology (AAGE). It is published quarterly (February, May, August, November) by (AAGE). AAGE is a nonprofit organization established in 1978 as a multidisciplinary group dedicated to the exploration and understanding of aging within and across the diversity of human cultures. Our perspective is holistic, comparative, and international. Our members come from a variety of academic and applied fields, including the social and biological sciences, nursing, medicine, policy studies, social work, and service provision. We provide a supportive environment for the professional growth of students and colleagues, contributing to a greater understanding of the aging process and the lives of older persons across the globe.

Submission Process All manuscripts should be submitted electronically, via e-mail attachment. *Anthropology & Aging Quarterly* accepts four types of submissions--*Research Reports*, *Policy and News Reviews*, *Commentaries*, and *Articles*.

*Research Report*s are brief discussions of ongoing or recently completed study and should be no longer than 2,000 words. *Policy and News Reviews* are pieces which offer thoughtful and reflective commentary on current events or social policies pertaining to aging and culture. *Commentaries* provide authors with an opportunity to discuss theoretical, ethical and other time-sensitive topical issues which do not lend themselves to a full-length article. Policy Reviews or *Commentaries* may range from 1,000 to 4,500 words. *Articles* are peer-reviewed and manuscript submissions should include the following: a cover page with the author's full name, affiliation, mailing address, and manuscript title; a 200 word abstract; the text; references cited; and tables or figures. Endnotes are permitted but should be used sparingly and with justification. *Articles* should not exceed 6,500 words, including all materials.

Manuscript Submission All submissions should be submitted via e-mail to the Editor, . Samantha Solimeo, at Geroanthro@gmail.com. Unsolicited Book Reviews are currently not accepted. If you are interested in authoring a book review please contact the Book Reviews Editor, Dr. Sherylyn Briller, at the Department of Anthropology, Wayne State University, Detroit, MI, 48202. All manuscripts should use the citation style outlined by the American Anthropological Association, available online at: http://www.aaanet.org/pubs/style_guide.pdf

Evaluation Manuscripts will be evaluated by the Editor and a combination of Editorial Board members and peer referees. Every effort will be made to expedite the review process, but authors should anticipate a waiting time of two to four months.

AAQ Submission Deadlines

Issue 29 (4) November 2008; DUE October 1st, 2008
Issue 30(1) February 2009; DUE January 2, 2009
Issue 30(2) May 2009; DUE April 3rd, 2009