Health care behaviour of Hmong refugees in Sydney

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HMONG
LAOS
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Abbreviations

ABS	Australian Bureau of Statistics
BIPR	Bureau of Immigration and Population Research
BIR	Bureau of Immigration Research
EAC	Ethnic Affairs Commission
ESCAP	Economic and Social Commission for Asia and the Pacific
HCS	Hmong Community Society
HSA	Hmong Society Australia
ILU	Intensive Language Unit
LGA	Local Government Area
MES	mainly English speaking
NES	non-English speaking
NESB	non-English speaking background
NHS	National Health Service
SLA	Statistical Local Area
SUNDS	Sudden Unexpected Nocturnal Death Syndrome
UNHCR	United Nations High Commissioner for Refugees

Front page: A Hmong Story-cloth. It provides a pictorial representation of the Indo-Chinese war. The history of the war is presented in horizontal rows, from top to bottom. It shows the American withdrawal, the years of repression that the Hmong suffered under communist rule and their escape to the jungle. Thousands escaped from Laos to Thailand by swimming across the Mekong River. At the bottom of the cloth, a Thai soldier welcomes newcomers and guides them to a refugee camp.

Reproduced with the kind permission of Professor Philip Courtenay, formerly of the School of Anthropology and Archaeology, James Cook University, Townsville. The cloth was made by Mrs. Yong Yia Lor.

Chapter 1
Geography of Health Care: A Case Study of Health Care Behaviour of the Hmong Community in Sydney

> Focus on ethnicity ... may obscure independent health problems: health costs consequent upon recent migration, a recent past history of torture and trauma, malnutrition, and/or other deprivations; of lack of English language; of a poor appreciation of the health care system; and the many burdens of being not-white, working class (or employed in working-class occupations) and female. In other words, structural and social disadvantages independent of ethnicity appear to be every bit as important as ethnicity in determining levels of morbidity (and mortality) and access to health services (Manderson 1990a:76).

Introduction

The Hmong, a minority group from Laos, began arriving in Australia in 1976, having fled their country after the Pathet Lao (Lao communists) came into power in May, 1975. Little has been written on the Hmong in Australia but one survey conducted in 1987 on the Hmong community in Sydney identified it as socio-economically disadvantaged (Lee 1987). At the same time, studies from the United States were discovering a significant problem of poor health status and unsatisfactory health care behaviour within various Hmong refugee communities in that country (Bliatout 1988a; Deinard and Dunnigan 1987; Scott 1982; Strand and Jones 1983). This study aims to examine the health care behaviour of Hmong in Sydney, and related socio-economic issues, in part to discover whether Hmong in Sydney exhibit similar health care behaviour and health status to Hmong in the United States. It will therefore both provide basic information on the Hmong in Australia, and specifically focus on the health care behaviour of Hmong in Sydney and, secondly, compare this with situations in the United States.

This study is primarily related to the field of the geography of health care, a sub-branch of medical geography. Contemporary studies in medical geography, which focus on the effects of social, economic and political conditions on health care behaviour, indicate that economic and social constraints frequently combine to

produce a deleterious pattern of poor utilisation of medical facilities among the most vulnerable members of society: the poor, the aged, and minority groups (Berman et al. 1994; Kearns 1992; Mackenbach and Kunst 1997; Meade et al. 1988; Najman 1994). Such a situation is likely to be especially relevant to Hmong in Sydney.

A focus on refugees, and in particular the socio-economic and cultural issues of resettlement and the impact they might have on health care behaviour, is a second theme of the study. Migrants and refugees, particularly those from a non-English speaking background (NESB), often find themselves in a marginalised position in society; many are employed in low status, low wage and often dangerous areas of the work force, or are unemployed and dependent on social welfare (Lin and Pearse 1990). A low proficiency in English and poor understanding of medical and social services hinder adequate access to these systems and they may only be able to afford low cost housing, which is often in a less healthy environment (Bates and Linder-Pelz 1990; Garrett and Lin 1990; Manderson 1990a). There is an increasing body of evidence which indicates that health is ranked by immigrants as a 'major need and, in many cases, the most common item for which they require information' (Batrouney 1995:10):. However, little qualitative and quantitative information on migrant health services and their consumers exists in this country, despite the fact that Australia has actively resettled NESB migrants since 1945 (Manderson 1994; Mitchell 1988). Instead, much of the research on migrant health has tended to focus on culture and ethnicity, with little acknowledgment of the potential influence of social and structural constraints (Manderson 1990a) and despite widespread acknowledgment that low socio-economic status is often associated with poor health.

The Hmong in Sydney, who are recent refugee arrivals to this country, may potentially be affected by many of these constraints. Given that 'inequality affects all working class Australians, regardless of their country of origin or period of residence' (Manderson 1990a:79), health care behaviour is a valuable area to

investigate in order to assess the extent to which this may be true, not only for the Hmong but for other migrant groups in marginal socio-economic situations. The Hmong in Sydney may also have special health care needs. Traditional herbal medicine and spiritual healing are important aspects of Hmong culture (Bliatout 1988a; Chindarsi 1970; Geddes 1976), and in 1992, a Hmong shaman was brought from Laos to Sydney by the Hmong Association specifically to work with the community (G. Lee, pers. comm., 1994). Nonetheless the health care behaviour of this community in relation to its special health care needs are currently unknown.

Studies of health behaviour are important at both a planning and an individual level. Provision of essential personal services is of enormous political and social significance in all economies, with health care often being the most expensive (Phillips 1981a). Governments are continually searching for strategies to ensure that 'the health care dollar is spent where it will be most effective' (Daly and McDonald 1992b:1). Moreover, reducing the burden of health problems in disadvantaged groups 'offers great potential for improving the average health status of the population' (Mackenbach and Kunst 1997:757). Greater knowledge about health care behaviour of a socio-economically disadvantaged refugee community in Sydney could be beneficial for all parties if planners and policy makers were better informed about which factors constrain and which ones encourage favourable health care behaviour.

Aim of the investigation

The primary aim of this thesis is to investigate the wide range of variables which influence the health care behaviour of refugee or minority groups and how such influences on one ethnic group may vary according to different places and in different contexts. Contemporary studies in the geography of health care advocate that such an approach is essential, especially as there is a tendency to focus almost entirely on the role of culture for the health care behaviour of NESB migrants,

whereas it is highly likely that such refugees may be facing other barriers to health care which are unrelated to their culture.

This study has been conducted by incorporating the material obtained from a case study of the Hmong community in Sydney, with relevant published data in order to examine health care from several different angles. Initially, a substantive background to the study is provided by a discussion of current themes in the geography of health care, a review of migrant health and the socio-economic status of Southeast Asian migrants in Australia, and a detailed investigation of health care behaviour of Hmong in the USA where most health care behaviour studies have been conducted.

Second, demographic, social and economic aspects of resettlement of the Hmong in Sydney are explored. This both develops a profile of the Hmong community and provides the basis for the subsequent detailed analysis of health care behaviour. The thesis next examines the major influences and constraints, social, political, economic, cultural and spatial, on the health care behaviour of Hmong in Sydney. It also assesses how this refugee group respond when they have a health problem and what variables influence their self-assessed quality of health.

Finally, the results of this study are compared and contrasted with published data on the changing health behaviour of Hmong in other environments. These data will be examined to see what factors have influenced Hmong health care behaviour in different social and spatial contexts.

This is the first time such an in depth study of this community has been undertaken in Australia, hence this thesis is intended to make a contribution in both the geography of health care and to a better understanding of issues of resettlement of refugee groups in Australia.

Culture, ethnicity and Southeast Asian: an explanation of concepts

The terms 'culture', 'ethnicity' and 'Southeast Asian' are often used throughout this thesis. For the sake of clarity, a short definition of each term is provided. *Culture* refers to human behaviour, social organisation, structures and ideologies (Manderson 1990b). It provides members of a particular group with a broad world view, an ideology, certain rules for behaviour, a knowledge of what it is appropriate to believe and how to express their feelings (Bates and Linder-Pelz 1990). Cultural patterns of behaviour are learned in infancy and passed on from one generation to another and each person contributes to that culture during their lifetime (Parsons 1990). However, culture is not static; it is dynamic, flexible, variable and adaptable, it changes through interaction with peoples of other cultures, as a result of trade, intermarriage, warfare, colonialism and migration (Manderson 1990b).

Ethnicity, on the other hand, emphasises people's cultural distinctiveness. Burnley, et al., (1985) found five common characteristics in defining ethnicity: they are the belief in a common origin, culture and customs, religion, race and physical characteristics, and language. Everyone belongs to an ethnic group but the term is often only applied to minority groups, and is necessarily imprecise.

'*Southeast Asian*' is used rather than 'Indochinese', for geographical correctness, except where the original reference uses the latter term. Southeast Asian refers to the geographical region in which Laos is situated, whereas Indochinese refers to those people living under a now defunct political regime.

Geography of Health Care

Medical geography

Medical geography is the sub-branch of geography which is concerned with the study of human health; it encompasses the ecology of disease and nutrition, location and utilisation of health services, and the investigation of factors involved in health behaviour (Barrett 1996). It has enjoyed a long history - its origins can be traced back

to the time of Hippocrates (approximately 460 - 377 B. C.), whose writings show that he was familiar with the impact of cultural and environmental interactions on health.

Medical geography has evolved to become both 'integrative and multi stranded', sharing common boundaries with the associated areas of epidemiology, anthropology, sociology, psychology and economics, as well as the applied disciplines of the medical care organisations, allied health professionals and physicians (Berman et al. 1994; Eyles 1990; Gursoy 1996; Jones and Moon 1991; Kearns 1992). It also shares some concepts and techniques with other social, physical and biological sciences. What distinguishes medical geography from other disciplines is its focus on the traditional geographic concern of place, that is, the local context of health, disease and social processes (Eyles 1990; Kearns 1992). Place can encompass physical as well as non physical attributes, as described below.

Geography of health care

In its narrowest sense, the geography of health care provides a spatial analysis of health care, health behaviour and the provision of medical services (Phillips 1981a). Typically though, it encompasses a broader concern in recognising the 'importance attached to social, economic and political aspects of the provision and use of medical and welfare facilities to counter human health problems', that is the social environment (Phillips 1981b:2), whereby space and place continue to remain a vital but less central component of the geography of health care.

In North America the geography of health care grew as a result of increased concern that medical geography should be studying health services with greater emphasis on provision of and access to services (Learmonth 1981), since sociologists had forged ahead in developing 'some understanding of (the) socio-economic determinants of many urban and rural health problems' (Pyle 1983:86). Such developments led to increased awareness of the connection between social and

economic constraints on health care with the allocation and use of health care facilities to explain the nature of inequalities within the health care system. Until that time, the use of health care facilities has been investigated mainly in terms of location and allocation, with less emphasis on social and economic constraints on health care behaviour.

The contemporary geography of health care has become less concerned with the traditional geographic focus on the physical attributes of place. It gives instead greater emphasis to the social attributes of a place, which Kearns calls a 'sense of place' or 'experience of place', which influence health care behaviour (Kearns 1992). Kearns argues that geography of health care should focus more on the convergence between the experience of place and socio-ecological perspectives as provided by health services. While health services can be seen as one of the institutional components of a place, the direct ministering of health care professionals usually enhances the health of individuals in other ways. Kearns observed that

> the presence of appropriate health services contributes to the broader health of the population first, a household or community may feel more positively about its place because of the types and styles of services available; and second, the particular configurations of service provision may enhance the level of interaction within the household or community (Kearns 1992:144).

As such, the health related characteristics of places themselves are given greater recognition alongside spatial relationships between individuals, places and institutions (Kearns 1992). In practice, this leads to greater emphasis on the effects of the non-spatial factors of social, cultural, economic and political constraints on health care behaviour, with less (but continued) concern for the physical factors of location and allocation of health facilities for a population.

The geography of health care has become a field where multi disciplinary perspectives are the desired norm (Daly and McDonald 1992b; Gursoy 1996). Berman et al., (1994) encourage the use of a 'variety of approaches' to 'illuminate the different aspects of a problem', as each discipline brings to the evaluation of health care its own traditional methods of study and evaluation. Phillips (1986) emphasises

the need for more research into health care behaviour, especially of the type which disaggregates that behaviour in order to distinguish particular social and economic patterns. Gursoy supports this position: 'no longer can the answer to a scientific question be found within the boundaries of a single discipline' (1996:583). By implication therefore a similar situation relates to culturally distinct groups who have migrated from developing countries to resettle in culturally, socially, economically and politically dissimilar countries.

The evolution of the multi disciplinary and trans disciplinary nature of the geography of health care has fostered greater interaction with similar disciplines, thus creating an enriched environment in which to study health care behaviour. The changing nature of this discipline is reflected in the wide range of variables that need to be investigated in studies of health care behaviour, and these are discussed below.

Variables

The variables which will be investigated in this study include both spatial or distance variables and non-spatial factors. The outcome of interactions between variables may produce unpredictable and unique outcomes and thus must also be investigated.

Spatial, or distance, variables can be measures of both the physical and non-physical space between the health care consumer and the health care provider. Physical measurements include map, road and time distance. The impact of non-physical spatial factors is harder to identify. They include: *perceived distance*: a patient's idea of how far away a medical resource is; and *socio-cultural distance*: the gap between consumer and provider in terms of social status or illness beliefs (Meade et al. 1988). In general, living close to a medical facility allows greater use to be made of that resource, but this is not always the case when other variables come into play, as will be discussed below.

Population characteristics such as age, sex, social class, education level, religion, influence of neighbours and friends, ethnicity and previous experience are all important in determining health care behaviour (Meade et al. 1988; Phillips 1981b). Thus, previous experience with health care will affect the kind of help that is sought. Older people may exhibit different health care behaviour from younger people; women may use different medical facilities than men; and being from a low social class or belonging to a minority group often leads to less accessibility to health care due to lack of knowledge of the medical system and perceived constraints.

Social variables include social space, or the framework within which the subjective evaluations and motivations of members of the group can be related to behaviour and external characteristics of the environment, as well as the social environment, which includes those characteristics which make up the social identity of an area and which reflect criteria of social differentiation, such as class and ethnicity (Goodall 1987). Social variables are related to policies affecting quality of life.

Economic constraints: While those in lower income groups usually have less access to adequate health care, this is not always true (Meade et al. 1988). For example, an American study found inconsistencies in the relationship between income and use of hospitals: the poorest people, who received Medicaid payments, demanded services at higher levels than the marginally poor, who could not claim these benefits (Phillips 1981b), but their real income would have been critical to their health behaviour, and both groups were disadvantaged with respect to other groups in society. Health behaviour also may be mediated by how people choose to use their income, with those on low incomes having less health choices and less ability to pay for services.

Political variables include the system of government and the action of power wielding groups. In countries where social welfare has been well established, most people will have access to a minimum level of health care but may have little access to top

quality care. Britain, which has had a government-controlled National Health Service (NHS) since 1946, initially removed many of the more obvious inequalities in health care provision, but the provision of 'free' and accessible health care has had little direct impact on health inequalities (Howe and Phillips 1983; Marmot et al. 1997; Najman 1994). For those on low incomes, complete freedom of choice in health care remains unattainable.

Cultural variables such as traditional beliefs and practices, religion, community structure and family structure, as well as whether the type of health care offered may be culturally sensitive, can affect the supply, uptake and geographical distribution of services (Eyles 1990; Waldram 1990). This in turn can affect the quality of health of the community as well as the quality of health its members are willing to accept.

Language barriers, where there is a lack of proficiency in the same language as that of the medical personnel, create a number of difficulties for the patient, such as making appointments by phone, explaining symptoms and understanding the doctor's explanations and instructions. For the medical staff, diagnosis is much more difficult, sometimes even with the use of an interpreter (Hazebroek et al. 1994) and potential patients may be loath to or unable to explain symptoms to a speaker of a different language. Even if the patient is fluent in a common language, 'interpretation' may hold different meanings for both patient and practitioner.

The *interaction of variables* can produce a unique outcome at a particular time and place. Distance can be distorted by political, cultural and economic considerations, or it may be a surrogate for other variables or a mask for the importance of other variables (Meade et al. 1988). For example, the higher rate of hospital use by higher income people living close to the medical facilities may be more related to their ability to pay rather than their proximity to the facility (Meade et al. 1988) or even their apparent poor health

In Labrador, Canada, Neuwelt et al., observed that the predominantly Caucasian residents of North West River used preventive health services at a higher rate than the adjacent Innu Indian community, and the latter group had a higher number of illnesses requiring medical intervention. He attributed the differences in quality of health between the two adjacent communities to differences in 'housing conditions, population density and other conventional social class variables that have been used in social class analysis' (Neuwelt et al. 1992:159) rather than ethnic and cultural differences. Poor physical access proved to be a further barrier to using the clinic as it was located within the North West River community, 2 kilometres away on the other side of the river which separated the two communities. This study also argued that the persistence of traditional healing practices within Innu society may have benefited the Innu and may have kept these morbidity data conservative. The Innu continued to seek and use traditional healers even though they had financially free access to Western medical care. The issue of continued use of traditional medicine will be investigated in this thesis. Similarly, a study of migrant farm workers in Niagara County, New York, found that a medical clinic set up specifically for the farm workers was not being used chiefly due to economic reasons, but not because of the actual cost of health care but because the workers had to forgo their wages if they took time off work to attend the clinic (Hales and Ford 1991). When the hours of opening were extended so that the clinic was open in the evening, the farm workers not only were more willing to attend, but they did attend. These studies demonstrate the importance of making access to health care facilities physically and economically accessible and appropriate to potential clients.

A large number of variables can potentially impinge on health care behaviour: some are spatial and others are non-spatial, such as social, economic, cultural and political factors. It is also highly likely that there will be variations in health care behaviour within cultural groups and within particular places. It is difficult to predict which factors may affect health care behaviour to a greater extent than any other, but

investigating a wide range of variables and the product of their interactions is essential.

Background to the study

Concern about the health care behaviour of Hmong in Sydney arose because of the significant social and economic differences which were found to exist between the Hmong and similar refugee groups in both Australia and the United States; in each country the Hmong seem to fare worse than other groups. Useful comparisons between the two Hmong groups may be made.

In Sydney, Lee's (1987) study found marked differences in unemployment rates between Hmong and other Asian-born migrants. The unemployment rate of the Sydney Hmong was 34.6% (at a time when the overall national rate was 8.7% and for Asian born, 15.6%), and 92.5% were process workers. It was also revealed that only 17.7% had completed high school. Lack of English was identified as a significant limiting factor in enhancing employment prospects.

Similar results were found in some areas of the United States. In San Diego, Weeks and Rumbaut found that while all the recently arrived Southeast Asian groups were at an 'elevated risk on practically every important socio-economic indicator', the Hmong were amongst the poorest of the groups, often running out of food before the end of the month (1991:328). The poor social and economic indicators that were identified in this study, such as poverty, living in crowded low-rent housing, low income, high unemployment, low levels of formal education (especially among Hmong women), are often associated with poor health care behaviour.

Several Hmong communities in the United States were found to have unsatisfactory health care behaviour, which led to a poor level of health. Research into the four major Southeast Asian refugee groups in the United States, the Vietnamese, Cambodians, Laotians and Hmong, who arrived in that country at the same time as

Hmong arrived in Australia, found great diversity within the health care behaviour of each nationality. Of the four groups, the Hmong were found to have the lowest levels of contact with American physicians and hospitals, and were also the most likely to rate their health quality as only fair. Their continued use of traditional medical practices was also common (Bliatout 1988b; Brainard and Zaharlick 1989; Deinard and Dunnigan 1987; Moon and Tashima 1982; Rowe and Specs 1987; State 1985; Strand and Jones 1983). This pattern continues within a number of Hmong communities in the United States (Capps 1994; Kunstadter 1996a). These findings demonstrate the differences that may exist between different ethnic groups from a similar geo-political region. This issue will be discussed below.

Researchers identified a number of barriers that may have restricted appropriate use of Western medical facilities by Hmong in the United States. In most instances, Hmong culture and medical belief systems were seen to be the most significant barriers. These two factors were thought to affect Hmong perception of Western medicine; many Hmong believed that the American system could not offer them what they needed in terms of health care as it largely ignores the supernatural aetiologies about which they are mostly concerned (Brainard and Zaharlick 1989). While Hmong culture and medical beliefs would have played a significant role in shaping health care behaviour, other factors which are unrelated to culture could also have been barriers to Western health care.

Hmong refugees in Sydney also face many potential and real barriers to good quality health care. They are from a non-English speaking (NES) country and as recent arrivals would have little understanding of the local health system and of many other customs and institutions in Australia. The community is also economically disadvantaged (Lee 1987). In Australia, where their health status and health care behaviour have never previously been studied, in their more or less twenty-year period of residence in the country, there should be some concern for their quality of health based on their disadvantaged economic position in this

country and the evidence from studies of Hmong health in the United States. This thesis seeks therefore to make a practical contribution to the understanding of Hmong health status.

In addition to being economically disadvantaged, most Hmong in Sydney live in the local government area (LGA) of Fairfield, 30 kilometres southwest from the central business district of Sydney. In recent years, this area has been characterised by rapid population growth, mainly through the arrival of large numbers of NESB migrants both from within Australia and overseas. Over 50% of the population were born overseas, 47.9% were born in a NES country, and a significant number, 15.3%, are from Vietnam, Cambodia and Laos. Over 60 different languages are spoken in this district (Fairfield City Council 1996).

Low socio-economic status typifies Fairfield, especially for NESB migrants, and may influence the overall health status and particularly that of the Hmong. Unemployment rates are high, but they are higher and of longer duration for those from a NES country. In June 1996, the unemployment rate in Fairfield was 14.8%, at a time when the rate for Western Sydney was 8% and 7.5% for the whole of NSW (Fairfield City Council 1996). Migrants from a NESB are also over-represented in lower paid employment, especially women. As a result, immigrant families are over-represented as recipients of social security benefits. Occupancy ratios are the highest of any local government area in Sydney, at 3.43 persons per dwelling; it is 22% higher than the Sydney average, which is 2.81 persons per dwelling (ibid). Fewer residents have tertiary education qualifications in comparison with other areas of Sydney, and more Fairfield residents have no formal qualifications at all. However this situation is improving. Migrants from a NESB have lower levels of educational qualifications than those of English speaking migrants. Fairfield also has a relatively young population that is continuing to grow, a higher fertility rate (1.74%) than the rest of Sydney (1.29%), low levels of English language proficiency and low private health insurance cover.

A number of practical reasons prompted a focus on the Hmong in Sydney: the population is small enough to allow the whole of the community to be included and no selection criteria were needed. Currently most reside in a small number of adjacent suburbs in Sydney, making access to the community more convenient; they are a socially and economically disadvantaged minority group. They have lived in Australia for long enough to have had some experience of the local health care system; they have a long history of traditional herbal medicine and spirit healing; many have learnt English well enough to be able to participate in a study conducted in English; one of the community leaders was able and very willing to assist with initial and continued contact with the community; and finally, there is a large body of published material from the United States which can be used for both background material and later for comparisons and contrasts.

The Study Group: The Hmong

The paucity of knowledge about the Hmong community in Australia in general and their health care behaviour in particular, especially in the light of findings in American studies, were the main factors which prompted the present study. Several reasons account for the lack of knowledge of the Hmong in Sydney: official methods of categorising new arrivals, the small size of the population, media and academic focus on the largest Southeast Asian refugee group, the Vietnamese; and general ignorance of the diversity between the refugee groups. In Australia, all migrants are recorded by country of birth, not by ethnic grouping (EACNSW 1994). Such a system therefore 'loses' ethnic minorities such as the Hmong, whose country of birth was either Laos, Thailand or more recently, Australia. In addition, official records do not record the language or religion of small groups. In most studies, Hmong are generally subsumed into the 'Indochinese' or 'Southeast Asian' category, where data is aggregated for people from the three countries of Laos, Thailand and Vietnam

(1984; Evans 1990; Goldstein et al. 1987). Neither system is able to adequately identify nor take into account the specific situation of needs of the Hmong.

The Hmong population in Australia is very small even within the Southeast Asian population. The first Hmong refugees from Laos arrived in 1976 and by 1983 the Hmong population had only reached 344 (Lee 1986). By the early 1990's, 1000 Hmong refugees had resettled in this country and today their population Australia-wide is about 1600 persons (Courtenay and Wronska-Friend 1995; Price 1996). They have resettled mainly in the Eastern states. Melbourne has approximately 400 Hmong (Falk 1993/94), Sydney less than 300, Innisfail 500, and there is a small community in Tasmania. The Sydney Hmong population appears to have now stabilised at around 200 people.

A small number of Hmong refugees initially entered Australia on humanitarian grounds (Hazebroek et al. 1994), but the majority of arrivals have been sponsored family members. They initially settled in the eastern capital cities of Sydney, Melbourne, Hobart, Adelaide and Canberra (Jupp 1989; Lee 1988). In the late 1980's, significant secondary migration from Hobart to Far North Queensland created a community of 500 Hmong in the Innisfail and Cairns region (Courtenay and Wronska-Friend 1995). In 1988 about 100 family members from Hobart migrated to Far North Queensland, hoping to improve employment prospects and for the pleasant climate. They were later followed by other families from Hobart and family members from other states (Courtenay and Wronska-Friend 1995). A small number of Hmong from Sydney have also moved to Innisfail. The Sydney Hmong population appears to have now stabilised at around 200 people.

The arrival of significant numbers of Southeast Asian refugees into Australia began fairly suddenly in 1975 and increased substantially over the next few years. There were 46,000 arrivals by 1980, this had increased to 85,000 by 1985 (Viviani 1985). Furthermore the largest group, the Vietnamese, attracted most media and academic attention, which Viviani suggested was one of the reasons that, during the first year

of the refugee crisis, only Vietnamese refugees arrived in Australia, even though at this time there were 80,000 Laotians and Cambodians in Thai refugee camps (ibid.). The size of the Vietnamese population in Australia, concentration of population groups in certain geographic areas and, more recently, various social problems that have emerged, have helped maintain a high media and academic interest in this community.

Such a large influx of people into Australia from a similar political and geographical region and in such a short period of time may have fostered a general ignorance of the diversity between the different groups, especially for such small groups as the Hmong. However, the Southeast Asian population is extremely diverse, as outlined below. Such diversity suggests that it would be incorrect to assume that their health care behaviour and patterns of adaptation would all be the same, but these groups may share some features due to similarities in their geographical and political backgrounds.

Migrant Health in Australia

Several studies have been conducted into migrant health in Australia which help to identify important variables affecting migrants and their health care behaviour in the Australian setting. The large numbers of migrants and refugees from Europe who arrived in Australia in 1945 after the end of the Second World War were the first settlers to this country from non-Commonwealth and non-English speaking (NES) countries who were encouraged to settle permanently (Bates and Linder-Pelz 1990).

While the Government assisted in many areas of resettlement, such as with housing and employment, it was slow to respond to the specific health care needs of migrants from a NESB. For the first 25 years of post-war immigration, the delivery of health and social services was made on a totally monocultural model (Bates and Linder-Pelz 1990). The neglect of ethnic health policy and services during this period

was due to several factors: the prevailing social, ideological and political constructs, the relative good health of immigrants, and the 'invisibility' of migrants who were selected on the basis of being physically similar to locally born Anglo-Australians (Bates and Linder-Pelz 1990; Batrouney 1995; Garrett and Lin 1990; Jupp 1990). It was expected that in a very short time these non-Commonwealth migrants would adopt the Australian way of life, therefore it was thought that there was no need to set up special programmes for them beyond basic assistance upon arrival. In addition, selection criteria ensured healthy migrants as it both required migrants to have good health and encouraged young migrants.

Although a number of problems for NESB migrants in the health care area were identified during this time, it was not until 1973 that NSW became the first state government to employ migrant health workers and the Department of Social Security started translating its welfare forms into languages other than English (Bates and Linder-Pelz 1990; Mitchell 1988). The subsequent arrival of Southeast Asian refugees from 1975 onwards 'heralded a dramatic challenge' to immigration policy and to other health and government sector practices (Garrett and Lin 1990) and gave impetus to the development of a large range of ethno-specific services. Once again, their main focus was service orientated, mainly providing interpretation services in various health care settings.

In the following years, the range of services established to facilitate access and equity in the health care system for NESB migrants grew rapidly (Bates and Linder-Pelz 1990). There has been a general move, especially in the most populous states, to attempt to overcome the barriers to access to health services experienced by NESB migrants, and making service provision more sensitive to the characteristics of an ethnically diverse clientele (Alcorso and Schofield 1992). However, many policy decisions for ethnic health have been made with very little research into migrant health itself (Manderson 1990a; Mitchell 1988), even though the government has been aware for a considerable time that the initially good health enjoyed by

migrants deteriorates following settlement and the resultant adoption of 'Australia's lifestyle'. This was noted as early as 1986 by the Better Health Commission report (Manderson 1990a). But by 1988, Mitchell was still concerned that

> despite many direct and indirect references in reports and policies to migrants and their health, as well as the overwhelming presence of health services in the lives of every Australian, it is surprising that critical attention has not been focussed on migrant health services and their consumers from NESB (1988:8).

But apparently little has changed, as even more recently Manderson observed that

> there has been relatively little funding for research into issues associated with ethnicity, immigrant status, and particularly, NESB (1994:1277).

Recent research has continued to overlook immigrant groups, 'creating and reflecting the lack of qualitative and quantitative information' of immigrant groups (Manderson 1994:1278). For example, the National HIV/AIDS Strategy of 1994 made no reference to NESB people, thus ignoring the particular problems of communicating information to their communities (Manderson 1994). In particular, research on migrant health tends to focus on culture with only minimal acknowledgment of social and structural constraints common among migrant groups, such as low socio-economic status, poor education, lack of understanding of the system and racism faced in medical settings (Manderson 1990a). This study is an attempt to address this problem as it will investigate the broad range of variables associated with influencing health care behaviour.

Much research, because of how the data have been collected, continues to group immigrants according to their geographical origin, ignoring the diversity and considerable differences within countries and across political boundaries (Bottomley and de Lepervanche 1990; Powles and Gifford 1990); this is especially a problem for small communities such as the Hmong. While their country of birth is Laos, they are neither ethnically, linguistically nor culturally Laotian. By aggregating racially and geographically similar groups, smaller groups such as the Hmong 'disappear'. While generalisations may be helpful indicators of a trend or tendency, they are not useful when they create stereotypes (Parsons 1990). Although Southeast Asian

refugees share some geographical and political similarities, they are very different in many other areas (Bui and Bertelli 1990; Manderson 1990a). Manderson explains

> Within Southeast Asia, one might be more careful to distinguish between, for example, Hmong,...Lao, Khmer, Vietnamese-Chinese, and Vietnamese, and indeed between the peoples of north and south Vietnam; to distinguish between urban and rural dwellers, peasant farmers and professionals. Such ethnic, class and geographic differences are themselves a short-hand for major differences in native and second languages, cultural practice, belief systems, familiarity with, access to and use of health care systems, educational levels, income and prior and present class position (Manderson 1990a:79).

These factors are all relevant to understanding how people think of illness and health, and what they do, in terms of diagnosis, treatment advice and medication, when they are sick. Variations in behaviour and need which could be significant will remain unknown if relevant information is unavailable. Small case studies such as this one, which seek to provide more accurate and detailed information, should encourage others to be more aware of the problems of cultural stereotypes and making too many generalisations.

In addition, NESB migrants may share many aspects of health care behaviour with Australians who are in similar socio-economic circumstances. It is well recognised that low income Australians suffer a greater number of health risk factors than those higher up the socio-economic scale (Bates and Linder-Pelz 1990; Bor et al. 1993; Garrett and Lin 1990). Men in low status occupations tend to report more illnesses, chronic conditions and days of reduced activity than men in higher status occupations. Bor found children living in socio-economic disadvantage had a high rate of health service utilisation, many chronic health problems and poor dental health (1993). Education too affects health status; people with lower levels of education tend to have high blood pressure more frequently, to smoke more, to eat more foods rich in cholesterol, to have poorer nutrition generally and to be more over-weight (Bates and Linder-Pelz 1990). A study in Western Sydney, an area with lower levels of income than the rest of Sydney, and which includes Fairfield, found that premature deaths were higher and residents were hospitalised more frequently

than those in areas of greater wealth. In addition, even within areas of Western Sydney, it was found that those areas with the greatest socio-economic disadvantage also suffered the worst health (Bates and Linder-Pelz 1990). A large number of immigrants live in these areas, and may fare worse than their Australian-born counterparts, as Manderson states:

> Inequality characterises the experience of all working-class Australians, regardless of their country of origin or their period of residence in Australia, and it is even worse for those who lack adequate communication skills in English (1990b:xvi).

Thus the perception of the healthy migrant ignores the evidence that socio-economically disadvantaged local government areas with high proportions of immigrants experience the worst health outcomes, such as higher rates of mortality and morbidity, low birth weight babies, and infant mortality and morbidity (Bates and Linder-Pelz 1990; Batrouney 1995; Garrett and Lin 1990).

More importantly, such an impression allows ethnic communities to be seen as not only suffering no special disadvantage but even to be complimented on their healthy lifestyles (Garrett and Lin 1990), despite the fact that many migrants suffer serious disadvantages such as high unemployment and low socio-economic status, are segmented into often unhealthy manual manufacturing jobs, lifestyles which are commonly associated with poor health and may be suffering from the psychological impact of wartime experiences and life in the refugee camps (Jupp 1990). There is evidence that the comparative health advantage of migrants upon arrival decreases over time as NESB immigrants approximate more to the health status profile of the Australia-born (Batrouney 1995). Nothing is currently known of the health status of Hmong in Sydney. Thus, during the course of the research, health status of Hmong refugees, how it had changed by the time of the interview and how it is related to their health care behaviour will be investigated.

Southeast Asian refugees and health

Health studies of Southeast Asian refugee communities in Australia can provide some background data against which this study of Hmong can be compared and contrasted; they also highlight the potential variables that need to be investigated. Southeast Asian refugees in Australia suffered similar periods of war in their countries of origin, left for similar socio-political reasons, spent some time in refugee camps and arrived in Australia as refugees in the last 20 years. In their countries of birth, Western medicine had been introduced to some extent by both the French colonial government and missionaries. However, each country also had its own informal system of traditional medicine. Differences between the groups have already been acknowledged (above) and will be taken into account in the following discussions.

Currently there are no studies of Hmong health care behaviour in Australia but two recent investigations discuss specific aspects of change to Hmong traditional behaviour during childbirth (Rice 1997) and Hmong funeral customs (Falk 1994), both of which are relevant to health[1]. Rice found that while the Hmong women in Melbourne sought medical care from Western medical practitioners during pregnancy and birth, they still adhered to many of their traditional practices, even if they had been modified to fit their current situation in Australia (ibid.). For instance, all Hmong women gave birth in hospitals rather than in the traditional place, their home, but in order to avoid a later illness, strictly followed the traditional Hmong post-natal diet of particular foods and the custom of keeping very warm and avoiding anything cold. Falk reports on how the Hmong funeral ceremony underwent considerable modification at a particularly stressful time in an attempt to be both acceptable to Australian health regulations but still retain the essential aspects of the rite, that is, to instruct the soul on its journey to join the ancestors in the world beyond (Falk 1994). These investigations demonstrated that Hmong can

[1]The importance of following post-natal customs, funeral ceremonies and reincarnation in relation to health and health care behaviour will be discussed later in the thesis.

be both willing and able to modify their health related behaviour to suit new circumstances if and when necessary. This study will investigate in greater detail other elements of Hmong health care behaviour.

Case studies of other small Asian migrant groups are rare. These studies provide useful and specific data, such as Han's recent study of the health status and use of medicines by elderly Koreans[2] (1996). Not only did the elderly Koreans feel healthier since they had been in Australia, they were more likely to use Western medicine than *hanbang* (Korean herbal) medicine, not because they no longer believed in the efficacy of *hanbang* tonics, but because Medicare provided all their health care needs for free (Han 1996). However, younger Koreans continued using *hanbang* medicine because they could afford to. Similarities and differences between the Hmong in Sydney and the culturally dissimilar Korean group may help to identify what are important social, economic and cultural variables of health care behaviour.

Most other studies have been conducted into various aspects of the health care behaviour and social, economic and political circumstances of Southeast Asian migrants (mainly the larger Vietnamese group) or of the more general Asian community. A large number of studies are of the Vietnamese-born population (Bui and Bertelli 1990; Manderson and Matthews 1981; Tran 1990b). Some focus on Southeast Asian mental health (Eisenbruch 1990; Lien et al. 1990; Rice and Lien 1993), others have investigated NESB women's health, pregnancy and childbirth (Alcorso and Schofield 1992; Hopper 1992; Rice 1997; Schmied 1989; Xuan 1993), and some have examined early medical screening procedures (Christopher et al. 1978; Goldstein et al. 1987).

Often the studies are necessarily general through a lack specific data, thus much research must rely on information relating to the much broader category of 'Asian',

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[2]Although Koreans are not from Southeast Asian, the major Korean migration to Australia started in the 1970's, with about 500 Koreans who worked in 'the battlefield of Vietnam War' (Han 1996). It is useful to look at their health care behaviour because they have had the same access to health care in this country as other recent arrivals. In addition, they also have a traditional system of health care.

'migrant', or 'NESB' rather than a specific nationality or group. Only a few studies focus on specific communities and tend to investigate either cultural or spatial variables. But interaction between spatial and social variables is common, hence the focus of this study on both social and spatial variables, among others. Nevertheless, the existing Southeast Asian health studies provide a useful starting point for the current investigation.

Initial interest in the 'quality' of health of Southeast Asian refugees reflected concern over the poor living conditions the refugees had been subjected to, both in their country of origin and in refugee camps. Health screening took place in processing centres overseas and many Southeast Asian refugees underwent further health screenings upon arrival in Australia (Christopher et al. 1978; Goldstein et al. 1987). In general, Southeast Asian refugees were found not to have the same health problems as other Australians, that is diseases which are related to Western lifestyle and diet, such as ischaemic health disease, and circulatory and respiratory disease (Bui and Bertelli 1990). Instead medical screenings of refugees found high incidences of infectious diseases as well as high levels of dental caries (Christopher et al. 1978). Difficulty with compliance both in following medical instructions and returning for follow up examinations became a major concern for medical personnel. In some instances, refugees were reluctant to disclose symptoms 'as they believed (quite wrongly) that this may prejudice their Australian residential status' (Christopher et al. 1978:287). Thus, any perception of refugee's initial 'health advantage' was more related to their lack of 'Western' illnesses rather than because they had no illnesses. Later studies focussed on other aspects of the health and health behaviour of refugees from NESB communities such as mental health (Eisenbruch 1990; Lien et al. 1990). The experience of mental health is beyond the scope of the current study. Nevertheless, mental health problems can manifest themselves years after the initial trauma and may become a significant health care problem in the future.

Southeast immigrants: health profile and health behaviour

The difficulties in referring to specific data on the Southeast Asian population only and the problems caused by generalisations have already been mentioned. While acknowledging this shortcoming in the available data, it can highlight important variables specific to the Australian context for this investigation.

Tran provides a very general account of Southeast Asian and Vietnamese health care behaviour in Western countries. He notes two salient features: firstly, while 'faith healers' and 'witch doctors' have become negligible in the health care system of the Vietnamese community, they are still active in the Hmong population, and secondly that among first generation Southeast Asian refugees, traditional ideas, customs, and behaviour are 'still very common' (1990:90). Tran found that the health care behaviour of Vietnamese refugees reflected the continuing influence of traditions and habits. Self medication was still common, involving a combination of Western and oriental herbs and medicines and traditional treatments. The decision to go to the doctor and the reaction to the care given were influenced by cultural factors and previous experience. Hospitals were 'viewed with great wariness, as a last resort where people went when they were dying', and that if alternatives were available, Vietnamese patients might elect to use those, at any time in the course of the illness (Tran 1990b). However, conversely, a survey of hospital admissions of Vietnamese to Melbourne hospitals found that this group's admission rates were almost twice that of the general population and higher than all other groups (Powles and Gifford 1990). Such findings need further analysis and highlight the importance of more specific and detailed case studies where other contributing factors can be investigated.

The health status of Southeast Asian refugees may be affected by other factors. Vietnamese and Asian populations tend to suffer from diseases of the genito-urinary tract and respiratory illnesses. Asian males[3] have a higher rate of smoking than all

[3]The incidence of smoking among Asian females was so low that it was negligible.

other population groups. For example, 41.8% of Asian males smoked compared to 32.5% of Australian males, but expenditure on alcohol in households where the head was born in Asia was the lowest of all Australian households (Bui and Bertelli 1990; Powles and Gifford 1990). In the last 20 years, Southeast Asian mortality rates and causes of death have been shown to be very different to both that of other Australians and of other migrants. The rate of death by accidents, poisonings and violence for the Vietnamese population was four times higher than that of the Australian-born population (Manderson 1990a). However Vietnamese mortality did not appear to be related to poor physical health; as such Vietnamese mortality will probably not be improved by any changes to the health arena. It is unknown why the rate of violent death for Vietnamese is so high, but Manderson (1990a), suggests that the poor social and economic circumstances of the Vietnamese population may play a significant role in their health status (and mortality figures). In 1990 the average income for Vietnamese was 73% of the Australian average, more than half were employed in unskilled and semi-skilled occupation categories, their unemployment rate was more than three times both the Australian average and the rate for all overseas born, and they were more likely to live in medium or high density accommodation and rent rather than own their homes (Manderson 1990a). Therefore causes of death may reveal more about social and economic conditions rather than quality of physical health.

Vietnamese women were likely to experience potential problems during pregnancy and childbirth because of their traditional beliefs and practices during this period as well as other women's health issues (Xuan 1993). Their lack of understanding of (Western) preventative health care in general meant that in the central Sydney health area, 34% were found to attend their first ante-natal visit later than was considered safe for antenatal care, a large number did not attend post-natal clinics, many had not heard of Pap Smear tests let alone had them done regularly even though the incidence of cervical cancer in Vietnamese women was higher than the

NSW average, and that their rate of breast examination and mammography screening was very low. The reasons behind their behaviour were not necessarily culturally linked but appeared more related to the social and economic circumstances in which they were living and issues of relevant health education and literature. A campaign which specifically targeted Vietnamese women for mammograms had reasonable success, measured by the constant flow of attendance by Vietnamese older women after the campaign (Xuan 1993). Language difficulties, concern over being examined by a male doctor, little concept of preventative health care as practiced in Western medicine and the economic need to return to work, sometimes within one week of the child's birth, were the main reasons behind much of the Vietnamese women's health care behaviour.

There remain large gaps in the understanding of migrant's health status and health care behaviour in Australia. Partly this is a function of over-generalisation and aggregation of data on geographically similar migrant communities, the problem of cultural stereotyping and a general lack of specific research, even though migrants from NESB have been in Australia for over 40 years.

Review of variables

This brief review of migrant health in Australia, focussing on the health of Southeast Asian refugees and the health care behaviour of minority groups in other countries, reveals a range of variables which may potentially influence the health care behaviour of Hmong in Sydney. The Hmong community's low socio-economic status and problems with language may hinder the development of quality health care behaviour. Hmong are culturally distinct from other Southeast Asians and thus may suffer specific cultural barriers to adequate health care that will remain unknown if their cultural needs are assumed to be similar to the larger groups. It is unknown what position traditional medicine maintains in the health care regime for this community. Previous medical experience in Laos and the Thai refugee camps may have influenced their current health care behaviour. It is unknown whether the

size and distribution of the Hmong population in Sydney has created social and spatial barriers to good health status. It is also important to discover actual or perceived health status as this is an important variable which might also influence their health care behaviour. These issues will be investigated in this thesis.

Vietnamese, Cambodians and Laotians: Social, demographic, education and employment profile

Although various significant differences between the Hmong, Vietnamese, Cambodians and Laotians have been acknowledged (above), geographical, political and historical similarities allow some valuable comparisons and contrasts between these groups, mainly in the area of family composition, socio-economic status and education. As stated before, low socio-economic status is commonly associated with poor health status. Most of these data are comparable with results from the current study even though they refer, in many cases, to Vietnamese-born, Cambodian-born and Lao-born residents. All the Hmong interviewed in this study were born in Laos rather than Australia.

Size of the population and distribution of the communities

In 1991, 121,813 Vietnam-born people resided in Australia with 47,352 in Sydney. A high proportion lived in the outer Western suburbs within the City of Fairfield or in the middle ring suburbs. The Cambodian population of 17,555, is much smaller than the Vietnamese population in Australia, and 7,723 (44.0%) lived in Sydney. Cambodians also lived mainly in the outer Western suburbs of Sydney, within the cities of Fairfield, Liverpool and Campbelltown (BIPR 1994; BIPR 1995). In 1987, the Lao population in Australia was 7220, and by 1991, 3710 of this group of refugees resided in the Fairfield LGA (Fairfield City Council 1996; Price 1996).

Family composition

The Southeast Asian population was relatively young; almost half were under twenty upon arrival, and were young compared to other overseas-born NESB

migrants(Bui and Bertelli 1990). In 1991, the median age of all Australians was 32.0 years, but the median ages of the Vietnamese and Cambodian-born population were 29.0 and 30.0 years respectively (BIPR 1994; BIPR 1995).

Marriage outside the Vietnamese community has been rare; only about three percent of marriages had been to non-Vietnamese by 1990 (Bui and Bertelli 1990). Cultural, social, linguistic and historical reasons may account for this low figure for first generation Vietnamese. This may well change for subsequent generations. The divorce rate is lower than that of Australians (Vietnamese: 6.6%, Australian: 11.9%), which may indicate a more stable family unit, or could be related to other factors.

Vietnamese families are larger than Australian families. The Vietnamese fertility rate of 2.2 is higher than the Australian rate of 1.9, and many Vietnamese families include a large number of unattached minors (Bui and Bertelli 1990). In the Vietnamese community, 38.8% of families have three or more offspring, whereas the figure for all Australians is 25.1% (BIPR 1994). The number of Cambodian families with three or more children is even higher at 44.5 per cent. In the Vietnamese community, households are larger, with 4.1 persons per household, than the general Australian population, at 2.8 persons per household, and one third of all Vietnamese households consisted of 2 or more families (Bui and Bertelli 1990).

Citizenship[4]

In 1991, the rate of citizenship for all Australian overseas-born was 61.4%, but among immigrants from NES countries, the proportion was significantly higher than those from mainly-English speaking countries (MES). The Vietnamese had an above-average rate of citizenship, at 71.7%, and the Cambodian figure was even higher, at 79.0% (BIPR 1994; BIPR 1995). These figures are consistent with the historical trend among predominantly refugee immigrant communities (BIPR 1994).

[4] This data was included because of the extremely high rate of Australian citizenship among the Hmong which became apparent during the research.

may reflect acknowledgment that they have very little option of returning to their country of birth, but again, other factors are likely to be involved.

Socio-economic status

The unemployment rate of many of the Southeast Asian refugee communities, while improving with the length of time they have been in the country, continues to be much higher than the Australian figure, and those who are employed generally work in semi-skilled and unskilled sectors. In 1991, the unemployment rate for Vietnamese-born was 39.8 %; that for Cambodian-born was similarly high at 39.6% (BIPR 1994; BIPR 1995). The unemployment rate in 1986 for Lao-born was lower, at 22.8% (Coughlan 1991). At this time, the unemployment rate for all Australians was 11.6% and for those from a NESB, 16.8%. Coughlan suggested this difference between the refugee groups was because Lao refugees tended to attend English language classes before joining the work force, whereas Cambodians and Vietnamese often enter the work force soon after arrival (ibid.). The present study will investigate the existence of such behaviour within the Hmong in Sydney. The number employed in semi-skilled and unskilled jobs was significantly higher than that of the Australian population. Sixty-three percent of working Vietnamese, 71.3 % of Cambodians and 79.9 % of Laotians were employed in semi-skilled and unskilled jobs, whereas approximately 35% of all Australians were employed in these areas. Most of the changes in the occupational distribution have been due to Australian-trained Southeast Asians entering the work force (ibid.).

The home ownership rate in these communities is increasing but is still far below the Australian figure: by 1991, 13.3% of Vietnamese and 13.7% of Cambodian refugees had purchased their own homes, whereas the Australian home-ownership figure was 41.0% (BIPR 1994; BIPR 1995). Home ownership is obviously important to these communities, as 37.2% of the Vietnamese and 34.0% of the Cambodian communities are in the process of purchasing their own homes (ibid.). Almost half in each community are still renting.

Education

By 1991, a small number of Vietnamese-born (6.8%) and even fewer Cambodian-born (3.3%) had obtained post-secondary qualifications[5]. Both figures were substantially below that of the total Australian population rate of 12.8 per cent (BIPR 1994; BIPR 1995).

These data will be compared and contrasted with socio-demographic data obtained in the current study, to provide a better picture of the state of resettlement of the Hmong community compared to the Vietnamese and Cambodian communities.

Methodology

The research for this thesis combines original fieldwork conducted with Hmong householders in Sydney with an examination of relevant published material.

The Hmong community in Sydney is both small and compact. Thus, potentially all families were able to participate in this study. Contact with this community was facilitated by one of the community leaders who provided the names and addresses of all the Hmong householders and also informed them of the research project. The participants were initially contacted by telephone in order to explain the aims of the research and to request permission to interview them. Refusals were very rare and most people were pleasantly surprised that someone was interested in studying their community.

In addition to a verbal explanation of the research, on the first visit I also gave them a written explanation of the research in English, with my telephone number, the University which I was affiliated with and the support and encouragement I was being given by their community leader (see Appendix One). As they kept this letter, they were able to discuss it with other family members after I had left. Many did so,

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[5] Includes higher degree, post graduate diploma, bachelor degree, undergraduate diploma and associate diploma (BIPR 1994).

and on subsequent visits, were more aware of my aims and pleased to continue participating.

The fieldwork consisted of formal questionnaires and open-ended interviews with Hmong householders over a period of two years, from March 1993 to December 1995. At this time, the total number of Hmong living in Sydney was a little over 200, consisting of about 32 households. Forty-one householders from 29 families participated in the interviews. Most people provided some further information regarding other household members, such as husbands or wives who were at work, children who were studying at the time of the interview and older family members who could not speak English. As this group of households is almost the complete Hmong community, these 29 families will be regarded as being representative of this group in Sydney. The wide range of sources permitted more depth to the data set than if the interviews had been kept to a strict formula. Later interviews were conducted with a small number of doctors who were seen by many of the Hmong.

The interviews were conducted in the people's homes as this was the most convenient for the participants. This also provided an opportunity to observe and document more about the participant's lifestyle. For example, discussions of photos of the family or Laos prompted people's memories, people were happy to show and explain to me about their herb gardens, and it also allowed greater awareness of the social and economic situation of the household.

Almost all of interviews were conducted in English, and all were audio taped, with permission from the interviewees, and later transcribed. Taping the interviews allowed greater flexibility in the interview and amount of information to be obtained. Most Hmong had sufficient English to obviate the need for an interpreter. Only a very small number of interviews required an interpreter. Privacy has been a high priority in this research and attempts to maintain it have been made at every stage.

The research sought information about health care behaviour at the household level rather than at the individual level because of the structure of the Hmong household. Traditionally, Hmong households consist of the extended family, with the oldest male member of the household being regarded as the household head (Geddes 1976). In Australia, these households still embrace the extended family, but family dynamics and customs have been forced to change. The break up of families as a result of the war and subsequent migration to a third country has made it very difficult if not impossible to maintain traditional household structures and practices. In the United States, the household heads of Hmong families have become those members who can be referred to as the 'middle generation' (Danes et al. 1993). They are the married couples, sandwiched between their elderly parents and their own children, generally in their mid 20's to 50's, who now provide the financial and social support for the household. In general, this 'middle generation' of Hmong was born and raised in Laos, but their children had been born and/or raised in the United States. These married couples in general make decisions for, and support, both their children and their elders, who, due to language and age limitations, often cannot work outside the home.

The Hmong who have resettled in Australia are similar to their counterparts in the United States, especially in terms of socio-cultural backgrounds and refugee experiences. A 1987 study of Hmong in Sydney revealed that 10 out of 37 households consisted of 3 generations. Fifteen of the adults were deemed to be too old for work or unemployable. The group who were available for employment and thus would have had more experience in Australian society would fit with Danes' description of a 'middle generation'. These people are the ones to whom the questionnaire was primarily directed.

A greater number of men than women were interviewed. Initially it was expected to be the converse as most interviews took place during the day. However many of the Hmong men were unemployed or were shift-workers and were therefore available

during the day, many women were working or were students and so were not available. Several interviews also took place in the evenings and on the weekends. In some households, for reasons that were not explained, husbands participated in the interviews rather than their wives. The role of men and women in traditional society where the male is the head of the household played a role in the greater number of men participating. It is the role of the male family heads to deal with visitors, guests and strangers (G. Lee, pers. comm.).

It is unlikely that this led to a bias on the basis of gender within the sample. Most questions were directed at the household level and thus could be answered by either men or women. Participants were able to supply information about health behaviour and illnesses of other family members, and generally were the ones who made health related decisions. In addition, a discussion on terminology was held at the beginning of each interview, such as 'household head'. While it was always agreed that traditionally the 'head' referred to the 'eldest male of the household', most families agreed that in Australia this has generally become a redundant term: household discussions are much more a family concern with all adult members being involved. Within Hmong societies, it is too rigid a view that traditionally men had all the power within a household as several authors have pointed out that women were able to have considerable input into family discussions and decisions (Cooper 1986a; Geddes 1976; Kunstadter 1986; Tapp 1988). However, such input was likely to be more restricted outside the confines of the household.

The method of recording and presenting data was done in the following manner: households were recorded in alphabetical order (e.g., A, B, C, etc.) and people were recorded according to their gender and age (eg., F21). Thus sources will be referenced in the following fashion, where A(F21) is a female, aged 21, from household A. The quotations have been recorded as close as possible to the original version, with some corrections to grammar if it was necessary to make the meaning clear.

The Questionnaire

The formal sections of the questionnaire allowed data to be catalogued for the whole population. This enabled certain demographic features to be aggregated and allowed quantitative information to be compared and contrasted with other published data. In all other respects the study was a qualitative one, as qualitative methods are indispensable for the study of those aspects of health care which depend upon the social interactions between individuals or groups (Daly and McDonald 1992b). The flexibility of the questionnaire and the open-ended and sometimes unstructured interview style of the research, allowed a greater understanding of issues pertinent to this community, and the ability to ask questions in order to understand how this group 'make sense of their experience' (Daly and McDonald 1992b:9), and thus to gain information which otherwise would have been missed if it were not for the considerable amount of general discussion that took place at each visit.

The questionnaire was divided into two sections: Part A concentrated on socio-demographic information about the whole household and Part B focussed on health care. Both sections sought information about both current lifestyles as well as previous experiences in Laos and Thailand. Part A sought demographic information about all members of the household, Part B sought the views of the participant, who answered in their capacity as decision maker for the rest of the household. If at any time another member of the household wanted to get involved, or the question prompted discussion of other topics, this was encouraged.

Questionnaire: Part A

The population characteristics sought in Part A were aimed at building up a social, economic, demographic and educational profile of the Hmong community. This information was obtained from the following areas: *household characteristics* such as the number, age and sex of all the household members, their relationship to the household head(s), where they live and why; *economic information*, including their

previous and current employment (or unemployment), level of education attained, whether they own their home or are renting; *cultural information*, such as the sub-ethnic group to which they belong, their clan group, religious beliefs, how they currently practice important cultural events such as birth, marriage, death and New Year festivities, and how they perceive the current role of the Hmong Community Association; and *personal information* including the age they were when they left Laos, family employment in Laos, whether they were rural or urban dwellers, education in Laos, time spent in and experience of the refugee camps in Thailand, age and year of arrival in Australia and their reasons for coming to Australia.

Questionnaire: Part B

Part B was more directly related to the health care behaviour of the family. It thus sought information from the following areas: *health care in Laos* such as what was available, what they used and why in terms of Western and Hmong medicine, their perceptions of each system of medical care, which one they would have preferred, the role of the shaman and what costs were involved for all types of health care; *refugee camps* in Thailand, where information was sought regarding the availability and use of Western and Hmong medicine, what sort of medical care was offered in the camps, how they used each system and what they were able to do in terms of their own health care; *current health care behaviour*, such as how people chose their local doctor, what they think of him or her and where he or she is located, when and why they would use Western medicine, Hmong medicine and shamans, how they perceive Western medicine and Hmong medicine, availability of Hmong medicine, health care practices for their children, availability and use of interpreters, experiences with and attitudes towards hospitals; and *personal opinions* of their current lifestyle, self-assessment of their current health status, and attitudes towards Australia and the medical system.

A complete copy of the questionnaire is provided in Appendix Two.

Following chapters

Chapter Two investigates variables that have influenced Hmong health care behaviour in three different environments: Laos, the refugee camps in Thailand and the United States. This chapter sets out to provide an overview of how Hmong health care behaviour has changed according to various circumstances and in different spatial contexts in order to create a base against which to compare and contrast current findings.

Chapter Three presents findings from the first part of the research, the socio-demographic data. The comprehensive and up to date profile of population characteristics and socio-economic status of the Hmong in Sydney will provide the basis to observe what socio-economic changes have taken place in this community since the last similar survey was taken in 1987, and for comparisons with other similar refugee groups in Australia and Hmong in the United States.

Chapter Four focuses on the community's use of the Australian medical system and how traditional health care requirements have been accommodated in the Australian setting. Aspects of this community's resettlement and its influence on health care behaviour will also be investigated. Unique features of Hmong health care behaviour are discussed.

In Chapter Five, the findings of the current study are compared and contrasted with those of studies of Hmong in the United States, and with data on other Southeast Asian communities in Australia. The outcome of the influence of different variables on health care behaviour on the different groups of refugees is examined. Finally, the contribution of this study to the contemporary field of the geography of health care and to research into migrant health is discussed and the potential for further research in this field considered.

Chapter 2
Health Care Behaviour of Hmong in Laos, Thailand and the USA

> The public, mental, and environmental health needs of refugee people often go unmet because of barriers that render already complex systems of care inaccessible (Rowe and Specs 1987:23).

Health care behaviour of the Hmong has been influenced in the last century by four major factors: the arrival of missionaries and the French colonial government in Laos in the late nineteenth and twentieth centuries; the huge presence of the American military during the later years of the civil war; experience as refugees in the camps in Thailand; and more recently by their resettlement in modern Western countries. In each situation, their health care behaviour has had to adapt to increasing exposure to Western medicine and other outside influences.

The purpose of this chapter is to investigate how Hmong health care behaviour has changed during this time, according to the differing circumstances, and to identify significant variables. This will provide a basis against which the findings of the current research can be compared and contrasted. A brief synopsis of Hmong medical traditions and their role in traditional life initially provides some background to traditional Hmong health beliefs and behaviour. This is followed by a review of recent health care behaviour of Hmong in Laos, Thailand and the United States. Finally, the variables that can be identified as influencing health care behaviour will be examined in order to provide a baseline for the study in Sydney.

Hmong in Laos: A brief overview

Over the last 200 years Hmong have migrated from southern China in large numbers to resettle in Laos, Thailand and Vietnam, mainly to escape persecution from the Chinese authorities (Cooper et al. 1991; Tapp 1986a). In 1975 the Hmong in Laos once again found themselves targets of harassment and oppression from the Lao Government when the Pathet Lao came to power in May 1975, at the end of a

civil war which had 'dragged on intermittently' from 1949 to 1975 (Cooper et al. 1991). Those Hmong who had fought against the Pathet Lao, with financial and military aid from the United States, believed that their lives were in danger. As a result, large numbers escaped across the border to neighbouring Thailand, a flight which continued for several years. From an initial exodus of 17,000 in the first few months of the Pathet Lao takeover, by 1978 over 80,000 Hmong refugees were estimated to have left Laos. A little over 40,000 of this group reached Thailand; the rest died in their attempt to leave Laos (Tapp 1986a). As the enormity of the problem became apparent, the United Nations High Commissioner for Refuges (UNHCR) in association with the Thai Ministry for the Interior set up refugee camps along the border between Laos and Thailand to accommodate the massive movement of refugees.

Altogether, more than 120,000 Hmong have left Laos since 1975. Many Hmong left the refugee camps to migrate to third countries; the overwhelming majority (over 110,000) resettled in the United States. Much smaller numbers went to Canada, France, Argentina, French Guiana and Australia (Cooper et al. 1991; Speer 1995). Some returned to Laos at the encouragement of the Lao Government (Cooper 1986a). With repatriation migration to third countries, the camps have slowly emptied. The last refugee camp was closed in 1995.

Traditional Hmong Lifestyle

Traditionally Hmong are shifting cultivators, growing mainly rice and other food crops (Cooper et al. 1991; Geddes 1976; Kunstadter 1986; Lee 1986). Changes in lifestyle and location in Laos have enabled some Hmong to pursue other occupations. Recent moves away from their traditional agricultural practices and life in the highlands of Laos have allowed small numbers of Hmong to pursue careers in urban areas and become more permanent settlers in lowland areas (Lee 1996). They are also well known for being involved in growing opium, its cultivation having the dual function of considerably increasing cash income as well as being used for

medicinal purposes. In addition, many men became soldiers during the war and moved away from farming.

There are many Hmong ethnic groups[6] but there are probably only 5 major groupings (Courtenay 1995). They are described according to the dominant colour of their traditional clothing. These major sub-groups are the White Hmong, where the women wear white pleated skirts, Blue/Green Hmong, where the women wear dark blue batik-dyed skirts, as well as Black, Red and Flowery Hmong. Each sub-group can also generally be distinguished by some variation in customs and dialectal differences in language (Lee 1996). These differences do not impair the Hmong having 'a sense of being one people and shar(ing) common language and culture' (Courtenay and Wronska-Friend 1995:3).

Traditionally Hmong live in large extended family households, averaging 8 to 10 persons, although larger households of up to 21 members are known (Cooper et al. 1991; Geddes 1976; Kunstadter et al. 1993; Tapp 1986b). The oldest male is the head of the household while women, although having less power, may often play a pivotal role in family decisions, becoming mediators in many situations (Tapp 1986b). The Hmong also practise polygamy and have a well developed system of bride wealth[7]; while both practices are either illegal or unacceptable in Western countries, they may continue to be practiced in a clandestine fashion in some communities (Meredith and Rowe 1986; Rowe and Specs 1987; Scott 1982).

The Hmong are divided into a number of patrilineal clans. Ideally, several different clans are found in each village (Tapp 1986a). Villages can be as small as two or three households, or consist of up to 100 or more households (Geddes 1976). In Thailand and Laos, villages are abandoned every 10 to 30 years when the fertility of the

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[6]Chinese accounts list 53 sub-divisions of the Hmong people in Guizhou province, China (Courtenay 1995)

[7]Bride price: In Hmong culture, during the wedding arrangements, the families of the couple negotiate a suitable 'bride price', whereby the family of the groom pays an agreed amount to the family of the bride (Geddes 1976; Cooper et al. 1991).

surrounding land is exhausted (Geddes 1976). Thus their traditional lifestyle pattern is one of continually building up and then abandoning settlements in order to continue practicing productive swidden agriculture.

Many aspects of their traditional way of life have been affected by the massive disruptions this group has lived through in recent years. How and why certain traditions and beliefs have or have not changed, and how such changes may have influenced health care behaviour are important aspects of this study.

Traditional Medical Beliefs and Practices

A central component of Hmong culture is the structure of Hmong traditional beliefs. A mixture of ancestor worship and animism[8] governs traditional beliefs and practices for illness and healing (Bliatout 1988a; Chindarsi 1970; Geddes 1976; Tapp 1986a; Thao 1986). Traditional Hmong culture involves belief in many supernatural beings, including gods, spirits of places, household spirits, malicious spirits, and spirits of the dead, and all are able to cause illness or damage.

Hmong culture also encompasses belief in a 'mandate of life', whereby every person is given a decree or a mandate, upon which the Superior Being foretells the length of the person's existence and his or her fate (Thao 1986). Traditionally Hmong believe that an individual may become ill because their mandate has predetermined their illness, and dies because their death is due. Some suggest that this gives Hmong a certain degree of fatalism and it has been proposed as a possible reason for Hmong rejecting Western medicine and finding a Hmong cure for a serious illness (Brainard and Zaharlick 1989). However, for the Hmong the 'mandate of life' is perceived more as a reason for a person's death rather than a belief preventing people from seeking medical care. Hmong practice a wide range of health seeking behaviours,

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[8]Animistic causation of illnesses is when the activities of a soul, ghost or spirit bring illness, such as through soul loss, when the soul is thought to depart or is taken from the body; or by spirit aggression, where a hostile or mischievous supernatural being causes an illness or possesses the body of its victim for a period of time (Parsons 1990).

have a long tradition of indigenous medicine, actively use shamans, and show a strong commitment to maintain good health.

In traditional society, Hmong rely upon two systems of healing, spiritual healing and herbal medicine. Both systems may be employed at the same time, or used singly, and both are important elements of the healing process. Hmong believe that there are many sources of illness. The primary cause is the loss of soul, but natural causes, supernatural or spirit causes, magical or organic causes are also possible (Thao 1986). Hmong identify two basic classifications of illness: disorders of the body and of the spirit (Hollinger 1988). The two kinds of illnesses are treated by two different practitioners. Spiritual healers, or shamans[9], treat illnesses which are suspected of having a spiritual origin, and herbalists and masseurs are used for most other types of illnesses. A shaman can be either male or female, but generally herbal medicines are part of the women's world (Thao 1986). Not all women have knowledge of and access to herbs, but those 'gifted' with this knowledge will pass it on to their daughters and grand daughters. If a spirit cause is suspected, this must always be treated spiritually alongside any herbal remedies, or the patient may not recover.

Shamans are the only ones who have the unique ability to be able to communicate with the spirit world, generally by way of an ecstatic trance, as described below:

> The Shaman is the one who can actually cross the threshold between earth and sky, and human and spirit, and enter the side of reality that is unseen, but nonetheless real, to rescue captured or fugitive souls, battle with evil ogres, or reconcile an offended nature spirit. His or her special powers of communication with spirits are signified by out-of-body consciousness, the ecstatic trembling of trance possession (Conquergood et al. 1989:47).

[9]Hmong shamanism is not a religion but a way of healing. Hmong traditional beliefs form a religion of souls and spirits, gods and devils, which informs the genesis of life, death and disease, and the perpetuation of life through reincarnation. Contrary to some reports, a shaman never performs religious rites as such, like the funeral, the releasing of a dead person's soul or the commemorative buffalo sacrifice to dead parents. If a shaman takes part in a ritual, it is never as a shaman but in his capacity as a ritualist after he has secured a further qualification (Lemoine 1986)

It is the role of the shaman to perform the various rituals that involve communication with the supernatural beings (Chindarsi 1986). Such rituals are mainly concerned with fertility, protection of individuals and of the whole community (as in ceremonies for funerals, New Year and for the new born child), healing and curing and in the selection of a new shaman (Cooper et al. 1991; Westermeyer et al. 1989).

Traditional medicine and beliefs such as those of the Hmong, inevitably form an integral part of the culture of the specific group from which they evolved (Good 1976; Westermeyer 1988). As such, the Hmong system of healing shares many common elements with traditional folk medicines found in numerous rural settings in developing countries (Egawa and Tashima 1982; Good 1976; Thao 1986). These systems are logical (internally consistent), valid, relevant in their own behavioural setting and deeply rooted in (the) beliefs, values, social organisation, and customary behaviour pattern of the practicing community (Good 1976). However, as lifestyle changes, as it has in recent years for the Hmong, so culture and traditional medical practices adapt to new situations.

Health care behaviour of Hmong refugees at a particular time and place is a product of the interaction of traditional health practices and beliefs, recent external influences, experience with Western medicine and current lifestyle. The initial introduction to Western medicine for the Hmong in Laos most likely occurred with the arrival of missionaries and French colonialists in the nineteenth century, but was inevitably uneven (Chan 1997). Exposure to Western medicine increased dramatically during the 1960's and 1970's for some Hmong, when America provided massive financial, military, food and medical aid to the Hmong soldiers and their families during the years of civil war in Laos. Subsequent internment in refugee camps followed by resettlement in third (Western) countries challenged some traditional health care practices.

In the countries of resettlement, Hmong traditional medicine would have been little understood (Bliatout 1986; Kirton 1985; State 1985). Most likely, it would not have even been known of, or made known to, treating medical personnel. In each instance, health care behaviour would have been influenced and modified. The outcome of these changes will now be investigated for Hmong in Laos, the refugee camps and in the United States.

Recent influences on Hmong health care behaviour in Laos

In the past 100 years, both the missionaries and French colonialists brought modern medicine to the Hmong in Laos. The missionaries used Western medicine such as quinine as a way of attracting Hmong to Christianity (Capps 1994). Exposure to Western medicine through the French colonial government appeared to come about more because the French brought their medicines and health personnel with them for their own purposes, rather than because they were interested in improving the health status of the local population. During their rule, the French made little effort to develop Laos economically, socially or culturally (Chan 1997; Evans 1990). They were more interested in exploiting its natural resources.

More recently, the American military brought American medical personnel and Western medicine with them to Laos in the 1960's and 1970's. Hmong soldiers and their families were able to be treated by American medical teams. During this time, many young Hmong were also trained as nurses. Some refugees even tell stories of being airlifted by helicopter to larger medical centres for treatment (Kirton 1985). Those in isolated villages or who were not affiliated with the military continued to have little or no opportunity to use Western medicine.

The Hmong formed their own opinions of, and developed their own way of using, Western medicine, depending on access and the way it was offered. The way this system of medical care was distributed by the American military led to certain perceptions and misconceptions about Western medicine. Although only a limited

range of treatments and medicines was available, they were dispensed free, and diagnosis and treatment were fast and immediate as they were not impeded by laboratory tests, restrictions on drugs or postponed diagnoses in the interests of accuracy, as would be the case in a more formal setting in the United States (Kirton 1985). Those Hmong who experienced this type of care in Laos may have consequently believed that Western medicine would be fast, efficient and free. What was not understood was that they were being provided with a modified form of care that was not typical of that practiced in the United States. Such unmet expectations may have led to the less than optimal health care behaviour subsequently recorded of those Hmong who resettled in that country.

Even though Hmong had access to Western medicine in Laos, they continued to use their traditional treatments, especially where spiritual causes were suspected. As Western medicine does not address the spirit base of an illness, Hmong medicine remained necessary. In general though, Hmong began to use a 'bit of both' medical systems (Egawa and Tashima 1982). Some developed certain beliefs about the efficacy of Western medicine: Western medicine was regarded as 'best' for certain ailments, especially acute illnesses such as fever and diarrhoea. The speed and power of antibiotics and injections in particular led Hmong to give Western medicine 'preternatural' powers (Westermeyer 1988). Spiritual healing continued to be important as long as there were people who practised ancestor worship and other forms of spiritualism and was regarded as being best for chronic illnesses where it was important to discern and treat the cause of the illness (Egawa and Tashima 1982). For the Hmong, the 'best cures' became those which were comprehensive and used medicine and knowledge from all available sources (Cooper et al. 1991). Shamanism did not preclude the use of other forms of medicine, instead it filled the gap not addressed by Western medicine, such as the spiritual cause of the illness and the psychological support, which may involve receiving gifts and attention during shamanic ceremonies, which may be important to the healing process.

Similar patterns of health care behaviour have been found in studies of Hmong in Thailand where Hmong villagers live modified traditional lives and have varied access to Western medicine. Although traditional health beliefs and practices have been influenced by Western medicine, Hmong in Thailand were found to continue to use traditional sources of treatment alongside Western medicine, where observation and anecdotal information suggested that Hmong often used traditional remedies (either herbal or spiritual) especially if the ailment seemed to be a common, non-life-threatening condition, or one which may have been caused by the spirits, before they went to a modern medical facility (Kunstadter 1996b). Thus, with the increasing availability of Western medicine, Hmong in Thailand chose to use traditional and/or Western medicine according to their own perceptions and beliefs of each system, what the illness is and what it has been caused by. They were not averse to using Western medicine, and they chose to use it if it they thought that it would lead to a cure.

With increased exposure to and experience with Western medicine during this period in Laos, Hmong developed certain beliefs and ideas about the role of Western medicine and traditional medicine in treating illnesses that may or may not have been accurate. At the same time, other significant changes were taking place in their lives in Laos: resettlement of Hmong villages during the war, break up of families, and the death of family members due to war and difficult living conditions. These events contributed to a breakdown in the transfer of knowledge of traditional medicine, as well as social problems and stressed the whole social and organisational system, including cutting people off from sources of herbal medicine or the best shamans. Thus, while Hmong were forming ideas about Western medicine, other events were reshaping their lives. This process continued during their stay in the refugee camps.

Hmong in the refugee camps

Refugees fled from Laos in three discernible waves. The first wave of 45,000 mostly Hmong refugees from Laos occurred between 1975 and 1977 (Long 1993; Tapp 1988). The second wave of 57,000, mostly of lowland Lao and Hmong, took place between 1978 and 1982. The third period, 1982-86, involved a fluctuating flow of refugees across the border according to political policies on both sides of the border, current resettlement practices, Thai policies towards refugees and political and economic conditions in Laos (Long 1993). As stated earlier, over 120,000 Hmong have left Laos since the end of the civil war.

In response to the initial huge influx of refugees into Thailand, the UNHCR set up camps and began coordinating food, shelter, and other services. Hmong mainly resettled in Ban Vinai refugee camp, and smaller numbers went to Nong Khai, Na Pho and Chiang Kham (see Map 2.1) (Maybin 1993). In 1979, 11,500 refugees were living in Ban Vinai; by 1986, the numbers had reached 45,000 the majority of whom were Hmong.

Life in the refugee camps was extremely basic, with overcrowded living conditions, poor sanitation and scanty and poor food supplies. Ban Vinai, for example, was only a little over 400 acres (Long 1993). Compared to the conditions some Hmong were living under in Laos, where conditions rapidly declined after 1975 (when the Pathet Lao took over and America withdrew its massive aid), it may have appeared to potential refugees that Ban Vinai, and the other refugee camps, with at least a regular supply of food, health care and other amenities, provided an easier life (Long 1993; Maybin 1993). In reality, conditions were severe in both situations.

Health care behaviour in the refugee camps

Only a small number of studies have been completed on Hmong health care behaviour in the refugee camps (Chan, 1997). The following is a brief summary compiled from this literature. Clinics and hospitals in the camps provided Western medicine and Western-trained medical personnel. Local camp members and

Map 2.1 Showing Laos in relation to Southeast Asia.
(Inset map showing refugee camps in Thailand)

volunteers from international agencies worked in the medical centres under the supervision of trained professionals. Hmong were able to continue using traditional methods of healing; herbs could either be obtained from the surrounding forests which were similar to those of Laos, and shamans were regarded as neither intrusive nor unusual, especially in a camp like Ban Vinai where the majority of the population was Hmong. Most health problems specific to the refugee camps were related to the general unsanitary conditions of the environment, lack of clean water, food shortages and the after-effects of the war (Munger 1986; Tapp 1988). They included parasitic infections, poor nutrition, and psychological problems.

Whilst in the camps, certain incidents which occurred, related to the administration of health care and perceptions of medical care providers, had a serious impact on Hmong and their subsequent health care behaviour. The majority of voluntary agencies involved in working in the camps were religious organisations, with a few secular organisations also involved from the beginning (Long 1993). Although not homogeneous, the Christian groups in particular were instrumental in influencing refugee life and perceptions of Western medicine.

One notable incident involved over-zealous Christian health care workers taking matters into their own hands. Ban Vinai had an extremely high birth rate. In 1983-85 it peaked at 4.55% (Long 1993). The high birth rate was attributed to the Hmong trying to restore their population numbers that had been so devastated by the war and their exit from Laos. Inspired by their leaders (who were now living in the United States), Hmong were encouraged to rebuild their numbers, re-arm and return to reclaim the land lost when they left Laos (Tapp 1988). The high birth rate in the camps was also related to the traditionally high birth rate of the Hmong.

This behaviour ran directly counter to the aims of the camp officials, whose prime concern was to keep down the rising birth rate and in turn, the number of new mouths to feed. A too-ardent implementation of this policy led to a very serious situation in one camp after three Hmong women underwent sterilisation in a camp

hospital run by a voluntary Christian organisation. It appears that the women were not properly informed of the consequences of the operation, and that the medical staff were also not aware that fertility and the ability to bear many sons was very important to Hmong culture. After this incident, many Hmong refugees were unwilling to go anywhere near a camp hospital (Tapp 1988). Other less serious incidents in the camps also created fear and mistrust of Western medicine. Some Hmong parents refused to follow the inoculation programme after three small boys suffered adverse reactions to being vaccinated (Tapp 1988). Both the translation of the procedures and their subsequent interpretation by the Hmong were major areas of misunderstanding in these cases, where an effort to 'do good' was made without fully realising the potentially damaging consequences.

In addition to concerns about the medical practices in the camps, Hmong were receiving information from relatives who had already moved to the United States, which raised new concerns about the nature of Western doctors in general (Hurlich et al. 1986). Hmong in the States were horrified when doctors performed autopsies, as is routine for all sudden deaths, on Hmong who had died of Sudden Unexpected Nocturnal Death Syndrome (SUNDS)[10], or later on people who died from car accidents or other causes (G. Lee, pers. comm.). Hmong have no tradition of anything resembling an autopsy, especially a procedure that may disfigure the body after death. Hmong funeral customs are complex, elaborate and essential to the culture. They are designed to give the dead person the best chance for a safe journey to the spiritual world, where a successful reincarnation will take place. Hmong fear that removal or amputation of body parts will be replicated in the next

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[10]SUNDS has occurred in both the United States and in the refugee camps in Thailand. It has affected all Southeast Asian refugee groups, but has occurred within the Hmong community to a greater extent. Since the first reported case in 1977, more than 100 Southeast Asians in the United States have died from SUNDS; the largest number of incidents was among Hmong males. All but one of the victims were male, the median age was thirty-three. All were apparently healthy and all died during their sleep. While the actual cause of the deaths remains a mystery, several possible reasons have been proposed, including genetic factors, stress of resettlement, and weakness caused by exposure to chemical warfare in Laos. The cause of SUNDS is most likely a complex interaction of genetic, environmental and behavioural factors (Adler 1995; Bliatout 1982; Munger 1986).

reincarnation. The effect of such stories and rumours led to a dramatic decline in Hmong wanting to go to America and an increased reluctance to see American doctors in the camp clinics (Tapp 1988).

The use that Hmong made of the camp medical facilities was, to a substantial extent, on their own terms. In Ban Vinai, and probably other camps which housed Hmong, Hmong refugees continued to rely on traditional healers and herbal medicine, and to observe ritual and ceremonial practices, much to the chagrin of relief agencies and officials.

Continued reliance on traditional medicine occurred for several reasons. First, in some camps the population of Hmong was large enough to ensure the presence of several shamans and traditional healers. The average length of stay for refugees in Ban Vinai camp was 7 years (Long 1993), thus traditional healers and shamans could become well established within the community. Second, access to herbs was easy, as many of the necessary herbs for traditional medicine and ceremonies could either be found in the forests surrounding the camps, purchased from local markets, or grown in camp gardens. Third, fears about Western medicine (or lack of access) led to a fragile relationship between refugees and the camp clinic staff, and misunderstandings between the two generally resulted in the Hmong refusing to use the clinics. Western medicine was also expensive to obtain, unless dispensed freely by aid agencies, and there were only a few of these agencies in each camp with their own limited supply of drugs (G. Lee, pers. comm.). Thus, in the refugee camps, Hmong used both systems of medical care according to availability, perception and experience of each.

Hmong refugees in the USA

Resettlement experience

Hmong refugees from Laos and from refugee camps in Thailand first arrived in the United States in 1975. From an initial arrival of 301 refugees that year, the number

peaked in 1980 with 27,242 arrivals (Olney 1986). Hmong continued entering in smaller numbers in the ensuing years and by the early 1990's over 110,000 Hmong had resettled in the United States (Cooper et al. 1991). Today the Hmong population in the United States is believed to be about 150,000 persons.

Hmong, along with other Southeast Asian refugees, were assisted in their resettlement through cash and other welfare benefits, funded by way of grants to the states from the Federal Government (Bertini 1989). All refugees were automatically eligible for cash payments and medical assistance for the first 36 months after arrival in the United States, after which they were only eligible for the same public assistance under the same criteria as applied to all Americans (US Department of Health and Human Services 1983; Zaharlick and Brainard 1987). In 1982 this period of assistance decreased to 18 months (Mason 1986).

Medical assistance was one of the target areas for these funds, as refugees were perceived to have a larger number of health problems than their American counterparts, largely because of hardships encountered in their homelands or the result of lengthy confinement in refugee camps (Boland 1981). In addition, the American Government believed that sound health was a prerequisite to getting refugees off cash assistance and into training and jobs, and thus self-sufficiency. However, economic self-sufficiency for the Hmong has not taken place as quickly as the American Government had hoped, and in some communities they continue to suffer extremely high rates of unemployment and welfare dependency. One major reason for this situation has been the outcome of secondary migration, which totally transformed the initial resettlement aims of the American Government.

When the refugees first arrived, the American Federal Government adopted a 'dispersal policy of relocation', whereby groups of 200 to 500 Hmong were resettled throughout the country in order to spread the financial and social obligations between the states, to avoid the formation of large immigrant enclaves in a small

number of communities, and to assist with assimilation as quickly as possible (Eisenbruch 1990; Kirton 1985). A wide range of voluntary agencies (Volags) assisted in this process. Thus, initial care for the refugees was provided by sponsors, whereby an American family or community would be responsible for assisting with the resettlement process. This involved helping the refugee family find a home, get a job and use the various services now available to them (Boland 1981). However, this settlement pattern became only a temporary arrangement for many Hmong (Helzer 1994). Lack of employment, poor proficiency with English, social isolation from other Hmong in their original place of resettlement and inadequate training and preparation given to the Volags were some of the reasons that led to massive secondary migration by Hmong refugees in numbers which American authorities had neither 'experienced the scale or extent of' among other immigrants to the United States (Kirton 1985; Tapp 1988) and was thus totally unexpected.

While the Hmong have a history of 'moving for betterment', in the United States, many moved more because of the 'shortcomings of the sending communities rather than knowledge of what might lie ahead' (Finke 1986). Family reunification and the ability to move freely between the states prompted the initial moves. In many cases, older Hmong encouraged younger family members to move closer to them. This was assisted by Washington's policy of encouraging family reunification (Scott 1982; Zaharlick and Brainard 1987). The presence of a clan leader or 'anchor relative' also played a role in influencing Hmong resettlement (Helzer 1994). The potential power of the clan leader attracted other Hmong, and a larger community gave that leader, and hence the community, more power. In later moves, Hmong refugees tended to concentrate in those states 'with generous public assistance benefits and lenient eligibility requirements' (Helzer 1994:52) as their socio-economic problems became more protracted.

Thus present day location of the refugees within the United States is very uneven. By 1990, over 90% were living in the three states of California, Minnesota and

Wisconsin. Currently, it is estimated that over 50% (70 - 80,000) are in California, 30,000 in Minnesota and 40,000 in Wisconsin. This pattern was not anticipated based on their initial placement and has created unexpected strains on welfare providers, especially where large communities have formed.

Unemployment and welfare dependency

The high rates of unemployment and welfare dependency which characterised the resettlement of Hmong in the United States were influenced by the size of and the speed at which the community grew. While high rates of each were more commonplace in the very large communities such as Fresno in California and the twin cities of Minneapolis-St. Paul in Minnesota, they were also prevalent in the smaller communities. In many cases, Hmong had experienced long-term socio-economic disadvantage.

In cities with a very large numbers of Hmong refugees, employment opportunities declined as the rapid influx of a large number of people with the same job skills (or lack of skills) could not be absorbed rapidly into the work force. In Fresno, the number of Hmong receiving welfare payments rose from 168 in January, 1980, to over 7000 by 1986, thus over half of the Hmong population of 13,500 were welfare recipients (Finke 1986; Hollinger 1988). This figure did not change in the ensuing 10 years as in 1995, 55% remained on welfare (Kunstadter 1996a). Similarly, in Minneapolis-St. Paul, another region where large numbers of Hmong had resettled, their unemployment rate also remained high for a considerable period of time. In 1987, 77% of the population of 10,000 were unemployed, with a similarly high number of welfare recipients (Tapp 1988). By 1991, the population had increased to 16,838, and the refugee unemployment rate, while it had declined considerably, was still high at 40%. In the twin cities, welfare dependency appeared to have continued at a high level for an extended period as, in an attempt to alleviate problems of poverty and to take advantage of the American welfare regulations, some Hmong families had broken up into numerous sub-divisions, with elderly aunts,

uncles and grandparents living alone (Westermeyer et al. 1989). While this strategy helped the extended family acquire capital resources for cars, homes and tuition, it unfortunately created other problems of loneliness, fear, and depression among isolated elderly members. In many smaller communities, where unemployment rates were lower, their levels were still unacceptably high (Kirton 1985). In Isla Vista, California, one of the smaller Hmong communities of 400 persons, the unemployment rate was 24% in 1985. In fact, higher unemployment figures for Hmong were so common that State (1985) commented that this particular community had a 'high' employment rate of 75 per cent.

The high unemployment rate and number receiving welfare benefits were related to more than the lack of available jobs. Most refugees were employable only in the more economically vulnerable sectors of the work force because their job skills and proficiency in English were low, which led to difficulty in improving their education and thus employment prospects (Downing 1986; Scott 1982; Stoumpos Gross 1986; Tapp 1988). In addition, many were concerned about losing medical and other benefits if they took up employment, especially since for most, employment options did not include medical benefits or job security. Conversely, those with better English and a better work skill level had lower rates of unemployment and generally were able to obtain jobs that offered medical insurance cover. More recently migration has occurred of young Hmong couples eager to find work and get out of welfare dependency. Many have moved to North and South Carolina to find employment (G. Lee, pers. comm.), and a special government initiative encouraged Hmong to move to Georgia for similar reasons (Duchon 1997) (see below).

The large size of some communities had the beneficial effect of becoming a resource for the community itself (Olney 1986). It allowed family members to share financial and personal resources, pool funds for large purchases, share child minding and caring for older members. Larger communities were also able to keep alive many Hmong traditions and aspects of culture and history that might otherwise have

disappeared when families were isolated from each other or communities so small that they found it too difficult or unacceptable by the wider community to follow their traditions. The greater power of a community leader of a large population also brought benefits to the community as a whole, especially within the larger US Hmong communities.

In addition, the considerable numbers of Hmong in the United States and their concentration in three states allowed many of the smaller communities to occasionally operate more like a larger community. Geographical proximity between communities enabled them to easily come together on a regular basis to celebrate special events such as weddings and New Year celebrations. Sometimes gatherings of up to 10,000 to 25,000 Hmong from different cities provided the opportunity for community leaders to discuss issues relevant to Hmong resettlement and for other Hmong to continue with traditional social interaction (Helzer 1994). On the other hand a large community involved some problems including the development of conflicts and factions, and a lack of unity and cooperation (G. Lee, pers. comm.).

Education and language

Low proficiency in English was reported in many studies as being a major social and economic barrier for successful resettlement in the United States (Downing 1986; Stoumpos Gross 1986; Tapp 1988). In Orange County, California, it was found that

> in spite of many individual successes in learning English in a short time, the community as a whole sees inadequate English as an overwhelming problem. English is seen as necessary for entry into jobs, for promotion on the job, for making use of job training, for higher education and for acceptance by the American community (Downing 1986:366).

However, Hmong adults have been shown to have significant difficulties in learning English, this was generally attributed to their lack of or low education attainments in Laos, or because many lived in areas where there were large concentrations of Hmong and hence less opportunity for social contact with English speakers (Green and Reder 1986; Weinstein 1986). Education was not easy to obtain in Laos and many missed education opportunities because of the many years of civil war and the

physical isolation of rural dwellers (Bliatout 1988b). In some instances attempts were made to address the particular difficulties experienced by Hmong[11], but many Hmong in their forties and older have failed to make a 'successful economic transition' in their new country (Kunstadter 1996a) and have resigned themselves to a life of welfare dependency (G. Lee, pers. comm.).

Nevertheless, Hmong in America value education for their children (Cohn, 1986), but in some areas the attrition rate of Hmong teenagers was very high. Several contributing factors have been identified. These include academic difficulties in school, inadequate direction and counseling, welfare disincentives and early marriage and pregnancy (Cohn 1986). In 1986, less than 5% were attending college in the United States although many more may have been attending part-time (Cohn 1986); this may now be higher (Kunstadter 1996a). Lack of funds severely restricted Hmong students taking up places in college. Consequently, Hmong may continue to be high users of welfare benefits and suffer the numerous problems associated with long term poverty for some years.

Family size and birthrate

The birthrate remained high for many Hmong in the United States, and was higher than that of the other Southeast Asian refugees (Balvanz 1988). Olney (1986) estimated the crude birth rate to be 5.0%, compared with the overall rate in the United States of 1.6% (Olney 1986). Special purpose studies of fertility rates of Southeast Asian refugees have consistently found high rates among Hmong women (Zaharlick and Brainard 1987). Traditionally Hmong have had high fertility rates; estimates put their traditional birth rate at between 4.4% and 7.1% (Kamnuansilpa et al. 1987; Kunstadter 1986). Kamnuansilpa attributes the continuing high birth rates

[11]There was a perception that Hmong who were literate in their native language were able to learn English at a faster rate than those who were not literate in Hmong, thus some language classes concentrated on teaching literacy in the Hmong language before teaching English to the refugees. Green and Reder were unable to find a direct causal link between faster acquisition of Engish simply due to the literacy skills of Hmong refugees, rather they suggested that those Hmong who were literate in their own language were more interested in also learning English, as 'individuals who desire to learn Hmong script tend to be predisposed to learning English' (1986:323).

to the Hmong desire to have large families, the high rate of marriage among teenagers and the reduction in infant mortality. These figures were gathered from a variety of sources and should not be taken as absolute. Nevertheless, large Hmong families in the United States seem to be the norm.

The combination of large family size and teenage marriage most likely contribute to the poverty cycle in which many Hmong find themselves. In such situations, they were reluctant to take up employment for fear of losing medical benefits for their large family and to avoid facing crippling medical expenses in the future; teenagers who were leaving school before graduation to marry and have children may later find themselves unable to obtain quality employment; and large families put considerable financial strain on a family's income.

Household structure

The Hmong population in the United States is young (Lor 1994; Olney 1986). In 1985, 25 to 30% of the Hmong refugees were under 5 years old, and 50% were under 15. In one small case study in Fresno, the number of children under 19 and persons over 60 constituted 74% of the population (Lor 1994). The large number of dependent family members put severe financial strain on the family income and other stresses on those who were regarded as the 'breadwinners'.

In St. Paul-Minneapolis 12% of the households were headed by women and they were generally poor. As most Hmong women have less education and work skills than men, and greater family commitments which may prevent them accepting employment, these families have a greater tendency to remain poor (Mason 1986). Despite the stipulation of the 1980 Refugee Act that women must have the same employment training opportunities as men, training programmes accessible to women have tended to be inadequate and inequitable, channeling them into programmes which only lead to marginal work such as house-cleaning and cottage

industry sewing (Mason 1986). Both these factors indicate that a continuing high rate of welfare dependency may continue for a considerable time in the future, especially in light of the high attrition rate of school students.

Religion and Christianity

In the United States, while a certain number of Hmong retained their traditional beliefs, a large number converted to Christianity. Some had already converted while they were in Laos as a result of the work of missionaries. Others converted once in the United States often because of their resettlement experience (Lee 1996), as the American government's sponsorship programme encouraged community groups, which were often Christian, to assist with the resettlement of Hmong refugees. This has also led to increased exposure to Christianity.

Many Hmong converted at the encouragement of their host family. Others felt obliged to convert as a way of showing their gratitude (Capps 1994). Social and economic factors also led to conversion: churches are generally charity minded and, as members of a congregation, refugees were able to obtain moral support and access welfare benefits such as food and clothing handouts (Capps 1994); belonging to a church assisted many find inroads into mainstream culture and to become more 'Americanised' (Helzer 1994); and the church could provide a much needed social outlet to a group of people who otherwise felt very isolated (Duchon 1997). In Atlanta, Hmong who were members of the church were far happier and more satisfied than their non-church going counterparts (ibid.). By becoming Christians, Hmong could also avoid the often considerable expenses needed for shamans' ceremonies and for funerals (Capps 1994). Conversion to Christianity required Hmong to give up their traditional belief in spirits, but there was some evidence that Hmong attempted to accommodate both Christian and animistic beliefs so as not to 'sever their links to an extensive genealogy and undermine a traditional understanding of how the world operates (Helzer 1994). Thus for some, conversion required a major change in lifestyle and beliefs which they found very difficult.

Traditions

Many aspects of Hmong culture have been retained by Hmong in the United States, the more obvious include the importance and strength of clan ties. Hmong continue to live close to other clan members, caring for elderly parents, seeking work in the agriculture sector, moving for betterment, using shamans and Hmong medicine, having large families and practicing teenage marriage (Helzer 1994). Other practices that may still occur but are less obvious to outsiders include polygamy and exchange of bride price (Meredith and Rowe 1986). Changes which have occurred to the Hmong way of life in the United States include greater educational opportunities, women being in the paid work force, female household heads, working in manufacturing industries rather than agriculture, less ability to sacrifice large animals for shamanic rituals, and a large number of Hmong converting to Christianity.

Thus, Hmong resettlement in the United States was characterised by the formation of several large enclaves, a concentration of population groups in a small number of states for both economic and social reasons, and high and long-term rates of unemployment and welfare dependency. The socio-economic situation for Hmong in the United States was so severe for so long that it led some to suggest that the group would become part of the permanent urban underclass (Duchon 1997). However, a study of recent Hmong settlers in Atlanta, Georgia, provided at least one example of successful resettlement and gave some clue to the variables involved. In 1990 Hmong were encouraged to resettle in Georgia with the aim of reducing their dependence on public assistance and because of its suitable employment prospects. Cash incentives were offered, and two high tech manufacturing facilities[12] were identified which needed workers who were quick learners but who needed no more than rudimentary English (Duchon 1997). In addition, Georgia offered several of the

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[12]At the time, local Hmong were performing the sort of work which is typically accessed by refugee agencies, that is, working in areas that were dirty, physically demanding and low-paying (Duchon 1997). Instead, in Georgia, they were offered work in industries which made cellular phones and contact lenses, where they enjoyed better working conditions, received training and were better paid.

same attributes found in other states desirable to Southeast Asian refugees, including mild winters, low unemployment rates and a substantial Asian community. By 1993, the Hmong population in Georgia was a 'modest' 2000 and was continuing to increase. A survey of 30 households found many indicators of successful resettlement. There was nearly full employment (only one person was unemployed), families had bought homes and farmland, and children had excelled at school and were going on to college. As well, many Hmong had converted to Christianity. The welfare benefits of doing so were considerable (as discussed above). As was found in other studies in the United States, Hmong in Georgia continued living close to other Hmong, household size was large (6.2 persons per household) and bride wealth was still practiced (although remained controversial). Certain unanticipated social, economic and cultural changes had taken place. Women were among the highest paid wage earners, which led to a greater degree of independence (and concern by some older Hmong), and some changes in family dynamics[13]. In families where education was valued, girls were just as likely to pursue post-secondary education as their brothers. These findings suggest that successful resettlement was possible given the right conditions. Georgia provided Hmong settlers with an environment which allowed for personal freedom and a range of choices for the new settlers (Duchon 1997) and demonstrated that variations in resettlement within the same cultural group are possible in different spatial contexts.

Overall, the resettlement experience of Hmong refugees in the United States has involved protracted socio-economic hardships and a high rate of welfare dependency, the formation of several very large communities, continuing difficulties learning English, especially for older and illiterate Hmong, major changes to their

[13]The affluent women were atypically independent. In one family, when the couple married, it was the man who moved to Atlanta from out-of-state because his new wife in Atlanta had the larger income. In another, a war widow owned her home, so her parents moved in with her, and her brothers purchased homes nearby. She had no interest in remarrying, which distressed her parents (Duchon 1997).

traditional way of life, and a maintenance of certain traditions. But Duchon's study revealed that a more positive outcome was possible in a different spatial, social and economic context. How Hmong resettlement has influenced their health care behaviour will now be investigated.

Health care behaviour of Hmong refugees in the USA

Many of the early studies of Hmong health care behaviour in the United States found that out of all the groups of recently arrived refugees from Southeast Asia, the Hmong showed a significant resistance to using mainstream Western medical care (August 1984; Brainard and Zaharlick 1989; Deinard and Dunnigan 1987; Egawa and Tashima 1982; Kirton 1985; Moon and Tashima 1982; Strand and Jones 1983). In addition, they were more likely to consider Western medicine as a last resort when traditional therapies fail (Brainard and Zaharlick 1989). Instead, Hmong continued to use their traditional medicines, though such health behaviour was unable to elevate their health levels beyond that of 'only fair' (Brainard and Zaharlick 1989). More recent studies have shown that this pattern of health care behaviour remains in place in some Hmong communities (Capps 1994; Helzer 1994; Kunstadter 1996a).

Two independent aspects of Hmong health care behaviour were identified in these studies: that Hmong refugees continued to use their traditional medical treatments, often regarding them as superior to Western medical practices and that they experienced poor health status. It is unknown however, whether their continued use of Hmong medicine had any relationship to their poor quality of health, as many variables are involved in determining health care behaviour (Eyles 1987; Meade et al. 1988; Phillips 1981a). Moreover, economic and social constraints, such as those experienced by Hmong in the United States, frequently combine to produce a substandard pattern of use of medical facilities among the most vulnerable members of society, and are often associated with poor health status. Identifying the barriers that have been able to influence Hmong health care behaviour in the United States,

either individually or especially in combination with other variables, may help determine their distinct effect on health care behaviour.

Potential barriers to Western medicine for Hmong refugees

Socio-economic barriers

A large number of Hmong in the United States are socio-economically disadvantaged, a common barrier to obtaining optimal health care. Many Hmong simply may not have been able to afford to visit the doctor or afford medical insurance. One Hmong community in San Diego was often found to run out of food before the end of the month (Weeks and Rumbaut 1991). In this community, the high rate of unemployment and welfare dependency, combined with large family sizes meant that there was little money available for medical bills. In addition, the costs involved in medical care consist of more than just the cost of the medical consultation. For example, those who were employed may have had to forgo wages if they took time off work for a medical visit because their low status employment would not cover their lost wages. Actual experiences with medical care also reinforced their fear of costs, for instance some Hmong received medical bills for $2000 for one night in hospital, or $10,000 for a confinement, which was money well beyond their means as few had health insurance (G. Lee, pers. comm.). Such expenses made other Hmong fearful of using Western medical facilities.

For some, the potentially high cost of Western medical care became a self-fulfilling prophesy. By delaying treatment until a minor illness became more serious, and thus requiring immediate treatment, Hmong who needed medical treatment often had to seek help at hospital emergency departments. But by delaying treatment, they increased their chances of having a more serious illness and a longer period of recovery (Strand and Jones 1983). Furthermore, the ensuing treatment was both more costly and time consuming to both patient and treatment centre. Such experiences reinforced common fears held by the Hmong that 'Western medicine always costs too much' (State 1985:19).

Demonstrating a slightly different concern about medical costs, and showing how political and economic variables may interact to produce a particular outcome, Hmong who were receiving welfare assistance in some cases were reluctant to seek employment for fear of losing their medical assistance (August 1984). The linking of cash assistance to medical assistance, whereby they lost both benefits upon obtaining employment, was criticised by many agencies working with these refugees as it acted as an inducement for refugee families to stay on welfare (Boland 1981). Hmong were fearful of potentially high medical bills in the future, a fear related to perception of costs, rather than to actual medical experience (August 1984). Health insurance costs were also very high, beyond the means of Hmong in unskilled, low paid jobs and the many who remained in the unemployment pool.

The administration of the welfare system in the United States restricted Hmong use of Western medicine: welfare benefits for refugees were limited to a certain period of time, after which eligibility reverted to being the same as that for other Americans. Those who thought that they had lost all of their medical coverage at the end of this period (poor skills in English may have made it difficult for them to understand the new regulations) may have restricted their use of Western medicine, based on their fears of the potentially high costs that they might incur after this period.

Influence of Hmong culture and the culture of Western medical care

The fact that Hmong had a well established medical regime that they continued to practice in the United States meant that they were not totally reliant on one type of medicine. As could be expected, at least initially, in the largest communities the availability of and encouragement to use Hmong medicine was greatest. Within many Hmong communities there appeared to be a wide range of traditional medicines and treatments that were familiar and at a cost structure that was understandable, flexible and affordable. In fact, some studies found the Hmong were prepared to 'shop around' to find medical treatment that they believed was more suitable than Western medicine (Deinard and Dunnigan 1987; Kirton 1985;

Kunstadter 1996b). Therefore, though Hmong were not using Western medical facilities, they were not forgoing medical treatment altogether.

While the large communities may also have been able to exert greater pressure on their members to use traditional medicine, since the traditional socio-political hierarchy remained more or less intact, traditional medical beliefs appeared to remain strong even in smaller communities of 400 to 1000 persons, where ambivalence towards and reluctance to use Western medicine was also observed (Capps 1994; Helzer 1994; Kirton 1985). It appeared however that Western medical facilities were used at a higher rate in the smaller communities, suggesting more limited access to traditional Hmong medicine or other social and cultural changes. While the larger Hmong communities may have been able to provide greater access to Hmong medicine, cultural preferences nevertheless remained strong.

Fears about Western medicine, which created problems between patient and practitioner, were related to cultural beliefs concerning causes of illnesses, fear of invasive treatment, male/female cultural roles and the clan/family role (Bliatout 1988a). Reluctance to agree to invasive procedures such as blood tests and surgery was also said to be founded in Hmong culture:

> The belief in reincarnation is an important component of Hmong traditional religion, and those who believe in it feel that actions in the present life directly affect what will happen in future lives. Since surgery is viewed by the Hmong as being the removal of part of the body, it is feared that surgery in the present life may cause the person to be reborn with that part missing in the next life (Bliatout 1988b:240).

Surgery posed a great problem for Hmong. Bliatout's study found that an 'amazing 100% of the 50 heads of households interviewed expressed negative views about surgery of any kind' (1988b:25). Those who continued to follow Hmong traditional beliefs considered that their beliefs were a primary reason that they did not accept surgery. In other instances, Hmong were found to agree verbally to a surgical procedure, but did not turn up at the appointed time. Others rejected invasive procedures (eg. lumbar punctures and Caesarean sections) often at considerable risk

to patient and foetus (Deinard and Dunnigan 1987). Cultural beliefs, combined with poor communication between patient and medical staff, led to several well-publicised conflicts between Hmong and American medical system. (Kunstadter 1995, Appendix Three).

Many studies linked Hmong cultural beliefs and attitudes, and their poor quality of health, to their ineffective use of the American health care system. Kunstadter, on the other hand, believes that 'lack of knowledge of the *culture of modern health care* (my emphasis) is one important source of problems which have occurred in delivery of appropriate health services for the Hmong population. At the same time, few of the health care providers in the United States know the historical and cultural backgrounds of their new Hmong patients' (1996a:22). Thus, poor communication between Hmong patients and Western health care providers has contributed to poor health care and poor quality of health for Hmong refugees. Hmong were found to have delayed seeking treatment from Western medical practitioners because of previous misunderstandings between the two parties, lack of knowledge of signs and symptoms of serious disease, lack of knowledge of preventative medicine and the dangers of certain behaviours. Thus, lack of knowledge of modern health care contributed in part to poor health status for Hmong.

Many Hmong, even when they did use Western medical facilities, did not always understand the reasons behind certain forms of treatment, and so became regarded as 'non-compliant' patients (Bliatout 1988a). Western doctors may not always have understood the explanations given by the patient and the decision making process by the Hmong, which generally involved the group rather than the individual (Kunstadter 1996a). Doctors may neither have been able to take the time to explain, nor been able to explain because of language difficulties, their diagnosis and treatment procedures. This led to some problems of non-compliance by Hmong patients.

In one study where physician contact by Hmong was comparable to that of other American citizens, patient resistance to using medications, and compliance with and acceptance of invasive treatments caused major difficulties (Deinard and Dunnigan 1987). Patients were found to stop a course of medication once they were feeling better, or not to take any medicine at all if they did not have any symptoms. This was especially a problem for the treatment of children who, through a positive Mantoux test, were found to have been exposed to the organism which causes tuberculosis but showed no radiographic evidence of active tuberculosis. Their treatment entailed a daily dose of medication for 12 months. But often, home visits by Public Health Nurses found large numbers of tablets in their original bottle (Deinard and Dunnigan 1987). A similar lack of compliance was found with other medications as information spread throughout the community concerning problems of the side effects of certain medications for parasites, resulting in patients not completing the course of medication or not taking it at all (Deinard and Dunnigan 1987). In some cases, patients would make appointments for medical procedures, and simply not turn up, thus wasting time and money for the medical institution. Thus, poor understanding of the need for completing a course of medication and long term medical treatments, procedures not found in traditional Hmong medical practice (Bliatout 1988a; Thao 1986) resulted in lowering the quality of health of the overall population, even when contact with medical personnel was sufficient.

Language and cultural barriers

The low proficiency in English of many Hmong affected their appropriate and effective use of Western medicine in several ways, as well as their quality of health. Low socio-economic status was more common among those with limited skills in English as they had poor job prospects, educational opportunities were more difficult to access, and it was more difficult to learn of medical assistance which they may have been entitled to because they could not read English (State 1985; Tapp 1988). Such language barriers thus compounded their ability to afford Western

medicine. Poor competency in English was a major problem in the health care arena for Southeast Asian refugees. But for the Hmong in particular, poor English skills were a major contributing factor to misunderstandings and problems with the medical system. Simply being able to explain symptoms and then understanding the explanation and course of treatment was difficult for those whose English skills were poor. Moreover, many words for medical terminology in English do not have an equivalent in Hmong (Kunstadter 1996a). In some cases translations caused unexpected problems. One family was upset because they thought that their child was being given 'seawater' through an intravenous drip. As there is no word for 'saline' in Hmong, the translation given to the parents was 'seawater' (Sawyers 1983). Such problems built on the stress that sick people were already suffering.

In an attempt to reduce language problems, Hmong interpreters and printed material in Hmong were provided, but they were not always effective. Hmong interpreters often found their role was fraught with potential conflict as they were forced to take on a role as cross-cultural communicator, but often they satisfied neither party (Bliatout 1988a). From the point of view of the medical staff, the interpreter's main role was to encourage patients and their relatives to accept the medical recommendations. On the other hand, Hmong patients expected support from the interpreters to put their point of view across. When neither side was able to come to an agreement, it was the interpreter who was deemed to have failed by both sides (Deinard and Dunnigan 1987). The role of the interpreter was much more complex than was first assumed and the expectations from both parties were greater than the interpreter had been trained and prepared for, as the role of cross-cultural communicator was poorly understood. Translated medical material often proved unsuitable to the Hmong because of a lack of research into what Hmong needed to know (Deinard and Dunnigan 1987), and in a similar vein, written medical information would have been better communicated through drawings, because the large number of Hmong who were illiterate in their own language.

Language barriers may also have prevented Hmong from being exposed to preventative health care and healthy lifestyle information, factors which may have contributed to poor health status. For instance, an extremely high rate of smoking was found among Southeast Asian refugees in San Diego: 28.6 % of Hmong men were found to smoke, 27.3% of Lao men and 56% of Vietnamese men (Bates et al. 1989). In addition to problems of lung disease, smoking is one of the three main heart disease risk factors, thus the potential exists for Hmong to develop further health problems from smoking at a later period (ibid.). In another survey in Cook County, Illinois, 72% of adult Lao males smoked (Levin et al. 1988). Unfortunately the Cook County data does not give any indication of the breakdown in numbers of Hmong and Lao men. Moreover, a preliminary report found that as recently as 1996, differences in discharge diagnoses existed between Hmong and non-Hmong children in a county hospital in Fresno. Hmong children exhibited much higher rates of infectious diseases, malnutrition, respiratory ailments and injuries than non-Hmong children (Kunstadter 1996d). Thus, poor levels of English among the more disadvantaged Hmong have contributed to continued high rates of health problems in some Hmong communities which are common to low socio-economic groups but are not necessarily based on ethnicity.

Perceptions of Western medical care prior to arrival in the USA

Previous experience with Western medicine may have led to a perception that Western medical care is cheap, fast and effective (Kirton 1985; State 1985). While Western medicine was available in both Laos and in the refugee camps, it was not practiced in the same way that medicine was practiced in the United States. Medical care dispensed by the United States military in Laos lacked many of the expensive, sometimes intrusive and time consuming diagnostic tests performed in the United States (State 1985). Hence, Hmong were confused by the large number of tests that are part of Western medicine in the United States. Some Hmong were concerned that American doctors were practicing on them because they were refugees because

of the large number of questions that doctors asked and the large number of tests that were performed before a diagnosis was made.

Sponsorship

The support provided to Hmong by their American sponsors did not always have the desired outcome of financial independence leading to satisfactory resettlement (Kirton 1985). In addition, the initial assistance available in their original place of settlement was lost as a result of secondary migration. Breakdown in the system of sponsorship may have significantly affected Hmong health care behaviour in the United States, as in situations where the sponsors and refugees co-operated and developed mutual support, health care behaviour developed in a more successful fashion.

Brainard and Zaharlick's study of the use of Western medicine by the four Southeast Asian refugee groups in Franklin County, Ohio, found that although Lao refugees 'appear to have the highest rates of utilisation of the Western biomedical system', Hmong refugees were found to have the lowest utilisation rates (1989:850). They attributed the differences to the relationship between the Lao refugees and their American sponsors. Many sponsors were employed in the social and health service agencies, where they were able to serve as culture brokers between their Lao clients and their agencies. In addition, the sponsors continued 'to earn the respect and loyalty of other ethnic community members through their ability to obtain jobs, housing and other services for them' (Brainard and Zaharlick 1989:850). In this community, sponsors who were responsible for Hmong refugees were not able to offer such a service.

While this study again highlights a severe imbalance between Hmong and other Southeast Asian refugees, it demonstrates that there may have been considerable benefit in maintaining contact with their original sponsors. The fact that many Lao sponsors worked in the welfare area meant that Lao in particular had easy access to

good information about eligibility for medical benefits, and could be educated about Western medicine and Western doctors. It is uncertain whether this was a feature of Lao health care behaviour or of sponsorship. Although Lao refugees were observed to use Western medical facilities at a similarly high rate in the refugee camps[14], other studies in the United States found Lao refugees showed similar low rates of physician use to the Hmong but higher use of hospital facilities (Strand and Jones 1983). The impact of sponsorship for Hmong in Sydney will be investigated in this study.

The overall barriers of being new to the country, not understanding how the medical system works and not speaking English could be considerable obstacles in using Western medicine. For some Hmong, simply arranging and attending a medical appointment were so difficult that they would forgo the visit (Bliatout 1988a). Difficulties involved arranging an appointment by phone and finding out about opening hours; negotiating public transport to arrive at the appointed time; arranging time off work and arranging child care (Kirton 1985). Members of the community may help with some of these arrangements, but the number of requests placed on the small number of natural helpers could be enormous[15] (Kirton 1985; Rowe and Specs 1987). One man in Isla Vista was eventually forced to call the community together to request that they not call him any more, as he had no time left to concentrate on establishing a life for himself and his family (Kirton 1985). Dependency on a small number of 'natural helpers' often led to delays in seeking medical care, as they may only have been free in the evenings or on weekends to

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[14]Ban Napho Camp, which had a majority of lowland Lao population (with very few Hmong), displayed a high rate of use of the clinics, which was not entirely due to a high rate of illness. The reasons for using the clinic included: that the clinic was easily accessible, thus those who lived furthest from the clinic had the poorest health; waiting in the line was a pleasant diversion to the boredom of camp life (and many people attended for trivial reasons); 'doctor-nurse dependence', as the camp residents had to go to the clinic for drugs that are normally available over-the-counter, such as paracetamol; and the service was free (Maybin 1993).

[15]Two of the researchers, Kirton (1985) and Capps (1994) mentioned that after they had begun their fieldwork and it became known throughout the Hmong community that they were able to speak Hmong, the number of requests for help grew enormously, especially in medical matters and as 'culture brokers' between Hmong and American life.

take ill people, especially older Hmong and children, to the doctor (Lor 1994). Such difficulties meant that the Hmong were not always able to use Western medical care even when they wanted to.

Christian Hmong

Christian Hmong in the United States either had already converted to Christianity in Laos, or became Christians after arrival (Bliatout 1982; Tapp 1988). Movement away from traditional beliefs had been so complete that in some areas, such as for the Hmong in Kansas City, the whole community had become Christian (Capps 1994). For the Hmong, conversion to Christianity required abandonment of shamanism and ancestor worship, that is of any practices which required belief in spirits other than the Christian God. Although Christian Hmong should no longer practice shamanism nor believe in ancestor spirits, giving up traditional herbal medical treatments appeared less important. In fact, many of the Christian Hmong in Kansas City continued to consider 'Hmong therapies most effective when Hmong-specific illnesses are detected' (Capps 1994:173). Thus Christian Hmong tended to draw ideas and practices from both Western and traditional Hmong medicine.

Christianity could offer similar benefits to traditional beliefs and practices only in an 'easier' form. It offered protection by only one God, rather than many spirits; it followed a relationship to the spirit world that was critical to social life and well-being amongst Hmong; and it provided relief from the costly and difficult burden of animal sacrifice and traditional ceremonies (Capps 1994). However, the actual changes in belief by this community were more ambiguous and many continued to attribute illnesses to spirit causes. Consequently while 'religious conversion and changes in the idea of the soul have resulted in less conflict surrounding necessary surgeries ... bio-medicine is used with some reluctance and ambivalence', in part because Western medicine, in particular surgery, is unfamiliar (Capps 1994). Similarly, Bliatout (1988b) found that while Christian Hmong were not adverse to surgery despite their traditional beliefs, they nevertheless feared the prospect of

surgery. Some fears were related to culture, for example, fear of disability caused by surgery, blood drawing and ghosts (or souls of people who had died) in hospitals. Some of these fears had been exacerbated because of their bad experiences with surgery and hospitals. Other fears were related to previous experience or stories they had heard of hospitals: they feared hospital personnel because of their own low proficiency in English, as well as having to undergo unexplained or unwanted medical procedures. Thus, even in communities which had theoretically abandoned much of their traditional belief system, reluctance to use Western medical services continued to exist.

Hmong in Sydney and the USA

Many of the variables that have influenced Hmong health care behaviour have been identified. Traditional Hmong health care behaviour was modified in Laos with the introduction of Western medicine, increasing exposure to Western medicine in Thai refugee camps, and resettlement in the United States continued the process of Hmong exposure to Western medical care. In the United States, Hmong health care behaviour has been shaped by the varied combination of perceptions that they already held of Western medicine, their current social, political, economic and educational position, the unique aspects of resettlement, alongside their cultural preferences, and their modification by changing access to employment, education or conversion to Christianity. The health care behaviour of the Hmong in the States was primarily found to be a function of traditional health care behaviour, perceptions, expectations and previous experience with Western medicine, their current low socio-economic position and factors which have contributed to it, size of the population, language and communication difficulties, aspects of welfare provision by the United States authorities, and the process and outcome of resettlement.

There are sufficient similarities and differences between the two groups of Hmong refugees in the United States and in Sydney to make meaningful comparisons about health care behaviour in each spatial context. Similarities between the two groups include their cultural background; their shared experience of living in Laos, refugee camps and resettlement in third countries; their socio-economically disadvantaged position in their country of settlement; and the process of secondary migration, which occurred on a large scale in the United States and also in Australia, albeit for much smaller numbers.

In addition, the United States and Australia also share certain traits: Western medical care is the mainstream medical care option practiced in hospitals and clinics. Very few Hmong were living in either country before 1975; in both Australia and the United States, English is the dominant language but both countries have schemes to assist refugees and disadvantaged people though these policies were administered quite differently in each country. Both countries have a history of migration from many parts of the world, and both countries resettled many other Southeast Asian refugees at the same time that the Hmong arrived.

Several notable differences also exist between Hmong in Australia and Hmong in the United States. There is a huge difference in the size of the Hmong population in the United States and in Australia, since Hmong communities in Australia are very small. Selection and subsequent resettlement of the refugees were different in each country. The United States has had many incidences of SUNDS but there are no reported cases of this problem in Australia (G. Lee, pers. comm.). Since SUNDS has been linked with environmental factors such as stress (among other factors), the lack of SUNDS in Australia may be linked to resettlement factors. The effect of these similarities and differences will be investigated in the field work, in addition to the problems of health care provision for NESB migrants in Australia outlined in Chapter One, in order to investigate the impact of a range of factors in influencing the health care behaviour of Hmong in Sydney.

Most studies of Hmong health care behaviour in the United States have thus emphasised a series of variables that influence health status in not unexpected ways. Similarly the variables themselves are reasonably familiar in the many studies of migrant and refugee health status, including such critical economic variables as income levels, employment status and welfare or unemployment benefits, social variables such as the size and structure of the community, language issues and the extent and impact of conversion to Christianity. However Hmong refugees live in very different places within the United States, including both metropolitan and rural areas, and there is a diversity of response to, and experience of, the American medical system. The existing American studies make little reference to these distinctions, or the significance of physical or spatial access to medical services, and tend to generalise across space and across the diversity of Hmong experience. It is the intention of this thesis to provide a more direct focus on the significance of space, place and diversity of response, as being of some importance for the health care behaviour of Hmong in Sydney.

Chapter 3
The Hmong community of Sydney: Demography, education, employment and resettlement

This chapter seeks to determine the current demographic, socio-economic and educational situation of the Hmong community of Sydney within the wider context of Southeast Asian migrant communities, as the basis for the detailed analysis of health care behaviour. Comparisons and contrasts are made with the situation of Hmong in other contexts, including the United States, alongside that of the general Australian population, especially in Western Sydney, and other Southeast Asian communities. It therefore develops a profile of a particular refugee population, that has hitherto escaped detailed analysis.

Demography

Interviews were conducted with 41 members from 29 families within the Hmong community of Sydney; the total sample population was 175, which constitutes almost the complete Hmong community (at a little over 200 persons). These 29 families can thus be regarded as being representative of this group in Sydney. The Hmong population is much smaller than the Vietnamese and Cambodian populations in Sydney, at 47,352 and 7,723 respectively (BIPR 1994; BIPR 1995), and this small population size is of some significance for various aspects of social and economic life.

A total of 41 people (15 females, 26 males) participated in Part A of the study. They ranged in age from 19 to 69 (females: 19–61, males: 21–69) (Table 3.1). Most Hmong were in the 21 to 50 age group (female: 11, or 73.3%, male: 23, or 88.4%). There was no difference between the ages of men and women in both the median (31–40) and the mode (21–30).

	Age ranges (years)						Totals
	11–20	**21–30**	**31–40**	**41–50**	**51–60**	**61+**	
Female	2	5	4	2	1	1	**15**
	Range	19–61	*Median*	31–40	*Mode*	21–30	
Male	0	12	7	4	1	2	**26**
	Range	21–69	*Median*	31–40	*Mode*	21–30	**41**

Source: Field work

Table 3.1: Age range of participants

Community wide, the largest group was in the 0 to 10 age group (64, 37%) and more than half the population was under 20 (54%) (Table 3.2). There was a small but significant number of Hmong in the over 61 age group (14, 8%) which was related to the sponsorship of parents from refugee camps. The Hmong population was relatively young compared to the general Australian population, reflecting the youth of the original Hmong refugees and traditionally high Hmong fertility. In the 1991 Census 54.3% of the Australian population was less than 35 years old, but almost the same percentage (53.7%) of the Hmong population was less than 20 years old at a similar time period. The Hmong were also younger than the Vietnamese and Cambodians, whose median ages were 29.0 and 30.0 respectively (BIPR 1994; BIPR 1995), whereas the median age for Hmong in Sydney was in the 11 to 20 age group.

Thirty six Hmong were married, four had never been married (but are still young), and one was divorced. One man had remarried after the death of his first wife. There were two divorces among Hmong adults who were not part of the sample. All except one of the marriages were Hmong marrying Hmong. There was one Hmong/Lao marriage that had taken place in Laos. Several traditions regarding marriage remain important to this community, such as marrying outside the clan

and marrying Hmong, and all the marriages have followed these customs (see Chapter Two).

	Age ranges (years)							
	0-10	**11-20**	**21–30**	**31–40**	**41–50**	**51–60**	**61–70**	**71+**
Community	64	30	35	16	11	5	12	2
Percentages	36.6%	17.1%	20.0%	9.1%	6.3%	2.9%	6.9%	1.1%
	Median	11 20	*Mode*	0 10			*Total*	100%

Source: Field work

Table 3.2: Age structure of the Hmong community

At the time of the study, as far as can be ascertained, no one had married outside the Hmong community but a small number had found marriage partners from other Hmong communities in the United States and France. This is similar to the Vietnamese community, where there have been very few marriages to non Vietnamese (Bui and Bertelli 1990). There were no marriages of very young couples, a common practice in traditional societies; the youngest recently married woman was nineteen. The high value that the community places on education, as well as active discouragement by the Hmong Society Australia (see below) are important factors in discouraging marriages of young women. How long other traditional aspects of marriage will continue is uncertain, as the younger Hmong who are growing up in Australia have greater opportunity to form friendships outside the Hmong group. Indeed, for such a small community, this is almost inevitable.

Hmong clans in Sydney

There are several Hmong clans (or family groups) represented in Sydney (Table 3.3), but only a small number, three, the Lee (10 families), the Vang (9 families) and the Yang (5 families) account for 83% of the sample population. These are male clan names; female clan names show the extent of the web of clan relationships as at least

44% of the women are members of these three main clans (unknown: 24%). All the Sydney community are from the same ethnic sub-group of Hmong, the White Hmong, and so share similar linguistic characteristics and traditions. Traditionally Hmong villages consist of several clans (see Chapter Two), but the mix of clans in Sydney has occurred because of the Australian Government resettlement criteria.

Clan	Number
Lee (Ly)[16]	10
Vang	9
Yang (Yiang)	5
Lor	3
Tongpao	1
Moua	1
Total	**29**

Source: Field work

Table 3.3: Number of families by name

The Hmong in Laos

Some Hmong previously lived in villages, some in towns, whilst several spent most of their lives in the military base of Long Chieng and others lived in Vientiane. They are not a homogeneous group of 'isolated hill-tribe dwellers' as they once might have been. In Laos, few shared a common background, and they probably have more in common with each others lifestyles in Australia than at any time in the recent past. Map 3.1 shows the various provinces in Laos where they used to live. While some moved often, all were from the same geographical area of Laos, in the provinces of Xieng Khouang, Luang Prabang, Sayaboury and Vientiane.

[16]Ly is the French spelling of Lee, thus, Ly and Lee are the same clan group. Yang and Yiang are also the same clan group.

Map 3.1: Lao provinces where Hmong in Sydney once lived.

The following accounts show how varied their lifestyles in Laos were, which was partly due to where they lived or what their father's occupation was:

> M(F24) I used to live in Vientiane. Because my father was a general, we had a house there. My family was originally from Xieng Khouang. The house that we lived in was a 'modern mansion'. We even had servants. We lived in this house in Vientiane until I was 8 years old, in 1978. My mother used to have a business selling clothing and fabric in the market.

> B(F33) We moved around a lot. We moved every 2 to 3 years. We moved because of the war. We would hear 'the communists are coming' so everyone took whatever they could, left their house and moved out.

> D(F29) I grew up in a town, and moved between towns very often. Because of the war, my family had to keep moving. I remember living in three different villages by the age of 10 but I don't know how many times I actually moved when I was young.

> A(M34) I started school when I was 7 or 8, which was older than usual, because I had to walk for one and a half days to get to school. So when I first went to school, my father took me and stayed with me for a couple of months. Then my father returned home and I stayed with someone else. I stayed at this school for 6 months and then I transferred to a closer one. It only was 5 to 6 hours walk away. I stayed with the teacher at one of these two schools because the teacher had the same surname. Therefore we called each other 'cousins', and so my mother asked him if I could stay with him. I had to provide my own food. I found it very hard to do this, walk so far and stay away from home at such a young age.

Many families moved more often that they would have done traditionally, due to forced evacuation of villages during the war. As a result, many suffered major disruptions to their lives, especially to formal education and farming. This mobility influenced attitudes to and the practice of health care.

Leaving Laos

Almost half (20, or 49%) of those interviewed left Laos in 1975 (Figure 3.1). Others left sporadically between 1970 and 1989, although a small but significant number left in 1978 and 1979 (9 people) when communist activity escalated (Tapp 1988). Most Hmong left Laos for the same reason: 'to escape from the communists'. Those whose

fathers had been soldiers or involved in the military in other ways and had been engaged in fighting the Pathet Lao, were particularly fearful of staying as they believed that their lives were in grave danger, as described in the following:

L(M30) My father was a farmer, growing rice, corn, everything, a typical Hmong farmer, he grew everything. We left on the 15th of May, 1975; this was the first day of communist rule in Laos, so that was the day most people started to leave. My family had relatives who were communists, and so we 'knew what the rules are'. My relatives didn't warn my family to leave, but we 'knew the rules'. My whole family left together, mother, father and three sons.

N(M36) We weren't prepared to leave until 'the last second'. We decided to leave when we heard that General Vang Pao and the other military leaders had left and flown to Thailand. We were surprised to hear this because we had been told that everything was all right, that the two parties had come and joined together, and that everything had become peaceful, there would be no more fighting and so we were happy.

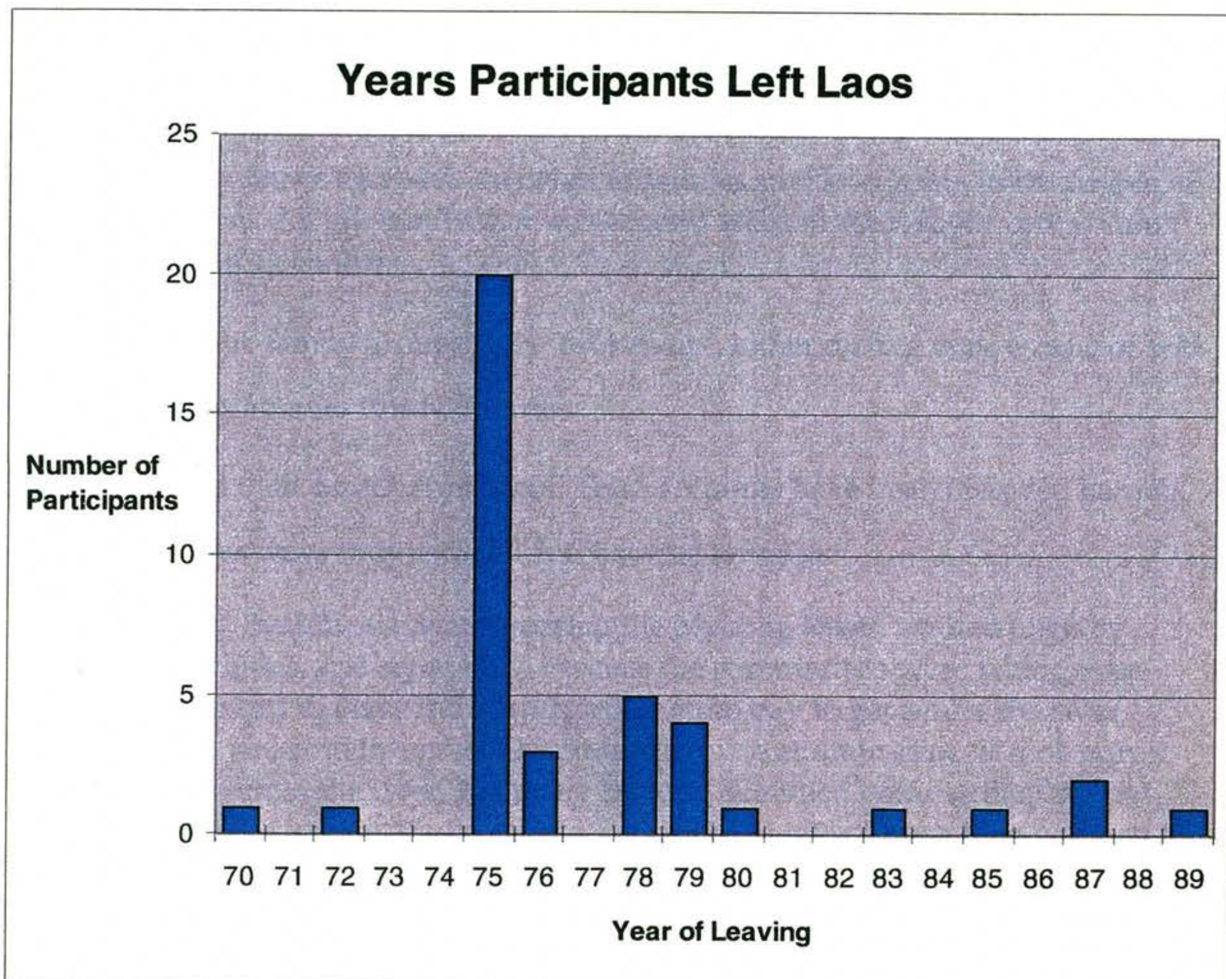
E(M31) The problem was the communists. Before 1975, the country was free, but there was a war. After we lost the war, the Vietnamese and Chinese helped the communists to fight. So we had to escape to Thailand because we were not communists. If we hadn't escaped, people who had fought against the communists, like my father, would have been killed. If my father hadn't escaped, he probably would have been killed.

Q(M55) I left as soon as the communists took over. I believed that I was in danger because I was a Hmong. We were told when we were soldiers, that if the country was taken over, we must get all our Hmong people out of the country. I fought for General Vang Pao. I was involved with the Americans. The United States government promised General Vang Pao that if they lost the country, they would take all of his people out.

A few families left to avoid being recruited into the army:

F(M22) I left because the government army was trying to recruit me into the army. I was already 14 and boys are recruited into the army from the age of 13 onwards.

T(M25) My dad didn't want his sons to join the army, and so we ran away from the communists.



Source: Field work

Figure 3.1: Years when participants left Laos

Several Hmong left in large (sometimes extended) families:

> D(F29) We left because my father was a soldier and probably would have been killed if he had stayed. We left with my family, altogether there were 12 people: my mother and father, sister and 4 brothers, myself, grandmother, sister in law, 2 cousins. We crossed the Mekong separately. About 6 people could fit on each boat.

> D(M36) My father was an army officer. We left because the communists took over and my family would probably have been killed if we had stayed. I left with my family, altogether there were 8 people; mother and father, 4 children and 2 grandparents. Because the communists took over my country and it was very hard to live there, also, my father was a soldier. Therefore, if we had stayed, the whole family probably would have been killed.

G(M25) My father was a soldier, and was part of the army formed to follow the Hmong leader, General Vang Pao. We left in 1975. I was with my family, about 10 members that included other relatives not from my immediate family

G(F25) My father had been involved in politics so it was going to be dangerous to stay there. All my family that was around went to the refugee camp. I am the tenth of 14 children.

Many of the large family groups were 'broken up', either during their escape or with subsequent migration to third countries.

Some described their escape from Laos. Their accounts have been included here to show the various ways they escaped and became refugees:

A(M34) By the time we were crossing the Mekong River, we had to go by different routes, and separately, because the communists were taking over. When you had to leave the country you had to pay to get across the river, otherwise you couldn't pass. The crossings were at night-time. It took only 5 minutes to cross the river. But many Hmong drowned because they are not very good swimmers. If you couldn't afford to pay for a boat, then you had to go into the jungle and cut bamboo, about 4 or 5 metre long, lash it together and then carry it for 3 days to the river. Then you floated across with the current.

C(M42) I flew from Sayaboury to Vientiane, and then got to the Mekong by car and taxi. Then we found some people who would help to organise the crossing of the Mekong.

D(F29) I lived in Pakhao near Long Chieng until 1975. In 1975, my family moved to Vientiane in order to cross the Mekong River but we were unable to do so. So we moved back to our village, were we stayed for one year. Then we moved to another village for two years (1978), then another village close to the Thai border and after that, I moved to Thailand. Each move was to villages that were closer and closer to the Thai border so that our eventual move across the border would not be so arduous. The last village we lived in was a half-day walk to Thailand, and soon after arriving in this village, we crossed the Mekong one night.

L(M30) My family left with the whole town, about 50,000 to 100,000 people. The whole town, the whole province, the whole country - hundreds of thousands of people left Laos. We only took our food. It was safe to walk along the roads, we didn't need to hide. It was like scenes in *The Killing Fields*, with what looked like the whole country on the move, only there was no shooting. I remember hearing, 'if you want to stay, you can stay, and if you want to go, you can leave'. At the time I left, we had freedom to move. The trip took about

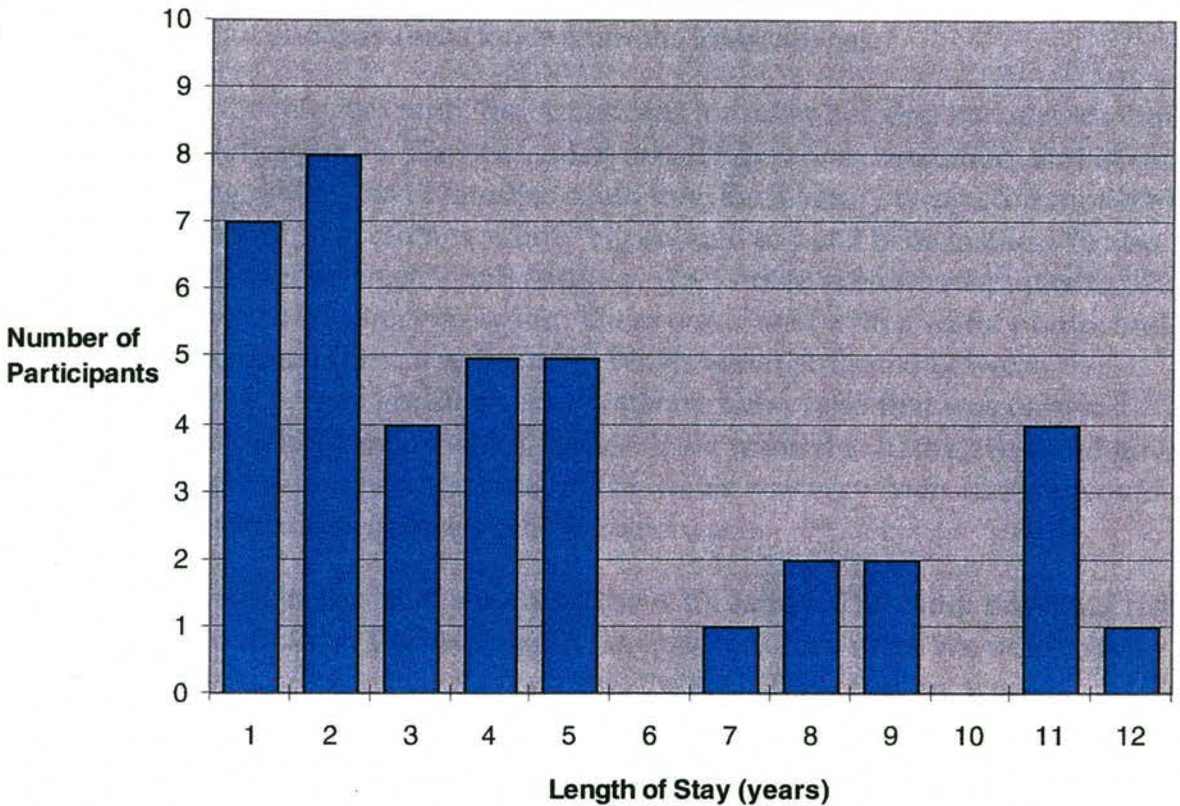
> 1 month to travel from Sayaboury to Thailand. I was about 10 years old and I didn't really understand what was going on.
>
> M(M28) My parents left first, and left me living with one of my brothers. Then my brother went back to Xieng Khouang, so I went with him. I stayed with my brother for a couple of years before we both escaped from Laos to Thailand. In escaping from Laos, my brother and I lived in the jungle for a while, still fighting with the communists.

As the above statements show, many departures were in some way connected with escape from the communists, either for fear of being killed by the Pathet Lao regime against which they had been fighting, because of concern over how the communists would rule Laos, or because they were evading recruitment into the Pathet Lao Army. A large number of the men had been soldiers. Some ex-soldiers mentioned that General Vang Pao had given them assurances that the United States would take care of them in the event of a communist take-over of Laos, and that they should leave the country in such a circumstance.

Refugee camps

All had spent at least some time in refugee camps in Thailand. The refugee camps were close to the Thai/Lao border; most Hmong were relocated from their initial camp to Ban Vinai (See Map 2.1). Most Hmong had spent less than 4 years in the camps while a few were there for much longer (Figure 3.2). Some were in the camps for up to 12 years; although the mode was only 2 years and the median 4 years, often because older family members did not want to leave, or because individuals did not meet the necessary criteria for migrating to a third country.

Conditions in the camps were fairly harsh: clean drinking water was hard to obtain, washing and cooking facilities minimal and food appeared to be of low quality. Several had to build their own houses and supply their own building materials. Some people provided fairly detailed descriptions of their time in the refugee camps:



Source: Field work

Figure 3.2: Length of time in the refugee camps

B(F33) In Nam Phong, the accommodation was very big tents. Initially, the army cooked for us as the Thai government would not allow us to cook in case we cut down trees. The food was cooked in a communal kitchen. We were divided into 4 groups and each group queued for their meals. It was Hmong food and there was plenty of it. However, this did not last for long. Many people died from diarrhoea, about 20 or 30 in one day. The Hmong blamed this on unclean food preparation and cooking methods. So we complained because of the deaths and the number of children who were sick and dying. After about 2 or 3 months, we were allowed to cook for ourselves. The Thai army allowed groups of us to go out into the forest to collect firewood for the week and the food was provided for us. After that, very few people died. Ban Vinai camp, where I moved to next, was in the jungle and there were no fences. So we could go into the jungle and collect materials for building a house, and herbs for medicinal purposes.

C(F41) We lived in a small house, the size of a small lounge room and the 4 of us lived in it. We built our own house. It was big enough only for a bed and a

fire. We cooked in there too. We cooked all our own food. We were given rice, the meat and vegetables we had to buy for ourselves. We were given plenty of rice, but they didn't give us enough meat and vegetables which is why we would go out and buy these foods from the Thai villages.

E(M31) In the refugee camp, the Americans (or other helpers) had already built accommodation for us. They provided hostel type accommodation, that is, one big building where lots of families could live. Each family was accommodated in a small room. The room was only big enough to put 2 beds inside. We also shared a kitchen between 2 or 3 families. The kitchen area was separate to the sleeping area. It was very crowded. There was a well with a water pump, and water was pumped into a water tank. Water was distributed between the families. Each person got 20 litres of water each day, and that was only just enough for cooking and washing dishes. If we wanted to bathe, we could go to a river where a dam had been made. The water was very deep and we would carry water to another place to shower and wash.

There was no electricity. We used kerosene for lamps. The camp provided free charcoal for cooking. We also made charcoal from corn cobs. We were given rice but it was not very good rice, it was the sort of rice that we would normally give to the pigs. The UN provided the food for the refugees. There were six people living together in my family, and they were given one and a half kilos for a week, and meat, 5 grams per person for a week. So we would buy some special oil from the supermarket and mix it with some vegetables, and we would also buy some more, but very cheap, vegetables from the market.

Maintaining good health and nutrition was difficult in the camps. Families who had money were able to supplement their meagre diet by buying food from outside the camp, but even so, illnesses and deaths appeared to be common.

Leaving the refugee camps

Most Hmong refugees have resettled in the United States. In some instances, those who were unable to go to their countries of first choice, such as France or the United States, resettled in Australia. A small number of mainly older Hmong were prepared to wait in the camps until they could return to Laos and fight once again. Some stayed in the camps for a considerable period for this reason. Young people in particular wanted to get out of the camp as soon as they could but felt bound to stay because their parents didn't want to leave. However, a few young people did leave

on their own; some families have subsequently been reunited in Australia, whilst the families of others have eventually resettled in the United States. Some refugees simply had to wait for many years before resettlement could be arranged. Even within the present Australian community the refugees had a diversity of preferred resettlement options:

> D(F29) My father didn't want to go to another country and I really wanted to leave Thailand. I didn't care where I went, I just wanted to leave Thailand. My father preferred to stay in the camp and hope that eventually the communists would leave Laos. But after I had left Thailand and settled in Australia, then my family went to America, to Wisconsin. My brother went there first in 1980 and then sponsored the rest of my family.

> E(M31) We lived in the camp for such a long time because my uncle, who was there with his family living in the camp at the same time, didn't want to go to another country. My uncle is still living there. My family didn't have any relatives in another country who could sponsor them.

> Q(M55) I went to a refugee camp and was there for 4 years. I thought I would be able to go back, General Vang Pao told us that we could probably go back. So we waited for a long time. The 'headman' in the refugee camp told us that we must stay in the refugee camp so that we could go back to Laos. In the meantime, we lost everything, we spent all our money, and our kids were not getting educated.

> X(M28) My parents did not want to apply to go to a third country because they didn't have any education. They wanted to stay in the camp and see what was going to happen in Laos, hoping it would change, so that they could then go back to Laos. They were worried about the hardships they would have to endure if they moved to a third country when they were poorly educated and had very little knowledge about the new country.

Decisions about resettlement caused many problems for the Hmong, and in some cases caused family conflicts, especially where young people felt obliged to stay with their parents but wanted to move on, and older people preferred to return to Laos. While the refugees had only recently escaped from Laos in fear of their lives, they often knew very little about those countries offering resettlement. Large numbers of Hmong refugees remained in the camps; even in 1991 there were still 54,000 Hmong in Thai refugee camps. Although seven thousand Laos had been

repatriated, only 400 Hmong had returned (Long 1993). Older Hmong preferred to remain in the camps waiting for advice from their leaders, most of whom were already in the United States.

While in the refugee camps, Hmong refugees had to make certain critical decisions about their future, in particular, where to go to from the refugee camps, sometimes with inadequate or incorrect knowledge, as can be seen by the following responses:

> E(M31) There was no choice of where to go, but I was happy to be able to go to Australia instead of America. While living in the camp, I heard a little bit about other countries, some good and some bad. There are a lot of Hmong in America. We heard worrying stories about America. When the Hmong go to America, they learn about freedom, and this worries the older Hmong, who feel that they need to prepare for their later life. I heard better things about Australia. Letters arrived in the refugee camp and the information was shared around sometimes. Australia seemed better than America to me.

> G(M25) My family was planning to go to America but my brother came to Australia first, married, and then sponsored the rest of the family. Most of my friends and relatives are in America, only myself, my mother, sister and my brother came to Australia. My father is in America, he has remarried. My father's brothers, sisters and their families all went to America.

> P(M49) Initially I wanted to go to France, because I was able to speak the language. But France would only take soldiers and I was a Public Servant, so they would not accept me. I was interested in going to the United States too but they also gave priority to soldiers too, so I was not able to go there either. I chose Australia because I had learnt about Australia while I was at school. I knew that it was a 'young country'. I also had relatives here, and one of them sponsored me.

> X(M28) To be honest, I would have liked to have gone to America because I have lots of cousins there. I couldn't go to America because my father didn't want me to go there. He wanted me to come here and to stay with my cousin. I think that this is a great country too. I enjoy the freedom here. Also I have heard of a lot of bad things happening in America.

Australia was not always the country of first choice for several people, but others were also worried about going to the United States. Their decisions involved a desire to be reunited with relatives in America, but this was hindered by concern over worrying stories about the United States which were being circulated around

the camps; a preference for France by those who spoke French; a lack of choice because of the limited number of countries that would accept Hmong; the family reunion option that enabled access to Australia; and, for some, the belief that they should return to Laos and continue fighting.

Arrival in Australia

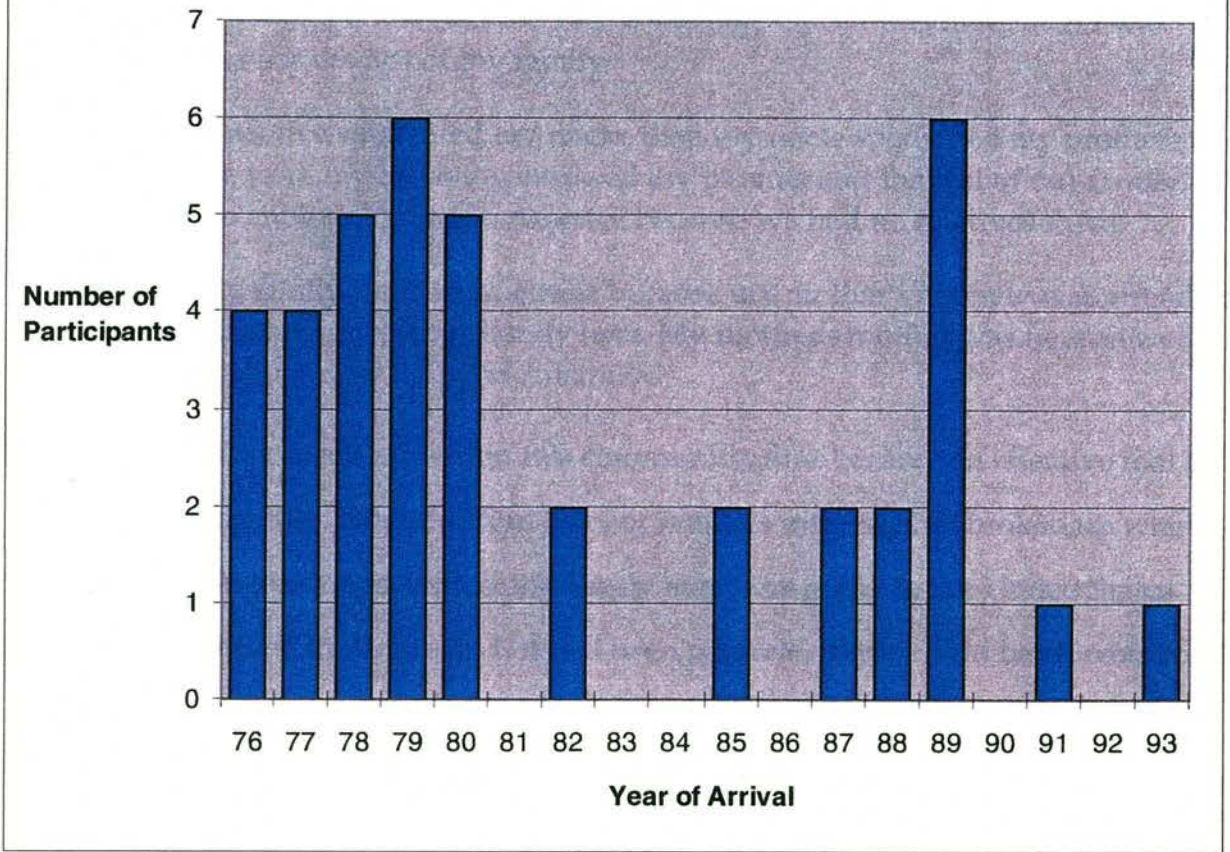
Over half (24) had arrived in Australia in the five year period after the war in Laos finished, that is, between 1976 and 1980 (Figure 3.3); smaller numbers arrived during the following years to 1993. The number of arrivals for 1989 appears large at six persons, however this was because four of the members of one family who arrived in that year participated in the study. By 1995, Hmong refugees had been in Sydney from between two to 19 years and the average was 13 years.

The age of the arrivals ranged from 3 to 65 years (Table 3.4). Most people were quite young when they arrived; almost 60% (24 people) were under 20 and both the median and mode were in the 11-20 group (18 people, or 44%).

The main reason Hmong in Sydney came to Australia was through family sponsorship (30, or 73%). Once one family or family member had settled in Sydney, then that family attempted to sponsor other family members who were still in the refugee camps. This has led to the unique composition of the Sydney community, where the families of three clans account for 83% of the population and most members are related through marriages between the clans. Others came to Australia through marriage or church sponsorship and one was sponsored by a prospective husband.

The following responses are from those people who arrived specifically through family sponsorship:

> B(F33) I came to Australia because my husband had a brother here, and he sponsored us.



Source: Field work

Figure 3.3: Year of arrival in Australia

	Age ranges (years)						
	0-10	**11-20**	**21–30**	**31–40**	**41–50**	**51–60**	**61+**
Participants	6	18	9	4	1	0	3
	Range	3–65	*Median*	11–20	*Mode*	11–20	

Source: Field work

Table 3.4: Age upon arrival in Australia

H(M55) In 1988, my elder sister and her husband came to Australia The Hmong people in Australia at this time didn't know much about Hmong customs, but my brother-in-law did. I am a shaman so my brother -in-law sponsored me. The Australian government allowed me to come to Australia to help the Hmong people because I am a shaman. Once I was here, then I was able to sponsor the rest of my family.

K(F33) A relative sponsored my uncle, then my uncle sponsored my brothers and after a year, my brother sponsored my parents and the rest of our family. We had no choice of going to America because we had no relatives there.

M(F24) My family came to Australia because my mother's nephew was already here, and he sponsored our family here. My mother's mother was here as well. All her family is now living in Australia.

Family reunion, as practiced within this community, thus became an effective tool to keep families together. Extended and nuclear families were further broken up when they left the refugee camps, with some family members going to the United States and others resettling in Australia. If it had been possible, most would have avoided the break-up of their family groups, but as they had to comply with the resettlement regulations of different countries, this was not always possible.

Place of residence

The majority of the families (62%) have resettled in the suburb of Bonnyrigg, in the south-western region of Sydney (Map 3.2) and a further 12 live in nearby suburbs (Table 3.5; Map 3.3). The most common reason offered for such clustering was 'because other Hmong live here'. Only one family lives in an area isolated geographically from the rest of the community, in Claymore. However, this family would eventually like to move to Bonnyrigg when it could afford to. This family had only arrived recently (at the time of the interview it had only been in Australia for four years), was a large family (9 members) and needed to rent a large house from the Department of Housing and thus had little choice of location.

Bonnyrigg is in the Fairfield LGA (Chapter One). It is one of the 'newer' suburbs in that it was not developed until the 1970's. Over the past 25 years, Bonnyrigg has

been characterised by high population growth, a large number of families with young children and a large proportion of the population (46%) who were born in a non-English speaking country (Fairfield City Council 1996).

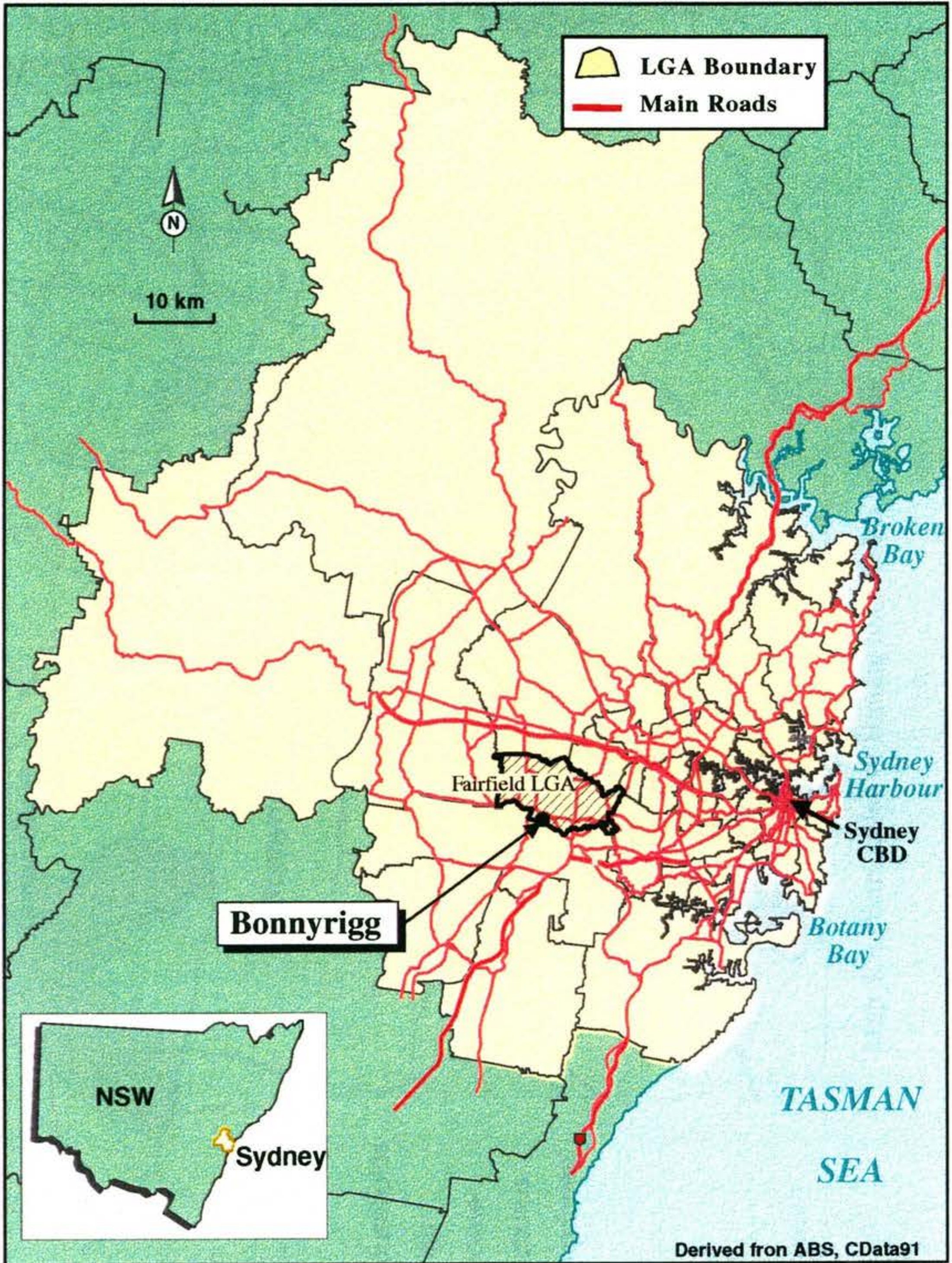
Suburb	Number of families
Bonnyrigg	18
Cabramatta	4
Kemps Creek	2
Canley Vale	1
Prairie Wood	1
Villawood	1
St. John's Park	1
Claymore	1
Total	**29**

Source: Field work

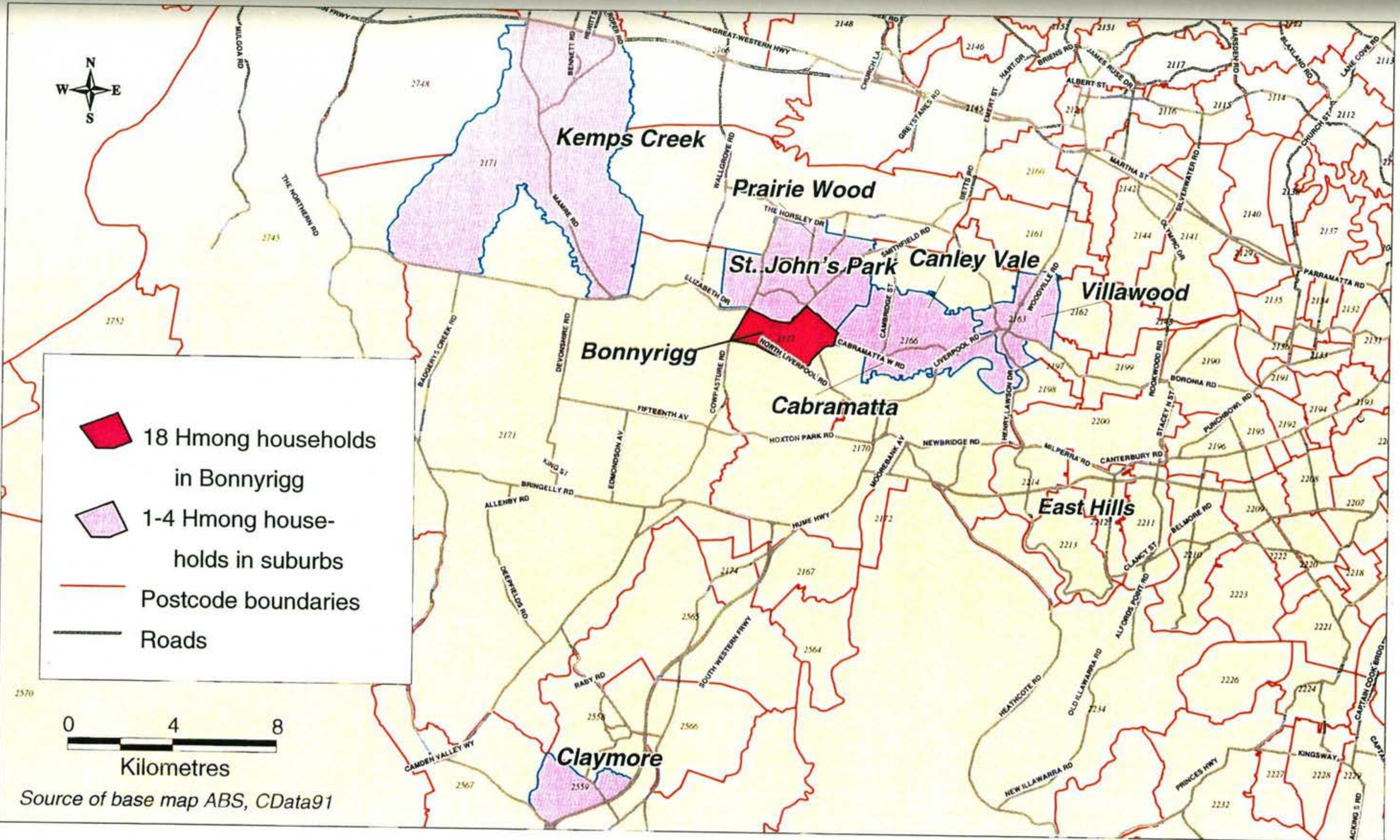
Table 3.5: Number of families by place of residence

Most people chose to live in Bonnyrigg to be close to other Hmong, to be near shops selling familiar food and because they could afford to buy a house in that area. A sample of explanations follows:

> A(F29) Most of my friends live in Bonnyrigg and I wanted to live close to them.
>
> D(M36) I live in Bonnyrigg because all the other Hmong live here. We like to live in Bonnyrigg with the other Hmong because we are only a small group. So, if someone is sick or need help, we can help each other.
>
> F(M22) The main reason for coming to this area is because it is close to the Cabramatta fruit and vegetable market where we can buy Asian food that we like and are familiar with.
>
> G(M25) My brother bought a house in Bonnyrigg, so I moved in and stayed with him for 5 or 6 years. After I married, my wife moved in as well. Now we live in a flat in Cabramatta and have been here for about 2 years. As we are renting, there was not much choice where we would move to, but Cabramatta is convenient to Bonnyrigg and our friends and relatives.
>
> L(M30) My family moved to Bonnyrigg because we could buy a house there. We also moved there because other Hmong were there too.



Map 3.2 Location of Bonnyrigg in Sydney metropolitan area show Fairfield LGA



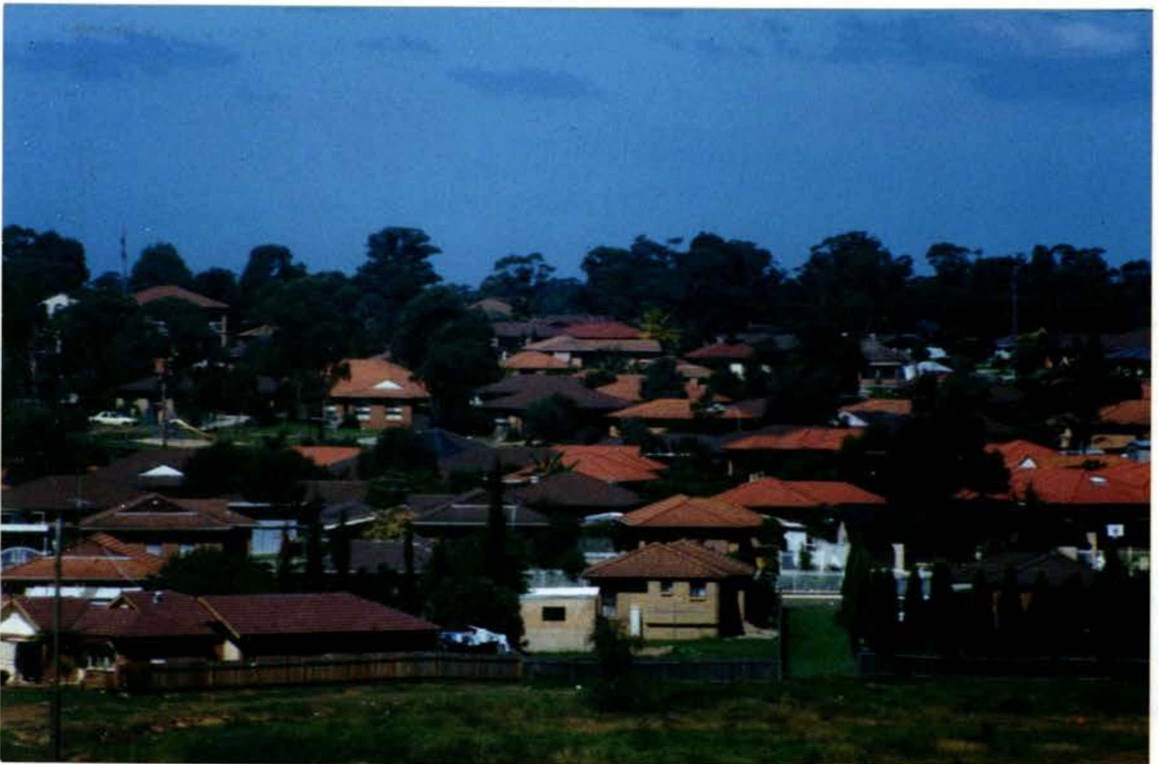
Map 3.3: Distribution of Hmong households in Sydney

R(M45) We live here because it is a cheaper area to live in, especially compared with living closer to the city. Also, lots of Hmong people live in this area, so it is easier to visit them and to have them visit me.

Living close to other Hmong appeared to be very important to this group. Such clustering had also been demonstrated by Hmong in the United States (Chapter Two). The spatially compact nature of Hmong households in the Bonnyrigg area indicated cohesiveness within the community and certainly facilitated easy communication between households. This was evident during the interviews as it was not uncommon for other Hmong to be visiting the family that was being interviewed. All but one family had a telephone, telephone calls were all charged at the lowest rate, many were only a short walk away from other Hmong homes and none were more than a short drive away (except for the family which lived in Claymore, a half hour drive away and where telephone calls to their area were metered). In addition, a small number of men helped arrange or interpret at some of the interviews with other community members. The impact of cohesiveness and communication on health care behaviour will be discussed in later chapters.

The initial reason for Hmong choosing to live in Bonnyrigg is unclear, but after a Hmong presence was established there, it attracted other Hmong. Financially Bonnyrigg was an attractive place for the Hmong as house prices in this area have been consistently well below the average Sydney price. In 1981 the average price of a house in the Fairfield Statistical Local Area (SLA), in which Bonnyrigg is situated, was $53,700 (compared to the metropolitan average of $82,800). By 1986, the average house price in Fairfield SLA of $71,700, had remained lower than the Sydney average of $107,400, and by 1991, the Fairfield average house price had only risen to $133,100 while the metropolitan average had risen to $203,700 (Burnley and Murphy 1994). Several people had been able to keep housing costs lower by building their own houses, sharing with other families for a period of time or moving into older houses. In addition, Bonnyrigg is a pleasant and attractive suburb. (Photographs 3.1, 3.2, 3.3 and 3.4).

Photograph 3.1: Hmong family and visitor in front of their home in Bonnyrigg



Photograph 3.2: View of Bonnyrigg

Photographs 3.3 and 3.4: Bonnyrigg shopping areas

The presence of a large number of other Southeast Asian communities had also encouraged Hmong to resettle in this suburb (Farrell 1993). The size of the population of Southeast Asians within the migrant population in the Fairfield LGA was considerable. Although Fairfield residents represented 133 different nationalities in 1991, 15.2% had been born in Vietnam, Cambodia and Laos and 19.4% had been born in Asia (Fairfield City Council 1996). Some Hmong mentioned that it was handy living close to Cabramatta, which has a substantial Vietnamese presence, where they could do their shopping, especially for familiar (Asian) food. (Photographs 3.5 and 3.6).

Location of the migrant hostels where the majority of the refugees were first housed, East Hills and Villawood (see Map 3.3), or easy access to employment, were not identified as influencing their eventual resettlement in Bonnyrigg itself, but probably played some part in their living in this area of the city. While many had lived in several other suburbs before moving to Bonnyrigg, very few if any, worked in this or any adjacent suburb. However, most of their employment options were in this area of Sydney.

Home ownership

Home ownership has been important to Hmong in Sydney; considering the short period of time that many have been resident in Australia, 42% already owned their own home and 19% were in the process of purchasing their home (Table 3.6). Several families were very close to full ownership of their houses. The number who had already purchased their own home was only slightly higher than the Australian home-ownership figure of 41% (BIPR 1994; BIPR 1995), but much higher than that of both the Vietnamese and Cambodian communities, at 13% and 14% respectively. (However, for both communities, almost 50% either owned or were in the process of buying their own home). Furthermore, Hmong home ownership was considerably higher than that of the rest of the Fairfield district, where 32.5% of homes were fully

Photograph 3.5: Peace Arch in Cabramatta

Photograph 3.6: Shops in Cabramatta

owned in 1996 (Fairfield City Council 1996). Thus, living in Bonnyrigg enabled many families to move out of the rental market and purchase their own homes. Those who were renting were all in Department of Housing accommodation. In directing their money into paying off mortgages rather than paying rent, the Hmong saw their money being used more productively. Some commented that in Laos, they did not have to pay for housing, the land was free and they built their own house using materials from the forest. In Australia, many saw rent as being 'wasted money' as they had nothing at the end of the rental period.

Housing status	Number
Own house	11 (42%)
Purchasing	5 (19%)
Renting	10 (38%)
Unknown	3 (1%)
Total	*26 (100%)*

Source: Field work

Table 3.6: Housing status by family

Some described how they managed to purchase their homes:

> A(F29) We own our house outright. Both my husband and I have been working, also other family members have helped us financially, so we have been able to pay the house off completely. It is common for Hmong families in Sydney to get together and help each other in such things as paying off a house.

> Q(M55) My father-in-law lived in a flat in Carramar and he had an empty room. So we moved in with him and lived there for 18 months. Then we moved into a housing commission house in Fairfield, until 1984. I didn't like living in the housing commission house because none of our neighbours were working. They all complained that I woke them up in the morning when I got up to go to work. Next we pooled our money together and bought my eldest son's house. In 1988, we again pooled money together and bought this house that we live in. In 1993, we pooled money to buy a house for my second son.

> This is the only way we can see a way of buying a house, that is, all working together. If you try to do it on your own, you will never get a house. Even

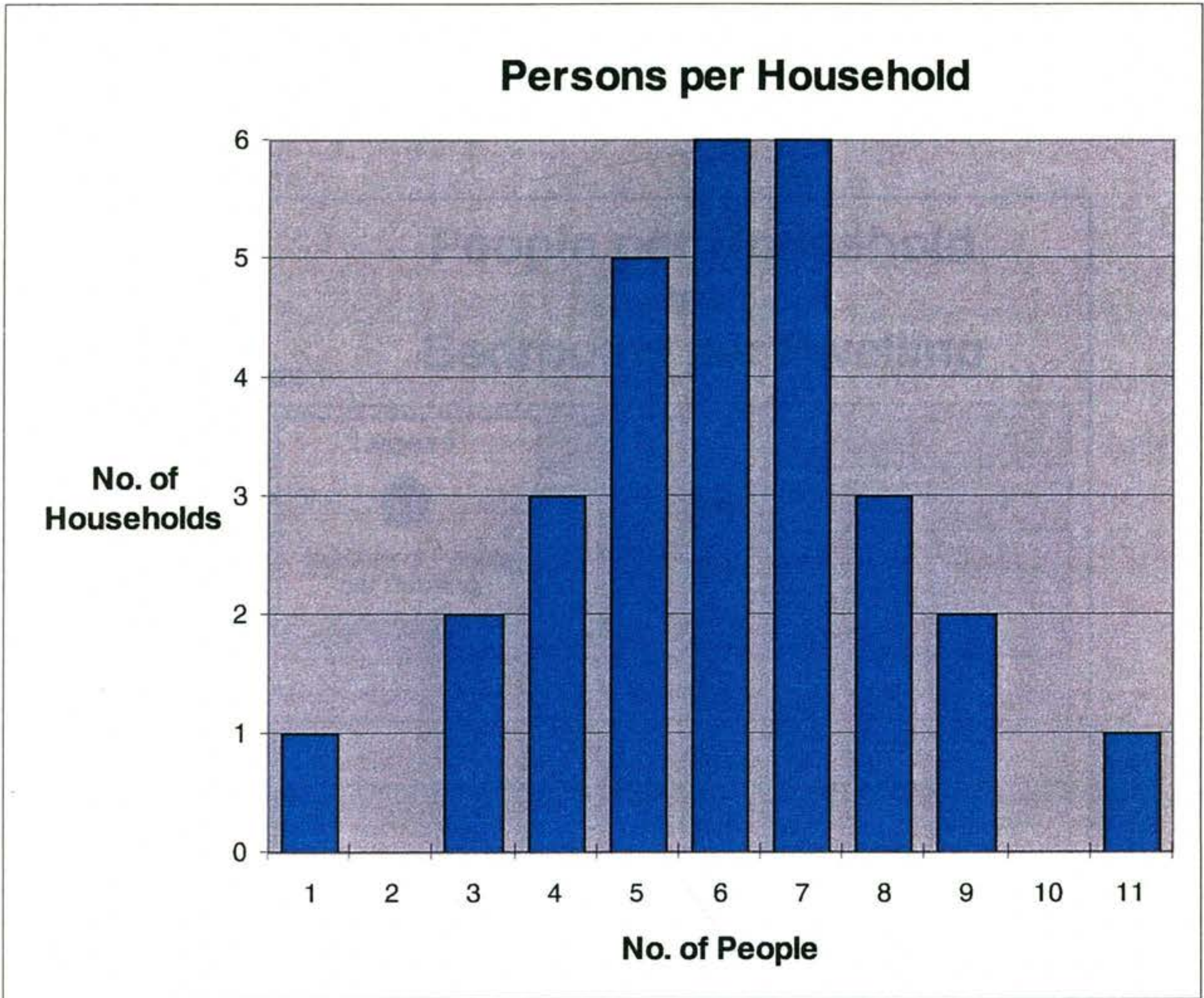
> though I have helped my son buy a house, I don't expect it to be paid back. It is now my son's money and house.

The practice of families helping each other financially had enabled members of this group to purchase their own houses. Choosing to resettle in an area where the cost of either houses or house and land packages was low, relative to the rest of Sydney assisted this process.

Household size and structure

Hmong households are large by Australian standards: they range in size from one to nine persons, the median is six and the mode is seven persons per household (Figure 3.4). The average household size of 6.1 persons per household was more than twice the Australian figure, and was also higher than the Vietnamese figure of 4.1 persons per household. The high fertility rate and the composition of extended households account for the large household size (see below). In comparison, the average household size in Australia during this period was 2.8 and decreasing (ABS 1994). Some households were noticeably crowded: one consisted of 7 people in a 2 bedroom flat; in another, there were 7 people in a 3 bedroom flat; and one house had 2 families with a total of 11 people living there (Figure 3.5). The majority of the rest of the households did not appear to suffer from severe overcrowding, though they were more crowded than the average Australian household.

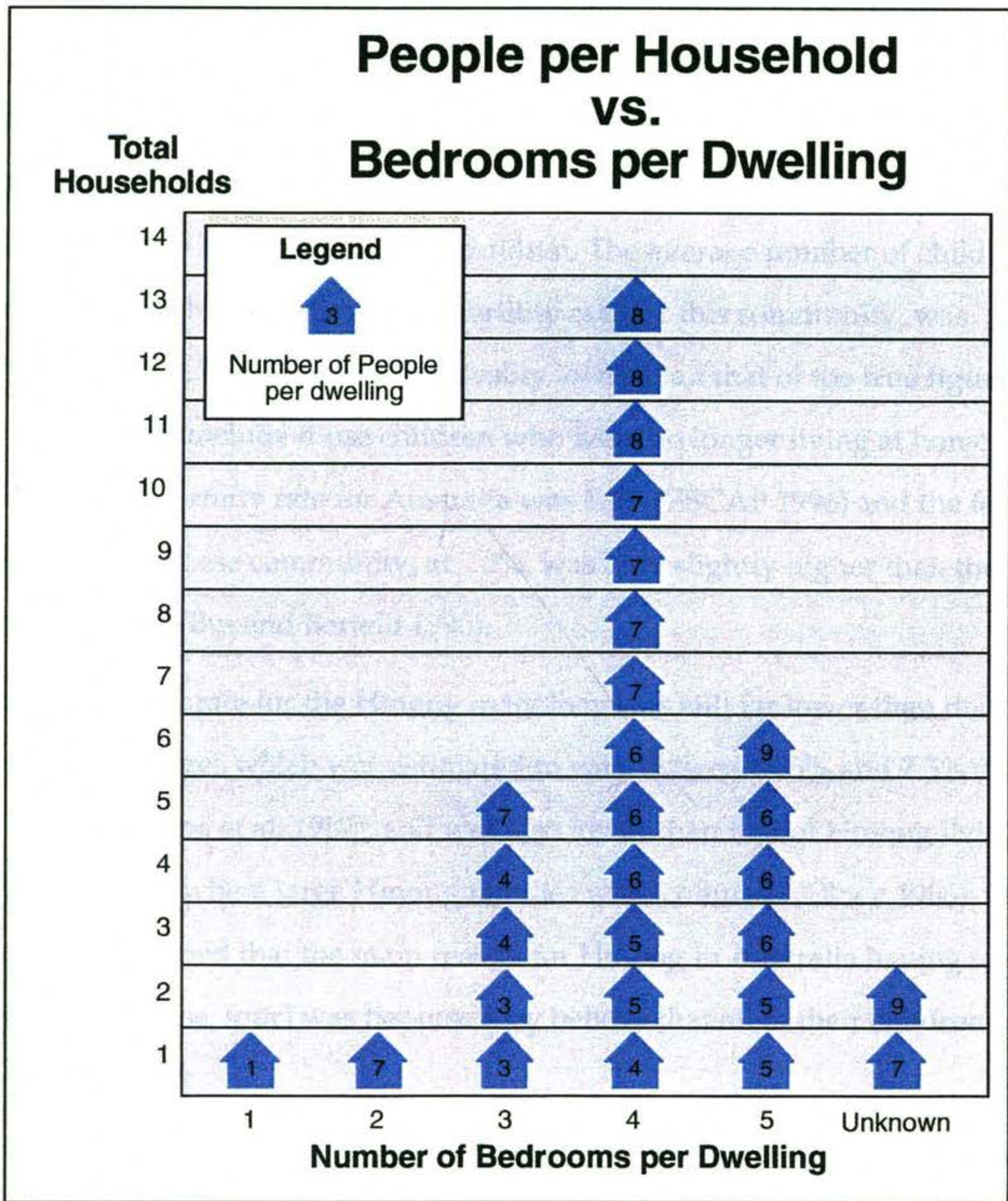
Fifteen (51%) of the households consisted of a single nuclear family; the 12 (41%) households that were extended families mainly included elderly parents who were living with a married son, and one residence was shared by two unrelated families. The significant number of extended families shows the extent to which the community had taken advantage of the Family Reunion Scheme, whereby younger families have sponsored their elderly parents to join them in Australia. One middle-aged woman was living on her own (the reasons for this were not pursued) and one household was headed by a woman; both practices would traditionally be uncommon.



Source: Field work

Figure 3.4: Household size

For the first few years after arrival, there were many more extended households; their number subsequently declined with family members reaching a financial state whereby they could afford to move into their own home. The number of extended families in the Hmong community was higher than that of the Vietnamese community, where in the late 1980's, when over one third of Vietnamese families were extended families (Bui and Bertelli 1990). The figure for the Vietnamese may also have subsequently fallen for the same reasons as for the Hmong. As according to Hmong custom, in Sydney, sons continued to care for their elderly parents (apart from the two exceptions mentioned above).



Source: Field work

Figure 3.5: People vs. bedrooms per dwelling

Birthrate

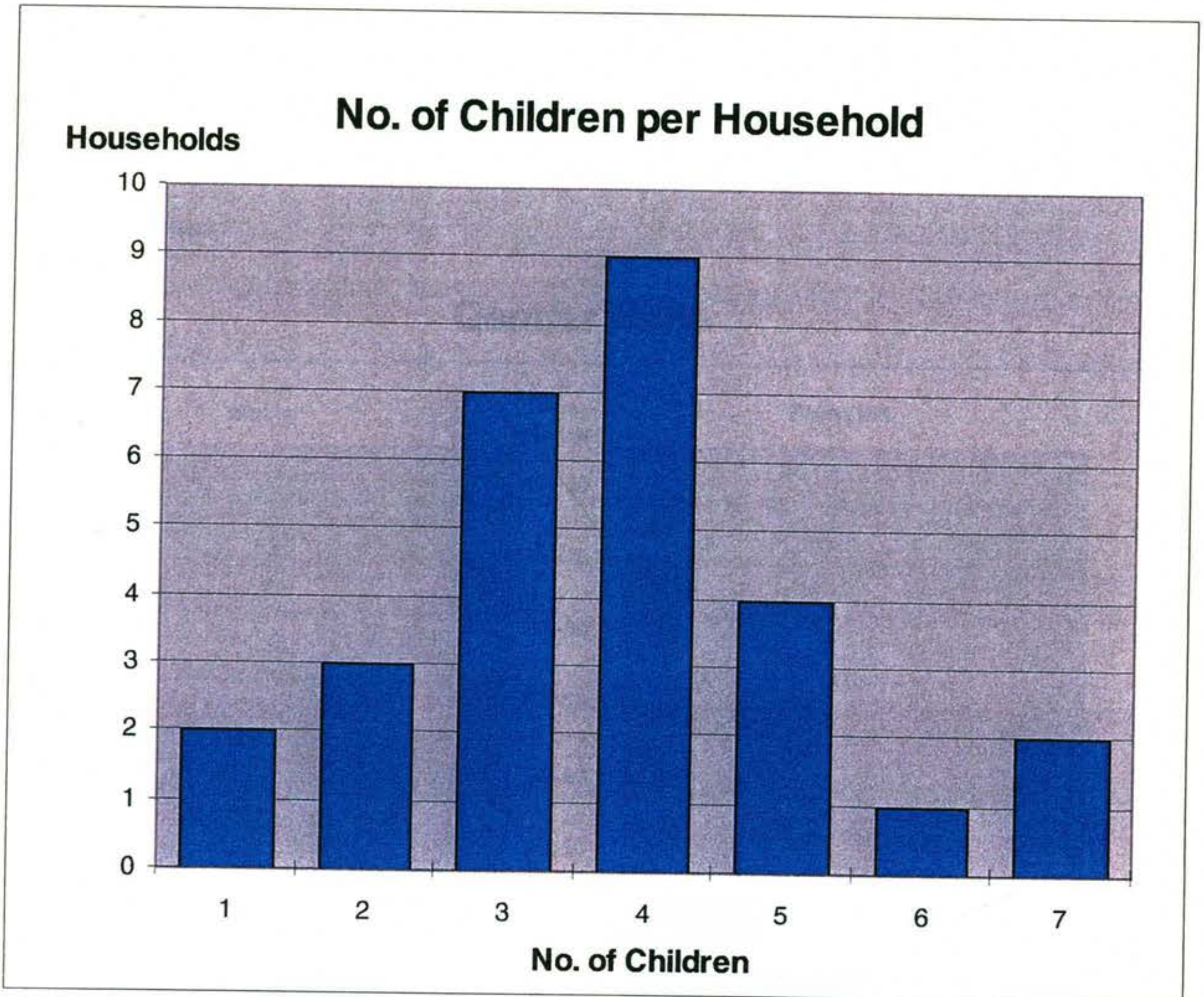
By Australian standards, the Hmong birthrate was high. Over 82% of Hmong households had three or more children (Figure 3.6) whereas the comparable Australian figure was only 25.1% (BIPR 1994; BIPR 1995). It was also much higher than for both the Vietnamese and the Cambodian populations, where 38.8% and 44.5% respectively had three or more children. The average number of children per household, a rough calculation of the fertility rate for this community, was approximately 3.8. This figure was probably lower than that of the true figure because it did not include those children who were no longer living at home. By comparison, the fertility rate for Australia was 1.9% (ESCAP 1996) and the fertility rate in the Vietnamese community, at 2.2%, was only slightly higher than the Australian figure (Bui and Bertelli 1990).

However, the birthrate for the Hmong in Sydney was still far lower than that found in traditional villages which was estimated to vary between 4.5% and 7.5% (Geddes 1976; Kamnuansilpa et al. 1987), and was also lower than that of Hmong living in the United States, where large Hmong families were common (Olney 1986). One respondent explained that the main reason for Hmong in Australia having fewer children (in her case, four) was because they believe that all of their children will live. She explained:

> Outsiders ask the Hmong 'why do you have so many kids?'. But the Hmong have lots of children in Laos because they can never be sure who will live and who will die. We understand fully that in Australia and America that if you give birth to four children then that is usually the number you will always have. Even though some people in Laos may have given birth to ten children, none of them may have survived (AF29).

Traditionally sons care for their parents in old age and mortality is high for the Hmong, so great incentive existed to have a large family, and especially many sons (see Chapter 2). Greater confidence in the long-term survival of their children has played an important role in the reduction of fertility in Australia. Indeed, a rough

comparison with traditional family size is apparent from 18 respondents who provided some information about their number of siblings. Their families ranged from 5 to 14 children, averaging almost 7.3 children.



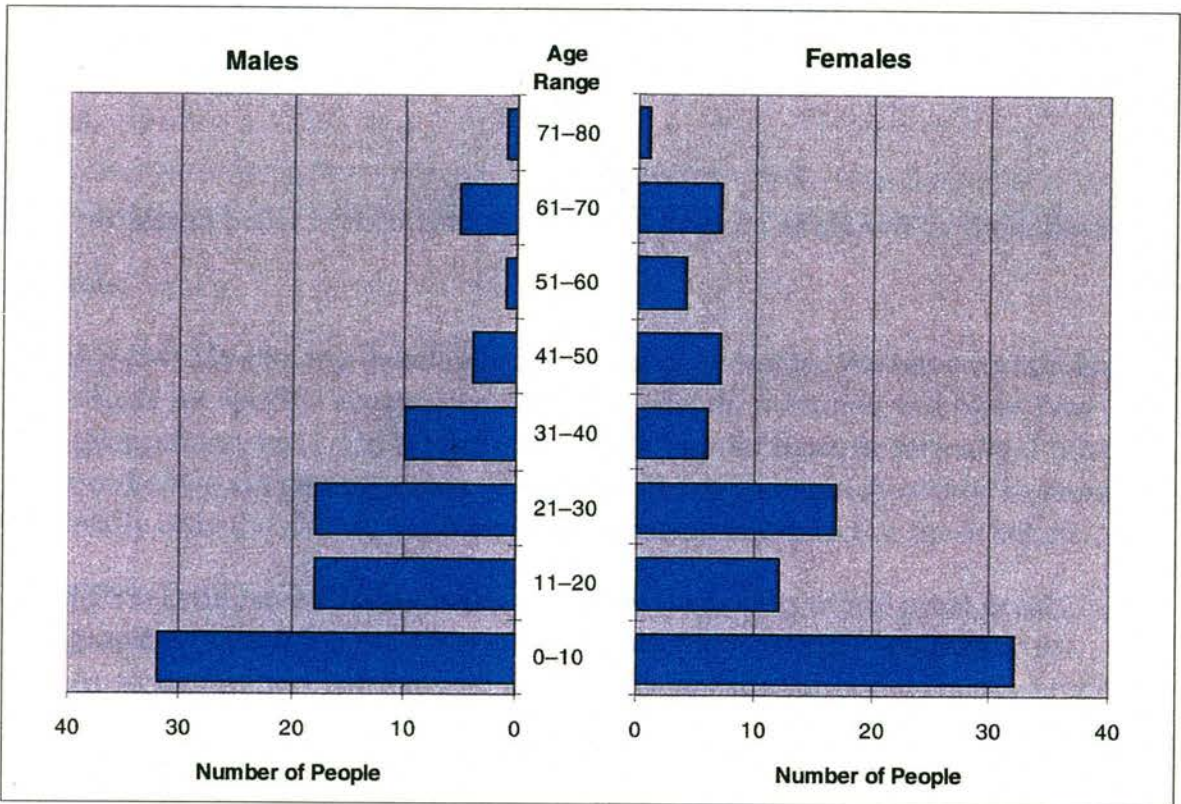
Source: Field work

Figure 3.6: Number of Children per Household

Gender Ratio

There were almost equal numbers of men and women within this community (females: 49%; males: 51%) (Figure 3.7). In some Hmong refugee communities, this ratio was skewed towards men due to migration requirements, where young, single men were the first refugees because it was believed that they were the easiest to incorporate into the work force; or it was distorted towards women if there were a

large number of households headed by women (see Chapter Two), as can happen during wartime when many men lost their lives fighting. Both of these factors have had some effect on this population group, hence the parity, though the sample size is small. Two households were headed by women, a relatively unusual occurrence in traditional Hmong society. In the older age groups, over 51, there were more women than there were men, which may be the result of men dying during fighting in Laos. In many of the accounts people stated that their fathers had been killed during the war.



Source: Field work

Figure 3.7: Gender ratio of Hmong community

Traditional beliefs

The majority (38 out of 41, or 93%), had retained their traditional Hmong beliefs and practices. Most described 'Hmong religion' as 'a way of life'. Two people had however already given up their traditional beliefs in Laos (one had converted to Buddhism and one had become a Catholic) and one had become a Christian since arrival in Australia. One woman who originally migrated to the United States became a Christian while in the United States, but had reverted to Hmong beliefs in Australia. Many within the community had therefore maintained their Hmong spiritual beliefs in spite of the fact that missionaries had been active in Laos since the late eighteenth century and that many Christian groups were working in the refugee camps.

Most professed belief in their traditional belief system, as shown by the following accounts:

> A(M34) My Hmong beliefs involve ancestor worship. We have certain Hmong rituals for specific events, like weddings, death, marriage and New Year celebrations, but I don't do anything on a regular basis or formally. I think that our beliefs are getting weaker now that we are living in Australia because really only the elderly people still understand and practice these beliefs.
>
> J(F33) I still have Hmong beliefs. I follow the beliefs of my great great grandparents. We have different skin, and thus are different people to Australians and Christians, so I must believe my traditional beliefs. I follow what the older people in the community tell me to do. When I need help, I go, to the old people for it.
>
> L(M30) I still have my own religion. That means that I have Hmong beliefs. I follow what I believe, which is a little different to what my father believes. We don't do anything in particular for our religion, as Hmong religion is part of our way of life. We follow certain rituals for birth, weddings, death and so on. I don't think that my beliefs and practices need to change now that I am living in Australia, as we are unable to change from being Hmong.
>
> It doesn't matter where my children were born, I believe that they are still Hmong, and of Hmong religion. I believe that evil spirits can still find you. You can't make an Australian a Hmong because Australians have Australian beliefs.

P(M49)In Sydney, not many Hmong have changed to Christianity, but in the future, who knows. After the old people have passed away, I don't know if the young Hmong will be interested in maintaining their ways. My children ask about the Hmong religion, and I explain it to them, but it cannot be taught at school.

Syncretism and dilutions to these traditional beliefs are apparent in the following accounts:

S(M35) I have some Christian friends and other friends who are religious, and they have invited me to join them. I believe in God, I believe in everything. These friends would like me to visit the church with them, but I want to maintain my Hmong beliefs.

W(M31) I believe in many religions; Hmong religion and culture, yeah, I still believe in it, Buddhism, I still believe in it, and Christian church, I believe in it too. But my mother, she has become a Christian now. I don't try to maintain my Hmong religion now, I'm sort of free of religion. I don't know why my mother has become a Christian, but she goes to church on Sunday. I occasionally go to church but my children don't. However, we do still follow many Hmong rituals. I'm not dominated by Hmong beliefs, I use something of all religions.

I(M21) I have traditional Hmong beliefs but I also believe that part of me is Buddhist. Hmong religion involves believing in ancestors, or ancestor worship. This means that I must follow the traditional rituals, have respect for the elders, remember dead relatives at certain times of the year, such as at the New Year Celebrations and at other times of the year.

I go with my Godmother on Friday to the Buddhist temple. We cook food for the monks to eat, and pray in the Lao (or Buddhist) way. Because I am young, the monks come up to me and are pleased that I am following their religion. My mother has no problems with me following the Buddhist traditions as well as the Hmong.

Those who have changed their beliefs explained why:

B(F33) I am Catholic because when I went to school in Laos, in another village, I lived with a Catholic family and so I became Catholic.

I don't do anything for my religion any more. Because my husband isn't Catholic, I don't go to church because I don't want to cause arguments. However, privately, I still believe in the Catholic faith. My beliefs are just as strong but I have modified how I demonstrate them. In Laos, I went to church every day. However, I still do have some beliefs for ancestor worship. My family does make offerings to the spirits when my husband feels this is

necessary. My children don't go to a Catholic school, but I have told them that at school, if the teacher asks them what religion they are, to say that they are Catholic.

H(F19) I had Hmong beliefs until about 18 months ago when I converted to Christianity. I became a Christian when I joined the Baptist church. I am the only one in my family who has changed in this way. I was introduced to Christianity at school and have taken it further myself. All my brothers and sisters believe in the Hmong beliefs. They tease me about my beliefs. I no longer have any belief in the Hmong religion. The respect of my parents and of my elders, I do have that, and I feel that I should continue that on. But as for the religion bit, it's way off and I won't believe in it.

R(M45) My family changed to become Buddhist, the same religion as my wife. My children are all Buddhist as well. In Laos, I started off with only Hmong beliefs. While I was at school in Laos, I changed to become a Roman Catholic, because I attended a Roman Catholic school. After I married, this caused some problems within the family, especially for my wife. So I was happy to change to Buddhism for her. I go to the Buddhist temple whenever they have a festival, and we go then to make some offerings. As a Buddhist, you are welcome and encouraged to go to the temple whenever you want to. You don't go to set services.

I would still would pay traditional respect in the Hmong way in the case of a death within the Hmong community, but for myself and my family, I would rather follow the Buddhist traditions for when I die.

Each person who had taken up a new religion maintained some Hmong social practices, but not those related to beliefs in spirits. This group, out of respect to other Hmong, either family members or the community, would generally be also involved in some Hmong traditional practices.

It is impossible to predict how long the rest of the community will follow Hmong traditional beliefs. The population is young; different religious beliefs are taught in school; there is no formal teaching of Hmong beliefs as they have always been regarded as part of their way of life; children are mixing with a large number of children from different backgrounds; the older Hmong who traditionally pass on knowledge about their belief system are finding it harder to do so in this country. Syncretism and the dilution of tradition are now apparent in the beliefs and practices of those who profess to have more traditional beliefs.

Citizenship

Almost all Hmong have become Australian citizens since settling in Australia (37 out of 41; 90%). Those who have not were the more recent arrivals, however they intended applying for citizenship in the near future[17]. These figures were consistent with historical trends of refugee communities. However, the rate at which members of the Hmong community had taken up citizenship was much higher than for both those of NESB and the overall immigrant population. In 1991, the rate of Australian citizenship for all overseas-born was 61.4%, and was 72.1% for immigrants from NES countries (BIPR 1994; BIPR 1995). Within the Vietnam-born population, 71.7% had taken up Australian Citizenship by 1991 and 79.0% of Cambodian-born had also done so, thus the rate of 90% for the Hmong was extremely high.

The reasons for becoming Australian citizens were varied, as can be seen in the accounts below:

> B(F33) If I come to Australia, I want to be an Australian person. I can vote and if I want to go overseas, it is easier with an Australian passport.
>
> C(M42) I became an Australian citizen in 1979, three years after I arrived. We have no more country except Australia, so we must become a citizen here so that we can get some benefits, such as the First Home Buyers Grant from the Government of $3000. If I hadn't become an Australian citizen, I would have to travel on a Lao passport. I used to have a Lao passport but I think that it is useless. It simply was used for crossing the Thai border.
>
> A(F29) I became an Australian citizen about 8 years ago, in 1985. Originally I became an American citizen while living in United States. However, I wasn't able to renew my American citizenship because I had only had it for 3 months before coming to Australia; American Government regulations require a person to live in the United States for a longer period of time before they can become a full citizen. I became an Australian citizen after coming to Australia because I wanted citizenship, was married and intended living here. However, I would have preferred to remain an United States citizen because all my immediate family live in United States.

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[17]To become an Australian citizen, one has to have been a permanent resident for two years; spouses, aged, disabled and children under 16 are exempt from these residential requirements BIR (1990).

D(F29) I became an Australian citizen in 1987. I did it because, as the Hmong have no country, they are neither Chinese nor Lao. Also, at the interview done in Thailand in order to migrate to Australia, I had to promise that I would stay in Australia and never return to my country. I had to swear an oath never to return to Laos. And if I come to Australia, I have to follow the laws of Australia. The United States does the same.

J(F33) I can't remember when I became an Australian citizen, maybe 7 years ago, because all of my children were born in Australia, and so they are all Australian citizens. So, I must become Australian citizen too. I was worried that if I hadn't become an Australian citizen, the officials may see that I am from Laos and at some later date decide to send me back to Laos, and away from my family. It may also be easier to get work as an Australian citizen. Some people have said, "how long have you been here? How come you haven't become an Australian citizen?"

Q(M55) Yes, because if we live in this country we must get our citizenship. In my first job, my boss said that if I took out citizenship, and I had any problems at a later date, the government would help me. So we took out citizenship after we had been here for 2 and a half years, in 1981-82.

Practical considerations were more common than national pride, as is usual amongst all migrant groups (BIR 1990). Hmong have become citizens in order to get a passport and travel overseas, and many have traveled, often to the United States to visit relatives; gain the greater security that many believe permanent residency papers can offer; obtain certain benefits that are only available to citizens, such as voting and cash assistance from the government; and repay (or thank) Australia for giving them a home when they were refugees. Thus Australian citizenship provides many advantages, especially in terms of financial assistance and ability to travel overseas.

Languages spoken

All the respondents were able to speak Hmong, but not everyone in the older age group could speak English. Many were concerned that younger Hmong children were using English more often than Hmong and so losing their skills in Hmong (Table 3.7). Many Hmong spoke more than one language. In addition to Hmong, the

majority spoke English (31) and Lao (24), but fewer were able to speak Thai (12). A small number spoke at least some French (7) and Chinese (2). Almost all were able to speak a little of at least one other of these languages but not well enough to regard themselves as being fluent.

A more important issue than the number of languages the Hmong did or did not speak, was the loss of the Hmong language that was occurring in the younger generation. By contrast many Hmong refugees over the age of fifty did not speak English. The community is very small, which makes maintaining their language more difficult than for larger refugee groups from a NESB. One unfortunate outcome of this was that the relationship between the elders (who traditionally hold an important role in the community), and the younger generation had become much harder to maintain as grandparents and grandchildren were losing their ability to communicate with each other.

Language	Number
English	31 (3 some English)
Lao	24 (4 some Lao)
Thai	12 (9 some Thai)
French	7
Chinese	2

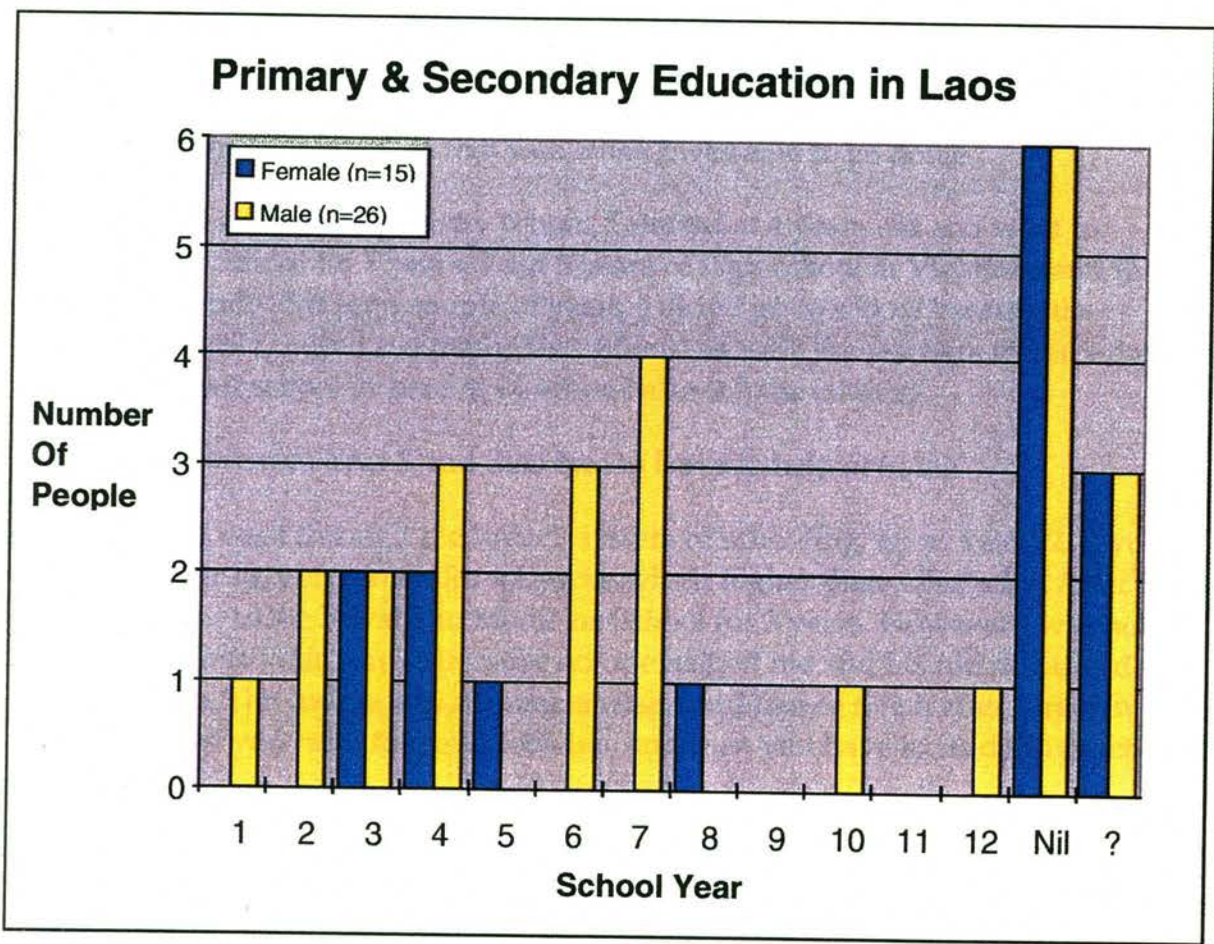
Source: Field work

Table 3.7: Languages spoken by participants (n=41)

Education

The French colonial government in Laos did little for local education during its rule. After independence in 1962, the new government attempted to correct deficiencies in the education sector, but progress was slow because of limited institutional capabilities and continued warfare (Thant and Vokes 1997). As a result education for Hmong in Laos was severely hampered because of disruptions that the war caused, lack of schools, remoteness of Hmong villages and other demands on

children's time, especially that of girls (Figure 3.8). Nine people mentioned that they moved around every few years to escape from the fighting and the communists. Even with such hardships, three men and one woman completed (or attempted) post-secondary education in areas of nursing, medicine and teaching. To even have such an opportunity, either their family lived in Vientiane or the student lived with relatives in Vientiane. Most people only reached a minimum level of education if they went to school, and the standards reached for girls was lower than that of the boys. Older Hmong have received little (if any) formal education, particularly if they were living in remote areas.



Source: Field work

Figure 3.8: Primary and secondary education in Laos

Several described their experiences of attending school in Laos:

> C(F41) I went to primary school for 6 years and finished in 1965 when I was 13 years old. I studied for 2 years in Laos to become a nurse but I didn't finish my training because I got married when I was 17. My husband was a pilot and we moved to Thailand to live.
>
> C(M42) I went to primary school, from Year 1 to Year 6, and received Lao Primary School Certificate. I chose to go to the secondary school that trained people to become teachers. After 5 years you could become a Primary Teacher. Another 3 years qualified you to become a secondary school teacher who could teach Years 7, 8 and 9 at high school. I was qualified to teach French, Geography, History, and Social Studies. My main qualification is French.
>
> E(M31) I had to travel for my primary education. In my village, we only had Year 1 to 3 at the school. If you wanted to continue Year 4 to 6, you had to go to the city. It was called Nan Nhao, and it was 11 hours walk away. I stayed for half a year at a time, that is, for a semester. At the end of each semester, there was a month holiday, so that was when I was able to go home.
>
> F(M22) I completed primary school, I started at 4 years old and went to primary School for 7 years. I did 3 years of high school in Vientiane and lived with friends. But for a couple of years, I didn't go to school because the communists caused too many disruptions; as well, the teachers weren't there to teach. I left school in Laos at 14 when I also left the country.
>
> K(F33) I went to Year 3 and then had to leave to help at home.
>
> PM(49) I went through the French system of schooling, up to Year 12. If you pass Year 13, you can go for a Degree which higher than a Bachelor. After Year 12, I went to the Royal Lao Medicine School for 3 years. However I was not able to finish this course because no-one helped me and I could not afford to continue. The course was a 6 year course, but I had to finish after three. In Laos, first you have to pass Medicine, and then you have to study to practice as a doctor.
>
> I have only one sister and she didn't go to school. My wife only went to primary school.

Difficulties in obtaining an education were numerous, they included lack of finances, the distance students had to travel to get to school, being female, very young children having to live away from home, too few teachers because they were involved in the war, and other disruptions caused by the war. Despite these obvious

hardships, and the situation where the modern system of education was not part of Hmong traditions, many families tried very hard to educate their children.

In the refugee camps, educational opportunities were minimal. In Ban Vinai where most of the Hmong refugees were interned, primary education only was provided in Thai and Lao under the administration of the Thai Ministry of Education. Education outside this system, such as English classes, was provided by American volunteers or other private operators (Long 1993). Most of the private classes incurred a fee, which many refugees could not afford. As was common in Laos, girls tended to drop out of school early as they were required to contribute to household incomes. Refugees from other camps recall similar educational systems to those in Ban Vinai. Some mentioned that other languages such as Chinese were also taught. Two men learnt some pharmacology and chemistry and worked in a camp pharmacy, but such training gained in the camps was unrecognised in other countries.

During the present study, information was obtained about education both participants and other family members had obtained in Australia. The larger sample provided a more realistic representation of the community's achievements. In this sample, information about secondary education levels attained was obtained from 20 women and 30 men. A further five women and 12 men attended English language classes only. Whether or not the refugees went to school in Australia was almost entirely dependent upon age: school-age children went to school, older refugees qualified for English Language classes only.

The English classes were provided by the Australian government, most adults went to classes that ran for 3 months but some of the teenagers attended classes for 12 months in preparation for going to school. The reasons for not attending included being too old or too busy taking care of children. Below are some accounts of how some members in this community learnt English:

C(F41) I haven't studied English at all, I didn't attend the English classes provided at the migrant hostel because I was too busy taking care of my two young children. I learnt my English at work.

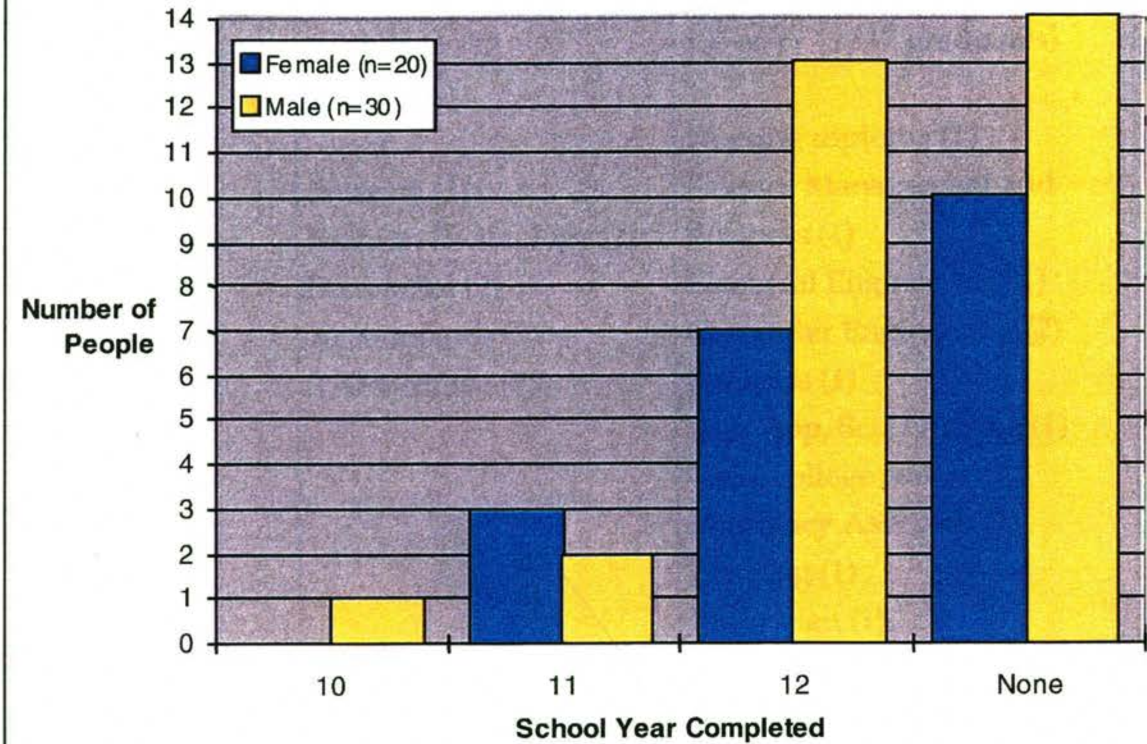
C(M42) I learnt English for three months when I first arrived, then I started work and have not done any more study since that time.

ZA(M27), ZB(M33) ZC(M30) We studied English classes through the Adult Migrant Education Unit for about 3 months. After 3 months, you are regarded as having finished and competent, regardless of what your English was like. The trouble is the way that we were taught English in the migrant centres is not good, there is too much reading, using the dictionary and not enough speaking. This is why we think that our English is not very good.

H(M50) In Australia, I have studied English on a part-time basis. I studied it in the factory where I work, once a week for 4 hours. The factory provided the teachers.

The rate of attempting and completing secondary school and continuing on with post-secondary education for this refugee community was striking. Of the 50 persons over the age of 17 who had attended secondary school, 40% had completed Year 12 (females: 35%,, males: 43%) (Figure 3.9), a figure similar to that of the general Australian population (females: 33%, males 45%) (BIPR 1994). Such figures show a huge improvement over the rates in 1987, where education figures revealed that only 17% of the Hmong community had completed high school (Lee 1987). More significantly, almost all of those who completed Years 11 and 12 had continued with their education (female: 9 out of 10, male: 13 out of 15).

While female and male levels of achievement were similar, Hmong men had gained more valued qualifications, especially in terms of potential earning power, than women (Table 3.8). Men had become nurses, electrical and computer engineers, draftsmen, electricians, finance and business managers. Women had completed nursing, secretarial courses, accountancy, fashion technology and other TAFE courses.



Source: Field work

Figure 3.9: Level of secondary education reached in Sydney

Improved rates of education achievements were partly due to more Hmong children completing the majority of their education in the Australian school system, but the figures on success also demonstrate that Hmong valued education highly for both sexes. The figures for those who had completed secondary school are more favourable than those of both the Vietnamese-born and Cambodian-born populations, where 6.8% and 3.3% respectively completed secondary school. The rate of post-secondary education for men was higher than that of women in the Vietnamese-born and Cambodian-born populations, as it is in the general Australian population (BIPR 1994; BIPR 1995).

Item	Female	Male
Post-secondary qualifications	9 (of Yr 11/12 graduates) Nursing (1) Fashion Technology (1) Secretarial (2) Accountancy (3) TAFE course (2)	13 (of Yr 11/12 graduates) Nursing diploma (1) Finance Management and Business (1) Electrical Engineering (1) Computer Engineering (2) Business (1) Dip. App. Sci., Nursing (1) Tech. college course (3) Pharmacy Assistant (1) Drafting (1) Electrician (1)

Source: Field work

Table 3. 8: Post-school qualifications

Below are some accounts of experience in the education sector in Australia:

> E(M31) I learnt English when I first arrived in Australia. I went to the Migrant Education Centre for this, for one year. After that, I went to Westmead to learn Nursing, however after one semester, I realised that my language was not up to taking a formal course, I couldn't understand the lecture. So I went to the Administration and told them my problems and that I wanted to learn more English before I could do the course. This was not a problem to the course organisers, they said that I can return whenever I feel I am ready.
>
> I have also been to Tech in Ultimo to study to be a Pharmacy Assistant. I finished that course but haven't been able to get a job with this qualification because most employers only want women between the ages of 16 and 19. I felt that I was missing jobs because I was too old (at 30!). At Ultimo, I was taught how to advise people when they come to the chemist. My poor English holds me back. I find it difficult to understand Australians when they speak too fast.
>
> F(M22) I attended Cabramatta High School. First I had two years in the ILU (Intensive Language Unit) at the school, and then 2 years of normal schooling. Then I completed year 9 and 10 before leaving in school in 1990. I am my second year of a Drafting course, and am completing it part-time at Granville

TAFE. I have also learnt panel beating and spray painting on the job, and have been working in a part-time job for about 3 years.

G(F25) I went to school in France and completed high school there. I am currently doing a nursing course at Macarthur University, Milperra Campus. I am now in my second year of the three year course.

L(M30) In Australia, I started at Year 9 and completed to Year 12. Afterwards, I went to Wollongong University and completed a Degree in Computer Engineering, which tooksix and a half years. I have also attempted a post graduate course at Macquarie University but I didn't do very well; having a young family makes it much harder to study. I had no time to study plus nowhere to study in a fairly crowded house.

Q(M55) When I came to Australia, I wanted all my children to become well educated. When I arrived, my eldest son wanted to become a nurse, but was told that he was too old because he was 18. So he went to work. My other son was 17. He went to see his teacher at Carramar High School, and she suggested special English classes for 2 to 3 months. He moved from year 7 to year 10. He now has finished degree at university. I am very proud of him. In the camp, I dreamed every day that I must help my sons learn. But I was not able to do it for my eldest son.

These accounts demonstrate the mixed experiences involved in obtaining education on Sydney. Poor skills with English and age restrictions have held some back from improving their education.

Employment

A large number of people were too young to have been employed in Laos (18 males and 12 females). Of the men who were employed, three were involved in the army, three were government employees, and others were farmers or butchers. Only one woman had worked in Laos, helping in her parents' shop. Several spoke about their parents' employment in Laos; most of their fathers were farmers, soldiers or both (30), and the rest included a butcher (1), a businessman (1), a judge (1), a policeman (1) and a shopkeeper (1). One individual's mother ran a business selling chickens after her husband was killed fighting in the war, and another woman had a retail business in Vientiane selling fabric. The accounts below show some of the various

occupations in Laos which the people who were interviewed or their family members were involved:

> P(M49) After leaving University, I sat for the Public Service exam, passed, and got a job in a department similar to the Department of Social Security, it was called the Department of Social Welfare. I worked there from 1971 until 1975 when I left the country. It was a fairly well paid job.

> R(M45) After completing Year 12, I was 'promoted' to work in the languages section within the National Centre of Research, Linguistics. I was a Director within this Centre. I worked there from 1973 to 1975, until I left.

> D(M36) My father did not do any farming, his occupation was a soldier. Many of the Hmong men were soldiers. The less educated generally worked and became farmers, those who had been to school and could read and write, joined the army. They didn't join because they wanted to fight and be in the army, but the army paid very well and they could make more money being in the army than being farmers. Occupations that paid well in Laos were being a soldier and teaching.

> A(F29) In Laos, I was a student. My father was a soldier with the Lao Government and earned all the money. My mother ran the household.

> C(F41) My father was in the army but he died a long time ago so my mother provided for the family. In the family were 7 girls and 1 boy, I was the fourth child.

> C(M42) I taught French, Geography, History and Social Studies in Laos.

> G(M25) My father was a soldier, and was part of the army formed to follow General Vang Pao.

> H(M55) In Laos, I had to join the army, and was in it for 10 years. After I left the army, I became a butcher, and sold meat in the markets.

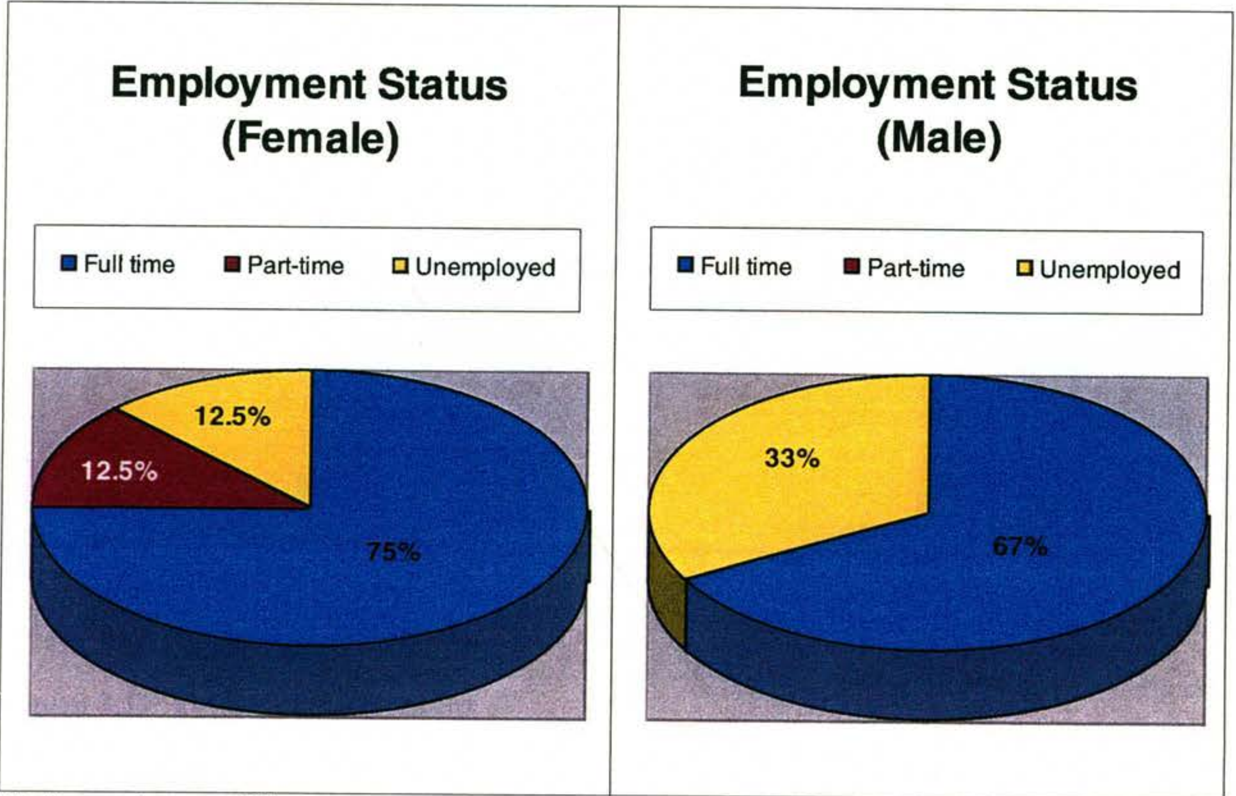
Employment options included farming, being a soldier, public service, retail trading and teaching. Those who were better educated had had better employment options, those with less education were generally restricted to farming. The war provided new employment options plus a chance to earn more money than farming could provide and many took advantage of this opportunity. In Thailand, most people were not employed (22 male and 14 female), although a few employment

opportunities did exist in the refugee camps: two worked in the camp pharmacy, one was a medic, and two worked as interpreters (one male and one female).

Employment data relating to both those who were interviewed and other family members were obtained during the research, and the larger sample provided a more realistic representation of the community's employment profile. In this sample, some 16 women and 27 men were eligible for employment, and 11 women and 5 men had opted out of the employment pool. The reasons for not looking for employment included being too old, taking care of young children, household duties, and 4 were full-time students. Some of the women said that they would seek outside employment if they had access to (free) child care, which for Hmong was traditionally provided by either grandparents or other family members. In the absence of such support, many were not able to afford formal child care since most were only eligible for low paid employment.

Both the unemployment rate and employment options showed some improvement over the survey undertaken in 1987 (Figure 3.10). In the present research, the unemployment rate of 26%, (females: 12.5%; males: 33%, these figures excluded part-time work) was somewhat less than in 1987, when it was 35% (Lee, 1987). However it was much higher than both the NSW figure of 7.5% (Fairfield City Council 1996), and the relatively high unemployment rate of the Fairfield LGA, at 14.8%. The unemployment rate of Hmong in Sydney was consistent with, but considerably lower than the high rates experienced by the Vietnamese-born and Cambodian-born communities, where the rate in each was 40% (BIPR 1994; BIPR 1995). Coughlan (1991) found the unemployment rate of the Lao community to be much lower than that of the Vietnamese and Cambodians, and attributed it to Laos learning English before they entered the work force. However, it was unclear if this was the main reason for the lower rate of unemployment among the Hmong, as discussed below. Unemployment for women was lower than that of men as many women were not in a position to seek employment as they were caring for children.

Juggling family responsibilities accounted for the number of women in part-time employment.

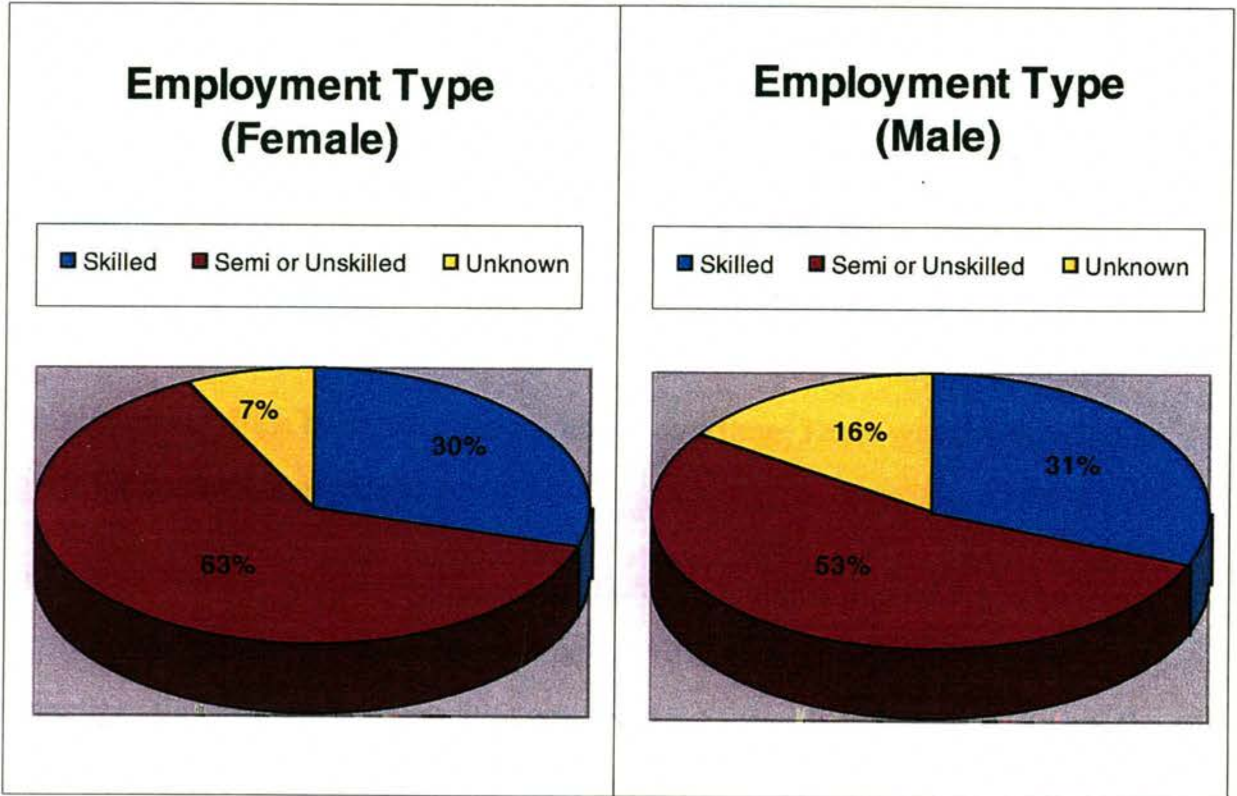


Total unemployment: 26%

Source: Field work

Figure 3.10: Employment Status, Sydney (females and males)

The number of Hmong who were eligible for skilled employment had increased considerably since the 1987 survey, when 92.5% were process workers and thus only eligible for employment in semi-skilled and unskilled areas (Lee 1987). In the present research, the number of skilled members had risen to approximately 30%, and 58% were semiskilled or unskilled (Figure 3.11). This situation was similar to that of the Vietnamese-born and Cambodian-born communities, where those employed in semi-skilled and unskilled areas were 63% and 71% respectively (BIPR 1994; BIPR 1995). All three communities continued to be mainly employed in the lower paid section of the work force.



Source: Field work

Figure 3.11: Type of employment

Lee's 1987 survey identified the lack of English as a major limiting factor in enhancing employment prospects, but other factors identified in the present research included limited employment options within the more vulnerable sectors of the work force, and the lack of skills which were not being enhanced in the work force. By the time of the present survey, the overall level of English had improved mainly because more younger members were doing most of their education in Sydney. Thus, they were leaving school with better qualifications. At the same time, many of the older Hmong were moving out of the work force to take up pensions. Such factors are likely to subsequently lead to more favourable employment figures, depending on the economic climate.

Many Hmong found that obtaining and maintaining employment in Australia was very difficult. As few had formal qualifications or a high level of competency in

English, they were very vulnerable members of the work force. Several had been retrenched when a company had closed down or relocated, or when the factory or business closed for the Christmas break. Some felt that their employers took advantage of them because of their poor English, the fact that they were new to the country and that they did not know where to go for help. One woman who was only receiving $95 per week (including overtime) felt that she was being underpaid. A friend advised her to look for another job, which she did, and moved into new employment which brought in $135 without overtime. There was therefore some basis for feelings of exploitation.

Although Hmong women were not traditionally engaged in paid employment, economic necessity has meant that those who can earn money, do. The financial benefit to the family where the wife was working was considerable: occasionally women were the only wage earner at times when husbands were unemployed. Women's salaries also enabled some families to purchase a house much earlier than otherwise would have been the case, and children could stay at school longer and have the opportunity for higher education. However, some women were exhausted as they coped with working full-time and running a household.

Several men were annoyed that their qualifications from Laos were not recognised by the Australian government, especially since some had quite high status jobs in Laos. On the other hand, many women enjoyed the opportunity to work outside the home. They liked to be able to earn their own money and felt that they now had greater status within the household as they were able to contribute to it financially. A number of accounts of employment experiences follow, as they best explain Hmong employment in Sydney:

> A(M34) I am a process worker. I have had many jobs since I have been in Australia. My first job was packing. I left this job to go to America to get married. When I came back, I got a job in microwave assembly. I stayed in this job for one and a half years, then the factory closed down. My next job was a Welder and Second Class Machinist. I worked there for 3 years, but I could not

earn much money so I left this job for a better paid one at Pilkingtons. At Pilkingtons, I was assembling door windows and shop fronts. I worked there for two and a half years, then Pilkingtons closed down and I lost my job. So, I went back to my old welding job, and worked as a casual for 4 months, then it ran out of jobs and the casual workers were retrenched. I have been unemployed for the last 6 months.

C(F41) I now work in a (confectionery factory) in Lane Cove. I have been there for 7 years and 1 month. I work afternoon shift and do a lot of overtime. So I feel tired most of the time. It takes me one hour each way to go to and from work. My first job after I arrived was in Villawood. I enjoyed this job but had to leave when I became pregnant with my third child. Then I had a fourth baby and didn't return to the paid work force until that baby was almost 5 years old.

D(M36) My first job was at a factory that made curtains at Mascot, I was there for 6 years. Then I was retrenched. Then I started to study English. After that I got a job at Homebush Bay. I was a process worker at Homebush Bay for two and a half years. Then the factory closed down and I am still unemployed. My father, who lives in the same house, is currently a factory worker.

G(M25) I have a job assembling computers. The first company I worked for was Hume Computers, where I was for 3 years. Currently I am working for another computer company and have been there for 1 year.

H(M50) I have been working at BTR for about 15 years, machining for car parts. This job is the first and only job I have had in Australia. I started in this job soon after I came to Australia.

J(F33) My first job was clipping cotton from garments after they had been sewn. I did this for about 4 or 5 months. I was dissatisfied with the money, $95 per week including overtime. So for my next job, I moved to Girlon, in Belmore, making spare parts for cars. This job was recommended by a friend who thought that I should be able to earn more money than $95 per week. In this job, without overtime, I was able to earn $135 per week. I was there for almost a year, and then had to leave when I became pregnant with my first baby. Currently I am working part-time at Steggles Australian Poultry. I have also had many jobs in between.

My husband works at Shelleys soft drink factory. He has been there for thirteen and a half years. Initially he was a process worker, now he is a Leading Hand.

K(F33) For the past 3 weeks, I have been working in a factory that makes lids for drink bottles. Before this job, I worked on a farm collecting eggs. I did this job for one and a half years. I have also worked in a furniture factory, making melamine and veneer furniture. I worked as a casual in the city, making belts

My husband works in a factory making fly screens. He got this job 3 months after he arrived in Australia and has been there ever since (about 13 years).

S(M35) My first job lasted for one week because it was so far away. I would get up at 3 am. and not get home until 10 p.m. The next job that I got is the same job that I am currently employed in. I work for Tube Makers and have been there for 16 years. They make both metal and plastic tubes. My first position was as a welder. Then the company was sold to another and I was retrenched. Two months later, the new company contacted me and offered me a job as an inspector, and this is the position that I am currently working in. It has better pay and better position.

The above accounts highlight the precarious position of many Hmong in terms of employment. As many were unskilled, they were very vulnerable to the vagaries of the economy as factories closed down, relocated or laid off workers after a downturn in work. Despite this, a small number had been in one job for many years, and others had been able to move up the ladder to take on more secure jobs. The few who did have formal qualifications appeared to be more secure. This trend may continue for those who were still at school and who are yet to join the work force.

Resettlement in Australia

General questions were asked about what Hmong liked or disliked about living in Australia, what they missed about Laos and how various aspects of their lives had changed in order to augment the data obtained about the community's socio-demographic, education and employment experiences. This discussion revealed certain gender differences and a concern about loss of Hmong culture in the younger generation. The Hmong Society Australia was established (see below) in order to assist with various aspects of resettlement experiences in this community. (Appendix Four outlines how the practice of traditional ceremonies has changed in Sydney.)

In general, women were more satisfied with their lives in Sydney than men. Many women commented that they had a much better life as a Hmong woman in Sydney than in a more traditional society. In Sydney many of their traditional tasks, such as

carrying water to the house, collecting firewood, or the myriad of other physically demanding and exhausting chores that women traditionally performed every day, had disappeared; their children were much healthier; they were more satisfied with being able to contribute to the household income through paid employment; and their husbands treated them better. Some explanations from women follow:

> B(F33) I like living in Australia because everything in Australia is so much cleaner; clean house, clean dishes. In Laos, the house was on the ground and thus had a dirt floor. The water came from the river, and had to be carried to the house. In my village, there was a small river and a small pond was dug where the villagers could get water. My mother and I had to carry the water from the river, uphill, for about 20 to 30 minutes. Only the girls carried the water, that's not fair, it's very heavy. Plus I collected the firewood.
>
> It is much better in Australia. In Laos, wives and women had no authority and wouldn't have been able to disagree with their husbands or a man. I think that education has been the key to the changes. Also, men have seen that it is not so bad if they have to listen to the women.
>
> In Laos, when my father returned from working on the farm, he would never offer my mother any help, such as helping look after the baby. Whereas in Australia, when my husband comes home from work, and I am busy, then I can ask him to help me by taking care of the baby. If I am tired and don't want to cook, then he will help. This would never have happened in Laos, I think most men would not have even known how to cook. 'Cooking is the woman's job', so they wouldn't have anything to do with it.
>
> A(F29) In Laos, it was up to the husband to provide for the family, thus he was the one who earned the money and was able to have a paid job. It also meant that he had a lot of control over his wife and enjoyed a lot of personal freedom as well. For example, the husband could 'play around' and not be punished, however, if his wife did the same, she would be severely punished.
>
> K(F33) In Laos, the wife had to do what the men wanted, whereas in Australia it is different and the men do not have so much power over their wives.

The impact such changes have had on women's lives can be summed up by the following: 'Often we joke about how (Hmong) women living in Australia smile more than they did in Laos. This is because they have more freedom about what they talk about, (and) they can ask their husbands for help' N(M36). (A brief account

of 'women's work' in a contemporary Hmong village in Laos is presented in Appendix 5.)

A greater number of men expressed dissatisfaction with their lives in Sydney than women, and a small number would like to go back to live in Laos 'if ever the opportunity arose'. In contrast, none of the women expressed a desire to go back to Laos. Loss of status in employment and less authority in marriage were areas of concern for some men. Men gave more mixed and sometimes contradictory responses than those of the women, as illustrated below:

> C(M43) Just because I have a better life here doesn't mean that I am happy. Maybe some other Hmong are more successful in their career and in their financial matters, but I think often about the old country. I don't like to live like I am, just doing the same routine every day, working every day and spending my money until I get old. I want, if I can, to go back and live in Laos if (when) the Government changes. I want to be able to realise my dreams. I think that life in Australia is too predictable: working, living and looking after your children. But in my country we like things to be new, unpredictable, exciting, and it is. You can go anywhere. In Australia, I feel inferior, and feel that migrants in general feel inferior. I think sometimes that life in Australia is boring and predictable.

> L(M30) The role of the mother and the wife has changed. Hmong women are trying to gain equal rights with the men now that they are in this country. The women are trying to be equal to the men and it's causing problems with the families. But they don't realise that because they are Hmong, they can't change.

> Q(M55) I miss Laos because it is my own country. It is a beautiful country, because, every month it is different: new birds, new insects, every 12 months, there are 12 different new things. But in Australia, there are very few changes. However, this country is a very good country. It is very healthy. We need to take very good care of this country.

> E(M31) I like living in Australia. But some people get very angry, especially of some of Australia's laws, especially the law that everyone is equal. We are talking about men here. They don't like the idea of Australian divorce, where the woman shares half of everything, and the woman generally gets to keep the children. In Laos, if the couple gets divorced, and the woman is 'at fault', the old men will ask the woman to go away and leave everything, including the children, for the father. On the other hand, if the husband hasn't taken care of his family, then he must leave alone.

I was concerned about divorce laws when I first arrived in the camp, but after I thought about it, I figured that it would be okay. Women can be equal too. There were families in the camps who would rather stay there than go to another country because the husband and wife are treated equal in other countries like America and Australia. I know of no incidents in Australia, but I have heard stories from America where the husband has been forced to sign divorce papers because his wife doesn't want to live with him any more.

N(M36) The main difference in Australia is that you cannot use your force. Whereas in Laos, a man could bash his wife if she did not do what he wanted. However, this cannot happen in Australia. I think that the way in Australia is the correct way.

H(M55) I miss the taste of the food in Laos. Hmong in Australia always say that the food tasted better in Laos, and last year when I went back to Laos for a visit, I can now confirm that it is true! I feel that the food tastes better (in Laos) because it is grown under more natural conditions. Here, there is too much 'artificial' food.

O(F19) My father and mother went back to Laos 4 years ago. My father said that it is much harder (now) because you have adapted to this lifestyle and now you need healthy things, whereas in Laos, everything is dirty, the food is not very clean, and he got quite sick. He used to remember the food as being much better, he remembered in particular one fish dish. In Laos, he ate it and got really sick.

Hmong women had a more realistic and practical view of their life in Australia compared to Laos, primarily because of their better personal and family situation. Men, on the other hand, were more nostalgic for Laos. In effect, living in Sydney has given Hmong women freedom and choices that were not available to them in Laos, whereas some men felt more restricted and resented their loss of status, ignoring the fact that they left Laos to escape from the communists, who are still in power. A similar difference in satisfaction with life in a new country was found in a Hmong community in Omaha, Nebraska where Hmong men felt 'robbed of a badge of influence' by not being allowed to show off their success by taking another wife (Meredith and Rowe 1986). Very few women in either of these communities supported polygyny. In Sydney, having an 'easier' way of life did not necessarily make Hmong men happier; lack of job status affected some, especially those who had obtained higher qualifications in Laos.

While most of the older Hmong were able to enjoy the physically easier lifestyle that Sydney offered them, many felt redundant since their lives were not as busy and were less important both within and outside the community. While they fulfilled an important role in terms of their knowledge of Hmong culture, they had had to forgo influence and rights when decisions were being made outside their realm of knowledge and authority. If it were possible, some wished to go back to Laos where they could be buried when they died.

The problems with the loss of communication between older and younger Hmong have already been discussed. Some generation differences were due to poor communication within families. A few of the older Hmong believed that Hmong children had lost respect for their parents; however, on the other hand, some of the younger Hmong were very accepting of their traditional roles and were prepared to adhere to them. Both older and younger Hmong had opinions in this regard, firstly about loss of Hmong language:

> S(M34) I think that most of these Hmong rituals will disappear for the next generation living in Australia; they don't seem to be interested. Even our language, I find it hard to talk to them in it. They are able to speak Hmong, but they find it easier to speak English. Even now, my younger brother, who has gone through the Australian school system, is able to speak Hmong, but his accent is about 50% changed, and he finds it hard to translate from English to Hmong. So for the many Hmong people who have grown up in Australia, if you want them to translate something to you, they often find it very hard.

> J(F33) My children speak 65% English and 35% Hmong. They speak English all day at school, but when they come home, we want them to speak Hmong, but the children listen to the Hmong and answer in English. Sometimes, I don't understand the English that my children are using and they are unable to explain to me in Hmong what they mean. I am worried about how long it will be before my children lose all their knowledge of Hmong language and culture.

> CM(43) My two older children have probably forgotten 70% of their Hmong language. The younger two don't speak it but they do understand it. There used to be a Hmong school to teach the language but it stopped because the numbers were too small. Besides, the children are not really interested in

> learning how to speak Hmong. The Hmong people have changed very quickly; the pace of change for Hmong has been very fast.

and second, concerning cultural expectations:

> R(M45) Life in Australia is very different. In Laos, children were taught to respect their parents. And the children never had one word of argument or object with what their parents say.
>
> But now in Australia, sometimes, my children start to tell me what to do. 'Dad, you're wrong'. Sometimes they try to teach you back. You think that you are a parent and that you teach them, but no, they say Australia is different, they teach you back. So sometimes, you don't know what to do.
>
> You tell them where you are from, but they tell you to forget that. 'We are not that (sort of) people any more. We are Australians'. So what can I do?
>
> I(M21) To my knowledge, there have been very few changes in the traditional attitudes of the Hmong. I don't think that these values will change because in my country it is very important for the younger people to respect their family. Whereas, in other cultures, this is not the case. In my case, I feel that I can't leave my family. I feel that it will always be my responsibility to take care of my mother in her own home.
>
> E(M31) I didn't want to give my children Australian names in the hope that they would not lose their culture, because it is so very different to Australian culture. However, at 5 years old, they are already going to school and are already learning about how to keep healthy. I think that this is much better than in Laos.

The small size of the population, the difficulty of practicing the language outside the home and the time involved for children to learn the language all have contributed to the loss of the Hmong language. Parents were concerned also about their children losing their 'cultural values', but many seemed at a loss to know what to do to stop them acquiring 'Australian' values, which some saw as poorer quality compared to Hmong values.

One major problem with younger Hmong losing their ability to communicate with older Hmong is that it will be more difficult for Hmong cultural practices and history to be passed on to this and especially the next generation. Already many traditional ceremonies have necessarily had to change either because some practices

were unacceptable or too difficult to perform in Australia, such as sacrifice of large animals, or were against the law, such as the marriage of young teenagers. A summary of people's recollections of traditional ceremonies in Laos and how they are practiced in Sydney is provided in Appendix Four in order to help comprehend the massive changes to their lifestyles which many have had to adjust to now that they are living in Sydney

Hmong Society Australia

The Hmong Society Australia (HSA)[18] was established to assist the migration and settlement of the Hmong community in Australia. It has five main objectives: to assist with settlement and welfare needs of Hmong in Australia; to promote mutual understanding between Hmong and other ethnic groups; to maintain Hmong culture and traditions; to promote Hmong in their new country; and to be a centre in which Hmong around the world can contact each other (Falk 1993/94). The HSA also tries to promote mutual support across clan boundaries in the virtual absence of kinship networks that traditionally oversee these activities. Thus it has replaced the social structure by being a focal point for members to fall back on in time of celebration or crisis.

There are State branches in Tasmania, Victoria, Queensland and NSW (incorporating the ACT group). Meetings are held in each state and are dependent upon when Society members think that they should be held. Through these meetings and an occasional newsletter, the HSA also helps Hmong in the different states maintain contact with and knowledge about other communities by gathering and distributing information. The newsletter publishes some articles in Hmong and others in English, and most articles are not translated into the other language. HSA meetings used to be held fairly regularly but increasingly are held in response to a

[18]The society has recently been renamed Hmong Society Australia from Hmong Australia Society. During the interviews, some Hmong used other titles for the society, however all are referring to the same society.

funeral. At such a time, the society would assist in certain ways, such as collecting money to give to the family members of the deceased person[19]. Both men and women attended the meetings in equal proportions, but the men tended to be more vocal (G. Lee, pers. comm.). Membership is open to everyone, including non-Hmong, over 18 years of age, but meetings are conducted in Hmong. This may change in the future as the second generation (whose understanding of Hmong language may not be good enough to understand Hmong spoken at the meetings) was only just starting to attend.

Several people explained how the Hmong Society operated and how they had used it:

> E(M31) In the Hmong Community Society (HCS) we talk about what is going on around us and see if there are any problems in the family that need to be solved. I see the benefit of the HCS being to keep the Hmong culture alive before it gets forgotten by the younger Hmong.
>
> F(M69) We talk about what things we should do to make things better for us living in Australia. Plan for the future. Old people are worried about the younger Hmong losing their language and culture, and so we discuss what to do about this.
>
> C(F41) The Hmong Society can be called for help in times of need. For example, last year three Hmong teenagers were drowned and the community was called together to help the three families of the dead teenagers, in particular to give them money to help the families. It also helps with the dissemination and explanation of Government information.

The Hmong Society served as an instrument to maintain community cohesiveness and dealt with feelings of isolation. It provided a forum through which members could come together to discuss issues pertinent to their resettlement process. It also served as a mediator between the Hmong community and Australian society, and particularly the rules and regulations of the Australian government: it was able interpret and explain how such factors might affect the community and what

[19]The cost of funerals could be considerable. In 1992, when funerals were held for three teenagers who drowned near Sydney, the cost of providing food to the large number of people, as well as the cost of a Western funeral were about $6000 (Falk 1994).

members should do. Through the organisation, the community could come together in times of need to solve problems.

Conclusion

The Hmong community in Western Sydney shared many similarities with 'middle generation' Hmong refugees in the United States. They were born and raised in Laos, but much of their adult life had been spent in Australia. Most children had been born and/or raised in Australia, but their parents had only spent a fraction of their lives in Australia. Consistent with Danes' (1993) findings in the United States, it was the middle generation who, because of their ability to speak English and earn an income, had taken over the role of providers and mediators for the older and younger members of the families.

The Hmong community in Sydney is small and its composition was a direct result of the resettlement process, whereby Hmong refugees who had already settled in Sydney sponsored other family members who remained in the refugee camps. As a result, three clans accounted for 24 of the 29 families, and most were related to each other either through birth or marriage. A strong sense of community existed within the group: most had chosen to live in Bonnyrigg so that they would be near other Hmong. Family support led to the surprisingly high rate of home ownership (above that of Fairfield as a whole), considering the continuing poor socio-economic position of most members.

In terms of education and employment several Hmong had already moved away from the traditional Hmong profile of poorly educated, remote rural farmers before they left Laos. A small number had received tertiary education and had been employed in skilled areas of the work force. Others had been involved in business or had become soldiers connected with the American military. The drop in status in lifestyle in Sydney caused some Hmong men to be less satisfied with their current

situation; by contrast women had been able to secure paid employment and many perceived an improved status in Sydney.

In Sydney, the Hmong community shared some demographic similarities with other Southeast Asian refugees: each community was young with a high fertility rate, households comprised a large number of members, had a high rate of unemployment and a large percentage who had taken up Australian citizenship. In each case, the rates for the Hmong were greater than those found in the general Australian population. Unlike the Vietnamese and Cambodians whose education levels remained low, the number of Hmong who had completed secondary school matched that of the Australian migrant/overseas-born population, suggesting that education was very important for this community. Rates of education attainment were high for women but men completed more financially valuable post school education.

A high level of unemployment persisted for the Hmong. While it had decreased since 1987, it remained much higher than both the overall NSW and Fairfield rates. Many women were involved in paid employment, but access to child care was a major factor in preventing more from seeking employment. The majority remained involved in the semi-skilled and unskilled areas, but the percentage was declining as younger Hmong with better education joined the work force and older, unskilled members left.

Loss of Hmong culture was a concern to many people. While almost all had maintained their traditional Hmong beliefs, many traditional roles had changed considerably simply because they were now living in a modern Western society. Of great concern was the language gap between older Hmong who did not speak English and younger Hmong who were not learning Hmong. Inability to communicate has meant that some values essential to Hmong culture cannot easily be transmitted to the younger generation, this is particularly relevant to health care

beliefs and practices. Men's and women's roles had changed substantially, with women being more satisfied with the changes than men. The Hmong Society Australia actively works to keep the community together by encouraging contact through regular meetings, where a variety of issues could be discussed in relation to Hmong traditions and Australian legal and social expectations. Nevertheless the fact that such a society exists partly emphasises the changes that have already taken place, even within a spatially cohesive and socially liked community, over less than two decades of residence in Sydney. Overall changing educational and occupational structures, language speaking abilities, gender and generational gaps, point to the emergence of diversity within even this small community. These continuities and discontinuities can now be examined in the context of health.

Chapter 4
Health care behaviour of the Hmong in Sydney: Past and present

This chapter examines the health care behaviour of the Hmong community in Sydney. A range of socio-economic changes were already taking place in Laos and continued to develop after resettlement in Sydney. The health care behaviour of the Hmong in Laos and Thailand, which was shaped by the medical options available and by Hmong preferences and beliefs, provided a frame of reference against which to observe and compare present-day health care behaviour. The chapter focuses on the community's use or lack of use of the Australian medical system and how traditional health care requirements were accommodated in the Australian setting. Health care behaviour has been investigated in terms of their actual behaviour and individual preferences. The range of social, cultural, economic, political and spatial variables was examined alongside the outcome of interactions between the variables, to assess the significance of particular variables on actual behaviour. This provides the basis for a comparison of health care behaviour in other contexts.

A slightly smaller number of people were involved in the more detailed analysis of health care behaviour. Although the number of households involved remained the same, fewer members provided information about their health care behaviour. The main participant (or participants) answered questions for the other members of the household. This also resulted in what proved to be an appropriate focus on the 'middle generation', as it became apparent early in the research that the middle generation increasingly made many of the decisions for the household. A total of 35 people were directly involved: 12 women and 23 men. They ranged in age from 19 to 55 years (females: 19-53, males: 21-55).

Health care in Laos

All the Hmong were aware of and had used Western medicine in Laos. By the 1960's, some participants recalled there being two hospitals in Vientiane, staffed both by Lao and French medical workers, as well as numerous clinics. Clinics supplying Western medicine were more common in Vientiane and the nearby towns, but less common or non-existent in the more remote villages.

Whatever the availability of Western medicine, most Hmong continued to rely on their own system of medical care: traditional herbal medicine for general illnesses and shamans for illnesses caused by spirits. Typically, most older Hmong in the villages had some knowledge of traditional Hmong medicine. Within a village, a range of medical knowledge existed which community members had some access to. Western medicine was mainly practised by Western medical personnel in the city, who also helped spread the knowledge of Western medicine throughout the country by providing rudimentary training to local health workers who were then able to dispense simple medications from clinics set up in rural areas. Several interrelated factors influenced initial health care behaviour of Hmong in Laos. They included proximity to and availability of health services, perception of each system, their suitability for different types of illness and the cost of health care.

For most people, the initial choice of which system of medical care to use depended upon which one was closest and easiest to use. Those who lived in or near Vientiane chose to use Western medicine first, while those in the more remote rural areas used Hmong medicine first.

Typical examples of the behaviour of the urban dwellers were:

> P(M27) I used Western medicine because I lived in Vientiane and there was no Hmong medicine available.
>
> R(M45) While I was living in Vientiane in order to go to school, I started using more Western medicine.

W(M31) My father and mother used Western medicine. I think that they did this because they lived in Vientiane. My father worked with Lao people so I think that the general community attitude would have been to use Western medicine.

Rural dwellers exhibited the opposite behaviour but for similar reasons:

P(M49) We lived in a village and there was no clinic. In the village, a lot of people had knowledge of herbs. We didn't have a (medicinal herb) garden, we just went to the bush to collect herbs. If we used the herbs and the person didn't get better, then they would go to the city to see the doctor.

O(F19) The problem with using Western medicine was that it was inconvenient - the hospital was a days walk away. Therefore we used Hmong medicine first, even though we were happy to use Western medicine.

X(M28) I lived in a village where we used Hmong medicine because that was all that was available. If Western medicine had been available, then we would have used that as well.

The following accounts sum up the general health care behaviour of the group:

Z(M28) (In Laos) we used Western medicine when we were in a city or town, but when we were living in the country, we would use Hmong medicine because there was no Western medicine available.

B(F33) I believe that both (systems) could work equally well and had no problems using both, either at the same time or separately.

Y(F53) We would use Hmong medicine first (because it was more convenient), and if that didn't work, then we would use Western medicine. We would use whatever works.

However, they would resort to the other system when it was available, if their first choice of medical care did not produce a cure. Several commented pragmatically that they only wanted to get better so they would use whichever system worked.

M(M28) (In Laos) my family used both types of medicine. Western medicine was around, but not always available.

M(F24) My parents would have used whatever medicine worked.

From these accounts, the initial choice of medical system appeared to be more dependent on geographic location and availability rather than on a specific desire to

use one system in preference to the other. However, the decision-making process became more complex if the illness did not go away after initial treatment, or if the illness was deemed to be caused by spirits (see below).

In the event of a longer term illness, with no apparent improvement from either system of treatment, people's perception of each medical system and of the 'cause' of the illness needed to be considered. In such cases people had to decide whether the illness was caused by spiritual disturbances, in which case they would require the services of a shaman, or whether it was an illness that could only be cured by greater intervention either from Hmong medicine or Western medicine, whichever system was not used initially. Family members, community elders or shamans assisted in making such decisions. Several people illustrated how they perceived the appropriateness of each system for certain illnesses:

> C(M42) I don't think one is better than the other, I think they complement each other. If you try Western medicine first and the patient is still sick, then you try Hmong medicine. It doesn't matter what order the medicines are tried in. I am happy to use Western medicine, Hmong medicine, shaman 'magic' or whatever is available, including calling your ancestors to help you.
>
> The shaman would be called when all other avenues of help had failed. A shaman was called when it was thought that the illness may be caused by spirits. He or she would have to work out what was causing the illness, and if it was spirits, then the shaman would work to find out why they were making the person ill, and appease (the spirits).
>
> Q(M55) For my family, we would use both types of medicine. If we used Western medicine, we would try it for 2 to 3 days, if it doesn't help, then we do our thing (use Hmong medicine). If that doesn't help, then we would send (the patient) to the hospital.
>
> T(M25) I think that in Laos, for non-serious illnesses, my family would have taken some sort of herbal medicine, but for more serious illnesses, they would have found Western medicine and gone to a doctor and hospital.

Such perceptions were based on personal and community knowledge of each system of medical care and how the illness responded to the initial medical treatment. If it was perceived that the illness was not caused by spirits, then either Western

medicine or Hmong herbs could be used; if spirits were deemed to be involved, then the illness could only be treated by a shaman. However, both Western medicine and Hmong herbs could be used alongside any healing performed by shamans.

Many also felt that each system offered its own unique benefits, that is, that Hmong medicine suited certain illnesses and Western medicine was more appropriate to others. Notions of the 'suitability' of each system generally became more important if the initial choice did not elicit a cure. While many claimed that the two systems complemented each other rather than competed, their knowledge of and experience with Hmong medicine was then far greater than that of Western medicine. Thus, while they mentioned the 'strength' of Western medicine, its 'scientific basis', its ability to treat the 'more serious illnesses', its 'safety' and 'accuracy', their greater familiarity with and understanding of Hmong medicine led to many providing anecdotal evidence from their time in Laos of cures mainly by Hmong medicine, used usually after Western medicine had failed, or simply where they had observed Hmong medicine to be better than Western medicine. It appears that because of their greater knowledge of Hmong medicine, they tended to believe that it was a more suitable choice. Examples of spiritual and herbal cures follow:

> N(M36) Hmong medicine is able to heal broken bones. One way of doing this is to put a spell into some water and then the person with the broken bone uses this water to wash the broken part, and it heals very quickly.
>
> C(F41) When you twist your ankle, herbs can be used as a poultice for 2 or 3 days, after which all the bruises will have gone and it would be better again.
>
> C(M42) In 1971 I had a bad toothache. One of my aunts came to my house and gave me some Hmong medicine with some boiled chicken and until now, I have never suffered from toothache, even though some of my teeth have decayed.
>
> At one stage in Laos, my mother was very sick, we tried (treating her) for 2 to 3 weeks but she got worse. So we carried her to the airport and asked the people to allow her in the plane and fly her to the hospital. When she reached the closest hospital, it was not able to treat her so it sent her to the capital (city). So she went to an American hospital and after 2 months she recovered. She had

some sort of skin problem, with a rash and infection. Later, she got the same sickness again but this time we did not go to the hospital again because it had been so difficult the first time. So we used the Hmong medicine and she got better. We didn't try this the first time because the people who knew this cure had kept it secret and no-one knew that they knew of this treatment. However, the second time my family asked for help from the other Hmong in the hope that someone would be able to (help us). Also we offered money if the other Hmong could help.

No one was sure how Hmong medicine worked in these different circumstances, but many were confident that for certain disorders, Hmong medicine was more suitable than Western medicine, although they were not able to explain how they decided. The above account of C(M42) highlights two aspects of traditional medicine, that cures may be kept secret, and use of traditional medical knowledge might incur a cost for the recipient. Thus, although medical knowledge was 'physically' available in the village, it could only be obtained according to cultural norms, as shown by the following account:

B(F33) If someone offered to help, for example, with their own special herbal mixture, it was very important to say 'please'. If you don't do this, then the herbal mixture will not help. I don't know why but it was important to do this. Of course, children did not have to say 'please', it was only necessary once you became an adult. It could be a bit of a game, the person offering the herbs may say 'no, no', however with persistent asking of 'please' by the ill person, the first would then provide the herbs.

Money was always involved (in using Hmong herbs), but generally only a small amount was given as a token. The herbs have a spirit too, so if money is given in exchange for herbs, they would be happy and would be pleased to make the ill person better.

Hmong treatment for C(M42)'s mother was delayed in the similar case discussed above, even though both the necessary herbs and knowledge were available in the village at the time the illness first appeared.

Cost seemed neither to deter nor encourage the use of one system in preference to the other. Both types of treatment required payment by the user, but the traditional method was more flexible than the Western system. Individuals recalled Western

medical care being provided free at the hospitals, however, once out of the hospital, medication had to be purchased at the clinics.

The cost of Hmong medicine depended on both the ability to pay, the illness to be cured and whether or not the cure worked. While the cost could be substantial, if the person was poor, payment was often only a token gesture to show gratitude to the healer. The more serious the illness, the greater the cost. In general there was no charge until a cure had been effected. Examples of payment include:

> Y(F53) You would be given Hmong medicine without charge; if it worked, then you would pay, if it didn't work, then you didn't pay for that medicine but you would go on and try some other Hmong medicine. But you had to pay for Western medicine regardless of whether it worked or not.

> N(M36) Sometimes you could ask for Hmong medicine for free, but not always. But if it was something like a broken bone, the patient didn't need to pay until it was fixed. If it wasn't fixed with the first type of cure, then the patient could go back and ask for something else. If the first Hmong healer does not have anything else, then the patient can go to another type of healer and not pay the first one.

People were prepared to pay for medical care, whichever system they used. Hmong were familiar with expensive health treatment as in some cases charges by traditional healers could be quite high, but the time to pay and method of payment were very different to that practised by Western medical personnel.

Thus, during this period in Laos, Hmong were able to make more choices about their health care, and were gaining confidence with and knowledge of Western medicine. They continued to rely on Hmong medicine but were willing to use Western medicine where and when it was available. In the more urban areas, especially Vientiane, some used Western medicine as a first choice. While their understanding and familiarity with Hmong medicine was naturally greater during this time, all were willing to take advantage of the choice that Western medicine offered while at the same time continuing to use Hmong medicine. Unusually, there seemed to be no distinction made between diseases at the initial onset of an illness.

It was only when an illness did not respond to a certain treatment regime, that people would then consider that the other system might be more appropriate or that a shaman was needed as the illness may be caused by spirits. This indicates that, even in Laos, Hmong health care behaviour was exceptionally flexible and pragmatic to an extent rarely recorded in most studies of health care behaviour in 'traditional' societies[20].

Health care in the refugee camps

Most of the community members remember living in the refugee camps in overcrowded conditions, with inadequate housing, unclean water, insufficient and poor quality food as well as being in constant contact with ill and dying people, fever, diarrhoea and malaria were the most common illnesses that people remembered. The following excerpts describe conditions in the camps:

> H(F19) All I can remember is the awful smell.
>
> C(F41) We lived in a small house, the size of a small lounge room and 4 of us lived in it. We built our own house. It was big enough only for a bed and a fire. We cooked in there too. We cooked all our own food. We were given rice, meat and vegetables. We were given plenty of rice, but they didn't give us enough meat and vegetables which is why we would go out and buy these foods from the Thai villages. We would wash our clothes in a small river. Drinking water was brought in a big tub and everyone had to line up to get some, it then had to be boiled before it could be drunk.
>
> E(M31) In the refugee camp, the Americans (or other helpers) had already built accommodation for us. They provided hostel type accommodation, that is, one big building where lots of families could live. Each family was accommodated in a small room. The room was only big enough to put 2 beds inside. We also shared a kitchen between 2 or 3 families.
>
> We were given rice but it was not very good rice, it was the sort of rice that I would normally give to the pigs. The UN provided the food for the refugees.

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[20]Because this conclusion was so unusual, the issue was frequently discussed during the various interviews, but there was an overall consistency of results, that reduced the possibility of retrospective interpretation of events or of wishes to project a particular form of behaviour within Laos. Unfortunately there are no similar studies of Hmong health care behaviour within Laos at that time which would provide a comparative perspective.

There were six people living together in my family, and we were given one and a half kilos of vegetables for a week. So we would buy some special oil from the shop and mix it with some vegetables, and we would also buy some more, but very cheap, vegetables from the market.

There was a well with a water pump, and water was pumped into a water tank. Water was distributed between the families. Each person got 20 litres of water a day, and that was only just enough for cooking and washing dishes. If we wanted to bathe, we could go to a river where a dam had been made. The water was very deep, we would carry water to another place to shower and wash.

K(F53) The refugee camp was very dirty. My family didn't get sick but other people did. It was a very small place and there were a lot of people crowded into the refugee camp. The water was very dirty.

B(F33) In Nam Phong, the accommodation was very big tents. Initially, the army cooked for the refugees as the Thai government would not allow them in case they cut down trees. The food was cooked in a communal kitchen. The refugees were divided into 4 groups and each group queued for their meals. It was Hmong food and there was plenty of it. However, this did not last for long. Many people died from diarrhoea, about 20 or 30 in one day. The Hmong blamed this on unclean food preparation and cooking methods. The refugees complained about the deaths and the number of children who were sick and dying. After about 2 or 3 months, the refugees were allowed to cook for themselves. The Thai army allowed groups to go out into the forest to collect firewood for the week and the food was provided for the refugees. After that, very few people died.

D(F29) Our family cooked for ourselves. There were 12 people in my family who lived together in the one house. We had to build the house ourselves from bamboo. It was difficult to keep clean in the camps, because it was very crowded, very little space between the houses. The houses were on the ground, with a dirt floor. It was generally hot, and only cold for a little while in December. We had to get our water from a well. The water was pretty dirty so we boiled it. After boiling it, the sand in the bottom of the pot was very thick and sticky, and difficult to remove. I lived under these conditions for 5 years, and it progressively got worse. We were given less and less food.

The health of the refugees deteriorated during their stay in the camps and many sought medical help through the camp clinics or used traditional treatments if possible. All recalled that their various refugee camps had clinics and hospitals. One person recalled that Ban Vinai, the largest camp for the Hmong refugees where

10,000 Hmong were at one time housed (Long 1993), had a hospital with 10 wards and 70 beds in each ward. Most recall the shortcomings of the medical provisions, as clinics were poorly stocked and hospitals were staffed by what the participants considered were poorly trained personnel.

Once again all used a combination of both Western and Hmong medicine. During this time, their ability to obtain Hmong medicine was restricted, but they were free to use it when they could. The clinics and hospitals in the camps only offered Western medicine, and foraging in the forests or growing their own herbs was possible but could be difficult. Some related their experiences:

> C(M42) There was one small hospital, it was very basic and could only give basic treatment. I didn't think that it was very good, and preferred to go to the Thai clinics outside the refugee camp. I thought that the hospital was very inefficient because you had to wait a long time to see medical personnel.
>
> Outside the camp were other clinics that the refugees could go to. If you could speak Thai, then you could explain what was wrong more easily. However, you needed money to use the Thai clinics, so if you had no money, then you had to rely on the hospital in the refugee camp.
>
> S(M34) It was very hard to get out of the camp and find Hmong medicine. Also, there was a hospital in the camp so it was easier to go there. There were two Australian doctors working in the hospital with whom I became good friends. These doctors came very early to the camp and stayed there for a long time. I think that they were attached to World Vision.
>
> B(F33) Ban Vinai camp was in the jungle and there were no fences. So we could go into the jungle and collect materials for building a house, and herbs for medicinal purposes.
>
> While in Nam Phong, the Thai army wouldn't allow us to go to the forest to collect herbs. We were fenced in and if we did go outside the compound, we would be captured and put in a cage, like a jail. Ban Vinai was much better. There were no fences, and we could go into the jungle, collect herbs and collect materials for building a house.
>
> There was a clinic with 2 Hmong doctors and 4 to 5 Hmong sisters (in Ban Vinai). There was also a hospital. However, every time we went to the clinic, we were told that the clinic didn't have the medicine so they couldn't help us. Even when we stayed in the hospital, there was no medicine, so the hospital simply was only able to provide rest and a cleaner environment for us.

> X(M28) In the camp it was quite hard to get herbs. Also, I was not interested in getting Hmong medicine. In the camps, my parents would use both medicine from the clinic as well as the shaman. But it was not the same as when we were living in Laos.

> S(M34) It was very hard to get out of the camp and find Hmong medicine. Also there was a hospital in the camp so it was easier to go there. The United Nations provided Western medicine. We were still able to use Hmong medicine when we were allowed to go out into the forests and collect suitable herbs.

The refugees were comfortable using both systems of health care while in the camps, and attempted to continue to incorporate Western medical care into their health care practices. However the poor supply of Western medicine in the camps made it necessary for them to continue to rely on Hmong medicine if it was available.

Though their quality of health declined, none of the participants reported having any major illness themselves at this time. However, this does not appear to be related to the type of health care available, but to the fact that many tried hard to keep reasonably healthy. Others found this more difficult and their health deteriorated. Many described their experiences:

> P(M49) During our first year, we had money from Laos, so we could buy better food for ourselves and have a greater chance of keeping healthy. During the second year, our money had run out and we were getting poorer and poorer so we decided it was time to get out.

> C(M42) A lot of people died in the refugee camp, many of the illnesses and deaths were blamed on the food and the water. I think the Thais took the water from the Mekong River which was pretty dirty. We cooked our own food. The food was supplied by the Thais, but I thought that this food was pretty poor. However, if you could buy your own food, you did and generally you stayed healthy.

> X(M28) I managed to keep fairly healthy because I was working in the hospital and was able to take care of my family.

> A(F29) My family was rarely sick in refugee camp, but our health definitely deteriorated during our stay in the refugee camp. It was difficult to get clean water, there was not a lot of variety in the food, washing facilities were pretty poor, and so most people had diarrhoea and colds.

J(F33) I think that when we were over there, we got sick more often because there were very many people in the refugee camp. There was a lot of garbage around, dirty water running in open streams. There was a hospital and I remember my family using it quite often.

The above statements show that most simply tried to keep as healthy as possible despite their poor living conditions but that, irrespective of choice of health care systems, this was very difficult in refugee camp conditions.

Health care behaviour in Sydney

Within Sydney health care behaviour changed substantially, especially from that in the refugee camps, as Hmong moved into a modern society, where Western medical care was more readily available than in any previous environment although, for various reasons, this did not necessarily mean that Hmong were able or willing to take advantage of it. It was quickly apparent that Hmong heath care behaviour was neither straight forward nor, necessarily, predictable. The following explanations illustrate some basic elements of the community's health care behaviour:

H(F19) When I get sick, I tend to go to the local chemist. If I go to the chemist and (the medication) doesn't work, then I would use Hmong herbal medicines. I would first ask my mother about Hmong remedies, and if she doesn't know, then my mother would ask my father.

S(M34) In Australia, if Western medicine doesn't help, then we use Hmong medicine. It is very hard to find the 'country medicine' in Australia. So when you have a pain or something like that, first we start with Western medication. It is easier to use Western medicine because with Hmong medicine, there are generally a few different herbs to mix together and it is very hard to find the correct herbs.

X(M28: When I am sick, I don't know much about Hmong medicine, so I just use Western medicine. We would still like to use it (Hmong medicine) but we can't get it.

V(M29) My family will use Western medicine first and later use Hmong medicine. Often, we will use both at the same time.

U(M27) I would use both types of medicine if I am sick. I would go to see the doctor first before using traditional herbs. My mother and aunt know more

about this type of medicine than I do. They grow a variety of herbs in their back yard.

K(F33) When someone in my family is sick, we would use an Australian doctor first, and almost exclusively. I don't want to use Hmong medicine. Although people in my community know about Hmong medicine, I don't think that they really understand it completely or know how to do it properly; for example, they don't really have the correct herbs.

F(M22) If I am sick, I first use Western medicine, because it is easier. The rest of the family is the same, because of lack of access to Hmong medical herbs. We live in a flat and are unable to grow any of our own herbs.

O(F19) Basically I find that using the Western medication is much easier. Hmong medication takes a while to use (obtain, prepare and administer). I don't know anything about it (Hmong medicine) so first I would have to go and ask my mother-in-law, who would then have to think of what would be appropriate to solve the problem. She would have to go out and pick it (herbs). Thus, it is a longer process to use Hmong medicine than to just go to the doctor and fill a prescription from the chemist.

L(M30) Bulk billing is what makes people happy about going to see their doctor because usually you don't have money with you. I can cope with paying for the prescriptions but would rather not pay for the doctor's visit. When I saw a Macquarie Centre doctor (near my place of work), rather than a local doctor. I was charged $25 and could only claim back $18.

These accounts revealed a considerable variety of reasons behind their health care behaviour, ranging from the availability and ease of use of Western medicine, both physically and financially, to some of the difficulties encountered if and when using Hmong medicine. Nevertheless, Hmong medicine remained important for most people.

These statements already suggest several significant and unexpected findings. First, all of the community members had used and would continue to use Western medicine and Western-trained doctors. Second, a strong pattern of health care behaviour was detected which was common throughout the community. At the onset of an illness, they would first consult a doctor and follow the advice offered and the medication prescribed. If, after about 3 to 5 days this treatment did not appear to be working, then they would often turn to traditional Hmong medicine. If

this treatment regime also failed or they had been ill for some time without any relief from either medical system, then they had to decide if a shaman's services were needed as the illness may be caused be spirits. Western medicine and Hmong herbal treatments were often taken jointly. Third, most people continued using traditional herbs and shamans, despite the widespread use of Western medicine. Each of these three situations was unusual and could not easily have been predicted. These issues can now be elaborated on further.

The most significant factors to influence Hmong health care behaviour were the Australian health care system, Hmong culture, some aspects of resettlement and previous health care behaviour. In addition, individual preferences for each health care system, which were not revealed in the overall pattern, were also critical as they revealed specific areas of change within the community. Less significant factors such as choice of doctor and health care status are also discussed.

The Australian health care system

Through Medicare, the Australian health care system provides access to free treatment as a public (Medicare) patient in a public hospital and free or subsidised treatment by practitioners such as doctors, specialists, participating optometrists or dentists for specified services (Health Insurance Commission 1997). Medicare had enabled all Hmong refugees access to the Australian health care system by removing much of the financial burden of health costs. It provided the refugees the same quality of medical care available to the rest of the Australian community at a doctor's surgery of their choice or in a public hospital. It has allowed them to use Western medicine when and as they thought appropriate. Many participants themselves identified Medicare as one of their principal reasons they used Western medicine.

However, Medicare does not cover all health-related expenses, such as the cost of the medications as well as the financial effort needed to get to the surgery.

Attempting to minimise these extra costs influenced their choice of doctor. All preferred doctors who direct-billed[21], who did not write too many prescriptions and who practised in their local area. Those Hmong who received unemployment benefits also received a Concession card that provided them with extra financial help for the cost of most medicines. While this enabled them to keep medical costs even lower, no-one thought that this was a good reason for being out of work. The influence of cost on medical care was illustrated by the following accounts:

> B(F33) The visit to the doctor is free, however, the prescriptions can cost a lot. Sometimes it can cost $50 - $60 to fill the prescriptions. I find it frustrating that even though I may spend that much money on prescriptions, the medicines don't always work.
>
> C(M42) I also like the Vietnamese doctor in particular because he doesn't prescribe too many medications. Some doctors give too many prescriptions. If I get too many, then sometimes I do not buy all the medicine.
>
> D(F29) Dr. N. always tries to ensure that everything he prescribes is available on the health care card (Concession card). If it is not available on the health care card, he always checks to see if I can afford it. However, I have told the doctor that if it will make me get better, then I don't mind paying.
>
> E(M31) Cost is not really a problem because I am on unemployment benefits and so most things are free if not very cheap. Prescriptions cost $2.60 each with a health care card (Concession card).
>
> A(F29) When my husband is working, then we must pay everything above the Medicare rebate. This doesn't make too much difference for the doctors visits, however, it means that sometimes medications can cost a lot. For example, if you take 2 or 3 children to the doctor, sometimes the cost of the prescriptions can add up to $60 - $80 for one visit.

The cost of prescriptions could be high, especially if several prescriptions were needed, as shown by A(F29). Two of the doctors who were preferred by several Hmong men and women routinely prescribed a minimum of medication. Both

[21]Direct-billing (sometimes called bulk-billing) is when the practitioner bills Medicare directly, accepting the Medicare benefits as full payment for the service, and the patient incurs no cost. If the practitioner charges a fee, then Medicare will pay either 85% of the Schedule fee, or the Schedule fee less an amount of up to $50, whichever is the larger amount (Health Insurance Commission 1997).

doctors were well aware of many of their Hmong patient's financial status, moreover both believed that this was one aspect of good quality medical practice. (Other aspects of choice of doctor are discussed below).

Private health insurance could reduce the burden of unforeseen high medical costs if more private medical services were used. The rate of private health insurance among the Hmong was extremely low. Only two people, one who was skilled and employed, and one who had severe lung disease, were insured although a small number (4) have been insured in the past but had cancelled their membership, generally when they stopped work or became unemployed. One man cancelled his insurance when he discovered, through the experience of his wife and son being in hospital, that it did not cover all their medical expenses, and thus did not appear to be worth the cost.

The low rate of health insurance was consistent with that of other low income groups and other residents of the Fairfield district (Fairfield City Council 1996). The extremely low rate of private insurance among Hmong was because most were satisfied with Medicare. They mainly used the public health system, private insurance could be expensive (between $1000 and $2000 per year depending on the type of cover provided) and most felt that they were relatively healthy and therefore did not need extra cover. The low cost of public health care meant that all in the community were able to use Western medical care; it influenced their actual health care behaviour because it allowed them to choose a doctor whereby they could keep other health-related costs as low as possible.

Hmong culture

The continued use of Hmong herbs and shamans appeared to be strongly related to the influence of older Hmong family members (those over 50). However, their influence was diminishing when medical preferences were taken into account (see

below). They grew herbs[22] and knew about Hmong medicine and were able to advise and encourage younger members to use traditional treatments. Most younger Hmong admitted to knowing very little about Hmong medicine although a few younger men were interested in learning more. In Sydney, the influence of older family members remained high throughout the community as almost every participant had at least one older family member either living with them or living with a sibling nearby. Even though only a small and incomplete range of herbs was available and knowledge was patchy, and some younger people were concerned about using herbs because they did not understand how they could work, or whether they would work in Australia, almost all would use and had used Hmong medicine either on their own or according to the advice of others. (Photos 4.1 to 4.6 show some of the range of herbs and their uses available in Hmong gardens in Sydney). A few examples of the successful use of Hmong medicine in Sydney were provided:

> H(F19) There is a Hmong medicine for removing bladder stones. Medicine is drunk, and then later the stones should be passed. My mother uses this cure every so often as she regularly gets bladder stones, the symptom of which is a really painful stomach. She has used the Hmong medicine and on one occasion, she passed the stone afterwards.

> B(F33) About six years ago in Australia, a young girl hurt her hip while roller skating and walked with a limp for a long time afterwards. The doctor kept saying that there was nothing wrong with her even though she had quite a pronounced limp. So her mother mixed up some lemon grass and whisky (a traditional Hmong treatment) and put it on her hip, and now she walks normally.

> B(F33) Recently I had a rash, it was late, all the doctors were closed and I didn't want to spend time waiting at the hospital, so I called my mother-in-law. She suggested crushing some lemon grass and then putting it on my skin for one day. I did this and in the morning the rash had almost completely disappeared. I then went to see the doctor that day.

[22]Almost every household grew at least some medicinal herbs in their garden, Hmong who were more interested in using herbs grew a wider variety.

Photograph 4.1: Aloe Vera, family liliaceae (Hmong call it White Pineapple). Its uses include the relief of burns. The stalk is broken off and either the liquid or the crushed stalk is applied directly to the burn. It relieves the pain of the burn, helps prevent the formation of blisters and stops the skin peeling. Other indications for use include high fever, weak limbs and in the prevention of rabies (Pake 1987).

Photograph 4.2: Family Zingiberacae (tumeric). Only the root is used, and it has several uses, such as to clear a blocked nose caused either by having a blood nose, blocked sinuses or a cold. A piece of the root is broken off and sniffed. It can also be used to help a person suffering from paralysis after a stroke. The root is crushed and massaged into the limbs of the patient. In addition, it can also help people who are suffering from fluid retention. It can also be used to treat dysentery (Pake 1987).

Photograph 4.3: Family Piperaceae (pepper family). It is used to help disperse the blood in a bruise. The leaves are crushed into a paste and then applied directly to the bruised area. Further uses include prolapse of the uterus, arthritis and gonorrhea (Pake 1987).

Photograph 4.4: Family Malvaceae (hibiscus). It is used to help relieve skin rashes. The leaves are crushed and applied to the rash.

Photograph 4.5: The Hmong herbalist who explained the properties of the herbs.

Photograph 4.6: Garden area showing lemon grass and "mother-in-law's tongue". The latter is used to cure white spots which men often develop on their necks.

B(F33) If my children have diarrhoea, fever or a stomach ache, I mix up some herbs by crushing them, mixing them with an egg and steaming the mixture. Then I give this to the sick child to eat.

But in some cases, help had to be obtained from outside this community:

K(F33) I have not had a stomach ache for the past 2 years. Lao friends recommended a Hmong person who lives in Queensland. They said that he was really good. He knew what medicine to recommend me to use. My husband and I went to visit him 2 years ago. We had to pay money to learn what medicine to use. So for the past 2 years my stomach has been really good, whereas before that, I was really sick. I feel that he really helped me because before this, no-one could touch my stomach, but now, I am fine.

M(M28) After we had been married for two and a half years, we still didn't have any children. My parents sent us some Hmong medicine from the USA. We tried it and it worked! Two children in 2 years.

Such local successes with Hmong medicine have ensured its continued use. However knowledge of Hmong medicine was diminishing, and some of the participants had to look outside the community, as the last two cases indicate, for specific traditional cures. More importantly, it did not appear that much of the knowledge of traditional medicine was being passed down to younger Hmong. Even at the time of the interviews, only a small number of the participants said that they understood Hmong herbs even though most used them (and their children knew even less), and would not know what to do unless they could be advised by an older person. In addition, a significant proportion of the community preferred not to use Hmong medicine (see below), hence the future use of Hmong medicine may decline.

The role of shamans in Sydney continued to be important. Approximately three-quarters (76%) of the Hmong said that they had either used a shaman since they had been in Sydney or would if they had to. Somewhat unexpectedly, no differences were detected by age, but gender appeared to be important; half of the women but only one man would not use a shaman. The two women who were Christian would not use a shaman. Traditional cultural influences thus remained important; some

58% (7 out of 12) of those who preferred not to use Hmong herbs showed that they would use a shaman if they needed to, though five of these participants were in a particular family situation where that preference was likely to be strong. Of those who were happy to use both systems of medical care, 81% (13 out of 16) stated that they would use a shaman if they needed to. However, a quarter of all the community would not use a shaman, suggesting some weakening of the traditional belief system (though the extent of rejection of shamans in other contexts is unknown). Photos 4.7 and 4.8 show a shaman's altar.

In terms of health care, it was argued that shamans could help in several ways. They could investigate and treat a long term illness when a spirit cause was suspected, and offer protection from evil spirits, such as for those who were about to have an operation, who were in hospital after an accident, or when a baby was born. Those who would not use shamans gave a variety of reasons. Some were concerned that the shamans might make a mistake and that they might be worse off, others were fearful of breaking the law, especially if animal sacrifices were involved. Some were worried about disturbing their neighbours, as some ceremonies could be very noisy.

Some men and women described their experiences of using a shaman:

> D(F29) We don't use traditional healers for illness, but for other things. For example, my mother-in-law likes to use traditional healers because she sometimes has bad dreams that make her feel bad. She dreamt of people who have passed away a long time ago. This made her very worried. So we called a Hmong man to our house to perform a ceremony to explain these dreams. He may say 'maybe your spirits go to heaven and want to go with someone' so he will come and do a ceremony for her.

> V(M29) Generally when someone goes to hospital, a shaman is involved. The shaman does not go to the hospital in general, but once the patient comes home, then the shaman will do a ceremony at home for that person. There may be a party and other people will come and visit too.

Photographs 4.7 and 4.8: A shaman's altar. It shows important items such as the gold spirit papers, burnt incense, bowls of spirit water and other offerings to the spirits.

M(F24) Once my daughter's mouth became really swollen. I didn't know what it could be and I had never seen it before. My parents suggested that it may be some sort of evil 'who knows'? It may have been my ancestors wanted money, and they were showing this by trying to take control of the kids. So we burnt paper money and burnt incense sticks. The swelling went away.

P(M49) The old people say, if you go to the hospital and the medicine given doesn't work, then there must be something else wrong, so you have to try Hmong healing, such as 'Soul Calling'. We use eggs and call the spirit back home, because maybe the spirit has been scared away or is lost. If we get better, then it is attributed to the spirit calling.

I have a little shrine in my house for the spirit to live in. For myself, I haven't been interested in changing to Christianity. We keep our shrine in our house to house the spirit. When you are sick, or your baby is sick, or if you have been to the doctor and you are not getting better, you can call for help. No special ceremony, you just talk. The altar has four corners so that it can look after you, they are for your money, your health, your life and to take care of the animals (in Laos).

One shaman described how he would help in the case of illness:

H(M50) When a Hmong person is sick, and after many visits to a doctor for the same condition and nothing has improved, they ask me to consult the shaman spirit. I have to find out what caused the sickness and after a few days, if the patient improves, then that means that the spirit is helping, and that's it. Usually a pig or a chicken is sacrificed, but that depends on the family. If the family doesn't want to do the sacrifice, it doesn't matter. My job is to restore the health of the person. The sacrifice is made so that the person stays healthy and as a thank you to the spirits. The animal is sacrificed so that it's spirit can replace the person's spirit.

While a decreasing number of people understood or even really believed in the powers of the shaman, very few were willing to give up their beliefs, indicating that it had been easier for them to change their behaviour than to change their beliefs. While many had not used a shaman, they would if they had to, indicating that belief in spirits had not disappeared, although it was declining in matters related to health care. Ninety-three per cent of the participants maintained that they still followed traditional Hmong spiritual beliefs, and while all would use Western medicine, only three-quarters would use a shaman if Western medicine did not cure them.

However, the powers and role of shamans did not preclude the use of Western medical care; as emphasised earlier, Hmong were prepared to use both systems according to their beliefs and knowledge.

Pregnancy and birth

Pregnancy and birth was one area where little intervention would (traditionally) take place, but which in Australia is firmly within the domain of the medical system. Traditionally Hmong women 'do nothing special' during pregnancy. The baby would be delivered at home with the help of the woman's family, often her mother or another knowledgeable woman. After the birth of the baby, certain customs were to be followed. For the first month, the mother must keep warm, thus she could not wash soon after the birth and had to follow a special diet of chicken, chicken soup and rice, avoiding any cold fluids or foods. Hmong believed that if these rules were not followed carefully, then it was highly probable that the woman would get sick in later life (Eisenbruch, 1990).

In Australia, Hmong women were expected by the medical profession to follow a more formal procedure during pregnancy and birth. At the minimum, they were required to have regular pre-natal checkups and possibly various tests, including ultrasound and blood tests, while they were pregnant, and to give birth in a hospital. In practice, all Hmong women who had had children in Sydney followed much the same pre-natal system as other women in Australia. However, after they had given birth, most followed certain Hmong traditional requirements.

All the women interviewed had visited their doctors for check-ups during the pregnancy, all had their babies in a hospital, and all had a shower soon after the birth. Many liked having their pregnancy carefully monitored. One woman observed that there 'seems to be more complications in Australia' with pregnancy, she had never heard of high blood pressure during pregnancy before {B(F33)}. None had any objections to giving birth in hospital. In fact, most preferred it, since

hospitals were 'clean and modern' {M(F24)}, and 'in Australia, you know that the person helping you is qualified in this field', whereas in Laos, 'you could never be sure of the qualifications of the person helping' {B(F33)}. None had a problem with showering after the birth because as the water was 'warm water' they wouldn't get cold. Some women described their experience in hospital during the birth of their babies:

> A(F29) In Australia, I found it no problem to have a shower after the birth, in fact, I enjoy it and think it is better. However, it is easier to have a wash here. In Laos, the water would have to be carried from a few miles away and then heated up.
>
> B((F33) When I was in hospital to have my first baby, I was very surprised to be offered ice to suck during labour[23] . Most Hmong people say that when a woman in labour or for the first month post partum touches something cold, their blood will stop and they will get sick. So I asked for hot water to drink, and was given it.
>
> I don't really believe that this is true because I think that really there is no difference between Hmong women and Australian women in this respect. However, when I was in hospital after the birth of one of my children in February, I did drink some cold water because I was so hot, and I became ill. It frightened me quite a lot. When my mother-in-law came, she told me that I was crazy. So my mother-in-law brought me a herbal drink that she made from herbs from her backyard, and after that, I felt better. I wonder if it was all psychological.
>
> G(F25) I followed the Hmong postnatal traditions of not drinking cold drinks and not eating cold food. My family brought in my food every day, which was chicken soup. I didn't eat the hospital food at all. But I think that I probably could have. Even though I knew that I shouldn't eat the hospital food, sometimes I did and it didn't seem to affect me. The staff in the hospital didn't say anything when I didn't eat the food, I think that they understood. Even the Chinese people, most of the time, have their food brought into them too.
>
> I showered after the baby was born, this was not a problem so long as the water was warm and not cold. Everything that you do must be warm, not hot nor cold.

[23]This is a fairly common practice in Australia today.

> E(F28) I think that medical care (for pregnancy and birth) is much, much, more better than in Laos. When we were living in the refugee camps, I gave birth to 5 children but 2 died.
>
> I have only had one baby in Australia. My husband brought in Hmong food to the hospital for me. But because my baby was bottle fed, I did not have to follow the strict diet for the first month, so long as I kept warm.

Avoiding being cold and following the traditional Hmong postnatal diet or chicken and chicken soup cooked with special herbs (Photo 4.9 and 4.10) were the most important aspects of women's health behaviour after childbirth. There seemed to be little concern from the nursing staff that the families of Hmong women brought their food into the hospital. This may have been related to the area of Sydney where the hospitals were located: almost 50% of people in the Fairfield district are from a NESB and 15% are from Vietnam, Cambodia and Laos (Chapter One). Thus the fact that they had special dietary requirements or behaviour may not have been particularly unusual or unexpected based on the local population. Only 3 out of 14women interviewed were prepared to ignore traditional dietary restrictions, and only one drank cold water and reported no ill effects. She didn't worry because 'if the doctor said it was okay, then it must be' {N(F35)}. Most of the women followed these postnatal rules because it was 'Hmong custom', and 'just in case' so as to 'to prevent getting sick in later life'. One woman explained that 'it is too easy to not worry about your health while you are young, however it is important to prepare for a healthy old age' {M(F35)}.

Many of the women bottle fed their children in Australia, but the change from breast feeding to bottle feeding was already occurring in Laos. Several women said that they had bottle fed their babies in Laos, using tinned condensed milk, and others reported that in Australia they used a mixture of both types of feeding methods. Bottle feeding was perceived to be 'easier', especially since many had commitments to work or study; some were not able to breast feed. One thought that bottle feeding was healthier for the baby, being concerned that breast feeding might pass diseases

Photographs 4.9 and 4.10: Eupatorium genus, possibly species lindleyanum. This herb is used for flavouring many Hmong chicken dishes and it is an essential ingredient in the post natal diet. The addition of this herb to chicken and chicken soup helps the new mother maintain her strength after she has given birth. It is also used to help cure gout and arthritis. It is cooked with lemon grass and a shin bone, which has been broken so that the marrow can escape. Hmong believe that the bone marrow in this dish will help relubricate the persons' joints.

on to her baby. Hmong women were either escaping or ignoring the current general encouragement to breast feed, as well as the potential health benefits for mother and child, or they simply had far too many commitments to consider breast feeding. One woman's explanation of why she chose to bottle feed is consistent with many others who chose to bottle feed their babies:

> E(F28) I had already breast fed 3 children and I wanted to try the bottle for this one to see which way was easier. I could then pass this information on to my daughters and other people. I think that bottle feeding is much easier than breast feeding, especially because it gave me more freedom in not having to be around all the time to feed the baby.

As was demonstrated above in terms of general health care behaviour, Hmong women were prepared to change certain aspects of their traditional behaviour in order to obtain what they perceived as better quality health care. Again, it was harder to change traditional beliefs and thus many continued with certain aspects of postnatal behaviour for fear of becoming ill later in life. While they agreed that no one could 'prove' now or even later in life what may have caused an illness, most women preferred to be safe than sorry and follow traditional dietary practices. That many discussed this issue, and that some had chosen to disregard it, indicated some degree of weakening of Hmong belief.

Personal preferences

Documenting previous health care behaviour revealed that some elements of the current pattern of health care behaviour could have been anticipated. The pattern of contemporary practice was emerging well before their arrival in Australia and Western medicine was not a completely new system of medical care to the refugees. Once living in Australia, the refugees primarily needed more to familiarise themselves with the Australian medical system, rather than with Western medicine itself. Necessarily particular individuals did this in different ways and at different times, reflecting the varied personal influences on health care behaviour.

The pattern of health care behaviour which has generally evolved, suggesting overwhelming support for and acceptance of Western medicine but a continued willingness to use shamans and Hmong medicine, did not demonstrate what community members actually preferred to do concerning health care. When preferences were taken into account, four distinct groups could be identified: those who chose to use Western medicine and kept their use of Hmong medicine to a minimum (37%); those who commonly used both types of medicine and showed no predilection for either system (46%); those who preferred to use Hmong medicine when they could (6%); and those who used mainly Western medicine because they had no access to Hmong medicine, which they would have used alongside Western medicine if possible (11%). These variations were related to the particular influence of Hmong culture, gender, age, traditional beliefs, new religious beliefs, and the perception of the suitability of each system for various medical conditions. No significant differences were observed regarding the length of time they had lived in Australia, the level of education or employment status.

Differences in preferences for and perceptions of the suitability of each medical system had some gender basis. A large percentage of the women (75%) preferred to use Western medicine and were not interested in using Hmong herbs, whereas only 11% of the men shared this view. Women's preference for Western medicine (and resistance to Hmong medicine) may have been one of the key outcomes of the changing social structure of the community and the greater freedom for women (Chapter Three). Hmong women in Sydney were better educated than ever before; many were in the paid work force and thus exposed to many new influences. They have had to take on a greater role in family decisions. As mothers, they were specifically given information about the health care needs of their children by local medical practitioners.

Traditionally older Hmong relatives would offer health care advice to their daughters and daughters-in-law. However in Sydney, the level of English of many

'middle generation' Hmong women had allowed them greater access to knowledge about the Australian health care system, enabling them to make their own, choices informed by two different systems. In addition, very few of the 'middle generation' women had their own parents living with them. In every case, extended families contained the parents of the male participant. Thus, the particular community situation in Australia, influenced by the many years of upheaval before eventual resettlement in Sydney, appeared to have reduced the influence that older Hmong traditionally had on their daughters-in-law. The circumstances involved in the community's resettlement have given Hmong women greater confidence in and ability to make their own health care decisions.

Varying perceptions of the suitability of Hmong medicine for children were also observed between women and men, the former were less keen on using Hmong medicine for their children, whereas men showed no such concern. Many women felt that because their children had been born in Australia, their illnesses had 'local' causes and they developed 'Australian' illnesses, which therefore needed to be treated by the local health care system, as shown by the comments below:

> J(F33) My mother knows some herbal treatments, but if my children are sick, I prefer to take them to the doctor. I don't use Hmong medicine for my children. I believe that because they were born here, the weather and the food here are totally different to Laos, so whenever they are sick, I will take them to the doctor.

> D(F29) I will often use Panadol first, and if they (the children) don't get better, then I will go to the doctor. I don't use Hmong medicine for my children or for myself.

Conversely, men rationalised the use of Hmong medicine for their children as they believed that Hmong medicine still had a role to play in all illnesses, and that Hmong herbs and Western medicine could treat different types of illnesses. Therefore, fathers were prepared to use both, depending on the signs and symptoms. They commented:

V(M29) My mother usually tells us what Hmong medicine to use, which we will, for our daughter. We would use Hmong medicine at times such as when our daughter has a fever and has been sick for more than a few days, and my family is worried about her.

E(M31) I have no problems using both types of medicine. If the herbs don't work, then I use Western medicine, and vice versa. My daughter had an itchy rash that wasn't getting better with Western medicine. So I used some herbs and it went away.

We use both herbs and also go to the doctor. I look at the sick child, and decide from the 'signs' whether or not to take her to the doctor or use herbs. So for stomach ache or vomiting, I just use herbs. If they are coughing, they may get pneumonia or may have measles, then I would take them to the doctor.

Nevertheless, Hmong medicine continued to be used for children to varying degrees. The mother of an ill child may choose not to use Hmong medicine for her child, but would follow the advice of, or not disagree with, a more senior family member. As discussed above, while the influence of elderly family members was diminishing, it had not disappeared altogether and appeared to be crucial in maintaining the high level of use of Hmong medicine.

Gender differences in the use of shamans have already been discussed above. Only one man would not use a shaman, whereas half the women did not want to use a shaman. The diminishing influence of Hmong culture and greater freedom of choice for women appeared to be the principal causes of gender differences.

Age had some bearing on preference for one system over the other. Most people mentioned that their parents preferred and used traditional medicine more often than they did themselves. But the inadequate supply of Hmong herbs meant that older Hmong also used Western medicine.

The few (3) people who had changed their beliefs continued to use Hmong herbal medicine but the two Christians no longer used shamans, as they no longer believed in Hmong spirits. Even those who were shamans or were closely related to shamans showed a similar mix of health care behaviour to the rest of the community. One of

the shamans explained why he went to a Western doctor before using Hmong medicine:

> H(M50) I use Western medicine because I want to know the *cause* of the illness and the doctors in Australia are able to diagnose the cause of the illness. This way, I know what caused the illness. After the doctor's treatment, if the condition is still the same, then I know what Hmong herbs to use and what to do as a shaman to treat the illness.

From a practical point of view, such behaviour would have reduced the amount of work a shaman would have to do in order to diagnose an illness if the Western doctor had already done so, though the aetiologies were likely to have been different. Hmong who were not shamans gave similar reasons for visiting a doctor, for if they knew the cause of the illness, then they would know what Hmong herbs to use if they were needed at a later date.

Thus, preferences of health care highlighted some areas where the influence of traditional culture was diminishing. At the same time, practical preferences demonstrated that, very few Hmong were willing to completely dismiss the potential benefit that traditional treatments might offer or refuse advice from older members of their family even if they did not believe in the treatment themselves.

Doctors

All the doctors consulted by the Hmong community (including members of the family that lived in Claymore) worked in the local Fairfield area. Most community members visited only a small group of doctors. Sixteen people visited one of three doctors, whilst the rest used various other local doctors. Some used more than one doctor; for example, several women visited a specialist obstetrician or doctors in the local hospital during their pregnancies.

A group of factors were identified as being important in the choice of doctor and ultimately, therefore of medical care. These included the 'qualities' of the doctor, aspects of culture and communication, convenience and cost (discussed above). These factors were interrelated and it was preferable to the participants that the

doctor combined several of these characteristics. Several described what they thought to be a good doctor; their responses included someone 'who seems to know what he is talking about', whose prescribed medications work, who takes the time to listen to them and who does not write too many prescriptions. The examples below illustrate their explanations:

> N(M36) We knew that a lot of Hmong people go to this doctor. I was looking for a doctor that would really look after us. When you go to see him, he talks to you nicely and he checks you thoroughly. We wanted a doctor who was happy to see us. We have been to some other doctors to try them out, but we didn't like them because they didn't check us thoroughly, they just asked a few questions and then they wrote a prescription. And they didn't talk nicely, as if they had no respect for you. So we don't go to see them any more. We wanted someone with a nice personality and who will really look after you time and time again. This doctor treats us nicely.

> D(F29) I like Dr. N. best because I don't have to wait for a long time and he is very nice. He listens to my problems, asks me questions and listens to me. I don't think that his understanding of my culture (because he is also Asian[24]) is any better than an Australian's would be. I have been to some doctors who write the prescription as I am talking and when I have finished talking, he has finished writing. I don't like this.

> C(M42) I also like the Vietnamese doctor (that we see) in particular because he doesn't prescribe too many medications. Some doctors give too many prescriptions, if I gets too many, then sometimes I don't buy all the medicine.

> B(F33) It confuses me because some doctors prescribe a lot of medicine while others don't. I would prefer the doctors to prescribe less medicine because I believe that the more medicine you take, the sicker you will become.

> V(M29) When I lived in Villawood, Dr. L. was my GP there. My baby was born while we were living in Villawood and so we saw Dr. L. with her when she was young. Now that we live in Bonnyrigg, we still see him because he (has a surgery) close by in Cabramatta. I also like him because I feel that he takes a lot more time than other doctors during the consultation.

As they were free to choose their own doctor, the doctors who were most used were those who had many of the preferred attributes. In most cases, doctors were

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[24]Differences between doctors were based on ethnicity. Participants used the term 'Australian' to mean a Caucasian or non-Asian doctor, they used the term 'Asian' to refer to a doctor who 'looks (Southeast) Asian'.

recommended by relatives and (generally Hmong) friends, which led to the majority of people visiting a small number of doctors.

Concerns over and experience of communicating with medical personnel significantly influenced the choice of doctor for at least half the people. There were several aspects of communication and culture that were important for participants. Some preferred an Asian doctor as they believed that Asian doctors would be better able to understand their way of explaining symptoms, and would prescribe medicine which was 'more suitable to Asians' (which generally meant a preference for smaller doses). Even those with a relatively good command of English preferred to go to Asian doctors. Hmong did not use Asian doctors because they thought that they would understand Hmong culture better than an Australian doctor would. They believed that unless the doctor was Hmong, they would have no greater understanding of Hmong culture than any other doctor (and there were no Hmong doctors in Sydney).

Being able to use a more familiar language than English with their doctor appeared to be more important to participants than his or her understanding of their culture. Seven people used one (ethnically Indian) doctor[25], because alongside other attributes, he also spoke Thai and some Lao, and most Hmong could speak some of these languages. With this doctor, they were able to better explain themselves using more than one language and thus felt that they then also received better treatment.

The following examples demonstrate the range of views.

> A(F29) We think that the doctors that we go to understand us better than Australian doctors because we feel that they understand our (Asian) culture. They are also Asian and we feel that they understand how we explain our illnesses. We have no professional problems with Western doctors, but we feel that because they don't understand our culture, that is, because they are not Asian, that it is very difficult to explain our symptoms. If we go to an Australian doctor, we don't know what to tell them about our illness in

[25]He was ethnically Indian, but had been born and raised in Thailand.

English. It is easier to explain problems to someone who understands our culture. We may know ten words about illness and symptoms that we can give to the Indian and Chinese doctor, but only four to an Australian doctor.

I feel that the Asian doctors will give their patients the sort of medication that will suit us.

C(M42) I feel better seeing an Asian doctor because our cultures are similar. For example, the Vietnamese doctor has more experience with Asian people so he understands our sicknesses better and this makes you feel more confident about his diagnosis.

W(M31) When my first child was very young, he had diarrhoea. I took him to both an Australian and Chinese doctor but he didn't improve. So we went to see Dr. S. (an Indian doctor) who was horrified to hear that the baby had been sick for 2 weeks. He gave us one bottle of medicine, Kaomagma, and the baby was better almost immediately. I thought then that Dr. S. really understood what an Asian patient would need.

B(F33) When I first arrived and didn't have much English, it was very hard to explain what was wrong. Now there are no such problems. I don't think that cultural differences are a problem, I see language as being the main barrier to good understanding. For instance, I didn't know how to explain diarrhoea and that I was breathless.

E(M31) I go to him because he speaks a little bit of Thai, but I don't think that he has any greater understanding of Hmong culture than any other non-Hmong would have. My parents prefer to go to him because they can speak to him in a familiar language. It is easy to take my parents to him because of the easier communication.

Even though Hmong preferred doctors from a similar cultural background and with whom they could speak a familiar language, they did not inform the doctors of any Hmong treatments they might also have been using. Dr. A suspected that Hmong patients used herbal medicine as 'one patient who came to see me had been chewing something which made her tongue black, so I guessed that she had been using herbal medicine'. Dr. S was 'not aware' that any used traditional treatments, and also thought that Hmong would not have access to traditional herbs in Sydney. It concerned him that some may use Hmong medicine because he thought that 'traditional medicines are Third World medicine' as it has 'no scientific basis'

therefore they should not be using them, even though he acknowledged that some worked[26].

As most Hmong in Sydney lived in an area with a large number of other Southeast Asian settlers and where a large number of Asian doctors worked, there was a high probability that those who preferred Asian doctors could exercise their choice. The preference for a familiar language at medical consultations became apparent in the interviews conducted in 1996 with the two doctors who were seen by eleven of the participants. Dr. S. who spoke Lao, Thai and English, had maintained a Hmong clientele since he opened his practice in 1981. Even those who had left to live in Queensland continued to consult with him from Queensland or visited him for medical advice when they were in Sydney. Dr. A., while of Asian ethnicity but who only spoke English, currently only sees one Hmong patient whereas he used to see about five families. Neither doctor used interpreters as they relied on other family members or their own ability to communicate.

Interpreters were available for Hmong who were in hospital, but in most cases, interpreters spoke Lao rather than Hmong. This confusion existed because Laos was the country of birth that would appear on all medical forms, and the interpreter would be booked according to this information. Most therefore used relatives to interpret or got by with whatever understanding of English they had. Difficulties in communicating adequately in English were identified by many as a major drawback to obtaining optimum health care. Without good English language skills, communication with medical personnel was limited. Despite being able to use medical care facilities when and how they wished, many felt that their poor English language skills prevented them from obtaining ideal medical care.

[26] Dr. S. also noted that Hmong patients displayed one unusual form of health care behaviour. Several requested injections to boost them when they were feeling run-down. He often complied with vitamin injections but also attempted to educate them on appropriate diet and exercise. Hmong belief in the benefit of injections began in Laos, where 'needle men' became very popular after the introduction of Western medicine (G. Lee, pers. comm.).

Many Hmong also regarded convenience as an important factor in choosing their doctors often but not always in addition to the above factors:

> X(M28) We go to this doctor when we are shopping in Cabramatta because it is convenient. We speak English to each other. He was not recommended, we just found him.
>
> C(F41) I go to these doctors because they live very close and they are convenient.
>
> J(F33) I use the local clinic, no specific doctor, whoever happens to be on duty at the time I go.

Both Dr. A and Dr. S were convenient for different reasons. Dr. A practices closer to Bonnyrigg, but Dr. S's surgery was in Cabramatta, which has a large number of Asian shops and where many Hmong shop for their Asian food. Thus a doctor's visit could be combined with a shopping trip.

Overall, the Australian health care system has removed much of the financial burden of obtaining quality health care, leaving participants free to go to the doctor of their choice. The quality of the doctor, the ability to communicate in a familiar language and some understanding of Asian health care preferences appeared to be the most significant factors in choosing a doctor. Many used doctors recommended by other Hmong, resulting in a small number of doctors being used by the majority. Those who had built up a relationship with one doctor generally visited that doctor all the time; others, especially if they thought that they had only a minor illness, preferred to go to doctors who were more conveniently situated.

Resettlement

A number of features of the resettlement of the Hmong in Australia influenced the development of the community-wide pattern of health care behaviour. These include the composition, size and location of the community and the influence of a Hmong 'mentor'. The community was small, at a little over 200 persons, almost all were related (24 out of 29 families belonged to 3 clan groups, and through marriage

many of these clans were closely related to each other) and most lived in or near Bonnyrigg because they wanted to live near other Hmong. In addition, a large number of Asian doctors practising Western medicine are conveniently located for Bonnyrigg. The influence of older Hmong in encouraging certain Hmong traditions remained strong. Forty-one per cent of the households included at least one older family member, and all the nuclear families except two had older relatives living in Sydney. A small number of shamans also lived in this community, and their presence was known to all. Almost all Hmong were members of the Hmong Society Australia (HSA). All these factors encouraged a high retention of traditional Hmong beliefs. In this close-knit community, the transfer of knowledge between households about both Western and traditional systems was relatively easy. Indeed, to a much greater extent than for most other migrant groups in Sydney, the Hmong very much constituted a community, if not necessarily with shared values, but occupying a particular place in Sydney and all of whose members knew each other.

A further significant influence on Hmong resettlement in Sydney was the presence of a Hmong person who had been living in Australia since 1965, ten years before the refugee crisis. He came to Australia as a Colombo Plan student, and started school at the Year 10 level. His subsequent tertiary qualifications include a degree in social work, which he obtained with the aim of returning to work in Laos. Thus, he was in an ideal position to help the Hmong refugees when they arrived in Australia: he was Hmong, had lived in Australia for 10 years and because of his experience as a social worker, understood the Australian health and welfare systems and knew people in these fields. As such, he helped newly arrived Hmong refugees settle into the country and explained to them what services were available. If he did not have the time or expertise, he would organise the appropriate people to come and talk to a group of Hmong. Sessions included health and family planning. He was also instrumental in assisting Hmong to bring their family members who were still in the refugee camps to Australia. A large number of participants mentioned the

considerable help that this man had given them both initially and in subsequent years.

Present health status

Many Hmong felt that they were healthier now than either when they were in Laos or in the refugee camps, but none were 'one hundred per cent' healthy. Many believed that their better health was related to better weather, better food, a more pleasant lifestyle, less pollution and a cleaner environment (but see the sometimes contradictory accounts below). However, the health requirements for entry into Australia only allowed the more healthy refugees to resettle and this may have led to a biased sample. Upon arrival, the majority felt that they had a satisfactory level of health. None reported any major illnesses in the refugee camps. Before migrating to Australia, all Hmong should have had a health check in Thailand, anyone with a serious illness would have been rejected (and recommended for treatment before reapplying). The relatively young age of the population, more than half being under 20 (Chapter Three), may also have led to a more healthy group. Their interest in maintaining a good level of health despite the hardships and difficulties during their long period in refugee camps, probably served them well in this country.

The community presented with a reasonable quality of health. A small number of people suffered from more severe illnesses, but in general, most were relatively minor. They included gout, tonsillitis and tonsillectomy, asthma, fevers and colds in children, skin rashes such as eczema, stomach pain, feeling run-down, childhood obesity, headache, back injury at work (which has prevented this man from returning to work), kidney stones (which were successfully treated by ultrasound in hospital), lung disease, high blood pressure and complications with pregnancy and child birth. Three had been hospitalised after car accidents and only a small number of Hmong have died, including one incident where three teenagers drowned. Several mentioned that some of the illnesses they now suffered from were very

uncommon or unheard of in Laos, such as asthma, high blood pressure and tonsillitis. Some thought that they developed different illnesses because of the weather, pollution and change of lifestyle. Two of the general practitioners used by this community did not think that Hmong had different illnesses from their other Southeast Asian patients, but did observe that they did not have the health problems that were related to alcohol use and abuse among European patients, nor many of the problems related to Western diet.

Consumption of both alcohol and cigarettes by all Hmong was extremely low. Only two men smoked (although another who had smoked for many years had given up 2 weeks prior to the interview because he was suffering from lung disease), none of the women said that they smoked. While over half of the men drank alcohol, most only drank occasionally at community and social functions. Rarely would Hmong men drink on their own or go out for the sole purpose of drinking alcohol. Thirty per cent of Hmong men never drank alcohol. Only 20% (3 persons) women drank, and then only at community functions, and nine never drank. Hmong refugees in Sydney had made a restricted epidemiological transition from communicable to non-communicable diseases, a pattern not unusual amongst migrants from developing countries.

The examples below provide some insight into the reasons for some Hmong believing they had better health in Australia, though some of the reasons are contradictory:

> N(M36) Yes, sure, my health is much better in Australia. In Australia, you just catch flu sometimes. Australia doesn't have any serious illnesses. In Australia, there are many, many things to make you healthy, such as clean houses, roads, air, fruit, drink.

> C(M42) Now that I live in Australia, I think that I am pretty healthy. I am rarely sick now. I have only been sick occasionally in Australia for no longer than 3 days and I have never been so ill that I have stayed away from work for more than 2 days. I think that I am 70 per cent healthy. I think that I am

healthier in Australia because the weather is more tolerable, the food which is plenty and excellent; it is very clean so I think that I have a better life here.

J(F33) I think that I am probably healthier now, however in Laos, there is not as much pollution. I think that food tastes better in Thailand, because the fruit and vegetables are harvested when they are ripe, not weeks ahead as in Australia.

ZC(M30) I think that Australia is a more healthy place to live in because the food and the hygiene are much better than in Laos, water and so on. But I think that living in Laos is better because the work is better, and there is fresh air and no pollution. The water is better because it comes from the stream and there is no pollution.

S(M34) I think that is it is healthier living in Australia because the weather is much better here. I remember Laos as being very hot and having a lot of pollution and dust. I don't think that the pollution in Australia is as bad as in Laos. There is less rubbish around. In the hills (in Laos), it is much cooler, especially in the jungle. However in the villages, there are lots of animals roaming around and it is not very clean.

None however felt that their health was totally adequate. This was related to how they felt about both their current lifestyle and their diet, as explained below:

M(F24) I think that I am 50/50, because I have some asthma and sometimes I feel pretty run down. However, I think that I am probably healthier here than in Laos.

R(M45) I think that one can be healthier living in Laos because in Australia, even though the life and the country are very good, 'top life', the food is no good, it is too rich in chemicals. Everything is artificial. I think that if there are too many chemicals in your body, eventually you cannot resist it and you will get sick. But in Laos, honestly, I swear to God, everything that you eat is fresh from the jungle and from your garden, we have never had chemicals sprayed on our food. So everything that you eat is natural and you are very healthy. You can get good food here (Australia) but maybe it is 10 times healthier in Laos. Taste is also completely different. For example, take an egg here and an egg in Laos, in Australia, the egg tastes completely artificial whereas it has a natural taste in Laos.

F(M22) Both my parents think that they would be healthier living here if the food was better quality. They think that the chicken and most of the meat is not quite good enough. They think that maybe the farmers do not know how to grow better food. They had fresher food in Laos because it all came from their

> farm. They think that the chickens that they ate in Laos, for example, tasted better than the chickens that they eat here.
>
> X(M28) I think that I was healthier in Thailand, because I am feeling very stressed in Australia. In Thailand, I was staying with my family, I was working as a nurse and I was able to look after myself. And I didn't have too many things to be responsible for and about. But now in Australia, I find it quite hard. I am living away from my family, always thinking about work and about education, so sometimes it gives me headaches and makes me sick. If you are stressed, then maybe you get sick.

As the above statements show, many Hmong were relatively happy to be living in Australia, though some were homesick for Laos and believed that this affected their quality of health. More older people than younger people, and men rather than women were nostalgic for Laos and the lifestyle they led. Men in particular believed that their current life in Australia affected their overall quality of health. Some men found it difficult to feel entirely healthy while they were torn between feeling that they should be appreciative of the safety and relative ease of their lives in this country, and missing many aspects of their more familiar lifestyle in Laos.

Conclusion

The study of Hmong health in Sydney, and the transition in health care behaviour from Laos, through the refugee camps to Australia, has indicated some unusual and unexpected conclusions. It has shown that health behaviour was already diverse within Laos, based on knowledge of two different medical care systems, and access to them, but also therefore to the diversity of the Hmong within Laos, in terms of occupations, place of residence and so on. Moreover health care behaviour was unusually pragmatic, based on the need for recovery, and thoroughly syncretic. Although the first preference was usually for Hmong medicine this was certainly not ubiquitous, but was dependent on the social context, cost and other factors. Thus even within what might have seemed a relatively 'traditional' society, Hmong health care behaviour was already highly flexible, and pragmatic, with diseases apparently never differentiated by cause but only by severity, and with the demand for 'needle men' already established.

Such a system might have been expected to become much more Western in a context like Western Sydney suburbia, especially after the disruption of Thai refugee camps and the ready access to Western medicine that existed there, and because access to Medicare was at very low, or nil, cost to all, some of the traditional Hmong medicinal herbs were unavailable in Australia, many young Hmong were quite unfamiliar with Hmong medicine, and very few were familiar with its practice in Laos. However there proved to be a remarkable persistence in the recourse to Hmong medicine for a wide range of complaints, and the syncretic structure of health care behaviour was surprisingly similar to the much earlier situation in Laos. Nonetheless changes had occurred, particularly amongst women and particularly in some areas (such as childbirth). Women proved more responsive to, and enthusiastic for, change, a reflection of the wider gains that they had made within society. Men were less responsive to change, a function of their own relative loss of status within the Hmong community in Sydney.

Some of this stability in health care behaviour was a function of the strong social support within the community, as shown by the continuity, indeed the strengthening, of community within Sydney, and facilitated by the presence within a small community of a number of shamans, who had prominent positions in the social organisation, and a respected sponsor. This was necessarily emphasised by the concentration of Hmong in a single suburb. Thus the transition in Hmong health care behaviour was limited, even within what might have been perceived as favourable conditions, and where other facets of modernity, such as the move to owner-occupation, the acquiring of modern education and a high level of citizenship (Chapter Three), had all occurred. This suggests that there is no reason to suppose that any simple unidirectional shift in the orientation of health care behaviour necessarily occurs, when refugees and migrants move from developing to developed countries, despite the existence of an appropriate context for such a shift.

The situation in Sydney can now be compared with that of the United States, to assess the key criteria influencing overall change in Hmong health care behaviour.

Chapter 5
Hmong health care behaviour: Review and synthesis

The primary aim of this thesis was to investigate the effects of different social, economic, spatial and political variables on the health care behaviour of refugees. This initially involved the effects of interaction of these factors on members of the same ethnic group but who were living in different countries, the Hmong in Sydney and the Hmong in the United States, and secondly, enabled some comparison of Hmong with other refugee communities in Australia, that is, mainly the Southeast Asian communities. The results of the fieldwork conducted with Hmong refugees in Sydney in conjunction with the data on Hmong refugees in the United States can be compared and contrasted in order to establish major reasons for the differences and similarities found in the two groups. Subsequently, comparing the conclusions on Hmong in Sydney with available data of health care behaviour of similar migrants from Southeast Asia in Australia enables the identification of local issues of health care behaviour which are relevant to refugees. In this context, cultural and social differentiations in health care behaviour might be expected to be more obvious as each ethnic group will have experienced roughly the same local political, social and economic influences during their period of resettlement.

This study has been based on several themes in medical geography. One was the relationship between socio-economic status and the quality of health and health care behaviour, and a second, on social and structural barriers to health care which refugees face but which are independent of culture and ethnicity. The importance of the social attributes of place, or 'experience of place', which Kearns suggested contribute to the broader health of the community are also investigated in the context of Hmong in Sydney (1993), and related to other contexts.

Health care behaviour of Hmong in Sydney and Hmong in the USA

One of the key themes which prompted this research was evidence that social and economic constraints frequently combine to produce a deleterious pattern of utilisation of medical facilities among the most vulnerable members of society: the poor, aged and minority groups (Bates and Linder-Pelz 1990; Berman et al. 1994; Kearns 1992; Mackenbach and Kunst 1997; Manderson 1990a; Meade et al. 1988; Najman 1994). Both Hmong in Sydney and Hmong in the United States had been identified as economically disadvantaged communities (Brainard and Zaharlick 1989; Deinard and Dunnigan 1987; Kirton 1985; Lee 1987; Rowe and Specs 1987; State 1985; Strand and Jones 1983). Nothing was known of the health status or health care behaviour of Hmong in Sydney, but research on Hmong who had resettled in the United States had found that they generally suffered a low quality of health (Brainard and Zaharlick 1989; Deinard and Dunnigan 1987; Kunstadter 1996a; Strand and Jones 1983) and that the combination of their poor use of the American health care system with Hmong culture were the main causes of their poor health status. However, for the Hmong in Sydney, a very different outcome was found.

The most significant variation between the health care behaviour of Hmong in Sydney and Hmong in the United States was related to the pattern of use of Western medicine and medical facilities. Throughout the community, Western medical care was the system of first choice for Hmong in Sydney, even though at the same time almost all continued using traditional medicine. They were neither fearful nor ignorant of Western medicine, nor were they particularly resistant to change, as other studies had suggested Hmong could be (Bliatout 1988a; Capps 1994; Kirton 1985). This result was very different to that generally found in the United States. In the United States, even later studies and those of smaller communities found a greater use of but continuing ambivalence towards Western medicine.

In the United States several common findings on Hmong health care were also observed, including the following: Hmong delayed going to an American doctor for

treatment for fear of the cost, so that if and when they eventually sought Western medical care, it ended up costing more (to either themselves, the health care system or both) (State 1985); they suffered from poor quality health (Brainard and Zaharlick 1989; Kunstadter 1996c), feared hospitals in general and surgery in particular, partly due to traditional medical beliefs or personal distressing experiences, stories from other Hmong (Bliatout 1988b; Lusetich 1994; Sawyers 1983), and feared certain medical tests, especially blood tests (Deinard and Dunnigan 1987). While not all Hmong in the United States exhibited these traits, the current study found none of these factors present in the health care behaviour of Hmong in Sydney.

A number of explanations help to account for these differences. In the United States, cost, or at least the perceived cost, of Western medical care appeared to create long-term significant barriers for Hmong refugees, regardless of whether they expressed any preference for one medical system over the other (Capps 1994; Kirton 1985; Kunstadter 1996a; State 1985). Such economic barriers included the long term poverty many suffered through prolonged unemployment or being employed in low wage areas, poor employment prospects because of low education standards and poor English language skills, large families surviving on low incomes, a significant number of families headed by women (commonly associated with low economic status), and lack of health insurance because it was expensive.

In addition, not all refugees were eligible for health benefits in the United States, few could afford private health insurance and many were unaware that they might have qualified for assistance because of the numerous regulations and varieties of eligibility criteria within the welfare system (Kirton 1985; Tapp 1988). For example, in California, when a Health Initiative programme was established, primarily to keep the cost of health care low for both patients and the state, the new regulations confused everyone, 'doctors, patients, Americans, and non-Americans' (Kirton 1985:144). More importantly, if patients did not follow the correct procedure of consultation according to the programme's regulations, then they would incur the

financial responsibility. To a poor, refugee population, unnecessary costs were to be avoided and thus it was preferable not to use Western medicine if possible. In some cases, Hmong took advantage of the welfare system, by preferring to remain unemployed in order to retain medical benefits for medical costs that they might incur in the future, even though they had no history of serious or potentially expensive illnesses (Boland 1981). Linking cash assistance to eligibility for medical assistance was criticised by many agency workers in terms of the inducement for refugee families to continue on cash assistance in order to maintain comprehensive health coverage (Boland 1981). Thus cost of Western medicine was a significant barrier to its use by Hmong refugees.

In Australia, health care regulations were far less confusing: all citizens and permanent residents are eligible for Medicare, regardless of their employment status, income and the period of time that they have lived in Australia. Medicare covers most health care costs at doctors' surgeries and in public hospitals. Hmong in Sydney identified the low cost of medical care as the major reason that they used and were able to use Western medicine. Medicare provided them essentially free health care and protected them from potentially unaffordable medical expenses. In addition, in an attempt to keep all medical costs to a minimum, several had also sought doctors who both 'direct billed' and who wrote few prescriptions

Further, and with some relation to cost, the differences between the actual practice of Western medical care in Laos and the United States appeared to have deterred Hmong in the United States from using Western medicine once they had resettled. Hmong in both countries had been exposed to Western medicine prior to their departure (Capps 1994; State 1985). In Laos, Western medicine, especially that provided by the United States military, was quick and free as it lacked many of the expensive and time consuming tests which are common practice in the United States. Once in the United States, the Hmong were confronted with a very different system of practice, especially in terms of costs and the variety of tests. These

differences possibly also affected their use of Western medicine as while they were familiar with Western medicine *per se*, the expense and lack of familiarity with the system of practice became barriers to its use. In contrast, in Sydney Hmong were still able to use Western medicine for a very low cost, thus they continued to use both Hmong and Western medicine in a similar fashion to the health care behaviour which they had already developed in Laos.

Free health care as provided by Medicare, was probably the most influential factor in enabling and encouraging Hmong in Sydney to use Western medical care. Medicare enabled this group to keep their medical costs to a minimum, regardless of either whether they were employed or not, or their level of income. Previous experience with Western medicine, the ability to choose their own doctor (and the good fortune of a few to find a doctor which they felt suited them best), and their freedom to continue with their traditional system of health care has also provided a relatively uncomplicated introduction to the Australian health care system. Essentially, removing economic barriers opened up the choices available to this community.

Concern over medical costs for Hmong in Sydney may also have been lower because of their relative good health, therefore there was less need to visit the doctor, purchase medications or use ancillary medical facilities that were not covered by Medicare. The illnesses they suffered from were generally minor and only a small number had needed medical care for serious problems. In the United States, problems of poor health status continue to be a problem in some Hmong communities. One study in Fresno, California, conducted as recently as 1996, found that Hmong children suffered from infectious diseases and respiratory ailments at a rate three times greater than that of other children (Kunstadter 1996d). Further research was being conducted into these results, but this illness pattern is common among people living in poor socio-economic conditions.

A variety of factors has contributed to the good quality of health of Hmong in Sydney. They appear to have been a fairly healthy group of refugees upon arrival in this country, possibly due to the attempts by many to take good care of their health while they were in the refugee camps and subsequently in Australia. Also, in accordance with Australian government regulations, all went though a health check before arrival in Australia and any who were found to be ill were treated prior to their eventual arrival. Very low rates of smoking and consumption of alcohol, social health indicators associated with better health status, were found among both men and women in the Sydney group. In contrast, in the United States, high rates of smoking were found among some Hmong and refugee men from Laos (Bates et al. 1989; Levin et al. 1988). Rates of smoking and alcohol consumption among Hmong women in both countries were expectedly low. Finally, Hmong in Sydney did not need to delay seeking Western heath care for fear of the cost. The corollary was that it was easier for them to maintain good health because there were no economic disincentives to seeking treatment early in the illness.

A more positive socio-economic resettlement outcome in Sydney has also favoured a better health outcome. There was no evidence of poverty within this community (although the few who had only recently arrived and those living in relatively overcrowded conditions were certainly disadvantaged), but it was a continuing problem for a large number of Hmong in the United States. A large number of Hmong in Sydney owned or were in the process of buying their own homes. Fertility had dropped considerably, which allowed women greater freedom to seek employment or study. There was less need for the extra income necessary in a large family, and thus households were less crowded. The number who had completed their secondary education was similar to that of the Australian population, with most having chosen to continue studying after leaving school. Moreover, the unemployment rate though remaining unacceptably high at 26%, had decreased from the 1987 figure of 35 percent. Although Hmong incomes were at the lower end

of the socio-economic scale, the community's achievements had been significant after less than 20 years, since all had arrived as refugees with low levels of education, few work skills suitable to an industrialised country and little English.

A greater willingness to use Western medicine by the Sydney Hmong might also have been because no-one had experienced any major distressing incidents with Australian medical staff and institutions, unlike the situation in the United States where several medical confrontations caused considerable concern to some Hmong and even involved the legal system (Kirton 1985). In the Sydney community, some people were relatively knowledgeable about Western medicine: three had completed their nursing training in Australia: in Laos, one man had completed 3 years of a medical course and one women had studied nursing, one had studied pharmacology in both Thailand and Sydney and two had worked in the clinics in the refugee camps. Their familiarity with Western medicine, for some at a professional level, may have prevented misunderstandings and confrontations. While this does not mean that all contact with medical personnel in Sydney was favourable, no problems were severe enough to stop Hmong using Western medicine and going to Australian doctors and hospitals, though several had 'shopped around' until they found a doctor whom they regarded as being 'suitable'.

Very few problems were also encountered by women who had given birth since their arrival in Sydney, even though they were exposed to a very different system of health care during this period. Most outweighed any shortcomings they encountered in their care with what they perceived were the benefits of regular monitoring of the pregnancy and of having a baby in a clean and safe environment. All were well aware of the high rate of infant mortality in both Laos and the refugee camps and welcomed the opportunity to deliver their babies under much safer conditions and with medical care readily available. However, it remained important to almost all women to observe traditional Hmong post-natal practices. No Hmong women who chose to follow their traditional dietary customs and only eat food

brought into the hospital by family members reported any problems with medical staff. Most of their problems that they encountered in hospitals were related to language difficulties, especially in the early years of their resettlement.

A further reason that might account for the few problems between Hmong and Australian medical staff was that the latter did not know that their Hmong patients were also using Hmong medicine. Hmong never told their doctors of their use of traditional treatments, and significantly, one of the community's most popular doctors with whom many felt that they were best able to communicate best with, was not informed that they used Hmong medicine. In turn, he thought that they would not have had access to traditional medical care and that they should no longer use it. Hmong patients were probably aware of this attitude in the medical profession in general and simply kept their use of traditional medicine to themselves.

The small size of the Hmong community in Sydney, and more generally in Australia also influenced health care behaviour in several respects. In the Sydney community of a little over 200 Hmong, only a small range of herbs was available and the number of people with Hmong medical knowledge was limited, thus a full range of illnesses could not be treated by Hmong medicine in this community. In contrast, in the United States, some of the communities were very large: there were over 16,000 Hmong in St. Paul/Minneapolis by 1991, and over 13,500 in Fresno in 1986. Over 50% of the total population of 150,000 lived in California. The larger communities were able to supply a greater range of Hmong herbs. Thus, as there were already considerable concerns over the cost of Western medicine, Hmong pragmatically continued using their traditional medicine as a system of first choice. Furthermore, as there were over 150,000 Hmong in the United States, it was easier to procure Hmong medicine from outside of the local community than it would have been in Australia, with a population of 1600. As Western medicine was virtually free to Sydney Hmong, there was no incentive to rely totally on Hmong herbs. However,

older Hmong did encourage the continued use of Hmong herbs even when younger members, in particular younger women, preferred not to use them.

These factors led to the general pattern of behaviour observed in Sydney whereby Hmong would first visit a Western doctor for a diagnosis and/or medicines, once the type of illness was known, then they would know what Hmong medicine to use. In this way, they used Western medical knowledge to assist with their subsequent use of Hmong medicine due to the limited knowledge of traditional medicine within the community. Hmong medicine was used because it was available and because it helped. In fact, several Hmong told of success stories where Hmong medicine had helped when Western medicine did not seem to. Thus, the 'success' of Hmong medicine also ensured its continued use alongside Western medicine.

There are several unique features of the Sydney Hmong community which account for many of the differences observed in health care behaviour and resettlement outcome between Hmong in Sydney and Hmong in the United States. Hmong who have resettled in Sydney were extremely fortunate to have had a relative who had been living and studying in Sydney for at least 10 years by the time of the communist takeover in Laos and who had a degree in social work. He was able to provide initial and continued assistance to the refugees in terms of clan responsibility, born through his role as a leader of the HSA, and more personally. He was also responsible for sponsoring or helping others sponsor relatives to Australia through the family reunion scheme. The HSA aimed at rebuilding a traditional sense of community and promoting mutual support now that they were faced with a different social, economic and spatial context. These two factors have led to a very cohesive community that provides positive social support for its members. In this community, most members are related to each other and/or to the 'mentor', either by birth or by marriage, and many have chosen to live close to other Hmong to maintain good communications and reduce feelings of isolation. A preference for living close to other Hmong was also common in many communities in the United

States, often encouraged by the influence of a clan leader or 'anchor relative' (Capps 1994; Duchon 1997; Helzer 1994; Kirton 1985; Tapp 1988). This was one of the reasons behind the massive secondary migration of Hmong refugees in the United States.

Resettling in Bonnyrigg and its neighbouring suburbs has enabled the cohesiveness of the Sydney community to develop. Over half of the Hmong lived in Bonnyrigg (18 out of 29 families). While living close to other Hmong reduced their feeling of isolation, living in an area of Sydney which has become home to the largest number of people from Southeast Asia in NSW has provided certain 'Asian' features in the local area. For example, they could shop in nearby Cabramatta for their familiar foods in a familiar market atmosphere. In terms of health care, a large number of Southeast Asian doctors trained in Western medicine practiced in this area of Sydney. This allowed the Hmong who preferred an 'Asian' doctor to shop around and choose their own doctor. Bonnyrigg also provided a sense of stability and permanence that most had never had before, as the Hmong were able to purchase their own homes at an affordable price, something they were not able to do as farmers in Laos. With all Hmong being in one area, it was easier to organise community meetings and celebrations, and no one had to travel far for local festivities.

The cohesiveness of the community and assistance provided by the 'mentor' was also helped by the fact that the community was very small. One person was able to assist the 30 Hmong households in Sydney (and usually fewer than that, as long-term arrivals became more independent), and provide more personal help when there are only a small number of people requesting such help. In terms of use of Western medicine in Sydney, this community leader also provided much needed assistance at medical consultations because of his knowledge of the Australian medical system and his high standard of English. His assistance has been ongoing as both a language and cross-cultural interpreter. This helped introduce Hmong

refugees to Western medical care in Sydney in a culturally appropriate fashion and helped allay fears and smooth out problems. In two communities in the United States, Isla Vista and Kansas City, Hmong themselves recognised the benefit of a person who understood the American medical system, and made an increasing number of requests for help from the two American women who spoke Hmong and who were conducting research in their communities (Capps 1994; Kirton 1985).

In the United States, mutual support within the community also contributed to greater success in resettlement (Capps 1994; Duchon 1997; Helzer 1994; Kirton 1985). Assistance could come from two sources: the American sponsor (or sponsoring community) or Hmong individuals and community leaders. In situations where the sponsoring community and Hmong were able to cooperate, successful resettlement was more likely to occur. In addition, the assistance provided by mentors within a Lao community had a significant effect on their use of and acceptance of Western medical care (Brainard and Zaharlick 1989). However, the system could easily break down, as when the Hmong moved away from their original sponsors, or the sponsors and Hmong did not understand each others' needs and motivations (Kirton 1985). In both situations, valuable assistance to the community was lost. When good assistance was available, it could be taken advantage of. 'Over use' of some Hmong helpers led, in at least one case, to a situation where the community was asked to limit their requests (Kirton 1985). Ultimately, at the individual level, the Sydney Hmong community was fortunate in having a single effective Hmong sponsor.

Another distinct feature of the Sydney Hmong community was that almost all of its members had retained their traditional Hmong beliefs of ancestor worship and animism. This may have been due to Australia's relatively *laissez faire* approach to resettlement of refugees: there is no particular push to become Australian, but 'it's good if you are like your mates' (Eisenbruch 1990:69). Also, Australia's policy of multiculturalism encourages ethnic groups to maintain their cultures without

prejudice or disadvantage, to embrace other cultures and to acknowledge common values which give all citizens a sense of being Australian (Falk 1993/94). Thus there was no encouragement by the Australian government for Hmong to abandon their traditional beliefs and to convert to Christianity. Only one person in the Sydney sample had been sponsored by a Christian organisation, and he had moved away from his original place of arrival to resettle in Sydney. As there were no limitations on welfare and medical benefits, there was little financial incentive for Hmong to convert to Christianity, as was found in the United States. In contrast, the United States government encouraged assimilation, depended heavily on church and community sponsorship to assist with refugee resettlement in the belief that this was how they would become successful American citizens (Eisenbruch 1990; Falk 1993/94). Conversion to Christianity and belonging to a church community provided many Hmong with a sense of belonging, a source of social activity, a way to develop an understanding of America as well as other financial benefits (Capps 1994; Duchon 1997). In Sydney, the HSA and various distinctive features of the community fulfilled many of these needs.

Significant gender differences existed amongst the Hmong in Sydney. In terms of health care behaviour, while men saw no difference between using Western medicine or Hmong medicine for their children, women, especially those with young children, preferred to use only Western medicine for their children's illnesses as they believed that Western medicine was more suitable to 'Australian' illnesses. No evidence of gender variation in preference and use of different medical system was discerned in the American studies. The differences in belief of appropriate health care in certain situations suggests that refugees, even when they are from the same ethnic group and have experienced the same socio-economic environment, can exhibit different health care behaviour. This presents a particularly strong case for devoting much more attention to gender in medicine and that it is important to look

at refugees not just as refugees, but as men, women, children, educated or illiterate, employed or unemployed.

Another significant difference between Hmong men and women in Sydney was that women were more satisfied with their current lives in Sydney and showed no interest in returning to Laos, whereas several men were nostalgic about Laos and the better lifestyle they had had and lamented their present loss of status. Women were happier for many of the same reasons that made men unhappy: basic everyday living was much easier for Hmong women in a modern home equipped with electricity and running water, their children were much healthier growing up in a cleaner environment and they had more rights within the family. More significantly, their ability to be employed in the paid workforce, relatively unusual for a Hmong woman in Laos, had several positive facets. Their much needed salary was welcome in these low income families, it enabled the family to purchase a home, could help their children stay on at school for longer, and women felt that their ability to earn a salary made them more important within the family. Women also enjoyed the social aspects of being employed outside the home and of meeting women and men from outside their community. Women's employment however was generally dependent on whether they had children, the age of their children and if they had access to free child care provided by their husband's parents.

A small number of men, on the other hand, felt considerable loss of status because they were only eligible for employment in the lower socio-economic sector whereas a small number had had higher status employment in Laos. Because their wives could now earn an income and had more freedom, they felt they had less authority in the family. A similar loss of status was also observed among Hmong men in Omaha, Nebraska, who were not allowed to show off their success by taking on a second wife (Meredith and Rowe 1986). A small number of Sydney men told of some of the concerns they had had prior to arrival, about migrating to a country where everyone was equal, where if they divorced, their wives would get to keep the

children and half of everything the family owned {E(M31)}. However, after many years of resettlement, none of these fears have eventuated and there was a general feeling within the community that women were much happier in Sydney than they were in Laos.

While improved status among refugee women is unusual, it is not unheard of. Hmong women in Atlanta, Georgia were found to be the highest salary earners, this afforded them a greater degree of personal and financial independence. (Duchon 1997). And in the Vietnamese population in Sydney, Vietnamese men perceived a loss of status at home related to their employment in menial jobs. This was made worse by the fact that many of their wives worked full-time and were no longer dependent on their husbands for material and financial support (Xuan 1993). In addition, better opportunities for females were also evident in the younger age groups in both the Sydney and Atlanta Hmong communities, where education rates for girls were equal to those of boys, both for secondary school and post-school education, which was a significant difference from the situation in Laos. In Sydney however, the young men pursued more financially beneficial tertiary and technical courses than women. Such gender changes suggest that data relating to refugees needs to be broken down into smaller and more useful categories, rather than studying this group under the larger heading of 'refugees'.

A communication problem had begun to develop between older Hmong who only spoke Hmong and younger Hmong who were increasingly speaking English. As traditional knowledge was passed on orally from older to younger Hmong, not only was much of this knowledge not being learnt by younger Hmong, but also the history and basis of Hmong medicine, and the role of the shaman and spiritual beliefs. Currently, most younger Hmong have followed what their parents and grandparents recommended in medical matters out of respect for their elders. However, as many in the community did not understand how and why traditional medicine worked, a rapid decline in the use of Hmong herbs appears inevitable in

the future unless steps are taken to prevent this happening. The loss of Hmong traditions has upset many of the older Hmong, and if it were possible, a small number wished to go back to Laos where they could eventually be buried.

From the preceding discussion, it is evident that economic and social constraints create barriers to effective use of the health care system. But in certain contexts and in particular places, such barriers can be minimised or eliminated. If a Western medical regime is to be used effectively and appropriately, a number of conditions need to be met: medical care needs to be economically, spatially and culturally accessible to all potential users; both medical and lay people need a solid understanding of the needs of refugees; regulations for financial assistance need to be clear and concise at all levels of use; improving English comprehension will further reduce barriers to optimal health care and dependency in other areas; and the role of a 'mentor' appears to be extremely important in terms of a culture broker in the country of resettlement.

Differences between Hmong in Sydney and the United States were therefore primarily a function of the apparently more healthy situation of Hmong in Sydney (the reasons for which are uncommon), the low cost of Australian medical care (which minimised uncertainty over its use), the greater success in obtaining employment (and hence income), especially amongst women, the more limited availability of herbs and traditional knowledge, and the particular significance of an effective sponsor in a small community.

Refugee health care behaviour in Sydney

A considerable number of the differences between the Hmong in Sydney and Hmong in the United States can be attributed to the influence of the different spatial, economic and social contexts of each country of resettlement. However, this study also enabled some limited comparisons and contrasts between Hmong in Sydney and other NESB refugees in Australia, generally other Southeast Asians, who were

from a comparable socio-political background, who experienced a similar resettlement process during a corresponding time period to the Hmong in Sydney and who had been influenced by similar local political, social and economic variables as the Hmong. However, case studies are few and specific data are rare, often because available data have been aggregated into broad categories. A detailed cross-cultural comparison of the health care behaviour of similar refugees in the Australian social, economic, spatial and political context is consequently not possible as only a few similar studies of this type have been done.

However, a study of elderly Korean men living in Sydney showed some parallels with the situation of Hmong. In terms of general health care behaviour, the main reason for elderly Korean men's use of and preference for Western medicine and their minimal use of traditional Korean *hanbang* (herbal) medicine was almost exclusively economic: Medicare provided all their health care needs at no cost, and they could not afford to use *hanbang* medicine as they had no income(Han 1996). While they were impressed by the health services in general (Western medicine had cured some illnesses which they believed could not be treated in Korea), they continued to believe in the efficacy of *hanbang* medicine and would use it if their family provided it for them. These men also thought that their better health in Australia was due to their much healthier lifestyle, such as drinking and smoking less, eating a healthier diet and living in a healthier environment.

Vietnamese were found to use traditional medicines as a routine part of their health care behaviour (Parsons 1990; Tran 1990b; Xuan 1993), but how their continued use affected their use of Western medicine, and the converse, were both unknown. The population of Vietnamese in Australia is much larger than the Hmong. In 1991, there were over 120,000 Vietnamese-born in Australia and 27% of these were ethnic Chinese (Reid 1994). Many were familiar with using Chinese herbal remedies that are available in the many Chinese pharmacies. However, it was difficult to accurately assess Vietnamese health care behaviour because of contradictory reports.

The Vietnamese regard hospitals with wariness, and would only go to one as a last resort (Tran 1990b), preferring instead to keep the patient at home and use traditional practices (Xuan 1993). For children in particular, it appeared that if Vietnamese parents had poor English then they were less likely to seek (Western) medical care for their children (Xuan 1993). However, a survey of hospital admissions of Vietnamese to Melbourne hospitals found that this group's admission rates were almost twice that of the general population and higher than all other groups (Powles and Gifford 1990). Such limited and variable data make comparisons and contrasts with the current research very difficult.

One area where there has been considerable research of health care behaviour has been on Vietnamese women's health care experiences in Australia (Adamson and Taylor 1990; Locke 1985; Manderson and Matthews 1981; Xuan 1993). One unfortunate consequence has been a subsequent tendency in the health care field to regard all Southeast Asian women as having the same or similar needs as Vietnamese women. But even for Vietnamese women, there has been a tendency to generalise, presume homogeneity in their health care behaviour and to regard cultural factors as fixed in time and resistant to change (Manderson 1990a), so that even they might not receive appropriate care. However, beliefs and knowledge of pregnancy and childbirth among Vietnamese women vary with their degree of education and rural or urban backgrounds (Xuan 1993). In the following comparisons between Vietnamese and Hmong women it is important to be aware of these data limitations.

During pregnancy and birth, Hmong women and Vietnamese women showed some expected differences and similarities. Vietnamese women had a relatively complex set of beliefs and behaviour which were observed during pregnancy, whereas Hmong behaviour during pregnancy was far less restricted (Rice 1997; Xuan 1993). In the present study, many Hmong women said that traditionally they did nothing special during their pregnancy. Pregnancy for Hmong women was regarded as a

natural part of a woman's life, and they continued to do what work they were able until they are ready to give birth (Rice 1997). It is only following settlement in Sydney where there has been an established system of care to follow during pregnancy, that they followed a more interventional system of prenatal care.

Both Hmong and Vietnamese have a similar belief about keeping warm and thus maintaining their strength for the first month after the birth. Both followed a postnatal diet and particular behaviour that were intended to keep them warm, but each group had varying but similar beliefs about their postnatal diet. Vietnamese women ate hot and salty foods, including fish and pork, chicken cooked with ginger during their four week postnatal period (Xuan 1993). Hmong women in Sydney preferred chicken, eggs and rice, all which must be eaten warm. Hmong women in Melbourne also included fish and pork in their diet by the third week of this period Rice 1997). Problems arose for Vietnamese women who had lost their traditional family support of their mother or mother-in-law, who would normally assist them during their postnatal period (Xuan 1993). This was not a problem for Hmong women in Sydney who had had babies in this country as all had had some sort of traditional family support, generally from their mother-in-law, often from their husbands and if necessary, from other members of the community. Their husband or mother-in-law took the required food into the hospital for the new mother.

Further differences were also found between the behaviour of Hmong in Sydney and Hmong in Melbourne. In Sydney, many women were readily accompanied by their husbands during the delivery[27], and said that this was traditional, whereas Hmong women in Melbourne preferred to have either their mother or mother-in-law assist them and not have their husbands present. The outcome was that they ended up going through delivery without any family member because their mother or mother-in-law were not allowed into the delivery suite (Rice 1997). Hmong women

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[27]It is common practice in Australian hospitals for the father of the baby to be present at the birth of their baby.

in Sydney preferred the safety and cleanliness of a hospital. If women had the financial option of having a more traditional home birth[28], some might have preferred to do so (Rice 1997; Xuan 1993). This was not discussed during the current study but neither was it indicated as a preferred option to hospital birth. In fact, most Hmong women in Sydney were able to maintain what they believed were the important aspects of delivery and postnatal care within the hospital situation without creating problems during their hospital stay: they showered because there was hot water to keep them warm, they avoided cold food and drinks, they waited for their traditional food to be brought in by their families, and just a few ventured away from traditions by eating hospital food and drinking cold water, with mixed consequences. Hmong women in Melbourne followed several behavioural restrictions during pregnancy to keep the baby safe from malevolent spirits, unlike the Hmong women in Sydney who said that they did nothing special during pregnancy.

The differences between Hmong women in Sydney and their counterparts in Melbourne, where Hmong in Sydney appeared less traditional than Hmong in Melbourne, may be related to the geographical regions that each community originated from in Laos. Most Sydney Hmong are from the regions of Xieng Khouang, Luang Prabang, Sayaboury and Vientiane (Map 3.1). The present research found that those who lived in or closer to the more urban areas were more easily able to use Western medicine than those who were more isolated. Hmong refugees in Melbourne are from the more rural and isolated Lao province of Sam Neua (Falk 1994), and thus were less exposed to Western medicine as practiced in an urban setting. (Examples of other behavioural differences can be found in areas such as the funeral ceremony, whereby Hmong in Melbourne perform what is thought of as the 'original' version, but Hmong in Sydney had simplified it and adopted some Lao vocabulary.) Further research would be needed in this area to investigate the source

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[28]Home births currently cost approximately $1500 and Medicare does not cover them.

of variations within the Melbourne community which would provide a broader explanation of present health care behaviour.

Both Hmong women in Melbourne and Vietnamese women were very uncomfortable with prenatal and postnatal examinations being performed by male doctors. This led many to reduce the number of visits to their doctors to the minimum (Rice 1997; Xuan 1993). This was not discussed by Hmong women in Sydney, but it is not a problem confined to immigrant or NESB women. Most women in Australia prefer to be examined by female medical personnel (Manderson 1990a). In addition, some aspects of health care behaviour are common in all low income groups regardless of ethnicity. Some Vietnamese women were required to return to their jobs soon after the birth of their baby, in some cases within a week of the birth (Xuan 1993). Hmong women also needed to return to work or study soon after the birth of their baby, which was the reason some gave for bottle feeding their baby. Thus in some situations, the economic need for the mothers' income outweighed a strict adherence to cultural practices.

The range of variables involved in health care behaviour has been clearly demonstrated in these studies of Southeast Asian refugees in Australia. Some are cultural, such as diet and the continuing use of traditional medicine in particular contexts, others are very much related to the social and economic context of Australia, such as giving birth in a public hospital and needing to return to work very soon after the birth of the baby and having low-cost access to Western medicine. However, only limited comparisons are possible between Hmong health care behaviour in Sydney and that of other Southeast Asian refugee groups, because of the surprising paucity of studies of this subject.

However this comparison does indicate that, especially in the case of Korean and Vietnamese migrants in Sydney, economic factors are of some importance, in that both groups were also relatively easily able to afford Western health care. This therefore emphasises the key comparison between the studies of Hmong in Sydney

and the United States. The comparison also emphasises the significance attached to changes in lifestyles, but also draws attention to the particular role of place. That is, Hmong migrants in Melbourne, at least in the context of women who had given birth in hospital, were different from those in Sydney, apparently because they tended to maintain behaviour patterns from the particular area of Laos from which they migrated. There may also have been variations limited to their particular place of residence in Melbourne.

Conclusion: The geography of health care and refugee health

Several of the results in this research were unusual and unexpected, and have therefore contributed to a new understanding of some aspects of the geography of health care. First, the investigation showed that under certain circumstances, economic disadvantage need not necessarily be associated with poor health. This contrasted with the findings of other health care behaviour studies (Berman et al. 1994; Kearns 1992; Mackenbach and Kunst 1997; Meade et al. 1988; Najman 1994). Despite Hmong in Sydney being economically disadvantaged, their quality of health compared favourably with that of non-disadvantaged Australians due to the interaction of a number of factors. They included free access to Western health care, the initial and continuing assistance of a mentor, the size, unique composition and cohesiveness of the community, the confidence and ability to supplement Western medicine with their traditional system of health care, the relatively good health of most refugees upon arrival and the almost complete absence of smoking and drinking. In addition, improvements within certain key social and economic variables, such as the high rate of home ownership (and everyone has a home), reductions in overcrowding within homes, and improved standards of education, have also benefited their health status.

Second, and in conjunction with the above finding, the social attributes of place, or the health related characteristics of places themselves, as suggested by Kearns (1992), have contributed to the broader health of the community. In Bonnyrigg,

community members are easily linked to each other, they live close to their relatives and other Hmong, with easy access to both culturally appropriate Western-trained doctors and traditional herbs. In itself, there is little that is particularly characteristic of Bonnyrigg; indeed it is probably the considerable anonymity of a relatively new suburb that enables the Hmong to live the kinds of lives that they choose (with few restrictions). Thus, Bonnyrigg has become the 'space' which has facilitated a better quality of health and satisfactory health care behaviour for the Hmong in Sydney. This is a similar conclusion to that of Kearns, where outpatient clinics in New Zealand, had become meeting places where community members gathered. Social interaction in a particular social context contributed to the well-being of the community. In the current study however, similar results were observed but in a different context and with a different approach. Whereas in Kearn's study, the clinic enhanced the health of the community, in Sydney, the particular development of a localised community served the same purpose, thus demonstrating that a positive health outcome can be facilitated by communication within the community but that this can take place in quite different contexts.

Similar favourable resettlement outcomes appear to have occurred in some of the more recent Hmong settlements in the United States, such as those in Kansas City, Kansas and Atlanta, Georgia, where the smaller communities were found to have satisfactory rates of employment, education attainment and home ownership within relative cohesive communities (Capps 1994; Duchon 1997). However, for the Hmong in Kansas City at least, the high cost of Western medicine continues to remain a barrier to its widespread use by this community. Neither the lower cost of medical care nor the development of a cohesive settled community may necessarily improve access to, and use of, Western medicine. This study has shown that in a particular context of refugee resettlement and with the economic barriers to health care removed, people can make a much wider range of choices regarding health care behaviour, with more satisfactory outcomes.

Third, this study has also demonstrated that the various indicators of socio-economic status that influence health care behaviour vary over time and may change at different rates. This is especially so for refugees and immigrant groups, who often arrive in a new country either lacking employment skills of possessing qualifications which are not recognised, and with little or no English language skills but whose childrens' employment prospects become similar to the wider community as they have gone through the local school system. For the Hmong in Sydney, while their level of employment and the number employed in the lower skills area of the work force were proportionately higher than that of the Australian population as a whole, in other areas such as education, home ownership and fertility, significant improvements had occurred. Resettlement is not a static process; communities are continually evolving and being influenced by different variables. How these changes affect health care behaviour are difficult to predict, but it is clear that the transition to a Western system is neither linear nor homogeneous. However, in terms of the geography of health care, this demonstrates the importance of investigating not only a wide variety of factors and their various interactions, but also how they change over time and for different individuals or groups within even a small migrant population. This was evident in the case of Hmong women, whose improved status in Sydney was unexpected, but not unique; both Duchon (1997) in Georgia and Xuan (1993) in Melbourne have also observed that refugee women's status had improved at least financially to the extent that some women earned more money than their husbands. Hmong women in Sydney were gaining more confidence in making health care decisions for their children and themselves, especially related to traditional Hmong post natal behaviour. Such differentiated results are a powerful argument for not looking at refugees as a homogeneous group, even when investigating a single, national, ethnic or cultural group, in terms of health care behaviour.

Fourth, one of the problems of studies of the health care needs and behaviour of migrants, especially those from a NESB, is that they are often seen as being related mainly to their culture or ethnicity, regardless of the situation where many are in a marginalised position in society. This study has shown the importance of looking beyond cultural and ethnic barriers and stereotypes to assess the influence on health care behaviour on social and structural barriers, such as the often dangerous and low paid areas where many migrants work, language barriers and limited knowledge of the welfare and health system. It has revealed that pragmatism and economics invariably outweighed cultural factors, even despite the community's cultural continuity, especially in a range of traditional health beliefs.

Fifth, the continued use of Hmong medicine has benefited the health status of the Sydney refugee community in several ways, beyond that of health alone. The older Hmong were able to maintain a more active and respected role within the community through their knowledge and dispensing of traditional Hmong herbs, while other community members were willing to accept the advice of the older Hmong as part of their health care regime, thus practising syncretism of the two health care systems. The use of traditional medicine may have also assisted with their generally positive resettlement as it provided them with an important link to their history and culture. Such behaviour was facilitated by the Australian policy of multiculturalism.

Finally, this study has shown that different manifestations of health care behaviour can be expected in different places and in different contexts. It has shown that refugees are not homogeneous, but that they do quite different things in different places. In particular, it was significant that women's preferred health care behaviour was found to be different to that of their husbands and that of more traditional Hmong. A small scale case study allowed greater insight into how the health care behaviour of the Hmong in Sydney had been influenced by their local physical, social and economic environment and their experience of place, where the presence

of suitable health services had contributed to the broader health of the population and how this had changed over time. Migrants, particularly those from a NESB, often rank health as a major need and in many cases, is the most common item for which they require information (Batrouney 1995). The findings of the current study suggest that there are a range of ways of providing adequate health care for new arrivals. Appropriate assistance with developing language skills, enabling family reunions and providing free medical care were identified as three areas where governments can help. Significant findings of the present study have highlighted the transdisciplinary and multidisciplinary nature of health care behaviour, the interactions of a range of variables and how policy intervention could take place.

Appendix One
Letter of introduction

THE UNIVERSITY OF SYDNEY

DEPARTMENT OF GEOGRAPHY

University of Sydney NSW 2006 Australia
Telephone: +61 2 9351 2886 Fax: +61 2 9351 3644

My name is Jenny Wang and I doing a Masters Degree at Sydney University in the Department of Geography.

I am interested in doing a study of the health care behaviour of Hmong immigrants currently living in Sydney. I want to look at the Hmong traditional way of life and the way of life most Hmong now live in Sydney. Most of all, I want to look at how the health care behaviour has changed and what has influenced these changes.

I would like to do this study by talking to you in your home. This will involve me visiting you on a few occasions at times which suit you. During these visits I will be asking questions about various aspects of the Hmong way of life and how they have changed. Some questions will be about the Hmong culture and others will be about education, employment, experiences in both Laos and Australia.

Many questions I will be asking will be about what sorts of experiences you have had with Australian doctors; on what occasions you use Traditional healers; what sort of health care you had available and used in Laos; what you think of Australian health care and traditional health care; whether you have been to hospital since arriving in Australia and what were your experiences you have had at a hospital; your experience with interpreters; your general state of health now compared with arriving in Australia; what problems you have encountered with the Australian health care system. I will also be asking some general questions about how long you have lived in Australia, what sort of household you live in and where you work, for example.

Gary Lee is helping me contact many Hmong families and will also explain to you what my study is about.

I hope you will be able to participate in my study and I hope it will be as interesting for you as I expect it will be for me. At all times I will keep all information private and anonymous.

Yours sincerely,

Jenny Wang
Phone: 9427–5927

Appendix Two: The questionnaire

Questionnaire for the participants

Part A: General Information About Members of the Hmong Community in Sydney.

Date:

What is the family name(s) of this household?:

How many families in this household?:

How many people in each family?:

What is the name of the main participant(s) of questionnaire?:

What is the relationship between the main participant and other members of the household?:

Is any one particular person regarded as being the head of the family? If so, who? Why?:

Names, ages and position in the family of each family member:

Type of accommodation? House, flat?:

Size of house or flat:

Extra Information:

For each adult participating in survey:

Personal Information

What is your full name and your position in the family?:

Age:

Gender:

Ethnicity:

What is your sub group? (e.g.: Blue/White/Black Hmong):

What is your family clan?:

What is your country of birth?:

How long have you lived in Australia?:

Have you become an Australian citizen? If so, when and why?:

What is your first language and what other languages do you speak?:

Are you married?:

Do you have children?:

Ages and sex of children:

Living at home, if not, where do they live?:

Extra Information:

Education

What sort of education did you receive before coming to Australia? How many years and what level attained?:

What sort of education have you had since coming to Australia?:

What formal skills and formal qualifications do you have? Where did you obtain these skills? (e.g. apprenticeship):

What other skills and qualifications do you have? (e.g., farming, business):

Do you read and write Hmong, English, or any other language?:

Extra Information:

Employment

What sort of work did you do before coming to Australia?:

Do you currently have a paid job outside the home?:

Where do you work?:

What sort of work do you do?:

How long have you been there?:

Extra Information:

Religion and Beliefs

What sort of beliefs do you and your family follow?:

What do these beliefs involve?:

How do you practice these beliefs?:

How has this changed since coming to Australia?:

Or, why haven't you changed religion since coming to Australia?:

Extra Information:

Historical Information

Before coming to Australia, did you live in a city, small town, village, farming community, other?:

How long did you live there?:

What sort of work did you do there?:

When did you leave Laos?:

Why did you leave?:

Did you go to a refugee camp or come directly to Australia? (or somewhere else):

How long were you in a refugee camp(s)?:

Where was the refugee camp(s)? (Name):

Were you alone or with your family?:

When did you arrive in Australia?:

Can you tell me some of your reasons for coming to Australia?:

Did you stay in a Migrant Hostel when you first arrived?:

Which one?:

How long did you stay in there?:

If you didn't stay in a Migrant Hostel, where did you stay?:

How long have you lived in this house?:

Was there any special reason for coming to live in this area?:

Are you renting or buying this house/flat?:

Extra Information:

Changing Culture

Can you tell me something about the traditional role of various family members, for example, of the father, mother, grandparent, son, daughter, eldest child, (or others)?:

How do you think these roles have changed since coming to Australia? In what ways?:

Do you think that these roles already changing before arriving in Australia? Please explain:

How would the following events traditionally be celebrated or practiced, and how do you practice them in Sydney? (birth, marriage, death, naming of child, healing, sickness in family or group, New Year celebration, others?:

What other rituals and ceremonies are important to your family? Are they still practiced in Australia?; Have they changed, if so, in what ways? Please describe:

How are various family and community members involved in these events?:

Extra Information:

Community Information

Do you have meetings especially for your community? What sort of things are talked about at these meetings?:

Can you tell me more about your community meetings?:

In what ways do the community leaders help you?:

Extra Information:

Part B: Health Behaviour Information of Hmong Community

System of Care in Laos

In Laos, what sort of medical care was available to you?:

Would you tell me about your health care system you used before coming to Australia? Ask questions such as:-

- the role of the Traditional healer:
- was there more than one Traditional healer? If so, how many and how did they differ from each other?:
- how did you make the decision as to which type of healer to use?:
- what sort of illnesses were they able to treat?:
- what sort of illnesses did Western health workers treat?:
- do you prefer one type of medical care to the other? Why?:
- did anyone administer Western medicine? If so, who? (Western trained doctor/nurse, traditional healer, trained health care worker, untrained person):
- what sort of costs were involved if you needed to see a medical person?:
- what would happen if you couldn't pay?:
- what helped you decide which type of healer/medicine to use?:
- what did you like about Traditional medicine?:
- what did you like about Western medicine?:
- what didn't you like about Traditional medicine?:
- what didn't you like about Western medicine?:

Can you tell me about changes you have seen in medical care in your home country over the last 10 years?:

What did you like/didn't you like about the changes?:

Extra Information:

Refugee Camps

Can you tell me about living in the refugee camps?:

How do you think this affected your health and your family's health?:

What sort of medical care was available in the refugee camps that you were in?:

Who provided it?:

What else was available?:

How did people deal with their health care needs?:

Please tell me about it?:

Extra Information:

B: Health Care Behaviour in Australia

Migrant Hostels

What was your health like when you arrived in Australia?:

Would you tell me about the medical care you received when you first arrived in Australia and while you were staying in the Migrant Hostels:

What did you like or dislike about the health treatment you received when you first arrived in Australia?:

Did you want to or you allowed to use traditional treatments?:

Did anyone ask if you wanted to use traditional treatments?:

Extra Information:

General Health Care Behaviour

Is there any specific doctor that you go to when you are sick?:

Who is this doctor?:

How did you choose this doctor ?:

For what reasons would you go to a doctor?:

Is there anything you particularly like about your doctor?:

What don't you like about the doctors in Australia?:

Do you think that sometimes the doctor you see doesn't understand your problems?:

Please explain how:

Is the cost a problem when you go to an doctor? (i.e.; fees, medication, time off work, other):

Are there any Western trained doctors from your own community?:

Do you prefer to go to them when you are sick? Why/ why not?:

Extra information?:

Hospitals

Have you ever been to hospital in Australia?:

Could you tell me about your experience in a hospital?: For example:

- reasons for going to hospital:
- what sort of people did you see in the hospital?:
- what did you like about the hospital care?:
- what didn't you like about the hospital?:
- have you had to go to outpatient services in the hospital? If so, can you tell me about it?:

Extra Information:

Women's health care

Would you please explain what you would traditionally do when you were pregnant?:

Had this changed before coming to Australia?:

In what ways?:

What would you now do if you were pregnant?:

How do you think this changed from your traditional practices?:

What do you like or dislike about each system?:

Would you please explain:

Have you been told or do you know about screening for certain diseases?:

What information from doctors are you given specially about women's health?:

Extra Information:

Children

What do you usually do when your children are sick?:

What sort of things do your children think of using different types of medical practices?:

Extra Information:

Language

Do you have any problems with making yourself understood when you go to a doctor at a clinic or at a hospital?:

How do you communicate with the doctor or other medical staff?:

Is an interpreter available for your language?:

Have you used an interpreter?:

Do you think an interpreter helps? Why/ why not?:

Is there translated information available for you in your own language to read about medical and other health services?:

If so, do you use it/ find it useful/ don't read it/ can't read it/ don't understand the medical terms/ other?:

Does a language problem stop you from getting information on health services?:

Do you think communication could be improved? If so, how?:

Extra information:

Traditional Healers

Do you use a Traditional healer(s)?:

How do you find out about Traditional healers?:

When would you go to a Traditional healer?:

What do you like about seeing a Traditional healer?:

Is there anything you don't like about Traditional healers?:

What costs are involved in seeing a Traditional healer?:

When would you go to both Traditional healers and Australian doctors for the same illness?:

Extra information:

Health-related Problems Commonly Reported by the Migrants

How healthy do you think you are? (excellent, good, fair, poor, don't know?):

Do you think you are healthier in Australia or do you think you were healthier before you came to Australia? Why?:

Do you have different health problems now you live in Australia? Please explain:

Do you smoke? More or less than before? How much?:

Do you drink? More or less than before? How much?:

Do you think your different lifestyle affects your health? Please explain:

What do you like or dislike about Sydney?:

What do you miss, or do not miss, about Laos?:

Are you privately insured or Medicare patients?:

Extra information:

Questionnaire for General Practitioners used by the Hmong

Did you know that a small number of your patients are Hmong?:

Do you think that you are able to distinguish Hmong patients from other Southeast Asian patients?:

(if not, provide a sample of family names to help the doctor identify Hmong patients, explain who the Hmong are, and start interview again)

Do you know long have you been treating Hmong patients?:

Do you know why this group of people come to your practice?:

What medical service do you think that your practice provides to the Hmong community that you think that they appreciate?:

What sort of illnesses does this group of people come to see you about?:

Do they have different illnesses to your other patients?:

Do you think that Southeast Asians have different illnesses to your other Australian patients?:

Do you encounter any problems with treating Hmong patients, if so, what sort of problems? (such as problems with compliance, lack of trust, lack of understanding medical language, illnesses, symptoms, medication, problems with payment, especially for medication, other):

Are there ways that you can keep medical costs low for certain patients?:

Prescriptions: Do Hmong patients ever ask you to keep the number of prescriptions to a minimum? Do they ask you to prescribe less medication than you think is necessary?:

Do you have any idea whether they purchase all the medications and follow the full course of medication?:

What do you do to overcome such problems?:

Do you think that there are problems of understanding because the Hmong are from a different culture? Explain:

Do you think that there are problems with the cost of medical care for this group of people? Explain:

Are there times when you need to use an interpreter? Can you tell me about this:

Is it easy to arrange for a professional interpreter if you need to use one?:

Are there still problems when an interpreter is used? (patient's don't understand medical terms, other):

When do you think an interpreter is absolutely necessary?:

If you don't use an interpreter, and there are some communication difficulties, what do you do? If the patient can't speak English, what do you do? (Use interpreter, relative or friend who can translate, don't need to use English, nothing, other):

What languages do you speak?:

How well are Hmong able to explain their symptoms?:

Do you have to spend extra time with Hmong (or other NESB) patients because of their poor skills with English, is this a problem?:

(such as understanding their illness, explaining their illness to them, and explaining the course of medical treatment)

The Hmong continue to use traditional Hmong medications in Australia, such as herbs, and sometimes, spiritual healers.

Do any of your Hmong patients ever mention that they use other medical treatments?:

Does it concern you if they did? In what ways?:

Do you think that Hmong patients delay visiting the doctor so that when they do come, their illness is more advanced? Or, do these patients visit the doctor at the 'appropriate' time?:

What quality of health do you think that your Hmong patients have in comparison to your other patients?:

Extra Information:

Appendix Three: Newspaper report

Cultures clash as nomads confront US medical law

By ROBERT LUSETICH in Los Angeles

A TEENAGE girl's refusal to undergo chemotherapy for a diagnosed cancer has brought to a head an ancient culture's struggle to survive in modern America.

When Lee Lor's family chose to pursue traditional herbal healings and consult their shaman about their daughter's ovarian cancer, a local welfare agency took them to court where a judge overruled the family and ordered the chemotherapy.

The 15-year-old girl responded by packing her herbal medicines and Hollywood teen-idol posters and running away from home, spending the last month on the run from authorities.

"I don't want you guys to cry," she wrote in a note to her family. "If I stay, there is so much trouble for me."

Her story has touched off tensions among the 30,000 Hmongs, refugees from the mountains of Laos, who have brought their 16th Century tribal customs to Fresno, an agriculturally rich city of 400,000 in central California.

"This case is about a big misunderstanding. The doctors and the social service people don't understand our culture," said Mr Shur Vangyi, a Hmong liaison officer.

The nomadic Hmongs, without a written language until French missionaries arrived 30 years ago, believe physical sickness has a spiritual root.

Shamans perform rituals to relieve the spirit of past-life burdens often thought responsible for the illness.

Western medical science gives little credence to such philosophy and doctors maintain Lee will die if not treated. But the Lor family does not even believe she has cancer, for which there is no word in the Hmong language.

Their chief concern is that chemotherapy will destroy their daughter's ability to bear children and therefore make her unmarriageable.

"If she cannot have children, she will not have that worthiness," Mr Vangyi said.

In Hmong culture, girls as young as 12 are encouraged to marry and bear many children. The average Hmong family numbers nine, by far the highest of any ethnic group in the United States.

Although this is not the first cultural confrontation over a medical issue (a few years ago a mother held police at bay with a gun because they wanted to take her son to a hospital to have a cancerous testicle removed) it is the first time Fresno authorities have not compromised.

"If she can be cured, the law is very clear. We have to intervene, we have to force the issue," said Mr Ernest Velasquez, the head of the social service department, which took the family to court.

Assimilation problems with the Hmongs, who began arriving from Thai refugee camps in the late 70s, have been longstanding, primarily because of the group's reliance on welfare. Two in three Hmongs in Fresno receive government handouts, the highest welfare rate of any ethnic group in the US, Mr Velasquez said. But many feel entitled to the money because of their ferocious support of the Central Intelligence Agency's anti-communist wars in South-East Asia.

"They paid their way here with their blood," acknowledges Mr Velasquez. "We (the US) promised them that we would protect them and help them. But some of their leaders have not made it clear this is not CIA money — it's welfare money."

Police have urged Mr Velasquez to carry a gun since he took the Lor family to court, while some of his officers have been physically abused by Hmong who do not want their welfare threatened. But Hmong leaders claim the welfare system to be the real villain.

"It's a system that rewards lazy people," the president of the Hmong Council, Mr Houa Yang, said. He said Hmongs who went to French Guyana, where there was no welfare, were very productive, but in the US, where welfare payments are linked to family size, the average Hmong father makes more from social security than by working in an unskilled job.

Other Hmong customs have caused difficulties in Fresno, including the practice of burning paper money and sacrificing animals in a three-day burial ritual, which led to one funeral home last year being burnt to the ground.

The Hmong, which means "free people", have for 2000 years been nomads, going from China to Vietnam, Cambodia and finally Laos.

"It's a pity," Mr Velasquez said. "They're a very, very independent people. Very good warriors and family people. Nobody's been able to conquer them for 2000 years."

The Weekend Australian, 10 December, 1994.

Appendix Four: Hmong traditions in Sydney

There were several ceremonies that most members of this community continued to practice in Sydney. They were the New Year celebration, naming the new baby, marriage and funeral ceremonies. All had been modified, as would be expected in a community that had experienced so many disruptions, especially in moving to a new country. The modifications that have been made to the ceremonies give some idea of the extent to which their lifestyles have changed with resettlement in Sydney.

New Year

Traditionally this ceremony takes place at the end of the harvest in November or December. It had been moved to coincide with the Australian Christmas break for convenience, as it was the one time of the year when everyone had some time off work. It remained a time for families and the community to 'get together' and 'wish each other well for the next year'. New Year also provided an opportunity for the community members to dress in traditional dress, which they either still sewed themselves or bought ready-made from Hmong in the USA, play Hmong music and sing traditional songs, enjoy their culture and involve their children in the more traditional aspects of that culture. The community generally hired a hall in the local area where they could gather together and celebrate the festival. Most community members were involved in this ceremony and enjoyed attending. Some participants described how they would have celebrated in Laos, and how this had changed in Australia:

> D(F29) In Laos, we sing songs, dance, throw the ball, and play for one day. While there is no special food for New Year, this is a time when we do eat meat. Every year, we would sacrifice chickens and pigs for New Year, as well as eat the freshly grown and harvested rice, which obviously tastes better than rice that is a year old.

> A(F29) In Laos, New Year used to last for one month, once all the harvest has been completed, thus, generally for the month of December. This was a time for

choosing a partner. Young girls and boys would 'play ball' for most of the day as a way of choosing a partner.

In Australia, it is generally for one weekend only, as close to December 30 as possible. It has been changed because people must follow the working week in Australia. It is a time for family get-togethers and also there is some 'playing ball' ('Play ball' is how boys and girls choose a marriage partner). It is a pretty quiet affair, there will be a party in the hall; boys and girls may still 'play ball' but only for about 10 minutes.

In USA, Hmong New Year celebrations go on for a week, because there are more Hmong and because most businesses close down over the Christmas break.

B(F33) In Laos, the family sacrifices one egg and 2 chickens at New Year. All the spirits that live in the house are called home and then the chickens are killed. People were able to 'read' the chickens' feet and were able to tell if the next year was going to be good or bad. If the next year was going to be bad, then more spirits would be called in to help the family have a good year.

The chickens must be 1 female and 1 male; the female is for the men's side and the male is for the woman's side. The egg is something special, like a lolly, and it is for everyone.

In Australia, we still do the same. Usually it is November, but it depends on the moon. Last year, it was on the 28 November. The same thing is done with the chickens. On the night of the New Year, the chickens are sacrificed and each family is at home for the celebration. The next day, everyone goes from house to house, to see the old people to beg for a lucky wish. The old people pledge good fortune to you.

The New Year celebration and its function of getting the community together continues to play an important role for this group, even though many of the rituals have been modified and it no longer coincided with the farming calendar.

New baby ceremony

This ceremony traditionally takes place 3 days after the birth of the baby. It is now held on a day as close as is practical to this time. The ceremony remained important because it calls upon the baby's ancestors' spirits to protect him or her, something which all Hmong parents who have retained their traditional beliefs wanted for their children, and which was probably encouraged by the older members of the

community. While the parents of the baby were involved in the ceremony, many said that they were unsure about what to do; they necessarily relied upon the elders of the community to perform the ceremony. Several were concerned that they did not know what to do and would like to learn.

'Australian' names were increasingly being given to Hmong children, mainly 'because they were born here'. Most still had a Hmong name, but they would be called by their Australian name. Several participants described how the naming ceremony was done now that they were living in Australia. While there is some variation in the actual ceremony, the general aim of calling on the spirits of the ancestors of the new baby for protection for the baby was still the same:

> A(F29) When the baby is 3 days old, 2 chickens of different sexes are sacrificed with one egg. This is to call the spirit to come home to the family. At this time, the baby is given a name. This is usually performed by the older people of the community. At a later time, a big party is held for the baby at any stage between 4 months and 1 year to celebrate its birth. All the family is invited to announce that there is a new baby. This is still done in Australia by most of the Hmong.

> B(F33) After the baby is 3 days old, then there is a ceremony for the baby to call its spirits home. In Australia, it is done after the baby gets home, maybe a week or a month later. The spirits of grandparents who have passed away are called to protect the baby and help it while it is growing up. Money is offered to the spirits and they are invited to the party. There is no custom as to how to name the baby; the baby is given a name that the parents like.

> O(F19) We would welcome the baby into the house with a little ritual soon after he or she is born. After a couple of months, you tie a white string around the baby's wrists to wish them luck and welcome them into the world. It is worn for a couple of days, during which time people 'put their wishes on it', then it can be cut off.

> C(M42) We have at least a small ceremony for the new baby, where we kill a few chickens, call the spirit of the newborn child, give the child a name; this is whatever the family feels like calling the child. We have a Ceremony of Introduction for the child so that it can be acknowledged by the ancestors. We would say something like: 'Today we have a newborn child and we call you to celebrate with us'. If you want, you can organize a bigger party, tie string

around the baby's wrist (for spirit protection), and call lots of friends to come to your house for a party. Most Hmong follow this ceremony.

D(F29) After 3 days, we have to choose the child's name, have a small party with the family, tie a string around the child's hand. I don't know what the string is for but it is part of our tradition. We call the spirits to come and stay with the family and help the family name the child. The string stays on for 3 to 4 days, up to several months. In Australia, because the mother and baby are still in hospital 3 days after the birth, the ceremony is postponed until after they both come home, at 5 to 7 days.

In Laos, the mother and baby do not go outside for the first month after the birth. They stay inside all the time. Now, because they go to hospital for the birth, day 1 is the day the baby arrives at home, so day 3, for the ceremony, is the third day the baby is home.

G(M25) We performed this ceremony when we named our children. We give a name to the child, we chose the Australian name for our children, and the Hmong name was chosen by the older Hmong, generally the grandparents. The parents of the newborn child are allowed to chose the Hmong name, but if it is not acceptable to the older Hmong, then they must choose another name. We killed a chicken, which had to be alive (an already dead one is not a suitable substitute). We killed it in the laundry in our block of flats. I am not really sure of the significance of killing the chicken and the rest of the ceremony.

The ceremony was still very important for many in this community and its role was essentially the same, that is, to protect the baby. Several modifications to the actual ceremony had occurred, such as when the ceremony was held, and how many and what animals were sacrificed. Several of the younger participants recognised that they really did not understand exactly what to do, they relied on the older members of the community to perform the ceremonies.

Marriage

In Australia, marriages generally involved both a Hmong ceremony, where the couple wear traditional Hmong clothing, and an Australian ceremony at the Registry Office, where the couple would wear Australian style wedding clothes. Marriages were probably taking place at an older age for both males and females, as shown by the number of young adults in their early twenties still studying and

living at home with their parents. Polygamy is illegal in this country, and bride price was officially frowned upon by the Hmong leaders, however the latter at least was still occurring within this community. Certain other customs were also continuing: the new couple would still generally move in with the husband's parents after the wedding for a period of time to be determined by his parents. In Australia however, because of the fragmentation of families caused by the war, this new family unit may remain for a longer period of time especially in cases where there are no other males or sons to care for the parents. Some descriptions of marriage and how it now takes place in Sydney follow:

> A(F29) In Laos, usually a ceremony is held at home. The couple then must stay at the home for 3 days. After 3 days, two chickens are sacrificed with one egg and then the couple are free to go away. The chickens and egg are then eaten, only by those who want to, I am not keen on eating these chickens. The two chickens mean that the married couple will have one girl and one boy.
>
> In Australia, people are starting to have two ceremonies, the Hmong ceremony where they wear traditional Hmong clothes, and a second Australian ceremony where they wear traditional Australian wedding clothes. Often, a hall is hired for a wedding. This is what the young people seem to want now that they are living in Australia.
>
> B(F33) In Laos, you only go to church if you are Christian or Catholic. Otherwise, the families of the couple get together and the husbands' family pays money (bride price) to the wife's family for the new wife. The families coming together acknowledge that the man and woman want to get married and thus they are married. Afterwards, they kill a pig, and then there is a ceremony and the rest of the villagers are asked to come and celebrate the wedding. They wear 'New Years' clothes.
>
> In Australia, I am not sure if money is still paid. There is a party, the marriage is registered with a Civil Celebrant. Most people are married in a hall. They wear Hmong clothes first and then to register the marriage, they wear Australian wedding clothes.
>
> C(M42) They have downgraded this ceremony a lot in Australia. I have only seen one wedding here. They wore Hmong clothes, because when you start a new family (i.e. when you get married), you must wear something nice so that you can have a good life, a good start. I think that they had a Hmong ceremony first and then later went to the Registry Office for an official service.

D(F29) We had a Hmong ceremony, wore Hmong clothes only. We think it is cheaper to wear Hmong clothes than Australia wedding clothes. We think that it costs $10,000 to have an Australian style wedding, whereas it only costs about $1000 to have a Hmong wedding. In Laos, there is no such thing as a wedding certificate. I don't think that there have been many marriages within the Hmong community so far.

H(F19) There is still an exchange of money at a marriage in Australia. In the old tradition, all the relatives would offer the new bride a small gift. That is added on to the value of the wife. The husband pays the money to the wife's family. The wife's family had to provide all the food for the wedding. The wedding celebration can go on for 3 days and 3 nights, non-stop. Generally it is in someone's house.

M(M28) We had a traditional Hmong ceremony. We wore Hmong clothes. For the first 3 days, we can wear anything we want, and then, on day 3, we wear special clothes for the wedding ceremony. After that, we went back to the bride's parents' house. The ceremony was generally performed by an old man.

We also had an official Australian ceremony, we hired a hall and asked a marriage celebrant to come and officiate.

E(M31) In Laos, marriage depends upon the families. If they are both rich and really like each other, then there will be a very big celebration. They will drink whisky and kill many pigs and cows, eat for three nights and three days, and invite over one hundred people. The groom's family must give money to the bride's family. If she is very beautiful and the groom really wants to marry her, then they will give a lot of money to the bride's family for the bride. And we still do this in Australia. I am not sure how much money exchanges hands in Australia but I think that it is probably very cheap, about $1000 to $2000 only.

In Laos, we would use silver bars and would give the equivalent of $2000 to $3000. I think it is also cheaper in Australia because Hmong don't buy expensive wedding clothes like Australians do; we wear our Hmong clothes.

Payment of bride price was still common within this community. It was difficult to estimate exactly how much is exchanged, but it appears to be considerable according to the above account {E(M31)}. Hmong were still marrying Hmong, as discussed in Chapter Three. The community association was trying very hard to prevent young teenagers, mainly girls, getting married, as would happen in traditional society, both because it is against Australian law and because they were trying to encourage

teenagers to gain an education. Teenage marriages did not appear to have taken place within the Sydney community.

Funerals

Traditionally, the funeral ritual extends over 3 to 5 days and takes place in the family home of the deceased, with the body present. It is a noisy, elaborate and exhausting ceremony, the extended community is involved and animal sacrifice is important. For more recent funerals in Sydney, special permission was obtained to bring the bodies home for a shortened period of time so that the appropriate rituals for this occasion could be performed, and animals sacrificed, either chickens or larger animals. Neighbours were informed of what would be happening for the next few days. Through this process the community had regained some control of an important ceremony. In other respects, they had to come to terms with certain aspects of death in this country over which they had no control, such as lack of choice of burial site, and autopsies, which were performed without permission of family members as is in accordance with Australian law (Falk, 1994). There had been several funerals within this community in the past few years; three of them, for 3 teenagers who drowned in 1992, have been well documented (Falk, 1994).

Some participants commented that they did not like following Hmong funeral customs because they were too noisy and must be annoying and disturbing to the neighbours. Some were quite self-conscious over how the funeral customs made them 'stand out' within the local community. The other customs discussed above were either quiet affairs such as the baby naming ceremony, or could be held in a hall where the noise would not disturb the neighbours, such as the marriage and New Year ceremonies, and could therefore be followed without bringing too much attention to the community. Traditional funerals, on the other hand, were inherently much noisier and more visible, and could bring a lot more attention to the Hmong community, which some members felt uncomfortable about. Some participants described both what they would do traditionally, how the ceremonies had been

modified in Sydney and in some instances, how they felt about funeral practices in this country:

A(F29) In Laos, the body remains at home for 4 days before it is buried. The body is buried in a place that the dead person has already chosen. Their wishes must be respected. If you don't do it, then the family is regarded as being no good. The spirit of the dead person will keep coming back and the family will become really poor. That's what we believe.

In Australia, the body is brought home overnight or for a day before it is taken to the cemetery. This is so that special ceremonies can be performed. Special permission was given to us for this to be done. The ceremonies are performed in order to send the dead person's spirit back to their ancestors so that they can live with them. The elderly people perform these ceremonies.

Even now, many Hmong, especially the elderly, would still like to be able to choose where they could be buried, however this is not possible in Australia.

Our mourning period lasts for 13 days; during this time, we are not allowed to wash our clothes, sew anything or comb our hair. But we can go to work. In Australia, we do change our clothes, but as infrequently as possible.

B(F33) Hmong traditionally bring the body home and certain customs are involved. One or two people play the drum, and the spirit of the dead person is sent to heaven. It is necessary to send to spirit to heaven because it cannot do it by itself; it might get lost if it doesn't know where to go. Then the body is taken to the burial site. In Laos, the body would be home for 1 to 2 days, but in Australia the body can only be home for less than 1 day. If you are a Christian, then you don't do this.

In Laos, bodies are buried wherever they want. Bodies are buried often somewhere near the house. At my mother's house, there was someone buried very close to the house and I found it very scary.

G(F25) In Australia, we follow the Hmong customs of bringing the body back to the house and performing Hmong customary death procedures. We believe that we need to follow our Hmong customs so that the body can be taken back to where it came from (to the spirit world)

E(M31) In Laos, if someone dies, we don't use coffins, we put the person on some tree branches. We get someone who knows what to do to send the dead person back to heaven. This knowledge is passed down from the parents to their children. We don't use a shaman to do the death ceremony, we use another person. After they have done the ceremony to send the person to heaven, then they use the drum and make music to celebrate the dead person.

> The dead person stays in their home for 3 to 4 days. We kill some pigs for them to take to heaven, because even though their body is dead, their spirit is alive and it needs to take food to heaven. If a rich person dies, then each of their children must kill one cow each for their dead parent.
>
> It is a problem in Australia because less people know what special custom to do when a person dies. I have been to some funerals in Australia. Last year three young boys drowned in Audley (1992). Another old lady died too. We did similar things to what we did in Laos. But we were not able to kill animals or the appropriate animals and this worries me. We didn't kill any animals. So those (deceased) people don't have those animals. The council wouldn't allow us to bring a cow home and kill it. So we have lost that custom.
>
> Another problem of conducting funerals in Australia for us is that there are less people who know what to do for a death ceremony, so I am concerned that they may not have had the correct ceremony.

In summary, the funeral ceremony and related rituals had been considerably shortened and modified to 'fit in' with their new environment. Interestingly, the community had been able to maintain some aspects of the ceremonies which most thought would be lost; one important gain was obtaining permission to have the body at home for a short period in order to perform some of the rituals. In addition, the worry by some about the disturbance to the neighbourhood of the funeral may be unfounded; neighbours were informed that a funeral was about to take place, and there were no complaints.

Appendix Five

Women's role and women's work in contemporary Laos

During a field trip to Laos in January, 1997, I had the opportunity to visit a Hmong village and speak with the second wife of the village leader (with the help of an interpreter), and observe some aspects of village life for Hmong women, albeit too briefly. However, the visit did provide a glimpse into a lifestyle that Hmong women in Sydney had left behind. This account is provided to help appreciate some of the Sydney women's comments about the vastly different lifestyle they now lead.

The village, Huai Nhyaang village, was in the Vangvieng District, situated on the edge of the Nam Ngum Reservoir (Map 3.1) (Photo A5.1 and A5.2). It had only been settled for about 6 years. Resettlement took place in line with Lao government policy to establish sedentary cultivation and move villagers into less isolated areas. The former village was 3 hours walk away. There were about 62 families in Huai Nhyaang; another 30 have remained in the older village. All movement in and out of the village was by boat or on foot.

The woman who was interviewed was 65 years old and was the first wife of the village leader. She had married at 14 years old and had had 11 children. Some of her children were living in the United States, and some had remained in Laos. During the interview, she became upset as she recounted how difficult life was for a Hmong woman. She never went to school, and deeply regretted not being able to read and write, especially now that she needed to correspond with her children in the United States. In addition, she still had to do lots of physically demanding work. The second wife had had five children to date.

Photographs A5.1 and A5.2: Huai Nhyaang village, showing the Nam Ngum Reservoir in the foreground and farming areas on the low slopes of the hills in the background.

She felt that living conditions in this village were better than in their previous one as now they were able to sell produce at a local market to earn cash income. Thus they grew bananas, mangos, papaya and rice. Turkeys were also sold at the market. Handicrafts were either sold at the market sent to the United States where their children could sell them (Photo A5.3). Their greater cash income had helped raise the standard of living in the village, but now there were more things to spend their cash on, such as tools, food, boats and fuel. Education expenses included books, uniforms and fees.

The villagers' reasons for moving to this area were diverse. They included factors such as better access to Western health care, that the children could attend the nearby local school, better opportunities to earn cash income, and also because the government had restricted the amount of land that they could clear to farm near their previous village. In order to expand their farming land, they had to move into this area and buy land from the nearby Lao villagers.

Water was a major problem in this village. In the previous village, water came from a mountain spring, but in Huai Nhyaang, the water had to be collected from a well. It was the job of young girls and women to get the water from the one well which supplied the village (Photo A5.4). All water from the well had to be boiled. In the dry season, the well could get very low and they had to look for other water sources, while in the wet season, the water got very dirty. The path to the well was steep and difficult to negotiate even when not carrying water, but even the older women still had to go to the well to collect water. There had been talk of a project for building a water pump but it had yet to eventuate.

The women also grew many vegetables and tended to the domestic animals. While I was there, I was at times surrounded by turkeys, chickens, ducks, dogs and pigs, which all foraged continually throughout the village and kept up a constant noisy racket (PhotoA5.5, A5.6, A5.7). There were also pigeons, bulls and cows which were

in enclosures. The domestic vegetable gardens were fenced to keep the animals out (Photo A5.8) Other farming takes place away from the village.

There was a Primary school in the nearby Lao village, less than 10 minutes walk away. If older children were to continue their education beyond this level, they had leave the confines of the village to attend a Secondary school. In this village, only boys continued their education as it was not thought to be safe to allow girls to leave the village on their own. There was little encouragement for girls to continue with their education as many were still marrying at 14 and 15. While I was in the village, some young teenage girls and boys were 'tossing the ball', a traditional way for Hmong to choose marriage partners (Photo A5.9, A5.10). Polygamy still occurred, but to what extent was not established.

The medical clinic was a half hour's walk away but most people continued to rely on traditional herbs, including bark and leaves. The villagers had retained a forest area close to the village for two main reasons: they believed that their ancestors' spirits lived there, and because they used many of the forest products for medicine and in shaman ceremonies. They also bred pigeons both to eat and for medicine.

What is significant about this interview is that although it took place in 1997, very little appeared to have changed from the accounts given by Hmong in Sydney, who were recounting their memories of Laos in the years before 1975, over 20 years earlier. The interview found that the status of girls and women was still very low. Their education was minimal and less than that of the boys, the marriage age remained low and women and girls continued to perform much of the time consuming and physically demanding domestic work around the village.

Photograph A5.3: Woman making traditional needlework.

Photograph A5.4: Girls getting water from the well.

Photographs A5.5 and A5.6: Scenes of Huai Nhyaang village showing the free-roaming domestic animals.

Photograph A5.7: Huai Nhyann village showing a woman feeding her chickens.

Photograph A5.8: One of the fenced domestic vegetable gardens.

Some major changes had occurred related to cash income as there was now more opportunity to earn cash by selling produce at the markets, and women could earn money for their handicrafts by selling them in America. The corollary was that now they had more things on which to spend their money, which was a similar lament of one of the Hmong women in Sydney:

> C(F41) One problem with Australia is that there are too many bills. Even though we own our own house, we still have to pay the council for services, and electricity and water. In Laos, more things like water were free.

Life was not easy for either group of Hmong, but for Hmong women in Sydney, removing many of their time consuming domestic tasks has freed up their time considerably, a dramatic change in lifestyle which most Sydney women had appreciated.

Photograph A5.9 and A5.10: Young girls wearing their New Year clothes and playing 'catching the ball'.

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