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This study is intended to provide information about the situation of first-generation Vietnamese women to the IRCO Parent and Child Program Department in Portland, Oregon. Nutrition intervention and food assistance currently offered to Vietnamese women enrolled in this program is the focus of the study. The women interviewed characterize themselves and their eating patterns as Vietnamese, though many changes in practice and concept reflect those of American culture. The study reveals several categories of food acculturation that act both separately and influence the development of each other. These categories are diet, taste, solutions, and concepts. Recommendations are made according to the categories and process of acculturation demonstrated by the participating women and the effects of this process on the health of the women and their families.

ACCULTURATION AND FOOD: A STUDY OF VIETNAMESE WOMEN IN PORTLAND, OREGON

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ACCULTURATION AND FOOD: A STUDY OF VIETNAMESE WOMEN IN PORTLAND, OREGON

Chapter 1

INTRODUCTION

The Immigrant and Refugee Community Organization (IRCO) provides assistance for refugees and immigrants in Portland, Oregon. The Parent and Child Program Department offers services for parents, including home visits for low-income families with children under age six. This parenting program at IRCO provides education and support for raising children. Services related to nutrition include child nutrition information, language assistance and reading food labels. The Department is also connected at various levels with agencies that provide nutrition-related services to their clients, such as the Oregon Food Bank and the Special Supplemental Program for Women, Infants, and Children (WIC).

This study is intended to explore the ways that Vietnamese women have changed as a result of differences in food and aspects of culture having to do with food between Vietnam and the United States. The purpose is to provide the IRCO Parent and Child Program Department a description of those changes and to relate it to nutritional intervention and food assistance currently offered to the women. The Department will gain a deeper understanding of the effects of acculturation on nutrition and food-related activities of their clients. This will benefit their clients through improvements in the Department's programs and their relations with affiliated agencies. This study also explores the complexities involved in the process of acculturation, specifically as it applies to the disciplines of public health and nutrition.

Setting

At the Department, according to its director, approximately 75 of families enrolled in the program (total 190) are Vietnamese. Not all of the Vietnamese families are considered 'refugees' by the United States government, but most came as a result of the displacement effects of the Vietnam War, such as joining family members. For this reason, this study refers to Vietnamese refugees and immigrants as "displaced." There is a significant Vietnamese population in Oregon. In Washington and Multnomah counties, 15,933 people reported Vietnamese ethnicity in the 2000 census (including Vietnamese-American), 1.4% of the total populations of the two counties (U.S. Census Bureau, 2001a).

Displaced Vietnamese families have also been resettled throughout the United States, mainly in Southern California, Texas, Florida, and New York (Kasper et al., 2000). In 2000, the number of Vietnamese in the United States was 1,122,528 (U.S. Census Bureau, 2001b). The population is projected to increase to 4,000,000 by 2030 (Ikeda et al., 2002). Displaced Vietnamese coming to the United States will continue to settle in Portland, mainly through secondary migration, as they have in the past (McKee, 2000).

According to IRCO's parenting department, about 90% of enrolled families in their programs have low-income status. Poverty is a well-known contributor to hunger and nutritional deficiency. To compound the problem, many low-income displaced Vietnamese have limited English skills (Ikeda et al., 2002). This leads to problems such as inability to read food labels and unfamiliarity with US nutrition education material (Satia-Abouta et al., 2000). The Department is concerned with the availability of traditional foods for Vietnamese families, as well as accessibility of nutritious and inexpensive foods. These concerns are echoed in the literature (Satia-Abouta et al., 2000; Yi-Ling et al., 1999).

Defining the problem

As displaced persons, Vietnamese in the United States face challenges such as low income, little knowledge of the language, food products, and food contents in America,

and the necessary changes in their food habits. The significance of daily activities, such as obtaining and eating food, are changing as well as circumstances (Mintz, 1996). The women's role in the home is challenged by new expectations for women from their family and American society. Food-related activities and women's roles change as a part of acculturation (Devine et al., 1999), which is negotiating accustomed ways of living and thinking within a new culture. Changes in food habits of Vietnamese families have direct effects on their nutrition and, consequently, health (Ikeda, 1999).

In many cases it is Vietnamese women who carry the responsibility of obtaining food and preparing meals for the family (Kibria, 1993). Those fulfilling the food-provider role are faced with become accustomed to the food system and related social structures of the United States. Vietnamese women and their families undergo a pattern of transition shaped by the food system and social structure and by acculturation, and this pattern will have effects on nutrition and finally health of the women and their families.

Chapter 2

LITERATURE REVIEW

Theoretical background

The treatment of food in anthropological theory can be described by two categories: materialist and symbolic. Materialist perspectives have been defined by Marvin Harris, who describes cultural phenomena such as food and eating as mediators between people and the environment (1985). More recently termed biocultural, this approach considers physical and social environments, including social and political structures, as determining culture and behavior (Himmelgreen, 2002). Nutritional science shares this perspective in its focus on the biological need for food (Lupton, 1996).

Symbolic perspectives focus on the meaning of food and elements of culture. This approach defines culture as symbols that express the worldview and identity of those in the culture. Food is an example of a public symbol (Geertz, 2000). The symbols also act to uphold the social structure; in the case of food, according to Lévi-Strauss, distinctions between food that is not eaten and food that is eaten maintain social structures and separate people from animals or other peoples (2000).

Humans, culture and society, and physical environment are the three major groups of factors having to do with food and nutrition (Johnston, 1987). Biocultural and symbolic approaches to culture and food recognize the interaction between these factors. The approaches differ in their understanding of the direction of flow of factors and their affects on food and nutrition. Symbolic approaches social and structural functions that overlay environmental or biological influences on food and culture (Lupton, 1996). Biocultural approaches ascribe causation to the environmental factors. Culture and symbols are created as a result of the environment (Harris, 1985).

Biocultural and symbolic approaches make assumptions that do not capture the reality of how people eat. A major assumption in both perspectives is that people will naturally choose to eat a diet that maintains physical health, and that there are either environmental or social factors that prevent them from doing so (Lupton, 1996). Nutritional anthropologists such as Dettwyler have found that this is not necessarily the case (1994). Another major assumption is that the causation occurs in one direction, that is either from environmental causes to cultural effects or cultural causes that overlay environment. On the other hand, environment, biology, and social factors all act as causative factors and as results in different contexts. For instance, the physical and social environments set the terms for food practices, as Mintz discusses, but at a time when a culture is threatened in some way, symbolic factors rise in importance as causative factors in changing food habits (1996).

This study makes use of both materialist or biocultural and symbolic perspectives in the anthropology of food. People entering the United States face sudden changes in physical and social environments (biocultural), as well as changes in social structure and meanings conveyed towards food (symbolic). Changes that occur in both of these groups of factors lead to changes in how a group of displaced persons eats and relates to food. People in situations of displacement respond to challenges presented them, and these challenges in part reflect the affects of social structure on their lives and specifically food practices; this relates to the adaptation and political economy models in biocultural nutrition (Himmelgreen, 2002). Displaced persons are also faced with a society that functions, oppressively or naturally, to keep them in a certain position within society; this relates to the various structuralist perspectives in the symbolic approach (Lupton, 1996). All of these aspects are at work in the lives of displaced persons, and especially so because all of the aspects have radically changed with the move to a new country. Therefore, all of these aspects are considered relevant to one or more of the results and findings of this study.

Acculturation and food habits

Acculturation is the process of negotiating accustomed ways of living and ways of thinking within a new culture. The new culture includes, among many other aspects, values and beliefs, social structure and food system, roles and expectations. It refers to the changes that take place as an individual or group of individuals comes into prolonged contact with another culture, and the one culture gradually takes on the characteristics of the other culture (McKee, 2000). Acculturation describes not only changing traits and characteristics one can see from the outside. Transitions in a person's lived experience may change one's image of oneself, one's view of the world, and the meaning that one gives to the objects and events of the world and one's own actions (Mintz, 1996).

Acculturation in the literature

The use of the term acculturation has declined in the field of anthropology, in part because of the multiple terms now used to describe the phenomenon. Acculturation is a term used by public health, nutrition, sociology, and specifically migration studies. The continued usage of the term in fields relevant to the subject and study population, acculturation is used in this study. The related terms are often used but seldom well-defined, as current migration scholars testify (Kivisto, 2001; Lewellen, 2002). The changing use of terms such as assimilation, cultural pluralism, multiculturalism, and transnationalism is the result of changes in both the reality and the understanding of changes over time in immigration and cultural change. These processes may be defined as "translation" and "mutual influencing" that occur from the meeting of two societies (Rapport & Overing, 2000). Acculturation here refers to all of these concepts as different manifestations of the processes of cultural change through migration. Adaptation is sometimes used as the umbrella term that contains these various modes of change (Hurh & Kim, 1984). Acculturation refers to those aspects of adaptation that are cultural in nature.

Assimilation, in usage, typically carries the idea of an (eventual) total conversion from one culture to another. A person from one culture, other than physical appearance, would be indistinguishable from the host culture. Multiculturalism allows for multiple ethnicities

and cultural expression, but may assume that these sub-groups adopt a host country nationality. Transnationalism includes a broader range of personal identities and is less a continuum than it is a creation of culture. Transnational migrants maintain ties to home culture communities in the arenas of family, business and politics, among others (Lewellen, 2002). Adhesive adaptation is a term that may be a type of transnationalism. Described in a study of Korean immigrants (Hurh & Kim, 1984), it refers to adopting traits of the host culture while maintaining aspects of culture of origin, especially cultural systems such as social network patterns.

All of these concepts have reflected both the situation at the time of usage and the expectations of the receiving culture. While ties with home country and ethnic identity have in the past been maintained to an extent, the nature of travel and communications, the globalization of business and politics have not only made such connections more possible for those who have migrated, but also more obvious to those studying the phenomenon (Kivisto, 2001). The different ways of acculturating may also reflect the different situations of each ethnic group or migration wave. The host culture's social structure, economic and ecological conditions, and immigrating persons' cultural and social systems, socioeconomic status and surroundings, and personal adaptive abilities all have demonstrable effects on the trajectory and results of acculturation (Dennett & Connell, 1988; Hurh & Kim, 1984; Montgomery, 1996).

More complexity is needed in analyzing acculturation, as many have noted (Kivisto, 2001; Lewellen, 2002; Rapport & Overing, 2000). While much discussion of acculturation has focused on the adoption of traits and values in a sort of ascending line from more to less, this view reveals an imperfect understanding of what culture is. Adoption of one's own culture is the result of pulling various pieces and rejecting others. The pieces fit together along the lines of a person's social status and other life circumstances and experiences (Kivisto, 2001; Lewellen, 2002). This process is repeated in acculturation, but is further affected by the culture and community of home and receiving countries.

What is clear from these myriad definitions is that people and communities forging a new life in a new country or culture forge that life in various and complex ways. This has always been the case, though the emergence of global systems and available resources has changed the shape of how acculturation has manifested itself over time.

Acculturation is recognized by public health nutrition as an important social factor in the determinants of diet and food choice. It is important, as acculturation continues to be used in the literature, that the conceptual understanding of the phenomenon is continually revised and developed. Much work with acculturation has occurred within psychology, and public health nutrition uses acculturation scales developed by psychologists. Psychological acculturation refers to an individual's adaptation of behavior and internal characteristics into another culture (Pham & Harris, 2001).

As a variable for studies of mental health and other outcomes for refugees and immigrants, acculturation is condensed into standardized scales. The Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA) is useful for many Asian immigrants, and other scales have been developed for specific immigrant groups (Chun et al., 2002). The use of these ethnically specific scales reveals some understanding of the differences in acculturation between immigrant and cultural groups. However, these scales are often based on the number of years in the United States (Satia-Abouta et al., 2002) rather than a depth of understanding of acculturation.

Research among displaced communities often compare various demographic and behavioral variables with the level of acculturation of subjects, including language acquisition (Wiecha et al., 2001), ethnic identity (Ogden & Elder, 1998), or multiple acculturation indicators (Kim & Sim, 2001). Some of these include a theoretical framework for the assessment and use of acculturation in their studies (Kang et al., 2002; Kim & Sim, 2001; Lee et al., 1999). However defined and understood, acculturation is featured in a significant number of articles regarding Asian communities and nutrition.

Sociology and migration studies in particular have done excellent work in examining the multifacetedness of adaptation and acculturation. They explore aspects of acculturation including structural and internal changes. The institutions and systems of the host culture, often termed structural elements, are related to the host culture's views and acceptance of the acculturating group. It also includes the acculturating group's acceptance of and willingness to participate in institutions of the host culture and self-perception of ability to do so (Hoerder, 2002; Hurh & Kim, 1984). The internal elements have to do with a person's choosing between various cultural practices, networks, affiliations, and identities of the culture of origin and the host culture.

Changing food habits

Anthropology has much to contribute to the study of acculturation in focusing on the cultural, rather than individual, aspects of the phenomenon. Changes occurring through acculturation not only have to do with individual preferences and psychology, but they are also ways of communicating within a culture and ways of being together as a unit (Pham & Harris, 2001). These cultural aspects of acculturation have been explored in relation to changes in food habits.

The interaction of structural and internal characteristics of acculturation is examined by anthropology, and the process can be clearly seen in regard to the general subject of changing food habits. In a study of rapid modernization, changes in the economy of a region of southern Italy affect food habits by increasing reliance on pre-made bread and self-service supermarkets (Counihan, 1999). The growing presence of supermarkets and products for sale such as bread is part of the structural change of the economy, while the use of supermarkets and purchasing the bread are choices (free or otherwise) of consumers. These choices, as Counihan illustrates, lead to changes in social relations, specifically from an interdependent community to a stratified society of individuals. People's actions and identities relocated to the self, rather than in the community. This is an example of what Mintz (1996) refers to as giving significance to the daily activities that have been changed by outside (structural) factors.

Similar changes in structural conditions occur in situations of acculturation as those of modernization, and these "outside" changes may be responded to in similar ways among an acculturating group. Certainly differences exist; the power relations that cause structural changes and, by extension, cultural ones are more visible or, at least, more acknowledged than in a modernizing society or especially in the normal course of changing food habits. The power of the host culture to change an acculturating group's practices and beliefs has perhaps been overemphasized in the past, as in the idea of complete or even forced assimilation (Herskovitz, 1958; Kivisto, 2001).

The host culture holds the power of causing changes of some sort in acculturating groups by creating the structural factors (Fieldhouse, 1995). However, it is the acculturating group that responds to those structural factors encountered upon entering that culture. The individuals, and indeed the group as a whole, may determine, to an extent, the result of such change, and certainly the significance or meaning such changes take on as they become established. One result may be seen in the increased significance of certain cultural icons, such as a food or beverage that carries an entire cultural identity (Mintz, 1996). Another result is a creative process. Rather than walking a line between two cultures, the acculturating group may combine elements, for instance food habits, of those cultures in a new way, ascribing a new set of meanings and significance to those ways (Lewellen, 2002; Mintz, 1996).

The treatment of acculturation in the literature reveals certain theoretical assumptions related to acculturation and to culture in general. A broadening and deepening of these theoretical views is needed as they are applied to public health and nutrition, as this theoretical orientation affects how displaced persons and persons of other cultures are handled in research. It also affects how programs are designed for cultural communities, or how these communities are included in programs intended for a more general population.

The self in transition

Acculturation has significant effects on the way one perceives oneself, and presents oneself to others. These changes in self also reflect back on the course that acculturation takes. These self-images and how they change are reflected in many ways, one being food and activities related to food. Food and its social affiliations are closely connected to the images and meanings of self (Counihan, 1999). As the self transitions through acculturation, these images and meanings and their expressions through food may take on greater significance, because the transition causes a kind of crisis of the self (Mintz, 1996).

Ethnic identity is an essential part of acculturation for several reasons. First, characteristics of a person's ethnicity change through acculturation. Second, a person's expression of one's own ethnic identity will change over time, and this expression influences the progression of one's acculturation. Food is a part of a person's ethnic identity, as is well known both academically and expressed in the part food often has in presentations of ethnicity. Food is also a means of proclaiming a person's ethnicity (Counihan, 1999; Mintz, 1996). The food that one chooses reflects a part of the person's identity. The way that a person eats food over time reflects changes in their ethnic identity. Most of the women express a Vietnamese identity directly and with their food, characterizing their typical eating patterns as Vietnamese rather than American or even a mix of the two, the latter of which being most often the reality of their eating patterns.

Ethnic identity not only reflects acculturation, but also shapes it. Considering oneself Vietnamese may tend to keep food choices from changing dramatically, though not entirely. Peoples immigrating to the United States will have one of two orientations to food – they will either keep to their own foods or try new foods, in general (Kalcik, 1984). Having a more American or "multiple" identity will cause more purposeful trying and accepting of new foods.

Closely related to ethnic identity is discourse, which is the way a subject such as food or nutrition is talked about. Discourse is a way that a person associates oneself with an identity or element of culture (Gans, 1985). In America, for example, there is a growing

scientifically-based discourse of nutrition among the general population (Counihan, 1999). Carbohydrates, fats, proteins, antioxidants, and amino acids are catchwords in popular nutrition discourse. Probably few people exclusively base their eating habits entirely on these scientific principles, but often eat what feels good or what they want to eat at the time (Lupton, 1996). However, many Americans have a scientific and well-informed component of their identity, and these nutrition science principles display that sense of self.

The Vietnamese who also use these scientific principles in discourse certainly understand them as well as Americans do, but also incorporate them into their daily eating habits as well as Americans do – that is, they are just as likely as Americans are not to live by them (Counihan, 1999). The presence of these principles in their discourse on food and nutrition reflect a certain amount of acculturation into that "scientific" and "well-informed" identity of Americans. It also may shape the process of acculturation, because overall some choices about food will be based on these principles, though not all of them. These choices, over time, change the foods that they generally eat and how they think about the foods.

Manifestation of one's identity reflects and shapes the state and process of acculturation. Since food is a quintessential expression of identity, identity will show these effects in the food one eats, how they are prepared, and how they are discussed. It is important to understand that identity and practice do not change uniformly or simultaneously. They change separately, but feed and shape the changes in each other.

Acculturation: static vs. dynamic

Many nutrition programs consider only traditional food habits and not the personal and cultural attributes behind them. A major assumption demonstrated in the literature is that acculturation equals habits. Dietary acculturation concerns only dietary habits, that is, the actual foods chosen and eaten (Romero-Gwynn et al., 2000; Satia-Abouta et al., 2002). Satia-Abouta does use a very specific term ("dietary acculturation") for her specific definition (degree of consumption of Western foods). Both Satia-Abouta and Romero-

Gwynn emphasize the need to understand changes in diet that occur as a result of immigration. Romero-Gwynn makes little reference to the changes in surroundings, structures, roles, and identities that lead to certain changes. Satia-Abouta begins to explore some of these as correlated with changes in diet, but does not establish explanatory relationships between them.

Devine et al. describe, from a nutrition education perspective, changes that immigrants make in entering a new society (1999). Food choices and habits were revealed in Devine's study as the result of a complex set of factors, both social and environmental, that act in tandem with a dynamic sense of ethnic identity. Ethnic identity is not only a history or statement of origin. It is also a symbol that communicates to others and to the bearer one's self, social relations, and cohesion within a group (Kalcik, 1984). Importantly, these symbols are not static but dynamic. Kalcik notes the flexible nature of both symbols and their meanings or functions. Food, as part of this symbolic expression of identity, may adapt and change to a new culture in much the same way as it adapts and changes within a culture over time. It is not just the foods that change, but the meanings and functions of the foods in relation to an identification with community.

The qualitative study by Fishman et al. (1988) revealed some mechanisms influencing declines in breastfeeding and increases in formula feeding of Vietnamese mothers. The authors note that the influence of humoral theory[1] in feeding practices is likely to change with the changing demographics of the Vietnamese community in the United States (that is, it is becoming younger and more acculturated). It is important to recognize these changes and adjust programs and interventions working with Vietnamese communities accordingly.

Thus incorporating knowledge of acculturation into nutrition intervention and food assistance programs working with displaced communities is not simply recognizing traditional food habits, or even a "traditional" culture. Incorporating acculturation will

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[1] See Health and nutrition in Vietnam, page 15

involve a recognition that the individuals in ethnic groups will be in some state between an ethnic identity and an American identity. This will include a set of roles and expectations related to food that represent their traditional and American cultures, such as gender, family, and roles assigned by poverty and other structural constraints (Kibria, 1993; Shin & Shin, 1999). They will also have food ideals and values that may or may not be met to some degree and that are also changing (Fishman et al., 1988).

Vietnamese in the United States

When the United States armed forces withdrew from Vietnam in April of 1973, the North Vietnamese conquered the south. Many South Vietnamese as well as ethnic Chinese left Vietnam in subsequent years because of political oppression from the North Vietnamese Communist regime (Do, 1999). This "first wave" of Vietnamese displacement occurred as United States troops were evacuated from Vietnam, and South Vietnamese military and government officials followed. The "second wave" included peoples oppressed by social changes occurring throughout Vietnam as the North Vietnamese government exerted its power (Freeman, 1995).

In 1979 the United Nations High Commissioner for Refugees established the Orderly Departure Program to discourage the many Vietnamese currently leaving the country by boat and attempting to find asylum in nearby countries (and often being turned back if they made it overseas at all). The program offered automatic asylum in the United States or Canada for Vietnamese who qualified. As a result of the difficulties of navigating bureaucracies in two different governments, many who qualified for the Orderly Departure Program ended up waiting in their homes, in refugee camps in Vietnam, or attempting to escape by boat.

Today, refugees from Vietnam represent a mix of backgrounds (Geltman et al., 2001), including well-educated Westernized persons, and rural persons having little contact with the West (Do, 1999). The Comprehensive Plan of Action (CPA) in 1989 ended the open door policy between the United States and Vietnam, and asylum was much less easily

granted. During this time many who had been on the opposite side of the North Vietnamese government were placed in re-education camps. All of these people were later allowed to come to the United States under the Humanitarian Operation (HO) program (Freeman, 1995). Those arriving after the CPA hold a different position in American society than those who arrived previously. Benefits from the United States government have been limited, and relatives are unable to help them.

Health and nutrition in Vietnam

There is little sense in referring to a "traditional" Vietnamese culture in the country of Vietnam. The culture has continually transformed throughout the centuries due to foreign occupation, colonialism, and internal political and social struggles (Jamieson, 1993). There are also variations in culture and lifestyle due to social status, and ethnicity such as tribal groups and ethnic Chinese (Freeman, 1995). However, an exploration of the overall Vietnamese culture relating to health and nutrition in the past few decades, especially since the end of the Vietnam War, is useful in understanding the changes in the Vietnamese community in the United States.

The humoral system of understanding health and nutrition is used in many parts of the world, such as China and Latin America, as well as Western culture until the last few centuries. In each region, and even over time, many differences exist in this system (Harwood, 1998). In Vietnam, the system is documented to be in use; it may be connected to the yin/yang system that made its way to Vietnam from China centuries ago (Craig, 2002; Dorais, 1995; Jamieson, 1993).

The Vietnamese understand the body to work in much the same way as the physical universe and surroundings, as well as the social world (Jamieson, 1993). The body is an environment that requires a certain stasis; various influences enter and disrupt it, and other influences are required to restore its harmony. The disruption of the body manifests itself in the symptoms that we recognize both medically and socially (Craig, 2002). Socially, meaning that the symptoms recognized in the Vietnamese system are more broad-based than the symptoms we typically think of as illness in Western medicine.

The body and its sources of illness are understood not only in terms of the physical, but also emotional, behavioral, and spiritual (Craig, 2002).

Unlike most of Western medicine, Vietnamese believe that spiritual influences can also affect the physical body, and that spiritual means may be used to cure or guard against illness. Ancestor cults and holidays such as *Tet* (the Vietnamese New Year) serve as preventive measures for illness among other adversities. Spiritual interventions for illness include combinations of herbs, visits to temples, offerings and prayers. The Vietnamese also keep spirits who cause illness out of certain spaces with charms and phrases, staying near one's home, or protect the space of the body with silver bracelets, in order to avoid illness (Craig, 2002).

In the Vietnamese system, many different domains of causation and treatment – environmental, emotional, behavioral, and spiritual – work together and overlap. Western influence over the years has been incorporated into this system as yet another way to explain illness, and another form of treatment, rather than as an alternate system as a whole (Craig, 2002). Illnesses with a cause relating to the humoral system may just as easily be treated with Western medicine, and vice versa. There is a growing understanding of viruses, bacteria, and Western medical causes of illness; however, the humoral ideas of illness causation and treatment are not rejected by the general population but rather exist side by side (Craig, 2002).

The body can be said to be hot or cold, where the preferred state of the body is somewhere in between these. The balance of the body depends on food, the physical environment, and the social environment (Craig, 2002). Diet is one "influence" on the body that may put the body out of balance (Jamieson, 1993). "Hot" and "cold," in the Vietnamese system, may refer either to the actual temperature or to a particular essence held by a food or other entity. Of the body, hot and cold are permanent states (such as for male and female or body types), or they are temporary states created by some influence, whether food, weather, or social events (Craig, 2002).

Foods are labeled, by their nature, as hot or cold. Hot foods are spicy, alcoholic, or bitter, and cold foods are those with a lot of moisture or otherwise having to do with water (Craig, 2002). It is not only the content of the food, but also how it is digested in the body that is important for health (Craig, 2002). Certain elements of foods are also understood to affect the body. Fat in food strengthens the body against disease. It is especially eaten in the winter when it is cold and the body is most susceptible to the effects of dampness and wind. Fat is also an indication of wealth and high status, though it is understood that too much fat can cause illness. Vitamins and proteins are also known by Vietnamese as important elements that foods contain (Craig, 2002).

In Vietnam there has been a varied and changing understanding of health and nutrition. Traditional empirical knowledge, Chinese traditions, and various Western influences due to colonialism and capitalism in Vietnam all combine in the popular understanding of health and nutrition. This amalgamation of different sources of information and explanation seems typical of popular understanding and practice all over the world, including Western society. Ethnography reveals considerable focus on digestion, weight of foods, and effects on emotional status rather than simply the nutritional contents of foods (Counihan, 1999; Lupton, 1996).

The particular ways these different systems of knowledge have manifested themselves are unique to those living in Vietnam. The influences of Western medicine and science and how they have been filtered into the health understanding in Vietnam is similar to the way Vietnamese in the United States incorporate Western principles. This process of change is significant for its practical outcomes in programs with Vietnamese clients.

Though there is no one traditional culture, a description of foods typically eaten in Vietnam is useful to this study. The main part of the meal often includes rice, fish, and fish sauce (Koctürk, 1996). Rice is the most important element of a meal. Grains such as maize, sorghum, and sesame are eaten, but not with the regularity of rice, as evidenced by a Vietnamese proverb: "Rice is like a blood mother (Van Kiem, 1991)." Fish typically accompanies rice, as another Vietnamese proverb states: "Rice and fish are like mother

and son (Van Kiem, 1991)," but meat may also be eaten. There are other sauces such as bindweed in the Vietnamese cuisine, but fish sauce is most commonly eaten. Seasonings include garlic and lemon (Van Kiem, 1991). Meat, fish, or shrimp is quick-fried (sautéed or stir-fried), and vegetables accompany the meal. Tropical fruit varieties are eaten in Vietnam (Koctürk, 1996). Green tea and aromatized black teas are common drinks, along with rice alcohols (Van Kiem, 1991).

Health and nutrition of Vietnamese in the United States

Changes in food habits of displaced Vietnamese have direct effects on nutrition and, consequently, health. Young people, who go through the process of acculturation faster than adults (Matsuoka, 1990), are more prone to adopting Western dietary habits. Young are consequently higher in fat and cholesterol (Wu-Tso et al., 1995). There is evidence of chronic dietary-related conditions as a result of these changes (Bermingham et al., 1996; Mitchell et al., 1997; Tomisaka et al., 2002).

Vietnamese diets in the United States typically add soft drinks, coffee, and beer, European fruit varieties, and snacks in the Western sweet/savory style (Koctürk, 1996). These changes along with consumption of fast food mean higher fat, cholesterol, and sodium in the diet, and fewer grains, fruits, and vegetables (Ikeda et al., 2002). Pork lard is replaced by butter, though Vietnamese may continue to use soya bean oil (Koctürk, 1996).

Several nutritional deficiencies have been described for Vietnamese, or more generally Asian, displaced persons. High sodium, fat and cholesterol (Hung et al., 1995; Mitchell et al., 1997) and low zinc, calcium, and fiber (Wu-Tso et al., 1995) are commonly cited in United States and Australian Asian populations. One study among pregnant low-income women from Southeast Asia finds that intakes of fat, folate and calcium are lower than a similar non-Southeast Asian population (Newman et al., 1991). These nutritional deficiencies have measurable effects on the Vietnamese populations. These include pneumonia and other infectious diseases (Katsumata et al., 1993; Si et al., 1997), anemia associated with folate and vitamin B-12 deficiencies (Luong & Nguyen, 2000), and increased risk for stroke and vascular diseases (Anh et al., 2001).

Very young children may also be at risk because of the short duration of breastfeeding practices (Ikeda et al., 2002). Vietnam has a notably high rate of breastfeeding children and breastfeed children to an older age (Morrow, 1996), but Vietnamese women in the United States are among the least likely to breastfeed (Tuttle & Dewey, 1994). The 1994 study found that women believed they would not have sufficient milk, or high-quality milk, for breastfeeding. Breastfeeding and other nutrition-related practices in many cultures are related to various humoral belief systems[2] (Harwood, 1998). Women's responses in a qualitative study revealed that the humoral system is believed to affect the woman and the breastfeeding child differently, a conflict that women often resolve by using formula, or alternatively with cow's milk or rice soup (Fishman et al., 1988). One specific health affect of the trend away from breastfeeding is iron deficiency anemia, and recent studies have noted high rates of iron deficiency anemia in young Vietnamese children (Graham et al., 1997; Kwiatkowski et al., 1999; Sargent et al., 1996).

The issue of breastfeeding among Vietnamese in the United States provides an example of the interaction between beliefs and practices. One research example points out that immigrants vary in their belief and practice of the humoral system, which may take several forms: a person may know of the beliefs, but not practice them; they may claim partial belief in the system, defending parts that are similar to the Western medical system; they may adhere to some practices of the system (having been passed down from relatives) without awareness of their basis in the humoral system (Harwood, 1998). The different forms of adherence mold the conflicts between traditional beliefs or practices, and conditions in the United States.

These nutrition-related health problems of displaced Vietnamese may be reversed in part with changes in diet. Such changes may be brought about by nutrition education (Reed et al., 1998; Rossiter, 1994). However, there are other circumstances of Vietnamese in the United States that also need to be addressed in order to fully enable healthy diet changes.

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[2] See Health and nutrition in Vietnam, p 15

Nutritional difficulties

Two studies highlight the difficulties experienced by Vietnamese families in buying and preparing foods in America (Ikeda et al., 2002; Reed et al., 1998). These difficulties include access to and availability of traditional foods. This problem is multiplied by the difficulty of a low income, which many Vietnamese face in the United States, since traditional foods tend to cost more. The scarcity of Vietnamese produce decreases overall vegetable intake, and the same is true for sources of calcium (Reed et al., 1998). In regular supermarkets, it is difficult to decide what foods to buy, or to know the health benefits and drawbacks of American foods, and displaced Vietnamese also may not know how to store or prepare new American foods. Limited English-speaking ability compounds this problem (Ikeda et al., 2002).

All of these structural barriers shape the process of acculturation and the particular habits and attitudes accepted from the new culture and kept from the first culture. Vietnamese mothers of young families, for example, may follow a certain pattern of acculturation and changes in food habits which affect the health of their families, that is different from other cultural and social groups (Do, 1999; Kibria, 1993).

Women, family, and health

Roles of women in some societies are based on a gendered division of expectations in the family regarding maintaining and treating the health of children (Clark, 1998). This involves feeding children certain foods, using techniques for treating sickness from traditional and Western methods, and the access (or lack thereof) of social networks when support for these activities is needed. Changes that affect the family, such as immigration, will also affect those gendered roles and expectations.

Women in Vietnam are expected to defer to husbands, sons, and male authorities. Ideally men in the family have the final authority and quietness and subservience are valued qualities in women (Go et al., 2002). In reality, women in Vietnam have always held some power in the public sphere, and traditions depict women as heroic in social and political issues (Jamieson, 1993). In daily life, especially in rural areas, women and men work

alongside each other and approach equality in household matters. The influences of Confucianism, Communism, and French occupation have undermined some of women's power, at least in ideology. These changes have been most effective in urban areas where the lifestyle encourages gendered division of labor (Freeman, 1995).

Kibria's qualitative sociological analysis of Vietnamese women in the United States illustrates how these roles change (1993). Women typically have the primary responsibility for obtaining and preparing food in the family, as part of the woman's role to meet the family's needs. While it is traditionally valued for the woman to spend much time in preparing meals, as work schedules or other demands of the community structure require more of the woman's time, her role in the family changes. She instead must fix quick meals according to her new role as family wage earner or community liaison. In cases where the husband cannot find employment, this new role is further reinforced (Freeman, 1995).

The activities associated with the role of meeting family needs typically increases in the United States, because of their greater contact with social institutions such as welfare and the health care system. The low status of Vietnamese men in the United States economic system allows women more opportunity for financially providing for their family and themselves. Changes in kin networks also allow more focus on women's networks, where resources are shared, advice and information circulated, and tasks are shared (often involving food and health issues) (Kibria, 1993).

Often women must adopt social and economic roles unacceptable to their culture of origin. With this change are relationships with husbands and other men to which they are unaccustomed. In Vietnam, women's duties were called "the work with no name (Buijs, 1993)." In the United States, this "invisible work," including paid work, still falls under this category in the patriarchal structure. However, the sheer volume of their work, including preparing food for the family, and the current inability of men to fulfill their work duties give their work a greater significance. It also gives them greater, though as yet subtle, power in the family (Kibria, 1993).

Though Vietnamese men and women seem to have a remarkable ability to negotiate a foreign cultural system, while retaining, for the most part, cultural beliefs (Do, 1999), women tend to be more adaptive than men in displaced situations. Women are typically responsible for family routines, which gives them an immediate course of action upon arrival. Men, on the other hand, often lose status in employment as well as in the social realm (Buijs, 1993; Kibria, 1993).

Vietnamese women have exhibited a great deal of ability to negotiate their own needs within the constraints of not only the United States system, but also traditional Vietnamese culture at the same time (Kibria, 1993). For this reason, Laverentz' recommendation to determine the extent of a community's needs before education is relevant to Vietnamese women. Women are likely to have already made some adaptations, as exemplified by the study of breastfeeding (Fishman et al., 1988). Women's responses in this study revealed that the humoral system is believed to affect the woman and the breastfeeding child differently, a conflict that women often resolve by using formula. Observing how the women have already changed, rather than only focusing on traditional Vietnamese cultural traits, is important in truly addressing the nutrition-related needs of Vietnamese women.

Specificity of current data

There is little national data available on the health or nutrition of Vietnamese populations in the United States. The National Health Interview Survey, for example, collects information on "Country of Birth," but it is reported as "US-born" or "foreign-born" in their analyses (Pleis & Coles, 2002). Although information on Asian communities in general is helpful, the programs at IRCO would benefit more from information specific to Vietnamese or Southeast Asian communities, because this is the region from where many of IRCO's parenting program clients originate.

Most of the information on displaced Vietnamese is based in Australia and countries other than the United States. This information is useful, as there are many parallels between refugee experiences in the United States and in other countries. The bulk of

refugee research in general has been done in the UK (Sellen & Tedstone, 2000). There is much information on the health of displaced Vietnamese, but relatively little on nutrition. The literature that does exist, though, is in agreement and can be relied upon to determine some nutrition needs and outcomes for displaced Vietnamese.

There is a relative lack of data after 1995 or so, in part due to improvements in children's growth status by the early 1990s (Geltman et al., 2001; Yip et al., 1992). Yet some problems seem to still exist. Recent research in Portland indicates that the health problems of recently displaced Vietnamese are similar to concerns raised before the early 1990s (Kravitz, 2002). Distance from the time of the Vietnam War and the large waves of migration that came at that time (Do, 1999) may be a factor in the lack of interest in the literature. This may lead to a decline in interest even when the health problems still exist.

Comprehensive study and information about nutrition and health factors for displaced Vietnamese is needed. Inclusion of Vietnamese, as well as other ethnic groups, as available categories in national studies of health and nutrition will create a clear picture of the specific health concerns for Vietnamese and other ethnic groups in the United States. Understanding the national magnitude of these concerns can also guide research into the cultural and acculturation variables that affect the health and nutrition of displaced Vietnamese. Unfortunately, public health in general, and maternal and child health in particular, are fields that are susceptible to the whims of governmental and institutional policy (Garrett, 2000). This also affects priorities for health research, as witnessed in health research on Vietnamese communities. It is important that basic monitoring of the health of all populations continue even after the crisis point, so that programs and policies can continue to address the needs of specific populations and assist them to optimum health.

Strategies for nutrition and health

While these issues are necessary to address for the general population in the United States as well as displaced peoples, they should not overshadow the importance of the multiple

factors involved in acculturation, and their effects on the health and nutrition of displaced people.

The historical emphases of public health are reflected in the strategies implemented on behalf of ethnic and displaced communities (Garrett, 2000). Especially in the United States, efforts have shifted from environmental and structural changes such as clean water and immunization, to lifestyle and personal choice. This new focus is influenced by the improvements of the former in general in the United States (though many places still exist without such improvements), and the rise in chronic diseases has drawn the most attention in public health recently.

Social inequalities are, indeed, often understood to be created by poverty (Farmer, 1998). Poverty renders certain people unable to make those healthy choices researchers and policymakers believe they should make. The inequality is also likely to create the disease and nutritional inequities that poverty and other factors worsen or reinforce (Dettwyler, 1998). These results of social inequality have particular relevance for immigrants and refugees, since they often occupy the lowest rungs in American social structure (Freeman, 1995). However, there are more aspects of the situation of displaced people than poverty and social inequality.

Food habits of individuals and ethnic groups change not only through familiarity, recommendations and information from friends (Satia-Abouta et al., 2000), but also with changes in lifestyle and structure (Koctürk, 1996). For example, breakfast is the first meal to show signs of acculturation in studies of Chinese and Korean immigrants, and the reason reported for these changes is convenience (Lynn et al., 1999; Satia-Abouta et al., 2000). Convenience is related to the imposed structure of life in the United States, such as work schedules (Mintz, 1996). Such aspects of social structure may have an independent effect on nutrition and health unmediated by the effects of poverty. Yet poverty is nearly the sole consideration of the effects of social structure on nutritional health in government nutrition intervention and food assistance.

Federal nutrition programs reflect the same attitude, emphasizing poverty level in eligibility for the Food Stamp Program and WIC, and encouraging the most economical (and, consequently, most standardized) choices of food through the USDA Thrifty Food Plan (Kalcik, 1984). Studies across cultural groups in poverty, though, show significant variations in healthy practices such as breastfeeding (Fishman et al., 1988). Instead of constraints common to all groups in poverty, as Fishman et al. (1988) note, there must be factors specific to Vietnamese women that cause them to have the lowest rates of breastfeeding.

People in the process of becoming acculturated to the mainstream social life in the United States will make choices (consciously or unconsciously) about beliefs and practices that have to do with health and nutrition. These choices must be made because a change is necessitated by the structure of the country and social context that peoples of displaced communities have entered (Mintz, 1996). In the early days of public health, poverty may have made some people more likely to be affected by the lack of clean water and the need for immunization against diseases, but the clean water and immunizations were considered necessary interventions in their own right. Similarly, while the structural barriers to health of displaced peoples may be worsened by poverty, those structural concerns of health and nutrition themselves are worthy of attention.

Another result of this shift in emphasis in public health is programs that focus solely on education of immigrants, refugees, and minority populations in general. The assumption is that their culture leads to "bad" practices and they need to change to "good" practices (Reed et al., 1998; Rossiter, 1994). However, this approach is only useful in a public health sense to the extent that the beliefs and practices of the dominant group promote health and good nutrition more than the beliefs and practices within that culture. Additionally, this approach tends to disregard individual beliefs, identities, and their effects on these practices, as well as the structural and power relationships that limit or direct these practices; these factors are important in the development of nutrition intervention programs (Himmelgreen, 2002). The question remains, is it more important for the federal government to provide means, such as education, assistance, and social

support, to a nutritionally healthy diet according to government recommendations? Or is it important to provide means to an adequate and satisfactory diet according to varied and changing cultural standards?

Historically, nutrition interventions have attempted to educate ethnic groups as to the "proper" (i.e. American) way to eat (Kalcik, 1984). This historical look at nutrition education emphasizes that even as the need was recognized to understand the reasons underlying food habits, the emphasis remained on changing to a standard diet. Margaret Mead and the National Research Council's Committee on Food Habits found in 1943 that understanding the reasons behind food choices and habits is necessary for nutrition education and intervention (Kalcik, 1984). Recently, nutritional anthropology and public health have encouraged cultural variation in diets, as evidenced by studies involving refugee and immigrant groups (Ikeda et al., 2002; Romero-Gwynn et al., 2000; Satia-Abouta et al., 2002). More emphasis is placed in these studies on making healthy food choices, and traditional foodways that promote good nutrition are encouraged as well as incorporating social and community support. WIC is the agency involved in two of these studies, which reveals an interest on their part in developing nutrition education programs for immigrant populations, such as El Salvadorean (Romero-Gwynn et al., 2000) and Vietnamese (Ikeda et al., 2002).

The benefits of including the specific needs of ethnic groups in nutrition and other health education programs are exemplified by the lack of effectiveness of standard programs. Rossiter's breastfeeding education program is not alone in its lack of persistence in raising rates of breastfeeding (1994). It is likely that part of the reason for this failure of education to achieve its health goals is due to a lack of relevance to the community it is educating. From the turn of the twentieth century to the turn of the twenty-first, it has been noted that nutrition education (referring to lectures and classes presenting basic Western notions of nutrition) are not always desirable to displaced communities (Kalcik, 1984; Laverentz et al., 1999).

Laverentz' program with ethnic Nuer refugees from the Sudan revealed their preference for cooking and shopping classes and activities, and other practical help related to food in a new American context (1999). The study emphasizes the need for listening and learning the needs of communities before beginning an education program. Such an approach is beneficial for several reasons. First, it recognizes that ethnic groups have some beliefs, knowledge, and practices that lead to healthy eating. Programs will not undermine already healthy practices or duplicate knowledge already in their possession. Second, it may result in greater acceptance by the community due to trust built by listening and honoring the beliefs and practices they hold. Greater acceptance and effectiveness of the program will result from the higher degree of relevance of the information to the community. A third benefit of this approach is the recognition of food-related needs beyond a basic nutritional understanding. This helps to complete the knowledge needed to go about cooking and eating healthy meals in an unfamiliar context related to food. Thus the need for incorporating social and cultural factors into nutrition intervention is a growing trend that is demonstrating effectiveness.

For the most part programs through the USDA and other governmental agencies continue to rely on a standardized diet (Perkin & McCann, 1984). This may be a result of political economic factors (Himmelgreen, 2002), such as the influence on government nutrition education and programs by agricultural and food corporation interests. Agricultural interests such as dairy and sugar industries effectively shape many of the USDA's nutritional guidelines (Nestle, 2001). WIC foods are in part based on which fortified food brand bids lowest on its prices (Kotch, 1997). Neither of these instances show an interest in the nutritional needs of the people of the United States, whether immigrant, refugee, or born citizen.

Resources for Vietnamese in the United States

The public health emphases on poverty and education are important bases for addressing the nutritional needs of displaced peoples. However, they do not appear to adequately attend to the unique needs of these communities. The following section describes how

poverty and education have been addressed for Vietnamese in the United States by governmental and other programs. It will also explore ways the additional needs of displaced Vietnamese have been met in certain cases.

After coming to the United States from Vietnam and having undergone changes in environment, circumstances, and culture to some degree, the Vietnamese in the United States face a different situation regarding health and nutrition than they did while in Vietnam. For instance, people of displaced communities tend to hold a lower socioeconomic position in their new country compared to their home country, in part because they do not have the language skills required for the job or profession they held in their country (McElroy, 1996). For this reason, assistance from government agencies and other programs is needed by many Vietnamese in order to maintain adequate health and nutrition. These resources, however, are not available for all Vietnamese in the United States due to differences in migration status (Kasper et al., 2000).

Government refugee and immigrant support

Vietnamese coming to the United States have received varying levels of support from the United States government. This support varies depending on how and when individuals and families arrived in the United States. According to Freeman, refugees receive monetary support on arrival that is intended to help them become self-sufficient. The length of this support has decreased from 3 years to 8 months. The decrease in monetary support accompanied a decrease in English instruction, job training, and health coverage, all of which are necessary aids to self-sufficiency (Freeman, 1995).

These benefits are not extended to immigrants, and Temporary Assistance to Needy Families (TANF) does not always apply to immigrants either (Kasper et al., 2000). In the past this has not been a problem for many Vietnamese, since most of them have been refugees. Since 1980, though, more and more Vietnamese come to the United States through family members and the Orderly Departure Program, neither of which confer refugee status (Freeman, 1995).

The trend toward less and less financial and resource support reflects the anti-immigration sentiment in general and the mixed attitude toward the Vietnamese in particular (Freeman, 1995). Since the Vietnam War, the American attitude has been in part welcoming of Vietnamese out of guilt and responsibility. The attitude has also been hostile, because of personal feelings among Americans about the war and misunderstanding the displaced Vietnamese as enemies.

The increased need for governmental support on arrival and the decreasing ability to receive it indirectly affect the health status of the Vietnamese due to increased poverty. The inability to pay for health care and to buy food are recognized challenges to the health of refugees and immigrants in general and Vietnamese in particular. Besides these indirect health effects of increased poverty, Vietnamese have adapted their beliefs and practices concerning health and nutrition in common ways.

National family support programs

The WIC and Food Stamp Programs were both implemented nationally in the 1960s in response to the political awareness of hunger in low-income families in the United States (Fitchen, 1997; Kotch, 1997). The WIC program includes limited varieties of food containing nutrients typically lacking in diets of women and children at nutritional risk. The Food Stamp program is intended to make up a deficit in the food-purchasing ability of low-income families.

The WIC programs often include nutrition education (Ikeda et al., 2002), and partners with other health-related programs or services, such as primary care or early intervention. Eligibility is determined by low income, inadequacy of diet, and persons with special medical needs (Kotch, 1997). The program promotes breastfeeding, though it may also provide free formula (Tuttle & Dewey, 1994).

The Food Stamp program is based on the USDA's Thrifty (or Economy) Food Plan. This plan includes a set of meals developed by nutritionists to include adequate amounts of essential nutrients, at the lowest cost. The program determines a family's food

purchasing ability as a third of their income. The difference between the Thrifty Food Plan cost and this figure is the eligible amount of food stamps. Stamps may be used to purchase most foods (Kotch, 1997). Theoretically, the programs described provide multiple levels of support for Vietnamese mothers and other communities with similar nutritional and financial challenges. WIC and Food Stamps can supplement their income with the ability to buy more food.

The WIC and Food Stamp programs have limitations. The Food Stamp program assumes that a third of any given family's income will be spent on food; however, given the circumstances of low-income families, this is not always the case. A deficit then remains in actual food-purchasing ability (Kotch, 1997). However, the program does improve nutritional status of children in families receiving Food Stamps (Johnson et al., 1999).

WIC is beneficial for mothers and children and their intakes of iron, calcium, and certain other nutrients. For Vietnamese women, a study suggests that involvement in WIC may not provide the intended benefits (Tuttle & Dewey, 1994). Many of the Vietnamese women reported enrolling in WIC in order to receive the free formula. The study also mentions that the few items available, such as peanut butter, canned tuna, milk, and breakfast cereals, were not foods that the women would eat.

One WIC-related project in California demonstrated the benefit of tailoring a WIC nutrition education program to Vietnamese women (Ikeda et al., 2002). The program in this study provided supports other than education to Vietnamese women. These Vietnamese lay health educators provided the women with information on job opportunities, housing, education, and other community supports and agencies available to them. This link provided opportunities for Vietnamese women to establish themselves in the community and improve their life prospects for nutrition and health. There were significant differences in treatment versus control groups in dietary quality and nutrient intake after the education program, though persistence of the changes was not determined.

The employment of Vietnamese women to conduct the lessons and programs aided in recruitment of participants to this project as well as to other agencies. The Vietnamese teachers also were familiar with the Vietnamese community and the supports available within it, and could provide the women with information on job opportunities, housing, and education. These lay health workers, then, were an important link between Vietnamese women and support agencies, and opportunities for establishing themselves and improving their lives.

Despite the limitations of Food Stamps and WIC, the programs do provide some access to food for families with little means to obtain it. Refugee families are likely to be eligible, though illegal and sometimes legal immigrants are not (Kasper et al., 2000). However, it is clear that none of these programs specifically address the needs of displaced peoples in general, much less those from Vietnam. This is likely, in part, a result of basing foods offered on nutrient deficiencies, and focusing on cheap, fortified products that Vietnamese women are not likely to purchase, rather than a wide variety of foods that contain these nutrients naturally.

The Oregon Food Bank is another food resource available to Vietnamese families in Portland. The Food Bank distributes excess food, particularly from supermarkets, to families needing food. Distributions are held in various locations in the Portland area periodically, and those eligible come to the nearest location and receive a portion of the food that is available at that time. The food may be milk, juice, or packaged foods, or in the case of Harvest Share, produce, that have not sold quickly. This program allows food that would not otherwise be purchased to benefit those in the community who may not be able to buy it.

Also available to displaced Vietnamese, as well as many other groups of people, are home-visiting programs providing parent education and support for parents of young children. The IRCO parenting department where this study was conducted used Parents-as-Teachers and Healthy Start, both of which are nationally recognized parent education curricula. These curricula have only a few references to nutrition specifically. However,

home visiting programs have the capacity to be tailored to the needs of individual families, as well as include a holistic view of each family's situation, resources, practices, and behaviors (Gomby et al., 1999).

Policy makers see community involvement, including allowing programs to be oriented towards the expressed needs of the community rather than the researchers, as a complicated and inefficient strategy (Howell et al., 1998). The Parents as Teachers and Healthy Start curricula already suffer from not having frequent enough meetings with families (Gomby et al., 1999). Though adding a special nutrition section or even community social supports may add to this difficulty, it has been done successfully (Wagner & Clayton, 1999).

Research evaluating a Salinas Valley program using the Parents-as-Teachers (PAT) curriculum demonstrates that minority communities in particular may benefit from home-visiting programs more than the general low-income population (Wagner & Clayton, 1999). The Salinas Valley study showed differential effects on child outcomes comparing English-speaking Latina, Spanish-speaking immigrant Latina, and non-Latina groups. Children of Latina mothers benefited more than non-Latina children. Children of immigrant Latina mothers showed the most improvement in physical, mental, and social development. This greater effect was in part due to social supports provided by the program. The effects were still modest, but may have been greater if the program had been specifically designed and implemented for each group, including immigrant Latina mothers.

Tailoring the design of lessons and programs for specific displaced communities may lead to more improvements in child development. The WIC nutrition education project and the Salinas Valley PAT program both elucidate the need for and the effectiveness of programs that are able to or designed to address the needs of specific populations. Both of these programs demonstrate the need of displaced communities for materials and instruction in their own language, and individual attention that can address personal concerns as well. While the home visiting programs described here do not address

nutrition specifically, the format may be well suited to including support for obtaining adequate nutrition.

Summary

Vietnamese in the United States are a unique group of individuals, with a particular set of needs as far as health and nutrition are concerned. Vietnamese women have successfully met their own and their families' needs, and governmental support programs to varying degrees have aided them in their endeavors. Still, the data on health for displaced Vietnamese reveals that nutrition-related illness presents a problem for this ethnic group. Differences in belief and practice have important implications for how changing food availabilities and habits affect Vietnamese in the United States. The structural changes faced by displaced Vietnamese and internal factors of acculturation are not well understood or implemented in the nutrition literature. The lack of understanding will affect the quality of programs and services offered to Vietnamese communities.

Each person's views on and circumstances concerning health and food change upon arrival to the United States and continue to change over time. Changes in structure, attitudes, roles, and values may be expected to have direct and indirect effects on nutrition and health of displaced Vietnamese in the United States. Filling in the gap between programs in existence and the changing needs and circumstances of displaced Vietnamese will decrease nutritional health risks. The research presented in this thesis explores the gaps between a program and its Vietnamese clients, highlighting how the process of acculturation can be better understood in order to accurately serve this particular Vietnamese community.

Chapter 3

METHODOLOGY

A study was conducted in July and August of 2003 that was intended to explore the ways that Vietnamese women in particular adapt to the change in food and the culture surrounding food due to immigration. The IRCO Parent and Child Program Department makes use of parent education curricula that are used nationwide, including Parents as Teachers and Healthy Start. The parent education program is available to immigrants and refugees from many countries, including Vietnam.

The study population included clients of the parent education programs of Vietnamese origin, who are mothers of children below six years of age. In certain cases, the interview was conducted with the family member responsible for food preparation, such as the woman's mother or husband. There are seventy-five Vietnamese families out of 190 total families enrolled in the program, and interviews were conducted with members of twenty-nine of these families. Interview participants were selected by convenience sample. Three of the program staff were interviewed as well, who are also Vietnamese. The woman's typical responsibility for obtaining and preparing food for the family makes it useful to interview women to discover how families adapt to changes in food and the culture of food.

The parent education program uses Healthy Start and Parents-as-Teachers curricula to teach new parents how to support their child's development both physically and mentally. The education is conducted in home visits by program staff who are of the same ethnicity and speak the same language as the client. The program also provides parent support groups and referrals to outside agencies such as WIC (Special Supplemental Program for Women, Infants, and Children) and TANF (Temporary Assistance to Needy Families). The staff who work with Vietnamese clients are bilingual Vietnamese women.

The study included only persons of Vietnamese origin in order to include historical and cultural information in the research. While the program serves clients of other nationalities and ethnicities, including Russian, Hispanic, African-American, Cambodian, Lao, and Mien, about 75% of the clients are from Vietnam. The interviews reveal particular concerns, attitudes, and practices of the Vietnamese community. It also reveals general themes that apply to the community of displaced persons as a whole, in guiding research and program development with other communities involved with this parent education program. Focusing on one area of ethnic origin allows incorporation of cultural background information and the history of war and displacement of Vietnamese.

The parent education curricula are based on a child's developmental stages in the first five or six years of life. The material helps the mother to help her child develop properly, as well as monitoring of the child's growth and development by program staff. Nutrition principles for both mother and child are mentioned briefly in the curricula. The principles taught are focused on appropriate ages to start feeding cereals and gradually transition to normal foods.

The home visits include more than this parent education curriculum. Handouts are given that supplement the curriculum or that address different aspects of parenting, such as bonding with a child. Staff often make phone calls to doctors, agencies, and other community services when their clients cannot communicate with such services in English. Staff also may accompany their clients to landlord's apartments or governmental offices to help resolve miscommunications or to help them apply for services of use to them. Staff bring food from the Food Bank, or recommend the program to their clients. Staff also bring donated items for the child, such as diapers, toys that aid in the child's development, or baby food.

Method and procedure

The study took place in July and August of 2003. Two or three interviews were conducted each day, and took place at the clients' home. Program staff accompanied the

interview both for the comfort of the client and for translation purposes. Five of the interviews also included observation of the home visit with that client. Three program staff interviews were conducted in English; two near the beginning of the research time period and one at the end. In the process of the interviews, observations also were made of the program office and the program's involvement with the Food Bank program.

An interview questionnaire was conducted verbally with clients and lasted approximately 30-45 minutes. Program staff contacted prospective interview subjects by phone and scheduled interviews. After giving informed consent, each interviewee was asked a series of closed-ended (demographic) and open-ended (descriptive) questions. The staff who normally visit each client provided interpretation for most clients, as per the request of the program director. The staff speak Vietnamese and English, and those who have clients that do not speak English well are trained as medical interpreters, which qualified them to interpret. Responses were recorded with handwritten notes, as no client agreed to tape-recording the interview. After the interview, the notes were looked over and completed as soon as possible to ensure accuracy.

Informant interviews generally began with a greeting by the interpreter, introduction of the researcher, and invitation into the home. The interpreter conducted a brief conversation with the client and explained the research. The interpreter then read the informed consent document to the client and if the client was willing to participate, she signed the form. The researcher asked the questions on the questionnaire in English, the interpreter translated the question into Vietnamese and the client's response into English. In a few cases, the client was able to speak English well enough to conduct the interview without translation. After the interview the interpreter proceeded with the regular home visit if the researcher was to observe that client's home visit. After the interview the interpreter and researcher exited the client's home with the appropriate greetings.

Staff interviews are the interviews conducted with the program staff who work with Vietnamese clients. The purpose of these interviews is to understand staff's perception of the clients' knowledge of the educational material and content, access to programs and

services, how the clients benefit from the programs, and to explain cultural or other phenomena addressed in interviews. This information provides a triangulation for the information given by their clients.

All interviews, aside from the demographic questions, are based on topics including differences between food in the United States and Vietnam, healthy and unhealthy foods, and the ability to obtain an adequate diet in the United States. The interview participant is allowed to lead the interview. These details discussed by the participant are then elaborated by follow-up questions (Rossman & Rallis, 1998). Through this process, not every participant discussed the same details. The details discussed by each woman, though, reflect her thoughts on the subject. Staff interviews helped to determine whether such details could be attributed to other Vietnamese clients. Such details may be missed in a structured interview.

Observations include staff and clients during five home visits, other department activities such as their involvement in a Food Bank (Harvest Share) distribution. Observational data from these activities included what was done, how it was done, and responses of the clients or others involved. Written records such as staff logs of activities with clients included phone calls, home visits, and provision of items.

Analysis

Analyzing qualitative data involves finding patterns within the data that generate categories or topics, and patterns within those categories that are themes (Rossman & Rallis, 1998). Interview responses were analyzed for frequent themes within the topics discussed by the clients. Topics include: Food and ethnicity, Social environment (referring to routines, times, schedules, and surroundings present in the society), Food Concepts, and Nutrition Information and Change. Themes within a topic might include a specific issue that is raised often ('boiling meat before cooking' in Social environment) or a particular attitude about a topic ('WIC classes shouldn't focus on American food' in

Nutrition Information and Change). These themes form the basis of describing the acculturation experience concerning food and nutrition.

Topics and themes were also laid out in chart form, in order to more accurately compare responses to certain subjects. Short phrases were used to record types of statements or responses for each theme. Demographic questions were also included, to aid comparison of women in similar or different situations. Similarities in themes between the interviews and observations are discussed, and concrete evidence of reported events and phenomena are reported.

Justification of methods

The open-ended interview is a classic qualitative method of anthropology. The benefit of this approach is obtained through receiving the experience and opinions of the informant while minimizing the bias of the interviewer (Ervin, 2000). In this way, the use of qualitative methods and a narrative style may be more near the truth according to study participants than a quantitative focus (Counihan, 1999). Ethnography and the use of open-ended interviews provide insight into underlying causes and effects of phenomena than structured interviews are able.

Qualitative methods do not search for the ultimate truth, but rather multiple perspectives on the experience of a phenomenon (Rossman & Rallis, 1998). Multiple perspectives are important for the usability of this research, because it is important for agencies serving Vietnamese women to observe the details of daily life, seasonal events, and life experiences that standardized research and evaluation methods miss (Himmelgreen, 2002). A critical focus in qualitative methods may reveal the presence and effects of power relations (Rossman & Rallis, 1998). These power relations occur here between displaced Vietnamese and the societies, governments, world events and circumstances that have caused them to become displaced. Such circumstances, and even programs and services who aid displaced Vietnamese, determine to an extent how they will live in their new situation.

This is very important for research in health and nutrition for Vietnamese women and families. Most programs and evaluations in the literature focus on defined problems and across-the-board solutions. To aid the parent education program and the affiliated nutrition-related agencies, the problems and possible solutions are best known by the women who face them. These answers may come in forms not considered by the researchers developing a rigid set of questions and topics to cover in an interview.

Biases and limitations

Anthropological analysis carries some risk of researcher bias, as the researcher's perception of the data may generate topics and themes. The categorization of data in this study is intended to be taken from the emic perspective, or the perspective of the participants. Categories may, though, be influenced by the researcher's own culture and ways of thinking about the subject. The research design is intended to leave the interview subject open to discussing subjects that are important to her. In categorizing those subjects, though, the organization may be more relevant to the researcher's cultural styles of organization than reflecting the culture of the interview participants. The intention of this research is to inform services within the researcher's culture about the needs and situation of the interview participants, and the combination of emic and etic perspectives makes the research useful to programs and services (Himmelgreen, 2002).

A possible limitation in this study is the nature of using translators. Though trained as medical interpreters, the women's skills in English at times made it difficult to communicate the meaning of a certain question. At times the answer received did not seem to match the question, which leaves room for some error in the way the researcher analyses the statements. This limitation was corrected by communication with interpreters outside of the interview. The researcher's perceptions of cultural backgrounds for different practices, or the extent of applicability of a certain statement or practice, were included in staff interviews in order to test their accuracy.

The findings of this study are applicable to the Vietnamese women enrolled in IRCO's Parent and Child Program Department participating in this study. Generalizations may be made cautiously to the other Vietnamese women in the Department at the time of this study. The intention of this study is to explore the situation of displaced Vietnamese women and families and the strategies they have used to adapt. For the wider displaced and immigrant population, the study and its results may be used as an example of the possible issues and interactions of circumstances and acculturation results to be examined in further studies.

Summary

The methods and analysis of this study are congruent with its purpose. Asking exploratory questions, and analyzing the common elements of responses obtained a general sense of the culture and situation of the Vietnamese women involved in the IRCO Parent and Child Program Department. The results of this study are not intended to be the authority on acculturation and food among Vietnamese women. Rather, it is intended to suggest areas where further research may be conducted, such as in nutrient intakes, food practices, and social structural effects on food and nutrition[3]. Another result of this study is to place the process of acculturation in the context of these women's experience to round out the academic understanding of this phenomenon.

[3] See Advocacy, p 88

Chapter 4

ANALYSIS

Vietnamese women in IRCO's Parent and Child Program Department have changed their diets, tastes, meal solutions, and food concepts. The changes occur due to the differences in food and the aspects of culture having to do with food between the United States and Vietnam. The women most closely follow the type of acculturation termed "adhesive adaptation"[4] (Hurh & Kim, 1984). This section groups statements the women made into categories of similar subjects. The following outlines the current state of thought of the women on these subjects, and may not always reflect actual practice. How these changing conceptualizations relate to the process of acculturation will be explored.

The Vietnamese women involved in the study are separated into two groups as Table 1 illustrates. The main sample includes Vietnamese women enrolled in IRCO Parent and Child Programs, having children under 6 years old. The rest of the sample includes participants falling outside of those parameters, including four women whose high-school age daughters are enrolled as parents in the program, one man whose wife is enrolled in the program, and one Chinese woman enrolled in the program whose husband is Vietnamese.

Women in the main sample are an average of 33 years old, ranging from 25 to 43. Nearly all are married and have limited English skills, and have attended high school for some period. All but one are part of the third wave of migration after the establishment of the Orderly Departure Program in 1979 (McKee, 2000), as well as changes brought about by the Comprehensive Plan of Action in 1989 (Freeman, 1995). About two-thirds of the women are enrolled in WIC, make use of the Food Bank, and/or receive other forms of income or food, gas, or electric assistance.

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[4] See Acculturation in the literature, p 6

Table 1. Summary demographics of study participants[5]

		Women with young children	Other clients	Total
Age	**25-30 years old**	8	0	8
	31-35 years old	8	0	8
	36+ years old	7	4	11
Years in the US	**0-4 years**	7	0	7
	5-9 years	5	3	8
	10+ years	11	3	14
Marital status	**Married**	20	4	24
	Single	2	0	2
	Divorced	1	0	1
Number of children	**1-2 children**	14	5	19
	3-4 children	7	0	7
	5 children	2	1	3
Educational status	**< High school**	7	1	8
	High school	13	1	14
	College	0	1	1
Economic status	**No or limited employment**	15	1	16
	Full time	7	3	10
English ability	**None**	5	2	7
	Limited	13	2	15
	Good/fluent	5	0	5

Food and ethnicity

The phenomenon of acculturation, when applied to food, often is understood as the process of eating less of one's own food and more of the host country's food. It is also helpful to understand it as a change in characterization of foods. Vietnamese women

[5] Under educational status, "high school" and "college" include the school years of that level of school. "High school" refers to 9th grade through 12th grade, etc.

interviewed consider the food they eat Vietnamese, and Vietnamese food as "normal." While American food and practices are adopted, these are still on the fringes of normality. Acculturation can be considered progressing as American foods and Vietnamese foods replace each other as "normal" and "supplemental."

Food characterization

The initial question, "What foods do you eat?" is met either with specifically stating "Vietnamese food," or describing elements of a meal that are typically Vietnamese. In only two instances did women say they did not eat only Vietnamese food, out of the 26 who made a statement about the kind of food they eat.

> Here in America, I eat rice because everyone has rice – they have it with steak, meat, and shrimp. I also cook vegetables – spinach, salad, other Vietnamese salads, and mint. I add a little spice, but not much for the kids. I often stir-fry Vietnamese style. I make Vietnamese noodle soup, lots of Vietnamese dishes (Cô Luong).

Descriptions of daily meals included rice, which is eaten "every day" or "all the time," and is described as the "main thing" or the "best food." The preeminence of rice in eating is expressed in the statement: "I eat rice every day. If I didn't eat rice I would feel something is wrong (Cô Vuong)." A 36-year-old woman who has been in the United States for six and a half years used the word rice to refer to the whole of her habits of eating, "(referring to fast food) I do not prefer to eat these foods. Only the kids eat hamburgers, I eat rice (Cô Vó)."

The description would continue with two or three dishes listed according to their main ingredient, such as fish, meat, or vegetables. Sometimes the description included mode of preparation, such as soup, stew, or stir-fry. Unlike the quote above, these elements of a meal were rarely labeled Vietnamese. However, evidence suggests that most were describing Vietnamese meals. "A typical meal for me is steamed rice, meat or fish with either salt or fish sauce, soup, and sometimes fried vegetables. This is traditional Vietnamese food. I do not make American food at home (Bà Nguy)." The frequency of

fish, shrimp and pork, mint leaf and salad greens such as spinach, and soup or stir-frying in descriptions of food place the source of these meals towards Vietnamese rather than American eating (Ikeda et al., 2002; Koctürk, 1996; Van Kiem, 1991). Two women specifically characterized themselves as eating something other than Vietnamese food; these women had been in the United States for a longer time than average (12 and 14 years). They also both stated the feeling of food and eating what they like as their major food decision-making factor.

American invasion?

"I changed a little bit coming here because some vegetables they have in Vietnam we don't have in America, and in Vietnam we don't have broccoli or celery (Bà Tôn)." Vietnamese dishes or meals may change simply because of the different foods available. The change in location may also bring about changes in preparation. Several women use canned or prepared foods, either as a rule in preparing Vietnamese meals (Cô Thiếu, Cô La), or on occasion in serving American foods (Cô Thạch, Cô Truong). Using canned food was spread fairly equally according to amount of time in the United States. Also, because large appliances are standard in American kitchens, many women use microwaves and stoves instead of wood and charcoal fires (Cô Chu, Cô Thạch). Such changes are necessary adaptations to new circumstances. Adaptations of this kind are a preliminary step towards acculturation, but most likely do not reflect significant changes to a person's cultural orientation.

"Sometimes I cook American food at home, such as spaghetti with beef and noodles or bread with ham and cheese in the toaster (Cô Vó)." A few women stated that they either cook American food at home or go to an American food establishment more often than once per week. For most, eating American food is more occasional. However, American food has entered into the array of possible solutions for mealtimes, as when women say that they eat fast food or American food from a store when they feel "lazy" or do not have time.

Usually breakfast consists of coffee with milk and sweet bread, and sometimes noodles. This is similar to breakfast patterns in Vietnam (Craig, 2002; Kalcik, 1984). Interestingly, none of the women mentioned cereal, the most popular American breakfast food, in reference to breakfast. However, breakfast does show considerable difference from Vietnam (Cô Mai, Cô Qúach). Breakfast is the meal most often skipped when only two meals are eaten per day. Three stated specifically that they do not eat breakfast in the morning because they go to work very early (Cô Mai, Anh Cù, Cô Thái). This meal pattern is common in the United States. It does not seem to be common in Vietnam, for these women also state that they did eat breakfast in Vietnam.

These small changes, however, do not detract from the overall sentiment of eating Vietnamese food, as asserted by most of the women who consider themselves eaters of Vietnamese food. American food inhabits its own space, relegated to eating out, weekends, or children and husbands. These spaces are different for each woman or family. "I eat American food for breakfast, such as hamburger with beef, cheese, tomato, and salad [lettuce], or fried chicken, or beef steak (Cô Thiếu)." Certain meals or times are associated with American foods. Several women eat Vietnamese food for lunch, but prepare American food for dinner because of children or husbands who like these foods and are at home for dinner. Weekend is also a popular time for American foods. "I never have a chance to go to Vietnamese restaurants, I can make it at home, so I would rather go to American restaurants (Cô Mai)." Many women describe American food to be eaten at restaurants and Vietnamese food at home, though these boundaries are sometimes crossed.

Symbol and ethnicity

Eating Vietnamese food is a symbolic tie to the women's Vietnamese ethnicity. The women consider themselves to eat the same way as they did in Vietnam. In reality, the women do eat mostly Vietnamese food in a Vietnamese way. This reality is augmented by the strength of the Vietnamese characterization they ascribe to their eating habits. Minor changes have necessarily occurred as the women have entered a new location with

different foods and different expectations regarding time and routines. Eating American food also serves to strengthen their characterization of eating Vietnamese food, because it is described as an "other" or "special" food, rather than food normally eaten. It is important to the women, however acculturated their diet, that they present themselves as eaters of Vietnamese food, and Vietnamese food as the normal, daily fare.

Social environment and adaptation

Adaptation is the key to working within the given structural environment. The Vietnamese women who have come to the United States are willing to adapt to a new environment, including new foods, food quality, and differences in time and transportation. Displaced persons may be stereotyped as unwilling to yield, staunchly opposed to change in their eating habits (Kalcik, 1984; Mintz, 1996). However, while these women do not state that their eating habits have changed, changes have been made and they accept these changes readily, as predicted in the literature (Do, 1999; Kibria, 1993).

Food system

The availability of food presents certain difficulties, but there are also helpful aspects. Here availability refers not only to the presence of the food, but also the ability to obtain it (access) and the manner in which it is offered (aspects of the food system) which may affect how the women are able to cook and eat food. Food purchasing ability is generally greater in the United States than in Vietnam. "Meat in Vietnam is more expensive so we don't eat it much (Cô Luong)." The same is stated true for cheese and milk. Interestingly, these three items are also the ones most often stated as the source of nutrition in American food, valued for its fat content but disliked both for taste and for fear of getting fat.

Even canned and prepared foods are not considered prohibitively expensive, and the women appreciate their convenience because the women feel pressed for time in the United States. In fact, time is the most common hindrance to food availability, either

because they do not have time to properly prepare foods, or because they do not have time to shop for food whenever they need to.

The difference in market systems is remarked upon by eleven of the twenty-nine women. In Vietnam, they went to the market every day, bought fresh foods that were harvested or killed that morning, and they cooked those foods either that same day or marinated overnight (in the case of meat). In America, they go to the market about once a week, buy frozen foods to put in their own freezer, and they did not know where these foods came from or how long it had been since they were harvested or killed. They may cook a food a week after they bought it. The differences in the American system lead to certain difficulties to which the women must adapt.

Food quality

The difficulties begin with change in the length of time between food purchases. Not only time, but also transportation prevents the women from purchasing food every day. They must wait for their husbands to drive them to the grocery store. Additionally, in America it would not be useful to go to the store every day. As the husband of one woman mentioned, "The store does not have enough fresh food for us to shop every day...the food is frozen, so you transfer it to another freezer (husband of Cô Dạng)."

Twenty-three of twenty-nine interviewed mentioned the freshness or lack thereof, the different taste, or the different smell of certain foods. Many said that American foods taste and smell different, or that they are all frozen. "American food has a lot of fat and it is smelly. If it smells a lot I can't eat it (Cô Hùynh)." Generally these aspects of taste and smell were referred to in a negative sense towards American food. "In Vietnamese food everything is fresh, but here everything is cold and doesn't smell [like anything], and everything is frozen. In Vietnam when you buy fresh meat, you see the blood come out, which makes it taste better. Here everything is ice because it is frozen (Cô Thái)."

Freshness is a valued attribute of foods. Fresh foods are described as more nutritious. "The food in Vietnam is fresh, and this is nutritious. In America everything is frozen (Cô

Vanh)." Fresh food also has a preferred taste and smell, and reveals nostalgia for the food of Vietnam. "Meat in Vietnam is fresh and tastes better than in the United States, the quality is good (Cô Lam)." In eleven instances Vietnamese food, especially the meat, is described as fresh. This is often opposed to the frozenness of American food.

Despite their dissatisfaction with buying frozen food, especially meat, adaptations must be made because of imposed routines and circumstances, such as time, transportation, and food availability. To reconcile this conflict between desired meat quality and the quality of meat they are able to purchase, an adaptation has been made in meat preparation.

> Dirty comes from the meat, makes the water look dirty, and it is not safe to eat, because the meat here is frozen. The meat here is not as good because the food the animal eats is different than in Vietnam. [The dirty] comes from the food first then from frozen. There are germs in the meat because it has been a long time since it was killed (Cô Truong).

Boiling meat tended to be a practice of those who have been in the United States a shorter amount of time compared to those who specifically said they do not boil the meat.

Shopping only once a week means that the women must keep food longer than they did in Vietnam. A few women mentioned having trouble knowing how long to keep food in the refrigerator. The most common result of keeping frozen food is boiling the meat. The women boil the meat to defrost it, throw out the water, and boil it again up to three times. Many also wash the meat with salt. These practices are intended to clean the meat, and make the "dirty come out."

This is not a practice that has been carried over from Vietnam, but is based in Vietnamese beliefs about health and contagion, specifically their knowledge of germs and its connection with dirt. The frozen meat has a different quality than fresh meat, and when it is boiled it changes the appearance of the water, causing it to appear dirty. They believe that, though the meat is frozen to preserve it, because it has been a long time since it was killed, there are germs in the meat. This practice is an adaptation to the change in market systems.

On the other hand, there are positive aspects of the difference in food systems. The women state few problems with food availability in the United States because they have a much greater selection of foods, seasonings, and modes of preparation compared to Vietnam. "[In Vietnam], you don't have the food to compare [regarding nutrition]. Here there is Thai, American, Chinese (Cô Hòang)." A few commented on their experiences going back to Vietnam, and finding the foods and seasonings limited compared to what they eat in America.

Food availability and adaptation

This greater sense of food availability is no doubt enhanced by the increasing access to Vietnamese foods in Vietnamese markets in the area. Ten to twenty years ago, displaced Vietnamese replaced Vietnamese food with American food because there were few Vietnamese foods available. Because Vietnamese food is available to them, the other types of food merely add to their food repertoire.

Using foods that are available in the United States, as opposed to those that are not available, as in the broccoli and celery example, is a clear case of adaptation to the American food environment. The role availability plays in this adaptation is further illustrated in comparing the women's experiences finding food now and ten or more years ago. "When I first came [ten years ago], I couldn't find a lot of foods, now I find a lot of food. Some foods I couldn't make because I couldn't find the ingredients. Now I can make whatever (Cô Dòan)." Women cite the experiences of friends and family members who have been in the United States longer than themselves, stating that these friends could not find all the ingredients they wanted when they arrived.

Availability through programs and adaptation

The WIC program, the Food Bank, food stamps, and similar governmental resources provide an extra window of availability of foods for many of the women. Through their status as refugees, or the program for Vietnamese children of American soldiers, they may be eligible for these benefits whereas other immigrants are not. An observation at a Food Bank event – the Harvest Share – revealed the benefits of a large amount of fresh foods

to those participating. Other Food Bank events include more canned and boxed foods, even snack foods. In either the produce or prepared foods case there are a limited number of kinds of food available, based on the surpluses of local groceries and the distribution system of the Food Bank.

Though the amount of food that may be added to a participant's pantry is significant, the limited variety offered may diminish the availability of useable food by the lack of applicability to a participant's diet and situation. One woman discusses the Food Bank and WIC food programs at length.

> I am also involved in the WIC program. I used to get food from the Food Bank, but I am too busy to go get the food, and I can't eat what they deliver – I don't want to waste the food. I also get food stamps. The Food Bank gives American food, we don't eat very much bread, we use rice. What the Food Bank delivers, I don't know how to cook. Some things I could use, like canned fruit and chicken broth. I get cereal from WIC, so I don't use the cereal from the Food Bank. They give a lot of flour, but I only use a little flour. I use the beans (Cô Luong).

This woman's situation describes several limitations of these programs. One is coordination of services. WIC provides as much cereal as even American families could eat. Any cereal received from the Food Bank is likely not to be used, decreasing the total amount of useable food received.

Second, she does not know how to cook some of the foods she receives. Unfamiliar foods are less likely to be used and also decrease useable food. This point was verified at the Food Bank distribution, when some participants asked volunteers what to do with the cucumbers, or refused them because they could not cook them. This situation may be partly remedied by cooking classes that WIC offers. However, this potential does not seem to be met because participants and staff both report that the meals prepared in the classes are not very appealing to the Vietnamese women (Cô Dinh, Cô Dòan).

This woman does point out the foods that she uses, including canned fruit, chicken broth, and beans. On the other hand, the Food Bank gives her bread and flour as a staple, but

her staple food is rice. The staple food of a culture is the most persistent element of a person's diet (Koctürk, 1996). To provide a different staple food is to decrease the useable food because it will be used in smaller amounts than provided, and as the woman suggests, may be wasted rather than eaten. The Food Bank observation revealed a consideration for general cultural area differences. They discussed a couple of cultural foods that were specific to Russian and Asian ethnicities, and instructed volunteers to divide those foods accordingly. However, according to Cô Luong's experience, this cultural specificity does not always occur in the distribution.

Culture and adaptation

The women are able to adapt to new constraints on their food making abilities. Adaptation is shaped by the foods available, evidenced by changes over the last ten years in both eating habits and available foods, and by the limitedness of foods available through WIC and the Food Bank. In addition, innovative changes have been made to adapt to the new food system, such as boiling frozen meat. Such an example also illustrates the way that their own culture, such as contagion beliefs, shapes their adaptation. The new food environment, in adaptation, is reconciled with cultural beliefs rather than replacing those beliefs. The Vietnamese women are willing and able to adapt to a new environment, and cultural values shape the way that they adapt and include new eating habits.

Changing nutritional concepts

Acculturation in relation to nutrition may have less to do with knowledge of certain principles of nutrition, but rather how one defines the concept of nutrition itself and characterizes healthy eating. Acculturation may appear at a greater level because of familiarity with the discourse and concepts of nutritional science, while at the core new information and practice is simply incorporated into a Vietnamese understanding of health and nutrition.

"Nutrition" and "healthy"

Nutrition and healthiness of foods inhabit a broad spectrum of meaning described by the women. Though language barriers may be surmounted by translation and English instruction, it is important when drawing conclusions from such statements to ensure that words that translate from one language to another are understood in the same way. This difference in concepts was particularly evident through the interview process. Often when the women were asked to define or describe nutrition as a concept, they would talk about what they like to eat, whether American food is nutritious or not, or the difference between fresh Vietnamese food and frozen American food. One woman, whenever she was asked to describe nutrition, answered that she was afraid that if she ate American food, she would gain weight. Multiple clarifications of the question resulted in more details about the American foods that might make her fat, such as the Big Mac (Cô Hà). These answers were not what the interviewer expected, but do illustrate that nutrition is understood in a much wider frame of reference than Americans, especially from a scientific perspective, typically talk about.

When asked to define nutrition, or describe nutrition, responses varied from "vitamins in the meal (Cô Thạch)" to "fresh food with great taste (Cô Truong)." Lots of vegetables and enough meat, but more fish than meat, were common nutritional guidelines given by the women. As a point of interest, rice was never mentioned in relation to nutrition. When asked directly, one woman's husband said that rice and sweet potatoes are merely filling, and do not have nutritional value.

Some women do not consider calories or nutrition, but eating healthy is to eat when one is hungry or to eat what one likes. Often "healthy" food is based on how the food feels when it is eaten, or how one feels afterward. Nine out of the 29 interviewed specifically based their decision of what to eat on the criteria of hunger, taste, or the feeling of the food. Seven based their eating decisions on a balance of meat, vegetables, and other category such as fruit. One said that she bases her decisions on the food pyramid, as presented by WIC.

Whether these statements of decision making are accurate reflections of their eating decisions or not, it does reveal the locus of their understanding of nutrition. More of the women state that they mainly base their decisions on either a balance of foods or nutritional science concepts of health (three out of twenty-nine for the latter), which are common nutrition concepts in the United States. Women also mention taste, feeling, and hunger in reference to nutrition or healthy eating. These reflect nutrition concepts in Vietnam. The opposite is also true, that those who base their decisions on taste or feelings also mention nutritional science concepts: "When I am hungry, I eat, and that is healthy...American food is healthier because it has complete vitamins and nutrients that you need (Cô Trang)." Thus while nutritional understanding has a basis in either a scientific or a humoral orientation, it should be recognized that elements of both will be in effect simultaneously.

American food is considered nutritious

"American food is more nutritious than Vietnamese food" was a statement made by the seventeen women who made a direct comparison. For those who did not directly compare them, American food was also described as healthy, though looked upon unfavorably for taste or freshness. When asked what is nutritious about American food, explanations sometimes included vitamins and nutrients, possibly because of enriched foods: "I compare American and Vietnamese foods, and American food is healthier because it has complete vitamins and nutrients (Cô Trang)." More often the explanation was the higher fat content as a result of the amount of meat, cheese, and butter in American cooking.

> American food is more nutritious than Vietnamese food. American food has more fat than Vietnamese food, and American people easily get fat more than Vietnamese. American food is cooked with a lot of cheese, milk, and butter, but Vietnamese don't use it at all (Bà Ngụy).

The fatness of American foods in general, and the ability to get fat eating them, was the most common evidence cited of the greater nutrition in American food. This was especially true in reference to children. Many women are concerned with their children's

nutrition, especially in reference to their children's growth. This concern likely stems in part from the nature of the parenting program, which emphasizes children's growth and development. One woman's neighbors had also commented on her children's growth, which led to her concern that they were too skinny. Also children's growth is a concern for women in Vietnam, perhaps as a result of public health messages and prevalence of malnutrition.

A few women believed their children's growth adequate eating Vietnamese rather than American food. Other women would state that the fat in American food is nutritious for their children, to help them grow. Four out of the five women who specifically discussed their child's nutrition expressed this idea. One woman stated that fast food such as hamburgers and French fries are healthy for the children because the fat helps them to grow and develop (Cô Thái). The women's concern for their children's growth and their belief that the fat in American foods are good for their growth may encourage the children to eat more American foods. Unfortunately, this attitude could lead to overnutrition in their children if the trend of desiring more fat, calories, and specifically fast food continues.

Desirability of American food

If more "nutrition" is considered better in general, or even for children, the women do not consider more always better for themselves.

> Vietnamese food has a little bit of meat and the rest is vegetables, so American food is more nutritious...American food has too much meat for me...American food has more nutrition for children, but older people don't need to eat American food to get fat (Cô La).

Fear of getting fat (ten out of eighteen mentioned) was a common theme in discussing the health of American food, and another four expressed fat-related ideas, such as taking the skin off of chicken or having too much cholesterol. Of the four remaining who found fat a part of nutritional health, three qualified this statement by limiting it to certain people (children or those who aren't fat) or in quantity.

Some conflicts in information and concepts still exist. The information and way of understanding nutrition they learned from their parents and from public health messages in Vietnam occurred in the midst of a particular environment and situation. Malnutrition is a danger, and Western influences especially push for the elimination of specific vitamin deficiencies, especially regarding children (Thu et al., 1999; UK Partnership for Child Development, 2001). This situation may lead to the idea that "more is better" in regard to nutrients, including fat.

Upon entering the United States, the messages they learned changed, in part because the situation and environment is different. Overnutrition rather than undernutrition is the danger in the United States, and therefore fat and calories are discouraged. This idea is especially prevalent among women in the United States. This may explain why many Vietnamese women believe fat to be nutritious and healthy for their children, but do not want to eat it themselves and fear getting fat.

Though women considered American food nutritious, they also found the predominance of frozen foods not as healthy as the fresh foods of Vietnam. "The food in Vietnam is fresh, and this is nutritious. In America everything is frozen (Cô Vanh)." One woman explained that frozen food is not nutritious because it doesn't smell or taste fresh (Bà Tôn). With a few exceptions, Vietnamese food rather than American is praised as nutritious or healthy because of its freshness. Location or source of the food, which affects the quality and appearance of the foods, was a significant aspect of the healthiness of foods.

> Vietnamese food in Vietnam is more nutritious than in America, because the meat is frozen, and in Vietnam meat is fresh... Frozen food is not nutritious at all – [it has] no nutrition because it is not fresh; it is also not good (Bà Ngụy).

On the other hand, some distinguished between the meat in the Vietnamese stores, which is frozen and has more fat (Cô Chu), to the meat in the American stores, which is fresh and lean. Some women talk of the frozen meat in America because they buy it fresh in

the store but have to freeze it until they use it (Cô Luong). Others buy meat in the Vietnamese stores (Cô Lam), and this may be why some of them characterize meat in America as frozen, while many Americans buy "fresh" meat (that is, it is not frozen when purchased).

It seems that nutrition refers to fat or calories – the idea of energy or body developing substance – and that more is considered healthy. Just because they consider it healthy, though, does not mean that they want to eat it or even that they consider it a good thing to eat themselves. Though aware of what Americans consider healthy eating, the women eat mainly for taste and enjoyment. Most eat what they like, when they are hungry, or what tastes good or feels good to them. Fortunately, the Vietnamese foods that these first generation women like and that feel good are healthy, rich in vegetables and fruits, and low in fat and meat. The second generation, if their tastes turn from these healthy practices, may find the idea of eating what they like or what feels good to be more dangerous to nutritional health.

Causes and effects of health and nutrition

The humoral understanding of health, widely practiced in Vietnam, was difficult to detect in interviews. When directly questioned about "hot" and "cold" foods, the women did not seem to understand the question. In the course of describing how they ate and thought about nutrition, though, certain elements of humoral understanding surfaced, such as emotional and environmental causes and effects of health. It is also likely that the emphasis on how a food makes one feel, or eating what one likes or when one is hungry, is related to the humoral understanding and the importance of ease in digestion.

Certain foods were specifically described as "hot" or "cold." The distinction was sometimes based on temperature, sometimes spiciness or some other aspect of the food, such as whether "it goes to the throat or the stomach (Bà Tôn)." Hot foods included hot peppers (Cô Thái), and too much hot may result in heartburn, constipation, eye redness (Bà Tôn), pimples, upset stomach, and hostility (Cô Dinh). Vegetables and beans are cold foods (Cô Thái), and counteract the effects of hot food (Bà Tôn), such as bitter melon

for uneasy feelings (Cô Truong). American food was also described as cold, and this may refer mainly to temperature – Americans eat fresh salads, while Vietnamese cook nearly all of their vegetables (Cô Qúach). Emotions are also affected by foods, according to the humoral understanding. One woman eats sweet potatoes to counteract hostile feelings (Cô Truong). A cold state of the body is preferred, because "your body feels good, you sleep well...you calm down, you relax, you feel easy (Cô Dinh)."

The environment can be a causal factor in health and illness in the humoral understanding as well. In reference to food, the weather affects how the body digests and incorporates food. Two women (both, incidentally, the mothers of women enrolled in the program) refer to the need to watch the fat in their diet in the United States because "the water is different," that is, they sweat less. "In Vietnam, it is hot and water comes out of your skin so we don't worry about fat. Here I cook with less fat and sugar because the water (sweat) is different (Bà Tang)." Another woman explained that the connection between sweating and ingesting fat is that the sweat is the result of the body working harder.

> The weather [in Vietnam] makes water come out a lot. I worked really hard. I had to walk every day to the market to sell vegetables, and walk back home for lunch, walk back to the market to sell vegetables...here I stay home and cook, so I worry about my health (Bà Trinh).

The humoral concept showed an intriguing association to amount of time in the United States. Three of the five women who have been in the United States for two years or less mentioned the physical and emotional effects of food. Of those who mentioned humoral concepts (effects of weather; hygiene) who have been in the United States for more than two years, their age and status would cause them to be addressed as "Bà" (translated "Grandmother"), meaning they are of an older generation. This spread of the data suggests that the humoral concept is more firmly fixed in the older generation than in the younger, regardless of how long they have been in the United States. However, of the younger generation, the concept in this study persists for about two years into residence in the United States.

The humoral understanding is a working concept for some of these women. They are present in the understanding, but not as much a part of normal discourse about health as they are in Vietnam. More of the women are probably affected by the concepts, continuing certain practices without realizing or expressing their source. While the discourse is changing and concepts appear to be fading due to acculturation and nutritional science concepts, the broadness of understanding of causes and effects of illness characteristic of humoral concepts do seem to be kept as the framework for incorporating new information.

Nutritional science information

The opinion of a few of the women is that in Vietnam, people do not know about health concerns or that they are not concerned about the health effects of their food. "In Vietnam they didn't realize these things (about fat), they just ate (Cô Hòang)." Others, however, recognize what they were aware of in Vietnam. "In Vietnam they know nutrition, what is good for health – they should eat fish more than meat, eat fruit for good health. The best foods are vegetables and fruit (Cô Dào)." Now that they are in the United States, the women do express a concern for health and nutrition.

Awareness of health issues

About half of the women interviewed expressed concern for a specific health concern currently in the American health discourse. The most common were cholesterol and fat, followed by diabetes. Women also mentioned bone density, meat safety, too much sugar, MSG, and salt, and too little iron. Some of this similarity to American health concerns can be attributed to similarities in concerns between America and Western society, and Vietnam. Concern about fat is present to some extent in Vietnam currently, as is knowledge about vitamin and nutrient deficiencies (Craig, 2002).

Cholesterol may be a nutritional concern learned in the United States rather than in Vietnam, because its mention is accompanied by a reference to a doctor or even friends, and it does not seem to be a problem in Vietnam: "American food is healthy, but it makes people have higher cholesterol than in Vietnam ... In Vietnam, when you go to the doctor he doesn't talk about food because you only eat fresh foods (Cô Húa)."

Doctors and services

Sources of information for nutrition and healthy food (out of total twenty-nine) include doctors (eight), WIC (ten), and parents or other family members (five). Interestingly, some cited nutrition labels on food packaging (four) and various sources such as home visiting staff, college (in the case of their husbands), and their children. In few cases did the women state that the advice or information did not change the way that they cooked or ate, especially for doctors (one out of eight) and WIC (three out of ten).

These figures may indicate a high rate of success of nutrition information, but may be slightly misleading. Many do not see the doctor often, most commonly the women see doctors when they are pregnant. Advice is generally to drink more milk, eat fruits and vegetables, sometimes meat. Many Vietnamese, as in other Asian ethnicities, are lactose intolerant and cannot drink milk. Doctors and programs tend to push drinking milk regardless of whether the body can handle it. However, there are other calcium-rich foods available. Some women are aware of these, particularly leafy green vegetables, which are already a part of their diet.

According to doctors' advice, some women do drink milk during pregnancy. "In Vietnam I didn't like milk, didn't drink it. The doctor [in the US] told me to drink two cups a day. When I was pregnant I did, but not now (Cô Thạch)." The advice of doctors regarding food and nutrition, if given, is related mostly to pregnancy and children. It is also followed most closely during pregnancy and may, as in the above example, be discontinued after the birth of the child. This tendency reflects the Vietnamese values of taking care of the baby while pregnant, and taking care of oneself afterward (Rossiter, 1994). The expectation of "eating for the baby" is also present in Western thinking

(Lupton, 1996). Some women did report that they continue following the doctor's recommendations about milk and nutrition after pregnancy.

The experience of a woman's husband indicates a possible limitation in doctor's advice. "I saw the doctor for insurance. He recommended to eat more [of certain foods], but when the test from the blood was ok, the doctor didn't tell me to eat more, he didn't ask me to change anymore what I ate (husband of Cô Dạng)." This incident reveals a possible tendency for doctors to make assumptions about a patient's current diet and the deficiencies that may cause health problems.

WIC provides nutrition classes to many women in the program. Information recalled by the women included eating more vegetables and fruit, milk, and bread. They mentioned the Food Pyramid and learning what foods have a lot of fat, or high-sugar fruits. The most common change reported due to this information was to eat more vegetables. Since Vietnamese women reported eating a lot of vegetables to begin with, and vegetables are an important part of the diet in Vietnam, this may not be a large success for WIC.

WIC tends to focus on American food, as one woman said, "[WIC] did change how I cook – I eat some American food (Cô Bành)." Whether or not this is a desirable change for health depends on to what American food she is referring. For some, the focus on American food is a hindrance. "When they say, 'this is good for nutrition,' I think that is right, but when I buy it I can't taste it…it looked good, but I couldn't eat it (Cô Thái)." Another said that she did not know how to cook the American foods that WIC suggested. According to staff, WIC does offer cooking classes but the dishes WIC makes are too bland for the women's tastes (Cô Dinh).

The advice of parents, friends, and nutrition principles learned in Vietnam do not necessarily change what the women believe about nutrition, but are the foundation, since they learned this first and more regularly. Such advice seems to be, by the women's reports, in harmony with much of that given by doctors and by WIC, with the exception of milk. "The nutrition advice and information [in the US] is the same [as her parents

taught her], to eat vegetables and meat – some people only eat meat and that's enough, but no [one needs vegetables too] (Cô Thạch)." However, sometimes lessons learned from parents may not be healthy, such as eating whatever one likes (Cô Lam). There does not seem to be a lot of conflict between nutrition principles and information learned in Vietnam growing up, and that presented by WIC or doctors in the United States. More conflict arises in areas where many Americans also struggle – when the food they enjoy eating is not healthy according to nutritional guidelines (Counihan, 1999).

Trends in data

Examining trends in this data is not definitive, as the data cannot be analyzed statistically. There are observational trends that may fuel further research and understanding of acculturation. This study provided a cross-section of Vietnamese women in the United States, including new arrivals to women who have been in the United States for up to fifteen years and observing the state of their acculturation at the current time. Participants' statements also give information about how acculturation has changed over time, with changing social conditions.

Effects of time

The cross-section provides a brief look at how acculturation may progress over time. There do not appear to be significant changes dependent on length of time in the United States. Many changes, such as going to the supermarket daily or cooking with new equipment or without foods that are not available, happen immediately and are adjusted to on arrival, so the change does not appear in this cross-section, which does not include women who have arrived more recently than 6 months. Other changes, such as liking to eat American foods or cooking American foods at home, happen at variable rates or may not happen at all. Though these changes have been made over time according to these women, the cross-section does not show a clear correspondence. The data, then, may reflect more the social situation at this time than the process of change over time.

One benefit of this cross-section is to point out the high variability of data independent of time in the United States. Some women referred to nutritional science concepts, while others referred to humoral concepts. Some women considered American food fat and healthy, and others were concerned about getting fat from American food. Some women go to American restaurants when eating out, and others go to Vietnamese or Chinese restaurants. What is more interesting is that many women did these things simultaneously.

The process of acculturation is still happening, and the women are not "fixed" in one culture or the other. The two cultures reside together rather than replacing one another. The women follow the pattern of adhesive adaptation (Hurh & Kim, 1984); they keep Vietnamese ways of eating and understanding food, while adding American eating habits and understandings of food as it suits them. Time, or length of time in the receiving culture, is the current standard for measuring level of acculturation. Other variables used, such as language acquisition and ethnicity of friends, reflect the processes of acculturation better. However, in the literature these variables are still tested by length of time in the United States. The variability in types of acculturation and the overlapping of culture of origin and receiving culture are more difficult to measure.

Effects of social conditions

The United States and Vietnam are very different environments for cooking and eating. Since the women arrived in the United States at different times, whether 1975 or 2003, they have arrived into very different circumstances. Before 1975 there were very few Vietnamese in the United States. Vietnamese food was neither known by Americans nor available in most parts of America. Chinese groceries and restaurants were fairly common in metropolitan areas, providing some similarities to Vietnamese food. Currently, as more Vietnamese have become established in certain parts of the United States, Vietnamese groceries, restaurants, and other businesses are available (McKee, 2000). Vietnamese food is becoming more widely recognized among Americans as well.

Agricultural and distribution systems are more local in Vietnam, and in the United States are industrialized and nationwide. Not only are there some differences in the types and variety of foods available, but also in the means and equipment for cooking. As a result of this different system, Vietnamese women have made many adjustments to the way they would prepare food in Vietnam. Vegetables do not need as much washing and scrubbing as they did in Vietnam, for they are clean in the store. The use of stoves and the availability of semi-prepared foods (canned, boxed, pre-cut) also decrease the amount of work required to cook a meal. Refrigeration allows women to keep perishable food longer, and spend less time at the store.

This convenience also comes with a learning curve. They must learn how long food keeps in the refrigerator and in the freezer. They must become familiar with the packaged and already-prepared foods and how to use them. They must learn to plan meals ahead of time so that they may defrost the meat and do certain preparations to be ready to cook. They must also learn new tools and techniques of storage and preparation, and be able to apply them to the Vietnamese food that they eat. Frozen meat must be boiled to defrost it, and then boiled an extra time or two because the women believe that there are germs in the meat because it is not fresh as in Vietnam.

Overall the women express satisfaction in adapting to this new system. They are not difficult adaptations to make, particularly with the help of friends, family, and refugee assistance programs. However, the particular adaptations made may affect nutritional health in one way or another.

One adjustment to these new circumstances is eating fast food. It is surprising, given the preference for fresh foods, to find that fast food is the food most readily adopted into the regular diet. Women lament the prevalence of cheese and meat in American food, yet these are common elements in fast food, and of low quality or freshness. Eating at this type of establishment is habitual to some extent, ranging from once every two months to twice a week. Hamburgers and pizza are the most commonly eaten American foods.

Even women who do not eat at restaurants will go to McDonald's when they do not have time to cook.

Providing American food to children who do not eat Vietnamese food also is a problem commonly solved with fast food. Convenience makes fast food the American food with which these Vietnamese women are the most familiar. The status and symbolism of fast food as "the" American food also encourages familiarity. This familiarity, in turn, leads to acceptance of food that would not otherwise appeal to them.

Since acculturation is partly related to the availability of foods and means of cooking and eating, such differences in availability over time will cause different ways of acculturating. Women mentioned friends or relatives who arrived in the United States ten or twenty years ago, who now exclusively eat American foods. They say those arriving earlier could not find the ingredients to make Vietnamese food at that time. This reflects changes in the structural and social environment, which affects the American cultural expectations of people moving from other countries to the United States. Since Vietnamese arriving just after the Vietnam War arrived into the "melting pot" analogy (Beale, 2000), they became very much like Americans, at least in the food that they ate. The friends mentioned by the women learned to make American food, such as pizza, spaghetti, and macaroni-and-cheese, out of necessity.

By contrast, in the last ten years in the Portland area Vietnamese food has become available. Those arriving during this time period encountered the "salad bowl" analogy, and this has encouraged them to retain many of their cultural practices and appearances (Kivisto, 2001). Necessity does not drive those arriving more recently to make only American foods, so they may choose to make some American foods and some Vietnamese foods. How these social conditions affect the outward characteristics of eating food, as well as their cultural beliefs and ways of thinking about food, is a matter for further study.

Time is an important factor in the progression that acculturation takes in an individual and in a community. However, time period of arrival may be more predictive of the particular progression than time in the United States alone. The multiple other factors, such as food availability, social conditions and support, and individual experiences, which shape the progression of acculturation are more closely related to time period of arrival than the length of time in the United States.

New ideas and old ways

New ideas are incorporated into a broad concept of nutrition and health, with wide-ranging causes and effects of health and illness. For instance, the word "nutrition", though correctly translated, seems to be used in a different sense than is intended by Western nutritional science. American food is considered by most to be nutritious, even healthy, because of their high caloric and fat content because they are hard to get in Vietnam and much of the developing world. These are not considered by all good for one's health, though. The discourse of health and nutrition shows differences from that in Vietnam, and this is exemplified in the discussion of humoral concepts. These concepts did not readily present themselves, but causes and effects related to nutritional health showed the broad understanding of the humoral system in Vietnam.

This broad understanding may affect how they react to doctors' and other advice and their response to services. The women are not opposed to incorporating new ideas about nutrition and changing their eating habits based on nutritional guidelines presented in the United States. However, the way that these new ideas are incorporated into their thought and practice is shaped by the ideas that they grew up with and learned before coming to the United States.

Insights into acculturation

Exploring the particular experiences of these Vietnamese women in acculturation reveals some possible insights into the complexity involved in acculturation. Any one component of culture such as food is connected with other parts, such as health and hygiene, religion, language, economic systems, and so forth. When considering changes in an aspect of culture, such as those due to acculturation, one must also consider changes in the connected aspects of culture.

These insights are intended as phenomena for further exploration in the general field of knowledge of acculturation. As they are based on a small population of a single ethnicity, these are not intended to constitute working knowledge of any population more general than the Vietnamese women enrolled in the Parent and Child Program Department at the time of study. Specific areas for further, generalizable study will be discussed.

Food provision and acculturation

Food is more expensive in the United States than in Vietnam, but most of the women are more able to buy food in the United States than in Vietnam. As one older woman said, "In Vietnam when you wake up you don't know how to get money to cook. In America you wake up and you don't know what you will cook today." The food situation for Vietnamese has changed considerably in the past ten years or so. While friends that have been in the United States for many years had trouble finding Vietnamese foods, and often ended up cooking American foods entirely, those who have come recently are able to find the foods that they like from Vietnam. There are also more vegetables, seasonings, and other ingredients from which to choose. Though there are more foods available, the food in Vietnam is considered better quality than in the United States.

One woman said that she eats the mango and lichee in the United States because she ate it growing up, even though it does not taste good. The expectation of continuing to eat Vietnamese foods in the United States exists because these foods are now available, and have reclaimed their significance in the Vietnamese-American culture. As a result, the sense of having a choice about what to eat combines with the expectation that one will eat

Vietnamese food to reinforce Vietnamese ways of eating, including the staple and complementary food items (Koctürk, 1996).

There are several sources of food provision for these families, particularly WIC, the Food Bank, and Food Stamps. These programs do increase the amount of calories and nutrients and "foodstuffs" available to the women and their families. The kinds of food available, though, are important to consider. The purpose of services providing food to families with low income or at nutritional risk is to ensure the ability to maintain a healthy diet (Kotch, 1997). However, this purpose may not necessarily determine the actual foods provided by these services. Distribution programs such as the Food Bank are based on the excesses of the United States food system – the food that did not sell within a certain amount of time (Fitchen, 1997; Kotch, 1997). Nutritional needs of recipients do not have an influence in the foods provided. Though the concept of such programs is sound, and provide some food to those who do not have enough, the goals of a healthy diet are not easily met.

The WIC program is specifically designed with nutritional needs in mind. It is limited to a few specific nutrients, but these are nutrients most lacking in pregnant women and children who have limited ability to get food. WIC is more likely to aid in eating a healthy diet because of its design. The United States food system may have its effects, though, in what food is offered because inclusion of foods is based on the lowest available price (Kotch, 1997).

What both of these programs seem to overlook is what happens between purchasing or receiving the food and daily eating. The example of the woman who was enrolled in both programs[6] illustrates this point with breakfast cereal, provided in abundance by both programs. The Food Bank provided a certain bulk of food, and WIC provided certain nutrients. The potential of both, though, were not realized because of the impossibility of the family consuming that amount of breakfast cereal in one month. Such a task would

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[6] See Availability through programs and adaptation, page 49

be difficult for an American family, but the absence of cereal in the diets of these Vietnamese families adds to the difficulty.

Health concerns and acculturation

Overall, the health concerns that emerge from the health and nutrition literature are reinforced in this study. The tendency of adopting high-fat aspects of Western diets is a risk factor for cardiovascular and other diseases. These risks are recognized by many of the women. Risks for nutritional deficiencies are not as apparent in these women; their involvement in the parenting program and other resources such as WIC, the Food Bank, and Food Stamps mitigate the risk of nutritional deficiencies. Certain deficiencies that may result from food choices, such as calcium as a result of not drinking milk, are questionable because other sources of these nutrients are often present in the foods that they eat, in this case leafy green vegetables and marinated fish with edible bones.

While most Vietnamese cuisine is low fat and full of nutrients, there are some drawbacks. A large quantity of white rice is currently considered a health risk, particularly for diabetes. Fish sauce is very high in salt, a risk for high blood pressure and other vascular diseases. A benefit of introducing another array of foods is potentially the added variety that may mitigate the effects of these Vietnamese essentials. That potential, though, depends on the foods that will replace some of the rice and fish sauce in the diet.

The adoption of a Western diet is likely to have an effect on the health of these first generation women. Though their main food is still Vietnamese, and is full of vegetables, mostly unprocessed foods, and contains less meat, cheese, and butter, many women have replaced Vietnamese food at dinner with spaghetti, pizza, and hamburgers, which all tend to contain a lot of fat. For this reason, overall fat content of the diet has likely increased, as health studies have found among displaced Vietnamese.

These effects are likely to be much greater in the second generation. Many women state that their children "cannot eat" Vietnamese food, meaning that the children do not like the taste of Vietnamese food. Often the solution they have found is McDonald's, store-

prepared food, or home-cooked versions of fast food. It is likely that these foods are used because of the status of these American foods, and also because they do not know how to cook many American foods for which their children develop tastes. This practice is likely to have effects on food preferences of these children as they grow up. The women who grew up in Vietnam developed tastes for vegetables, fruits, seafood, stir-fried or boiled meats, fish sauce, and rice. The children, on the other hand, are growing up with high-fat, highly processed, low-vegetable convenience foods. Their tastes will likely develop in this direction, as many second-generation immigrants do (Mintz, 1996).

Adding to the likelihood of developing these unhealthy tastes is that the attitude of many women is to eat what they like, or what feels good. A young woman who came to the United States as a child, and now prefers to eat more American food, explains, "I was taught to eat what I like." For the first generation women, this is healthy advice, because their tastes generally lead them to foods that support their health. As their children adopt this attitude, their tastes may be leading them to foods that will put them at risk for disease, especially chronic disease.

It is difficult to say whether the fear of getting fat from American food is a result of acculturation into the Western ideal of thinness or not. Mass media and the availability of Western culture in Vietnam may have changed the traditional reverence for fatness in this and many other cultures, especially in younger generations. Also, while fatness is valued as a status symbol in Vietnam, excessive fat is also recognized as risky for health (Craig, 2002). It is possible that the women did not value being fat in Vietnam and are concerned about it in the United States where they see it is easy to get fat eating American food. However, it is an area for further exploration. As Counihan (1999) points out, acculturation is recognized among many stressors and social injustices in society for which eating disorders become survival techniques for women. This fear of being fat, if found to be common among Vietnamese women, may be a precursor for a prevalence of eating disorders in this community.

The fatness of American food is considered healthy in a sense, though not necessarily for everyone. Children are encouraged to eat American food, such as fast-food hamburgers, because the women believe the fat is good for the children and will help them grow properly. Yet they say it is not good for "fat people," or for adults who get fat more easily than children. In Vietnam many children are at risk for malnutrition, so consuming fat among other nutrients is important. The situation is different in the United States – especially for families with governmental and other support, getting enough food is not a problem. Also fat is considered healthy in cold weather. It is generally colder in this area of the United States than in Vietnam. While the women recognize these differences, they may not make the connections to the necessary adjustments in fat intake. A few women did mention that the cold weather made them concerned about fat. However, most still considered high-fat foods important for their children's growth.

Categories of acculturation

Acculturation is in many respects a learning process, and different subjects, so to speak, are learned in different ways: information is memorized and categorized; methods and actions are practiced and repeated; values are impressed on a person, imitated, and then internalized. Similarly, in this case of acculturation of food and nutrition, several different categories of acculturation with different ways of learning them can be outlined: acculturation of diet and practice, of taste, of solutions and ways of providing food to the family, and of food concepts (including health knowledge and concepts related to food). These particular divisions are chosen because they represent sub-processes in the overall acculturation process according to the way they are described by the women.

Acculturation of diet and practice

Practices having to do with food are internal factors such as cultural ideas of what foods are eaten, when they are eaten and with whom. These cultural ideas also stem from and generally harmonize with factors of structural environment such as food availability, the social structure, and other features of society (Mintz, 1996). In a situation such as acculturation, the structural factors often take precedence in influencing practices having

to do with food. Inside factors no longer harmonize with outside factors, and the hard reality must be yielded to. This disharmony can be seen in the experiences of these Vietnamese women, some of whom say they eat because they know they need to eat, not because they like the food.

Acculturation of diet is heavily influenced by the nature of those structural factors. Specifically, the amount of disharmony between internal and structural factors will relate to how much diet and practice become acculturated. The differences between the eating patterns of Vietnamese arriving ten or more years ago, who eat mainly American food, and those arriving in the last ten years, who mostly eat Vietnamese food, are explainable largely by the growing presence of Vietnamese grocers and restaurants in the area in the last ten years. Because Vietnamese food is available, there is not the same necessity to acculturate to American food. By exposure, choice, convenience, and other factors they do adopt some American eating patterns, though.

Many of these women are affected by the availability of food through programs such as the Food Bank and WIC. Vietnamese foods are generally not available through these programs, yet the women partially rely on them in order to obtain an adequate amount of food for themselves and their families. Ten or more years ago the lack of Vietnamese foods through such programs was not an issue, because few Vietnamese in America (in this area in particular) were able to get these foods on a regular basis.

Currently, Vietnamese foods are available in the Portland area, so these programs do not meet the expectations of Vietnamese culture in the United States, as they would have been previously. Adding to this expectation, as the women enter a new culture and must consciously maintain Vietnamese cultural aspects, obtaining certain Vietnamese foods becomes more important (Mintz, 1996). The challenge for women and families involved in these programs is another cultural expectation imposed on them through their low-income status in American culture. American culture typically expects those with low-income status to abandon the general cultural expectations in what foods to eat, whether American or Vietnamese cultural expectations, because as "poor" people relying on

government assistance, they should only buy basic foods to sustain them physically (Fitchen, 1997).

The American foods that do become a part of Vietnamese diets are decidedly not "basic" foods. Hamburgers, spaghetti, and pizza are among the most common, and they are generally purchased at restaurants and fast food establishments though are sometimes made at home. Many women specifically stated that they had not tried American foods other than these. The reason these specific foods are prevalent in the diet may have to do with the lack of necessity for trying other American foods, since Vietnamese foods are available, as well as the tendency of eating establishments to appeal to a wide variety of tastes (Kalcik, 1984).

American food may remain a novelty. Just as Americans will try *pad thai* or *phó* because these dishes represent Thai and Vietnamese cuisines, these women try hamburgers, spaghetti, and pizza because they represent American cuisine, if there is one (Mintz, 1996). Having Vietnamese foods available to eat daily, they feel comfortable "dabbling" with certain American foods but have no necessity to make American food their mainstay. The comment of one woman illustrates this point: "I never have a chance to go to Vietnamese restaurants because I can make it at home, so I would rather go to American restaurants (she goes to a fast food place once every two or three months) (Cô Mai)."

The process of including American foods into the diet and associated practices is affected by several factors. First, the surroundings and foods available, second Vietnamese and American culture and practices, and third how these two interact to shape the thought and action of the person. Acculturation of diet and practice may take unique courses in each displaced community, and to understand and be able to work with a community effectively requires an interest in their particular situation and course of acculturation.

Taste acculturation

Taste is an important part of acculturation, since people generally do not want to eat something that does not taste good to them. The women often state that they eat what

they like, what tastes or feels good. As a result of living part or all of their childhood in Vietnam, what they like to eat is Vietnamese food. Though they may eat American food for most dinners, for example, they will characterize their eating as Vietnamese. They say that Vietnamese food tastes better. Taste remains fixed on their culture of origin after most of the process of acculturation takes place (Kalcik, 1984; Mintz, 1996). However, tastes for specific foods may change more quickly, especially in the "accessory" and "complementary" foods (Koctürk, 1996).

Tastes may change through familiarity and if the reasons are strong enough, because food may be symbolically "good" (Lupton, 1996). As symbols and expectations of food changes, taste follows. In acculturation, associations of foods change because of a different context and different cultural meanings and experiences. Tastes are likely to change with the changes in associations and meanings related to food. Taste moves the locus of the acculturation process from objects and practice to symbol and culture.

Taste also has to do with the availability of foods, and motivations such as health or fitting in with new peers. If only American foods are available, as has been the case for Vietnamese until recently, American foods will be eaten, as a result of dietary acculturation. Taste acculturation may lag significantly behind, as evidenced by the women who do not like the taste of meat that has been frozen, even after ten or twelve years eating frozen meat in the United States. Yet many foods are eaten and accepted after only a year or less. Fast foods are particularly quickly accepted as good tasting foods. Fast foods are purposefully non-descript enough to be pleasing to the general, and now even international, public (Kalcik, 1984), so it is likely that the taste of fast foods is more acceptable to these women when they arrive than are other American foods.

There may also be other reasons for their quick acceptance as well. Taking the example of Americans trying *phó* and *pad thai*, there is a certain status conferred to people who try and like these particular "international" foods. Fast foods, representing American ways of eating, may confer a similar status in the Vietnamese community for trying and liking

these "foreign" American foods. Western food already carries status in Vietnam (Lupton, 1996), the most visible of which is fast food.

Dislike of a particular food may also hold a kind of status, or identify someone with his or her peer group. Boiling frozen meat has become a cultural practice among these Vietnamese women because of their beliefs about germs. It may therefore be symbolically important to uphold the preference for fresh meat from Vietnam to support this practice. Where culture has made accommodations for a dislike, the dislike is more likely to continue than a dislike for which no cultural accommodations have been made.

Taste is already somewhat ephemeral, which is why it is said, "there's no accounting for taste (Van Kiem, 1991)." The acculturation of taste is equally difficult to pin down. The symbolic aspects of food have significant effects on tastes and how they change. The symbolism of the food of one's country places overall taste in that country's cuisine. They symbolism of one's new country and a transitioning ethnic identity aids the change of certain tastes.

Meal solution acculturation

Eating is a biological necessity, and wives and mothers in Vietnamese and many cultures are generally responsible for meeting this physical need in culturally acceptable ways. One knows what types of foods are necessary for a meal and how to present it. For Vietnamese women, this meal repertoire takes the general form of three main dishes, each one representing a "food group" – meat, vegetable, fish or seafood. Rice, of course, goes with every meal. Specific situations also arise which require certain foods or solutions from this repertoire, such as eating a "hot" or spicy food when affected by cold or wind, bitter melon for uneasiness, or balancing a meal with hot and cold foods (Cô Truong, Bà Tôn).

The process of acculturation challenges the role of women in the family, particularly as the physical providers of food. In Vietnam, the food took a lot of preparation but they expected to spend a lot of time cooking the food. Probably other duties during the day

were also within the household, meaning that marinating, boiling and other preparations could be done at the same time. In America, the situation is much different. Women's responsibilities, though still having to do with maintaining the home (Kibria, 1993), have expanded to include more duties, such as communicating with community agencies, schools, hospitals, and utilities.

The nature of these duties also bring women away from their homes more, as the community is more spread out and more goods and services must be accessed away from home. This is especially true for those women living in the suburbs of Portland, who must travel into Portland to access some goods and services. American culture also expects that women will be away from home more than in Vietnam, whether working (which a few of the women in this study did), taking care of family needs, and other activities.

As a result, the women expressed a feeling of being much busier than they were in Vietnam, which prevented them from the time-consuming preparation of traditional Vietnamese cooking. Lack of time is a problem that has gradually gotten worse for those preparing food in America, as many must work and manage a household. This has led to a sort of repertoire of meals and solutions to meal problems. For Americans, going out to eat, using a crock-pot, or using packaged or canned foods to make dinner are typical solutions to the problem of time. Vietnamese women, who are presented with the same challenges of being busy during the day when they come to the United States, may make use of these same solutions to making meals. The women say when they are too busy, they go to McDonald's, or use canned or packaged foods.

Breakfast is a meal that often requires solutions because the women are too busy. Many skip breakfast altogether, which is a strategy employed by many Americans as well. However, American breakfast patterns are not adopted across the board. For instance, few Vietnamese women mentioned eating cereal for breakfast as Americans do. Some eat coffee and sweet bread, which is common in America and in Vietnam (probably as a result of colonization). A few mentioned eating American foods such as hamburgers and

burritos, foods that typically Americans don't eat for breakfast. This may reflect the traditional breakfast in Vietnam, where they eat noodle soup (Cô Du, Kalcik, 1984) and other foods that would also be eaten at other times during the day, not just for breakfast. In other words, the idea of having specific breakfast foods is more American than Vietnamese, so while the foods eaten are American, the timing represents Vietnamese eating patterns rather than American.

When women have only two meals per day rather than three, it is usually breakfast that is skipped. This is more likely to be an American pattern, as most people in Vietnam eat 3 meals per day. Thus, some changes due to acculturation are an attempt to follow Vietnamese patterns in a foreign country, and others are the acceptance of American patterns.

Lunch is considered in the literature the next most likely meal to change in a new context, but this pattern was not seen among the women interviewed. Research that shows this pattern was most likely based on men, who typically go into the work force and find it more convenient to eat American foods. Children, also, often have their lunch at school, making them more likely to eat American foods for lunch. The women would eat Vietnamese food for lunch, since they are at home during the day, and often have American fast food or make hamburgers or spaghetti for dinner for their families, especially the children who do not like to eat Vietnamese food.

Expectations from Vietnamese culture may also conflict with situations encountered in the United States. The practice of freezing meat to keep and eat later is not common for these women in Vietnam, and it is believed to have more germs and be less healthy than fresh meat. In Vietnam, meat is sold in the market and cooked on the day it is slaughtered. Americans solve the problem of germs in the meat by freezing, which prevents the germs from growing and "spoiling" the meat.

Vietnamese women came up with their own solution of rubbing the frozen meat with salt and boiling it three times, discarding the water in between, which both thaws the meat

and takes care of the germs. Meat is not boiled in Vietnam for the purpose of getting rid of germs, making this practice a result of acculturation. However, it is not acculturation in the strict sense because it is not a practice of the receiving culture. The practice probably arises out of the Vietnamese repertoire of solutions to food problems. It is a result of the same processes as acculturation – of adapting to a new environment and situation, and thereby "creating" culture (Mintz, 1996).

The way that meals and solutions are acculturated is affected by the situation presented by a new environment. They are also shaped by the culture of origin to an extent. This extent depends on the available repertoire of solutions to food problems available in both cultures. These arrays of solutions and how they may be incorporated should be considered in distinct ways by programs working with displaced communities.

Acculturation related to food concepts

Knowledge about nutrition and its relation to health may have more to do with increase in education than it does with acculturation. However, the way that new information is understood and used shows a relation to acculturation. Typically, new information about health and nutrition seems to fit comfortably in the broad conception of health and nutrition held by Vietnamese. For example, losing fat is connected to sweat. Nutritional science understands this to be the result of the body working hard. The weather in Vietnam also makes one sweat, so they say they didn't worry about fat in Vietnam. Though they understand that physical activity is a causative factor in losing weight, because of the similarity of sweating, weather is also seen as a causative factor.

The concepts behind food become acculturated much more slowly, it seems, than information is changed. New information can be added to a defined system, accommodated, and stretched to fit. After it has been thus stretched, the system will shift to better accommodate the information (Cross, 2000). The new information and ideas accepted are not insignificant, however, because they do result in changes in foods eaten and other practices, such as eating more broccoli, tofu, and beans, or cutting off the skin of chicken.

Acculturation relating to food concepts is a deeper layer of change. The biggest difference made by food concept acculturation is that as the concepts themselves shift, former patterns, practices, or information may be dropped rather than just added. This stage of acculturation does not seem to have happened significantly in these women, reinforcing the "adhesive adaptation" model (Hurh & Kim, 1984). It also may affect the sources of information that the person seeks and trusts. Women received nutrition information from doctors and WIC educators, but this information had limited effects on what and how the women ate by their own report. Changes made tended to be congruent with practices they already had, such as eating more vegetables. Another example involves doctors' advice to drink milk. Since Vietnamese women "eat for the baby" during pregnancy, this advice was often followed. However, Vietnamese women "eat for the mother" after pregnancy, so the practice of drinking milk is usually dropped immediately.

It is difficult to observe acculturation relating to the concepts of food and nutrition. There appears to be a certain amount of uncertainty in areas where concepts from Vietnamese culture and American culture conflict, such as the value or otherwise of fat in the diet. The uncertainty is a common response to conflicts in cultural values during acculturation (Kalcik, 1984). This process may change as acculturation progresses, and it is important to keep in mind that these women are somewhere in the midst of a process, and have not arrived at a final state of acculturation.

These four categories of acculturation are important to understand because their mechanisms and their outcomes may be different. They may happen simultaneously but at different rates, such as dietary and taste acculturation. They may happen selectively, as in eating fast food but not "every day" American food. They may also affect each other, as both dietary and meal solution acculturation affect taste acculturation. Similar processes, such as the creation of new cultural practices, may inhibit or affect acculturation, as the practice of boiling meat may inhibit accepting the taste of meat that has been frozen.

Acculturation is not a continuous, uniform process from 'culture A' to 'culture B,' as recognized by researchers in various disciplines (Hurh & Kim, 1984; Kivisto, 2001; Montgomery, 1996) and reinforced by this study. This conception of acculturation is important to understand because it affects how acculturation is employed in research and how acculturating peoples are managed in academia and in the real world.

Summary

The way that the women discuss food and nutrition reveal many changes from their life in Vietnam, as well as many things that have stayed the same. The ways that they have adapted to life in the United States have varying effects on health, both supporting health and presenting health risks. Their understanding of nutrition and its effects on the body is expanding, but the way it is expanding is determined more by understanding of health in Vietnam rather than by Western nutritional science and medical concepts.

Acculturation may affect the outcomes of health and nutrition among these women and their children, as the examples of acculturation categories illustrate. The conditions in Vietnam, the process of changing environments and foods, and adding "new" concepts to established practices and understandings in adhesive adaptation, all work together in ways that may affect nutritional health.

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

The particular changes and courses of acculturation displayed by the Vietnamese women may be applied to the IRCO Parent and Child Program Department Vietnamese clients. They are not necessarily applicable to other clients in the program, or the Vietnamese women in general. However, the depth and variation illustrated in this study may be used as an example in exploring the processes of acculturation in other groups. Following are recommendations for applying the acculturation patterns of these Vietnamese women to the programs and services that impact their health and nutrition.

Nutrition education and food provision

One of the services provided to these women is nutrition education. WIC is the primary source for this education, followed by the parent education program, doctors, and informally family and friends. At this point, it seems that the nutrition education is making some gains. However, the women find that the education given is not very relevant to themselves or their situation.

Conceptual differences

Doctors often recommend drinking milk, especially during pregnancy. Most of the Vietnamese women comply while they are pregnant, for common between the two cultures is the idea of "eating for the baby." However, when the baby is born, it is now time to "eat for the mother" for Vietnamese women (Tuttle & Dewey, 1994). Thus drinking milk is abandoned, as many of these women describe. Though doctors and WIC would recommend continued drinking of milk, some women consider the need for good digestion equally or more important than the need for calcium, according to the humoral system in Vietnam (Craig, 2002).

Another reason advice and education may not be followed is the lack of strictness in the Vietnamese humoral system. Negative effects of foods may be overridden by other concerns, such as economics, nutrition, or tradition. They may also be counteracted by modifying the food, such as warming the temperature of a food that has a cold essence (Craig, 2002). These ways of getting around food problems may be applied to principles or advice given by doctors or educators.

The breadth of these challenges to nutrition education require more than simply using Vietnamese food examples or incorporating a few "traditional" facts into medical advice. An open discussion between doctors and patients with a background of humoral concepts is recommended by researchers (Harwood, 1998). This advice applies well to nutrition educators, such as those through WIC. At the very least, programs may discuss nutrition recommendations with the women involved to find out what problems they may have following the advice, and facilitate them finding solutions for it out of their own understanding and circumstances.

The women already come up with their own solutions to food and health problems when a change cannot be avoided, such as boiling and salting frozen meat. Changes that come from the participants themselves are more likely to be accepted and retained (Laverentz et al., 1999). Discussing with the women what they currently eat and how they currently understand nutrition will help educators to identify the specific needs of the women and target needed areas, and not to make changes that do not work well and may undermine already healthy eating habits.

Conceptual differences in words are also important to address. Though language barriers may be surmounted by translation and English instruction, it is important to ensure that words that translate from one language to another are understood in the same way. Both may talk about nutrition and fat, for example, and think they are talking about the same thing but the concepts are different. The women say that American food has "a lot of nutrition." Reasons for this view include the greater cheese, butter, and meat content of American foods, and that the nutrition in the food is listed right on the box (the

"Nutrition Information" panel.) The nutrition listed may refer to the nutrients and vitamins, or just to the fat content. A nutritious food to them seemed to mean that it has a lot of fat, calories, and even nutrients. "Good nutrition" to them did not always mean "good for you." Several women discussed reluctance to try American foods because they feared getting fat. On the other hand, some felt that eating fat foods and even getting fat was a good thing, especially for their children.

Establishing the concepts as a first step in nutrition education may help prevent misunderstanding of nutritional principles. Terms used, such as nutrition, need to be discussed with participants about how they are used, in what context, and to what the terms apply. Educators should discuss with participants to find what nutrition information is problematic to participants. Problem areas should be targeted and the educator should help the women find solutions for themselves. For instance, in order to rightly compare American and Vietnamese foods in terms of nutrition, it may be useful to compare food labels of American and Vietnamese foods (and acquire nutrition information about Vietnamese foods if they do not have nutrition labels) to dispel misconceptions about fat, calorie, and nutrient contents of these foods. Ensuring that the women have a conceptual and working understanding of the information presented on "Nutrition Information" panels may be an issue (Byrd-Bredbennerr & Kiefer, 2000).

Meal patterns

Meal patterns and the way eating and food are ordered throughout the day, week, or other time period have effects on nutrition and the way nutrition information is incorporated. They change through acculturation to adjust to a new food system. These adjustments may lead to food content changes that may have healthy or unhealthy outcomes. They also influence what meals or times of day food changes are likely to be made, whether through acculturation or education.

Information about the American food system is needed to support the necessary process of learning the cultural food construct. Even for women who will for the most part continue to cook Vietnamese food, they still must work within the American structural environment of buying and preparing food. Source and use of frozen and packaged foods, transportation of foods, and farming practices are important topics for nutrition education so that the women can make choices about the foods to buy, decipher appropriate times and ways of keeping food, and answer questions about the quality of food. Programs should address fast food and the place it takes in American eating habits. Since fast food is most familiar, the women tend to think of it as representative of American food. Helping the women to understand the difference between fast food and everyday American cooking will provide a more balanced view of American food and the health benefits and drawbacks involved.

The design of meals can be used to promote healthy eating by understanding the practices that are already healthy. For instance, since fruit is a typical after-dinner dessert item for Vietnamese families, programs may encourage this idea rather than using an American dessert model (a concoction of refined flour, sugar, and butter) and trying to make it "healthy." A child nutrition program can look at infant feeding in Vietnam and find the healthy aspects, such as the use of vitamin-rich vegetables that are eaten by all members of the family.

The typical contents of meals are also adjusted through a combination of acculturation and necessity. Breakfast is the meal that changes the most in content when coming to the United States. Women and their families eat many different foods from coffee and breads to pizza, hamburgers and salad. In Vietnam breakfast usually includes foods that may also be eaten at other meals, such as sweet potatoes and vegetables. In other words, food eaten in the morning is not strictly labeled "breakfast food," as it is in the United States. Eating American non-breakfast foods may follow the Vietnamese cultural breakfast pattern. On the other hand, breakfast may be a relatively unimportant meal where eating cultural food is concerned, and gives them a chance to try American foods.

Such changes are important to understand because they show, first, where changes have been made and how they are likely to progress, and second what are the most motivating factors for how the women design meals and eating. Though the women firmly characterize the way they eat as defined by Vietnamese tradition and the food they themselves like, their families do have a significant influence on how these designs have changed. The greater availability of food in the United States compared to Vietnam, and also compared to the United States ten or more years ago, means greater flexibility to design eating and food according to other criteria, one of which could be healthiness. In other words, the diet is already expanding to include this wider array of foods. Addressing these motivating factors and their outcomes in the presentation of nutrition information will help guide the changes made toward attainable healthy goals.

Through acculturation, changes will be made to eating patterns, whether a few substituted ingredients or the whole cuisine. The women in this study express that they know about health and they want to be healthy. The task for nutrition education is to shape these changes into a healthy diet. Providing information about the American food system is an important step in helping the women achieve the healthy eating patterns they desire. Some of these changes may be the result of necessity, such as availability of certain foods or new schedule demands. Others will be made through personal identity or family preference. Finding these motivating factors is important for nutrition education to be effective outside of the classroom.

Food Provision

The experiences of the women with food in Vietnam and before coming to the United States were to eat whatever food is available in the market, and what they can afford. Many men, as well, were forced into reeducation camps after the war and ate only what was given them. Both of these experiences did not leave very much room for choice and preferences in food and eating. For this reason one might think that it does not matter what foods are provided to them in the United States because they can continue to eat what they can get. What they did eat in Vietnam, and the cultural food expectations based on what was generally available, shaped their food preferences.

Though there are drawbacks, food provision services provide needed food for many low-income families. The problem is, there are still pockets of low-income families for whom these services do not meet their food needs. Part of the problem is the cultural specificity of the foods provided. The foods fit very well into American culture in types and amounts provided. They are based on concepts of staple, complementary, and accessory foods (Koctürk, 1996) in the United States. However, the staples, complements, and accessory foods are different for people from other countries. Though both are readily available in the United States, a pound of flour is not as useable as a pound of rice for a Vietnamese woman. Services tend to universally provide more flour than rice, for example, based on the American staple. While Vietnamese women adopt American foods and practices, these are still on the fringes of normality. As acculturation progresses, American foods become more normal. The staple food, though, is the most lasting element of a person's traditional food (Kalcik, 1984; Koctürk, 1996; Mintz, 1996).

Diversification in the variety of foods available through these services or in the amounts and means of distributing them, unfortunately, will probably mean more effort and expense for the programs and this is why uniformity in provision has been favored. However, in order to meet the goals of providing adequate food and nutrition to all recipients of these services means a little smoothing of the edges of methods of providing foods.

The role of the Parent and Child Program Department

The review of programs and services offered reveals the potential for minority and low-income families to benefit from home visiting parenting programs, as they do currently. It also reveals the benefits of programs designed with the cultural and social needs of specific communities in mind. The changes illustrated below draw on the examples of the WIC nutrition education program (Ikeda et al., 2002), which provides nutrition education relevant to the Vietnamese cultural community, and the Parents as Teachers program models (Wagner & Clayton, 1999), one of which benefits minority populations in particular, and the other which includes personal development and community support in

the home visiting program. Combining these models in the IRCO Parent and Child Program Department will maximize the benefits provided to the program's Vietnamese client families, with the potential for benefiting other cultural communities as well.

Individualized family attention

IRCO's parenting programs are in a unique situation to be able to meet the nutritional health needs of Vietnamese client families. The placement of this program within IRCO's organization provides knowledge and resources applicable to displaced persons and their particular needs. The staff who work with these families are Vietnamese and speak the language. Staff meet the mothers and children where they live, in the context of the family's daily life. The entire meeting time is focused on that mother and her family and is not shared with others as in a group meeting. Parent and Child Program Department staff already provide assistance to the mother on an as-needed basis, such as help with reading food labels, bringing food from the Food Bank, help in enrolling in food assistance and other programs.

Given these aspects of the home visiting program, only small modifications are needed in order to truly individualize the program in a way that will support education and ability in nutrition and food habits. One is a move away from standardization of curricula. This may require more of the meeting time devoted to understanding the situation of the family. Critical thought will be needed to present the curriculum information in a way that acknowledges and addresses that situation. The program can continue to present other information or support that may go beyond simply educating the mother, such as helping her obtain resources, government assistance, and providing emotional support, giving her the ability to make needed changes in her life.

Health and food beliefs

Language acceptability, accomplished by translating materials, information, and conversation into Vietnamese, is not the same as cultural acceptability. The materials and information emerge from a worldview and an understanding of nutrition, food, and health that may differ significantly from that of the clients. These differences need translation as

well. That is, it is important to know how the families' beliefs about nutrition, food, and health differ from that of the curriculum and information provided, and to bridge that gap in appropriate ways (Laverentz et al., 1999). The Vietnamese staff working with the women do have the cultural and world view understanding needed to bridge that gap, and may be encouraged to continue applying translated information to the cultural situation.

This may involve finding healthy ways to deal with conflicts between the humoral system and the new behavior introduced. In the case of a breastfeeding study (Tuttle & Dewey, 1994), the women used formula or cow's milk to deal with that conflict. Other methods may include eating cold foods at the appropriate time before breastfeeding and hot foods at other times, or eating hot and cold foods to neutralize the hot and cold effects while breastfeeding (Harwood, 1998). It may not be necessary to either a) keep a cultural tradition such as the humoral theory completely intact, or b) to undermine it completely, in order to facilitate healthy changes. People of different ethnic groups make adjustments and adaptations to activities such as eating both within their own culture, and as they move to a new culture (Kalcik, 1984). It may be more effective to encourage changes to be made in the same way as the Vietnamese make changes themselves, that is, to help them find solutions that harmonize with their current mix of cultural concepts of health.

Social supports

The IRCO Parent and Child Program Department employs women from within the Vietnamese community, much as the WIC nutrition education program (Ikeda et al., 2002) employed "nutrition education assistants" (NEA's). An important outcome noted by the authors was the ability of the NEA's to connect the women with social supports both within and outside of the Vietnamese community. These supports included jobs, housing, and social services such as WIC. The Vietnamese staff of the Department also provide these supports. They recognize, by experience, the food-related needs of the women involved in the program. The staff help them enroll in services for which they are eligible, bringing food to their homes from Food Bank distributions, and communicating between the women and these programs when needed. They partner with Harvest Share,

which is the produce division of the Food Bank, and the program's staff volunteer at the distribution.

The program itself offers limited nutritional advice related to infant feeding, as well as an overview of the USDA's Food Guide Pyramid. Most of the women's nutrition education comes from the WIC education portion. Laverentz' nutrition education program illustrates the importance of expanding a program to include social supports (Laverentz et al., 1999). The women involved in this study expressed as their food-related needs help with grocery shopping, cooking American foods, and receiving instruction on cooking techniques. They were expressly not interested in general nutrition education, though basic concepts were incorporated into the cooking instruction design. The advantages of designing the program based on the requests of the women included interest in the program by the women they attempted to reach, as well as high efficacy in building skills and knowledge about cooking and nutrition in this community.

Advocacy

There are two branches of potential help that the program may bring to its clients. First is to use the example of recommendations given in this research, combined with their own knowledge, to inform the Food Bank and other programs to which the Department has a connection (such as WIC and the OSU extension service) about specific strategies that could be implemented by these programs and services in order to more effectively provide adequate food and nutrition. Such recommendations should not only address Vietnamese culture, but also the transitional culture and other situations of the women in the programs.

The Department may also adjust their own program to include more developed nutrition education, such as putting the nutrition information received from WIC into the context of the transitional culture and situation. Expanding the current model of home visiting at the Department will have effects on both the families involved with the program, and the program staff and administrators. Families will benefit from the program by finding an increased relevance of the program to their families needs, and both families and staff will

benefit from an increased rapport between them as the families feel that their specific interests are recognized and met.

The program modifications described use examples specific to the Vietnamese cultural community. However, the principles may be applied to families of other cultures, with the use of staff from that cultural community and an accurate and developing understanding of that culture's values and beliefs. These conditions are already in place at the Department. The program may, with careful consideration, implement the modeled program for other clients according to their specific cultures and backgrounds. The individualized and contextual nature of home visiting programs provides a unique opportunity for meeting specific cultural and social needs in regard to nutrition, growth and development of a wide range of families involved with IRCO's programs.

Also, the program may encourage further research into the food and nutrition of Vietnamese women and their families. An ongoing relationship with local universities may provide opportunities for such research at very little cost to the program through student research. More specific and statistical research is needed in several areas, based on the findings of this exploratory study. Such research should be grounded in the understanding of acculturation and the unique situation of these women in order to fully interpret the statistical results.

Research involving actual food and intake includes actual nutrient intakes of Vietnamese women and their families, in order to determine actual risks for certain deficiencies such as calcium or excesses such as fat, and comparisons of nutrient intakes of different infant feeding practices used by these women (breakfast cereal versus traditional boiled vegetables, for example). Research relating to food practices includes real-life comparisons of Vietnamese and American foods in daily cooking and eating, and the use of foods provided by the Food Bank and other services. Social and structural research may focus on effects of husbands at work and children at school on the makeup of the Vietnamese family diet, barriers still present for women involved in the program, comparisons of the food situation of higher income and lower income program

participants, the effects of immigration status on the food situation of program participants, and comparisons of the food situation of Vietnamese women and families involved in the Department and those who are not involved in a similar program.

Though the Department is not specifically focused on nutrition, they do informally provide similar support when the need arises. The program is already in a place to provide such networking and support to their Vietnamese client families. The Vietnamese staff, as in Ikeda's example (2002), have the potential to be a vital link between the family, the Vietnamese community, and the Portland community. This includes the institutions of government, health care, education, and other systems. It is appropriate in the Vietnamese community to provide these institutional links for families through women. Typically in the United States Vietnamese women are the family members in contact with these institutions on behalf of her family, rather than the men (Kibria, 1993). Providing women with support for that role and strengthening her ability to navigate through those institutions will benefit the nutritional health and development of women and their families.

Summary

In terms of food and nutrition, these women show some signs of acculturating. Even after ten or twelve years, Vietnamese ways of eating and thinking about food prevail. However, they do seem to have adjusted well in terms of food and nutrition in many ways. The women know where to buy food, how to obtain the means to get food, and they can recognize what foods and ways of eating are healthy and which are not. Much of these gains have been aided by their involvement in the parenting program, governmental aid, community supports on arrival, and the help of family and friends. There are still areas where better nutrition and healthy outcomes could be encouraged, such as the role of fast food in the diet, especially for their children's health, and a broadened understanding of the nutrients other than fat that support growth and development of the body.

The focus of health and nutrition regarding displaced communities has been level of acculturation and historically more advanced acculturation is encouraged (Mintz, 1996). Some researchers do recognize the hazards for nutrition that follow acculturation, as the typical Western diet becomes less healthy. Acculturation happens naturally as these communities live in the United States.

Acculturation is not necessary for nutritional health beyond the adjustments required to comfortably live in the social, political, and food system environments. These adjustments are more difficult for displaced persons with lower incomes and status than those with more resources. Cultural change is not necessary for an adequate adjustment. Since cultural change will happen, programs and services are advised to help shape those changes, through nutrition education and provision of food for these lower-income families, into healthier changes rather than unhealthy ones.

In nutrition education and provision programs, incorporating ethnicity and acculturation will involve recognizing that the individuals in ethnic groups will be in some state between their culture of origin and American ethnic identities. This will include a set of roles and expectations related to food that represent their traditional and American cultures, as well as reflecting the roles necessitated by poverty and other social situations. They will also have food ideals and values that may or may not be met to some degree and that are changing as well. A clear idea of the underlying structure and process of these changes will reveal how women and families can make healthy changes, and how healthy aspects of traditional diets may be maintained in the context of the United States food system.

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APPENDICES

Appendix 1

Qualitative Survey

The bold questions are the initial questions asked of the respondent. The non-bold questions are follow-up questions asked if they are not covered in the respondent's initial answer.

<u>How did your diet change when you first came to the US?</u>

How is this different from your diet now?

Where do you get most of your food? Why do you get it there?

Do you eat more packaged, prepared, "fast" foods in the US, or as you have lived here longer? Why do you eat more of them (or not)? What do you think of these foods?

Do you eat any other foods because of the way they make you feel?

Are there any foods you don't eat?

<u>Do you think about food differently in the US than in Vietnam?</u>

When you came to the US, what gave you different ideas about food, and good eating?

How have you adjusted to these different ideas?

Do you think you are able to eat well here? Do you think you are able to eat healthy here?

Are these two things different? Why are you or are you not able to eat well/healthy?

Do you think how you eat is different from other people? From what people, and in what ways?

<u>Why do you think people are concerned about nutrition? Are you?</u>

What are the best foods for you to eat? Are there different best foods for others to eat?

What are the best foods for your children to eat? Other family members?

What do you believe are the effects of food on a person? What does food "do" for you?

How does it affect your body?

How does it affect who you are?

Do you decide for your family what you will eat? How do you (or they) make those decisions?

When you were in Vietnam, how well did you feel you understood food and nutrition?
How well do you understand food and nutrition now, in the US?

In home visits, or through other agencies or sources, do you talk about food and nutrition?

Has this changed what you think about food? In what ways?
Has this changed what you buy, prepare, eat, for you or your family? In what ways?
Does your involvement in programs such as WIC, Food Bank, or Child's Path make a difference in how your family eats? Please explain.
Is there anything you think Parent and Child Development, WIC, or the Food Bank could do differently that would help you and your family to eat the way you would like?

Appendix 2

Demographic Survey

Where are you from in Vietnam?

What is your ethnicity?

How long have you been in the United States? When did you arrive?

Did you come to the US as a refugee or an immigrant?

How many people are in your family in the US?

Did they come at the same time as you?

When were your children born, and were they born in the US or in Vietnam?

Do you have family members still in Vietnam?

How many meals per day do you eat at home as a family?

Does everyone eat them?

Who prepares the meals?

How often do you eat at a restaurant or a fast food place?

Which establishments do you eat at often?

What programs other than PCDS are you involved in?

Do you know of any others that you could enroll in?