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Communication Between Health Workers and Ethnic Minorities in Vietnam

Shannon McKinn, MIPH; Duong Thuy Linh, BN; Kirsty Foster, MBChB, DRCOG, FRCGP, PhD; and Kirsten McCaffery, PhD

ABSTRACT

Background: Vietnam has made notable progress in reducing maternal mortality rates during the past 2 decades, but this overall improvement conceals regional and ethnic inequalities. Ethnic minorities in Vietnam experience high rates of poverty and mortality, and they face communication and cultural barriers when accessing health services. Poor communication with health professionals combined with limited health literacy is concerning, particularly in the maternal health context, and may exacerbate existing inequalities. **Objective:** This study explores primary health care professionals' perceptions of the quality of their communication with ethnic minority women during and after pregnancy. **Methods:** Semi-structured interviews were conducted with 22 primary health care professionals in Dien Bien province. A thematic analysis was performed using a framework analysis method. **Key Results:** Health professionals had mostly positive perceptions about their communication with ethnic minority women. However, they generally perceived the effectiveness of their communication as being based on women's individual capacities to understand health information (both the language used and the content) and factors such as ethnic and cultural differences, rather than reflecting on the suitability of information and materials or on their own communication skills. This placed much of the burden of communication and understanding health information on ethnic minority women and their families. **Conclusions:** Health professionals perceived of communication as being mainly a one-way street for the provision of health information, and rarely acknowledged the interactive nature of communication. Patient-professional communication and health literacy in Dien Bien province may be improved through the introduction of patient-centered communication skills training that applies health literacy approaches at the health professional level. [*Health Literacy Research and Practice*. 2017;1(4):e163-e172.]

Plain Language Summary: We looked at how primary health care professionals in Vietnam perceive their communication with ethnic minority women, particularly about pregnancy. Health professionals generally perceived the quality and effectiveness of their communication as being based on ethnic minority women's individual capacities and limitations. Applying a health literacy approach to communication skills training could improve patient-professional communication and health literacy.

Vietnam has made impressive advances during the past 25 years in lowering rates of maternal, child (ie, younger than age 5 years), and infant mortality. A strong political commitment to meeting targets set by the Millennium Development Goals has contributed to this progress (Minh, Oh, Hoat, &

Lee, 2016a); however, this country-wide success obscures regional and ethnic inequalities (Ministry of Planning and Investment, 2015; Malqvist, Lincetto, Du, Burgess, & Hoa, 2013). Dien Bien Province (DBP) is a small, mountainous province with a population of about 550,000 (General Statis-

tics Office of Vietnam, 2016a) in the northwest part Vietnam, bordering Laos and China. The predominantly ethnic minority and rural population of DBP experiences poverty rates, and infant, child, and maternal mortality rates much higher than Vietnam as a whole (Table 1).

Ethnic minority women in Vietnam are less likely to access antenatal care or give birth at a health facility (Do, 2009; Goland, Hoa, & Malqvist, 2012; Ministry of Planning and Investment, 2015; Malqvist et al., 2011; Malqvist, Lincetto, Du, Burgess & Hoa, 2013a; Minh et al., 2016b), and there is evidence that inequity in service use is increasing along ethnic lines (Malqvist et al., 2013a). Ethnic minority status often intersects with other factors associated with a lower level of health care use in Vietnam, including geographical and physical access factors such as difficult terrain and lack of transportation (Binder-Finnema, Lien, Hoa, & Malqvist, 2015; Do, 2009; Toan, Trong, Höjer, & Persson, 2002), lower educational level of mothers (Do, 2009; Duong, Binns, & Lee, 2004), and the continued practice of traditional customs in remote areas (Binder-Finnema et al., 2015). Although it is unclear how ethnicity and distance from primary care services interact to affect access to antenatal care and delivery services, ethnicity has been found to be a significant determinant of maternal health care use after controlling for household income and maternal education (Goland et al., 2012).

There are also communication barriers that affect ethnic minority peoples' access to and quality of care. The patient–health professional interaction is an essential pillar of primary care; however, in addition to linguistic and

cultural barriers, ethnic minority people in Vietnam often experience obstacles related to the patient–health professional interaction, including discrimination, poor attitudes from health staff, and a lack of culturally sensitive services (Binder-Finnema et al., 2015; Malqvist, Hoa, Liem, Thorson, & Thomsen, 2013b; UNICEF Viet Nam, 2011; Rheinlander, Samuelsen, Dalsgaard, & Konradsen, 2011).

Health literacy broadly refers to the factors that affect a person's ability to access, process, understand, and communicate about health information to make informed decisions (Berkman, Davis, & McCormack, 2010). Health literacy is needed for accessing and using health care and for interacting with health providers (Batterham, Hawkins, Collins, Buchbinder, & Osborne, 2016). Although there is little research on health literacy in low and middle-income countries, research in high-income countries has found an association between low health literacy and experiencing communication difficulties with health professionals (Easton, Entwistle, & Williams, 2013; Kripalani et al., 2010; Williams, Davis, Parker, & Weiss, 2002), and experiencing less patient-centered communication (Wynia & Osborn, 2010).

Although health literacy has not been measured on a population level in DBP, with the high levels of poverty, lower level of educational attainment, and the lack of Vietnamese language and functional literacy skills among many ethnic minority women (UNICEF Viet Nam, 2011), it is reasonable to assume that the level of health literacy is low (Lee, Tsai, Tsai, & Kuo, 2010; Paasche-Orlow, Parker, Gazmararian, Nielsen-Bohlman, & Rudd, 2005; Rudd, 2007). Low health

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TABLE 1
Comparison of Key Indicators Between Vietnam and Dien Bien Province

Indicator	Vietnam (Entire Country)	Dien Bien Province
Poverty rate (%)	7 ^a	29.1 ^a
Infant mortality (per 1,000 live births)	14.9 ^b	34.4 ^b
Mortality in children younger than age 5 years (per 1,000 live births)	22.4 ^c	53 ^c
Maternal mortality (per 100,000 births)	58 ^d	676 ^d

^a2015 data (General Statistics Office of Vietnam, 2016b).

^b2014 data (General Statistics Office of Vietnam, 2016a).

^c2010 data (World Health Organization, 2015).

^d2010 data (Ministry of Planning and Investment, 2015).

literacy and poor communication between health care professionals and ethnic minority people are concerns for the DBP Provincial Health Service, which has collaborated with the University of Sydney and the Vietnamese Women's Union to deliver maternal and child health workshops for health professionals and community leaders, with an emphasis on improving health literacy and communication between the two groups. This study explores how health professionals perceive the quality of their communication with ethnic minority women during and after pregnancy, and the factors that they believe influence the effectiveness of that communication. The overall aim of the research is to develop and support strategies to improve health professional communication to ethnic minority communities in Vietnam.

METHODS

Study Location

We conducted the study in September and October 2015 in Tuan Giao district, DBP. We chose Tuan Giao district in collaboration with provincial and district health service officials as a representative rural district at a significant distance from the provincial capital (approximately 80 km). The district is divided into 19 communes, with a population of approximately 100,000 people. Most people in the district are from the Thai ethnic minority group (UNICEF Viet Nam, 2011), with a smaller population of Hmong, Kinh, Khang, and Kho Mu people. Please note that Thai people are a Vietnamese ethnic minority group who are distinct from Thai people who make up the population of Thailand.

Recruitment

In cooperation with the District Health Service, we selected primary level health stations in five communes. These communes were purposively sampled to ensure that health stations with a range of characteristics were included. These

characteristics included distance from the District Hospital (4–45 km), predominant ethnic group of the commune population (predominantly Thai and Hmong communes were included), and whether the health station had a full-time doctor on staff (two of the five health stations had a full-time doctor at the time of the study). Three of the five communes were majority Thai with small Hmong populations, and the other two were predominantly Hmong. We also conducted focus groups with ethnic minority women in each of the five communes; we will report these results separately. The University of Sydney Human Research Ethics Committee approved the study, and the DBP Public Health Service, the Tuan Giao District Health Service, and the Vietnamese Women's Union approved and supported the research plan.

Participants

We invited all health professionals (doctors, midwives, nurses, pharmacists, and medical assistants) at the five health stations who had professional contact with pregnant women and mothers of children younger than age 5 years to participate in the study. We refer to the participants as health professionals throughout the course of this text to distinguish them from community (village level) health workers who have received basic health training and receive a small stipend. All participating health professionals were salaried employees working within the health system at the primary care level. We conducted interviews with all health professionals who were present on the day of the visit to the health station, and who were available to be interviewed. One health professional opted not to participate after reading the participant information statement. At one health station, three of five staff present were not able to be interviewed due to their work duties; however, we were able to interview the two staff members who had the most contact with pregnant women. Preliminary analysis of early interviews and thematic consistency among

interviews conducted across the five health stations suggested saturation of key themes. All participants gave written consent. We provided all participant information and consent forms to participants in Vietnamese, their working language. Participants were not compensated for their time.

Data Collection

We conducted semi-structured, in-depth, face-to-face interviews with 22 primary care health professionals (see **Table 2** for participant characteristics). We held interviews at commune health stations, during the course of the participants' usual working day, and they lasted between 23 and 85 minutes. S.M., an Australian doctoral student with experience in qualitative research, and D.T.L, a Vietnamese interpreter/research assistant with a nursing background, conducted interviews in English and Vietnamese. S.M. and D.T.L. also took detailed field notes, and discussed them in regular meetings throughout the data collection period.

Data Analysis

An independent third party translated audio recordings into English and transcribed verbatim in English, which enabled the checking and validation of the interpretation provided during the interviews (Squires, 2009). We performed a thematic analysis using a Framework Analysis method (Ritchie, Spencer, & O'Connor, 2003) to ensure rigor. This method of thematic analysis involves five steps: (1) familiarization with the data—three researchers (S.M., K.F, and K.M.) read a subset of interview transcripts and discussed initial themes and relationships within the data; (2) creating a thematic framework (S.M.); (3) indexing—we coded remaining transcripts according to the framework, with iterative revision of framework (S.M., K.F, K.M.); (4) charting—themes/quotes were summarized in the framework (S.M.); and (5) mapping and interpretation—framework data were examined within and across themes and participants, summarized (S.M.), and discussed with all authors (Gale, Heath, Cameron, Rashid, & Redwood, 2013; Ritchie, Spencer, & O'Connor, 2003). We managed and coded transcripts in Microsoft Word, and used Microsoft Excel for the creation of the thematic framework and subsequent charting.

RESULTS

We have divided the results into two main parts. The first section describes the typical content and delivery of health information between health professionals and ethnic minority women as the health professionals themselves describe it. The second section comprises the qualitative analysis of health professionals' perceived role of communication on women's health

behaviors and health outcomes and the perceived factors in determining the quality of communication with women.

Content and Delivery of Health Information

Primary health care professionals (doctors, midwives, nurses, medical assistants, and pharmacists) perceived themselves as an important source of information for pregnant women and mothers in Tuan Giao district. In the primary care setting, health professionals reported that they provide women with information about nutrition during pregnancy, abnormal signs and symptoms during pregnancy, iron supplementation, vaccination, and breast-feeding, and they encourage women to access antenatal care and to give birth at a health facility. Information is described as being mostly delivered verbally, with some use of visual aids such as pictures and flip books. Health professionals commonly referred to the *Handbook for Maternal and Child Health* (also known as the "Pink Handbook" [Ministry of Health, Vietnam, and Japan International Cooperation Agency, 2014]), which they reportedly give to all pregnant women in DBP when they present for antenatal care, and is designed to be used until their child is age 6 years. This handbook was developed and produced by an international development agency and the Ministry of Health. The Pink Handbook is a home-based record written in Vietnamese, and functions as a written record for health professionals, as well as an information source for mothers on pregnancy and child health.

Perceived Role of Communication on Women's Health Behaviors and Health Outcomes

Primary health care professionals had generally positive perceptions about their communication with ethnic minority women in the maternal and child health context. The majority of participating health professionals in this sample felt that their communication of health information with women on an individual and community level has been an important factor in improving health outcomes in their communes, which they perceived to be the result of an increase in adherence to health advice and improvements in achieving targets for vaccination, antenatal care, and facility-based birth. This perception was especially present among health professionals working in predominantly Thai communes, although it was expressed by health professionals in all five study communes.

As one female Thai pharmacist commented: "They don't give birth at home anymore. Now most of them go to the hospital to give birth. Their knowledge has improved thanks to our communication."

Health professionals also credited successful communication, and increased coverage of maternal and child health issues in the media, with a perceived decrease in harmful behaviors during pregnancy, such as continuing heavy manual farm work or working with toxic substances such as pesticides.

Before, when the media coverage of maternal and child care was limited, and the communication by health staff was limited, most pregnant women didn't know how to take care of themselves. They still worked in unsafe environments, and still did heavy work. But in recent years, with the communication work much improved, most women no longer do heavy work or work in polluted environment. (Medical Assistant, female, Thai)

However, almost all of the Thai and Kinh health professionals acknowledged that they often have trouble communicating health messages to Hmong communities, and observed that Hmong women were less likely to seek antenatal care and were more likely to give birth at home. This was perceived by both health care professionals in predominantly Thai communes with a small Hmong population who generally live in remote mountainous villages, and those working in predominantly Hmong communes where people do not necessarily live far from the health station.

The most difficult part is communicating with Hmong people. They live in a remote village ... Most of them give birth at home. It's always difficult to implement the National Health Target program with Hmong people. (Medical Assistant, female, Thai)

Approximately one-half of the health professionals also acknowledged that information provision is only useful up to a point, as they felt that pregnant women and mothers may understand what they need to do to care for themselves but are unable to do so due to economic or family circumstances. For example, they cannot afford to buy food to provide sufficient nutrition during pregnancy, or their family may not be able to spare their income.

It depends on the financial situation of each family. I might tell them that they need this or that to take care of the baby, but they can't afford such things. (Medical Assistant, male, Thai)

Perceived Factors in Determining the Quality of Communication with Women

Health care professionals' perceived the effectiveness of their communication as mainly determined by ethnic minority women's capacities, particularly their language fluency, education level, and literacy skills. Adapting communica-

TABLE 2
Participant Characteristics

Patient Characteristics	Number of Health Professionals (%)
Sex	
Female	15 (68)
Male	7 (32)
Age, years (range, 21-57)	
<25	1 (5)
25-34	10 (45)
34-44	3 (14)
45-54	6 (27)
55+	2 (9)
Primary health care position	
Medical assistant ^a	11 (50)
Midwife	6 (27)
Doctor	2 (9)
Pharmacist	2 (9)
Nurse	1 (5)
Years of practice (range, 2 months to 38 years)	
<10	4 (18)
10-19	5 (23)
20-29	3 (14)
30+	
Ethnicity	
Thai	15 (68)
Hmong	5 (23)
Kinh	2 (9)
Ethnically concordant with majority patient population	
Yes	16 (73)
No	6 (27)

Note. N = 22.
^aGeneral medical position requiring 2 years of vocational training.

tion styles or materials for women who were less skilled was rarely mentioned or discussed by participants; therefore, the communication skills of the health professionals were seldom reflected upon by the health professionals themselves. Two main subthemes emerged regarding the perceived quality of communication between health care professionals and ethnic minority women: "sharing the same language, sharing an understanding?" and "the difficulties of difference."

Sharing the same language, sharing an understanding?
The health professionals we interviewed generally perceived

good or successful communication to come from speaking the same language as their patients, particularly Thai health professionals working in predominantly Thai communes.

We are all Thai people, we belong to the same group, speak the same language, so it's easier to work with local people. (Medical Assistant, female, Thai)

Conversely, seven health professionals worked in communes where they were in the minority, resulting in cases where both the health professional and the patient were conversing in their second language. For example, a Hmong midwife working in a predominantly Thai commune communicated with Thai women in Kinh, which was a second language for both the midwife and the Thai women.

Some women don't understand the language so we have to ask other women to translate. I can speak Thai, but the midwife belongs to the Hmong group, so she has to talk to Thai women in Kinh language. Some Thai women don't understand Kinh language. (Medical Assistant, female, Thai)

For many of the participating health professionals, there was little acknowledgment that women may have difficulty understanding the health information they provided; the assumption being that communication difficulties largely stem from language discordance.

There's no difficulty if we speak the same language. The only problem is language difference. (Midwife, female, Thai)

Consequently, most of the health professionals who were interviewed seemed to assume shared language resulted in women understanding the health information. However, some of those health professionals also identified education and literacy levels among women as a factor determining how well women understood the information they provided, with "illiterate" women perceived as lacking the capacity to understand health information.

Literate women can understand right away. Illiterate women wouldn't understand even if I repeat the information many times, or just understand part of it. (Midwife, female, Hmong)

There was also an assumption that as long as someone in the household was able to read the information in the Pink Handbook given to pregnant women, the woman's health information needs were being adequately served. Several of the health professionals who discussed the Pink Handbook mentioned that women did not understand some of the information in the handbook or were unable to read it; their solution was to tell the women to take it home and have her husband or a literate child read it and pass on the information, thereby delegating the explanation of health information to a third party.

Some women are illiterate though so I told them to bring the handbook home so that the husbands and children could read it for them. (Midwife, female, Thai)

The difficulties of difference. Discordance between health professionals and patient language was common, particularly with Hmong people living in majority Thai communes, where the participating health professionals were generally Thai. It is in these cases that health professionals most commonly acknowledged that they have problems communicating. They described interactions with women of a different ethnic group as "difficult," (Midwife, female, Thai) whereas interactions within their own ethnic group are "convenient" (Midwife, female, Thai) and "comfortable" (Medical Assistant, male, Thai). Some women preferred to speak to a health professional from their own ethnic group, if available; a Hmong midwife working with mostly Thai colleagues reported that Hmong women would not attend the health station if she was not there.

Hmong people always ask before they come here ... ask whether I'm here or not. If I'm not here, other health staff would ask them 'what's wrong?' and the women would say 'nothing is wrong' and go home. (Midwife, female, Hmong)

Health professionals also perceived communication as difficult when dealing with ethnic minority women who they thought of as being "shy." This term was generally used to describe Hmong women who were reluctant to speak to a health professional or to present to a health station, particularly to give birth. Health professionals perceived this shyness to be due to a range of factors, including discordant ethnicity and/or gender between health professionals and women, language difference, and general customs of ethnic minority people.

It's their customs. They're shy and don't want anyone else to see their body parts ... They're shy in front of strangers. Ethnic minority women are shy like that. (Medical Assistant, female, Thai)

Some [Hmong] women are shy so they just keep silent when I ask them [if they understand health information]. They look at me intently but don't say anything. Some other women, when I ask them if they understand they say yes. (Midwife, female, Hmong)

For example, a female Kinh health professional described a "shy" 16-year-old pregnant Thai adolescent who asked for a referral to the district hospital but refused to disclose her pregnancy because the health professional was not Thai. She overcame her "shyness" with a male Thai health professional, suggesting the woman may have felt more confident disclosing her pregnancy to someone

from her own ethnic group, in her own language, despite their gender difference.

I asked her why she asked for a referral letter ... she said she has a stomach ache. I asked if there's any vaginal discharge, she said no. I asked if she's pregnant or not, she said no. Later [another staff member] talked to her in Thai language and she told him everything. She was shy and didn't answer me because I spoke Kinh language. (Medical Assistant, female, Kinh)

Several health professionals also believed that some ethnic minority women chose not to understand them "on purpose" when faced with health advice they did not wish to adhere to, particularly in regard to family planning (Vietnam has a two child policy; families who have more than two children may face punitive measures). A Hmong midwife described her frustration with this experience in regard to discussing family planning:

We speak the same language and understand each other, but they don't understand on purpose ... when I explain to them that they should use contraceptive methods for family planning, otherwise it would lead to financial difficulties. But they would say "No, I would never use such things." I try my best to explain to them, but if they don't want to understand then it's very difficult. (Midwife, female, Hmong)

This perception of willful misunderstanding on the part of women also denies the possibility that women may be making a conscious choice to disregard the health professional's advice, based on their differing health beliefs, understanding, preferences, and values.

DISCUSSION

Primary care health professionals in Tuan Giao district thought of themselves as important sources of health information for pregnant women and mothers of young children. They had generally positive views about their communication and its perceived outcomes, but they also acknowledged difficulties communicating with ethnic minorities, especially Hmong people. These difficulties were perceived to be mostly due to patient factors, particularly their ethnicity, language fluency, and literacy skills. When given the opportunity to reflect on communication problems that they had previously experienced with ethnic minority women, health professionals in our sample largely focused on these patient factors, leaving them little room to reflect on their own communication skills.

These results illustrate that health professionals considered communication to be an important part of maternal care generally, but there is little to no differentiation between the concepts of the one-way delivery of health information

and interactive communication with women. Although health professionals frequently talked about how they delivered health information, and what information they delivered, there was little mention of the importance of listening to women's perspectives or ensuring that they have understood health information. There was also a perception that communication with women was useful as a means to ensuring adherence with health advice, rather than being valuable in itself or as a means to strengthen health literacy or their relationship with women under their care. Previous research has identified relationships and communication as critical elements for enhancing health literacy, highlighting the importance of the patient-provider relationship and the need for a patient-centred focus to identify and address health literacy needs (Carollo, 2015). Conceptual models of the causal pathways between limited health literacy and health outcomes also suggest that improving the patient-provider interaction may mediate the effect of limited health literacy on health outcomes (Paasche-Orlow & Wolf, 2007; von Wagner, Steptoe, Wolf, & Wardle, 2009). This is concerning in the context of increasing the use of health services by ethnic minority women, as elements of the patient-provider relationship, particularly a receptive, respectful provider attitude and trust, have been found to be highly valued by women when choosing where to give birth (Kruk, Paczkowski, Mbaruku, de Pinho, & Galea, 2009; Kruk et al., 2010). Social stigma may also play a role in this setting. Research has identified discrimination and negative attitudes by health staff towards ethnic minority women as being a possible determinant of inequity in maternal and child health in Vietnam, as negative experiences may discourage women from seeking care (Malqvist, Hoa, & Thomsen, 2012).

The participating health professionals generally viewed pregnant women, and by extension the patient populations that they serve, within an individual deficit perspective (Dawkins-Moultin, McDonald, & McKyer, 2016); they commonly perceived communication issues to mostly be due to patient factors that need to be overcome on an individual basis, placing much of the burden of communication and understanding information about pregnancy on women and their families. Future health literacy and communication skills training in the district and the province should encourage health professionals to broaden this perspective to recognize health literacy, and communication more generally, as an interactive social practice that is co-constructed between the health professional/system and the patient through interaction and the patient/provider relationship (Aldoory, 2017; Rubin, Parmer, Freimuth, Kaley, & Okundaye, 2011). This may help to reframe the notion of communication

problems from being solely due to language or educational deficits among women to a view where health professionals recognize their responsibility in creating an environment conducive to more patient-centered care. By encouraging health professionals to take a patient-centered approach to communication that does not look at communication difficulties and low health literacy purely as a patient problem, they will be empowered to better respond to the limitations that they perceive in their patients. Little research has been done on patients' preferences and needs regarding patient-centeredness in patient-provider communication in low and middle-income countries, particularly in Asian countries. What research has been done indicates that patients have different needs based on their cultural framework and local social norms (Moore 2008; Ting, Yong, Yin, & Mi, 2016) but this does not mean that they are not open to a more patient-centered approach to communication with their health care provider (Claramita, Utarini, Soebono, Van Dalen, & Van der Vleuten, 2011; Kim, Putjuk, Basuki, & Kols, 2003).

Future health professional training in DBP could consider applying health literacy approaches at the health professional level (Batterham et al., 2016), with a focus on the following oral communication strategies for low health literacy populations: (1) the use of relevant action-oriented directives that clearly explain concrete actions that patients can take given their individual circumstances, (2) encouraging patients to ask questions, (3) using teach-back techniques to confirm patient understanding and identify limitations in a non-shaming way (Batterham et al., 2016; Oates & Paasche-Orlow, 2009) and (4) strengthening health professional capacities for problem-solving when they experience difficulties communicating with patients from a different ethnic group (Batterham et al., 2016).

Traditional health literacy strategies such as these emphasize improving how health professionals deliver information and give instructions, but our data suggest that health professionals should also be encouraged to take a broader view of communication as being more than simply delivering health information. Integrating health literacy approaches with culturally competent communication that emphasizes learning about patients' differing concepts of health and health beliefs is also necessary (Andrulis & Brach, 2007). We would add that particular attention needs to be paid to true patient-centeredness, and recognizing that cultural difference between ethnic groups can significantly affect communication. For this reason, health professionals should be especially encouraged and supported to develop tailored strategies for communicating with Hmong communities, together with Hmong community leaders. We are cautious in

drawing parallels between these findings and the larger body of research on racial/ethnic disparities and the impact of patient-provider communication. Much of the research in this area has been grounded in the specific historical and social context of the United States. However, research into the racial and ethnic disparities in the U.S. has underlined the potential role of poor communication in causing health disparities (Ashton et al., 2003), and drawn similar conclusions as to the importance of training health professionals to engage in better quality communication with minority and racially discordant patients (Shen et al., 2017). A recent systematic review (Rocque & Leanza, 2015) also highlighted the importance of cultural influences on patient-provider communication, and explored factors influencing ethnic minority patients' experiences of communicating with primary health care providers. Language barriers, discrimination, and cultural differences around values and beliefs were highlighted as important negative influences.

Strengths of this study include a heterogeneous sample, the high level of participation from health professionals, a rigorous analysis process, and the involvement of local collaborators. The main limitations of this study are that self-reported practice in interviews may differ from actual behavior, and there may be a related element of social desirability bias. We attempted to minimize this by using a neutral interpreter and reassuring participants of the confidentiality of their participation. Additionally, this is a cross-cultural study, and some responses may have been misinterpreted by the authors. We have attempted to limit misinterpretations by independently translating all interview audio data, and collaborating with a Vietnamese co-author (D.T.L.). The interview process and any actual or potential misunderstandings were also regularly discussed by the authors in regular meetings during the data collection process.

CONCLUSION

Health professionals consider communication to be an important part of patient care, but they generally perceived communication as one-way information provision, rather than an interactive social process. They perceive communication problems to be due to patient factors, including ethnic and language differences. There were specific barriers to communication with the Hmong population, which may need targeted interventions. Health literacy in DBP may be improved through integrating effective, patient-centered communication skills training for health professionals, strengthening health professionals' problem-solving capacities, and expanding health professionals' perspective of communication and health literacy to focus less on perceived pa-

tient limitations and more on their own capacity to respond to such limitations.

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