Child Health in Ethnic Minorities

Chinese and Vietnamese families

JOHN BLACK

Chinese families

For many generations there have been Chinese communities in our major ports, but only during the past 20 years have greater numbers come to Britain, mainly from Hong Kong, Malaysia, and Singapore. In London most Chinese families live in Camden, Islington, Lambeth, and the City of Westminster, though there are smaller communities or single families scattered all over London, owing to the large number of Chinese restaurants. In the rest of Britain the pattern is similar, with large communities in Liverpool, Manchester, and Bristol. There are also a few families from the People's Republic of China in London, mainly attached to or working in the Chinese Embassy. The ethnic Chinese families who came to the United Kingdom from Vietnam have rather different problems and are considered later.

Social structure and family life

Perhaps more than any other immigrant group the Chinese have tended to retain their social structure and cultural attitudes with little contact with local or national activities. The extended family is a very important aspect of their social life; for the children, respect for parents, relatives, older people, and "authority figures" such as teachers is an essential part of their attitude to life.

Religion—There are many Buddhists and also Christians of various denominations. So called "ancestor worship," more properly reverence or respect for one's ancestors, is important to most Chinese families and means looking to their ancestors for guidance. It is a way of life not a religion, and its practice is quite compatible with membership of a formal religious group. In the People's Republic of China there is no formal religion; religious worship is tolerated but not encouraged.

Language—Families from urban Hong Kong usually speak Cantonese and those from the New Territories may speak Hakka or Cantonese, or both. Many families from Malaysia and Singapore speak Hokien. Mandarin is also widely understood. Written Chinese, being in the form of ideographs, is, of course, understood by all Chinese people.

Naming system—The Chinese normally put the family name (surname) first, followed by the given names. In Britain, however, many families have adopted the British system, with the family name last, so it is essential to clear up this point at the beginning. When asking someone's name it is best to say, "What is your family name?" and "What is your personal or given name?" rather than to say, "What is your first (or last) name?" Older women may have retained their maiden names after marriage without adding the husband's family name, but this is becoming less common. When a whole family is registered, as in general practice, and the wife is using her maiden name it is best to put in brackets (wife of Mr . . .). Children normally take the father's family name; they may have

both English and Chinese names, or for use in school they may use an English translation of their Chinese given names. Thus Beautiful Morning in Chinese becomes, more prosaically, Dawn in English.

General medical problems

Chinese families do not use medical or social and community services as much as do British families. Parents may be reluctant to go to a doctor or hospital if they cannot explain what is wrong or are worried that they may not understand the instructions about treatment or drugs that have been prescribed. Similar fears and traditional self sufficiency may prevent them from claiming the social benefits to which they are entitled, resulting sometimes in avoidable hardship or ill health. Many families consult Chinese practitioners of traditional medicine or buy herbal remedies before resorting to Western medicine, though they are more likely to take an ill child straight to their doctor or to hospital.

Blood tests—There is often reluctance, or even refusal, to have blood taken for investigations, on the grounds that removal of blood causes weakness. Understandably, there may be considerable reluctance if many or repeated blood samples are requested.

Diet—There may be conflict between the dietary advice given by an antenatal clinic and the traditional changes in diet that are determined by the concept of "heating" and "cooling" foods. As pregnancy is regarded as a "hot" condition the mother may reduce her intake of "hot" foods such as red meat, oils, or fatty dishes. Dietary adjustments during pregnancy may require much time and discussion. A child may find food provided by hospitals unacceptable, and the parents should be allowed to bring food into the ward. Weaning may also cause difficulties; most Chinese infants are weaned on to congee (rice porridge) mixed with chopped meat and vegetables, and the mother may not accept the advice given by the health visitor or advisors at a baby clinic. Adequate supplements of vitamin D are important. Older children and adults do not drink milk, and it is pointless to try to force them to take it as it may cause abdominal discomfort or diarrhoea (for further discussion see below under lactase deficiency).

HEPATITIS B

Hepatitis B (HBV infection) carriers in pregnancy¹

About 10-20% of adults in South East Asia are potentially infective carriers of hepatitis B; most are asymptomatic, but a few have evidence of hepatic disease (see below). In sub-Saharan Africa, the Indian sub-continent, and the Mediterranean area about 3-10% are carriers. Apart from special categories (see below), the indigenous population of the United Kingdom and the West Indian community are very rarely carriers. As infection occurs within family groups women belonging to the ethnic groups mentioned above who have been born and remained in Britain all their lives may be infective. Pregnant women in all the at risk groups should, therefore, be screened at their first antenatal visit. In addition, irrespective of ethnic or geographical considerations, other groups who should be screened are: (a) women who have had hepatitis B

during the last trimester of pregnancy; (b) women who have received numerous blood transfusions for β thalassaemia major, sickle cell anaemia, or other haemoglobinopathies; and (c) those known for or suspected of drug abuse by self injection.

Those whose blood contains hepatitis surface antigen (HBsAg) should be screened for hepatitis e antigen (HBeAg), the presence of which in the serum indicates increased infectiveness. Women with HBsAg, particularly those who also have HBeAg, can infect their infants around the time of delivery, or subsequently. Infants infected at birth (transplacental infection is rare) commonly become asymptomatic carriers without adverse effects during early life and are major contributors to the pool of persistent carriers in the community. Rarely, such children may develop clinical hepatic diseases (see below). Infants or children infected some time after birth are less likely to become persistent carriers.

Management of pregnancy and delivery—All pregnant women in the groups at risk mentioned above should be screened at their first antenatal visit. If the mother is found to be a carrier all blood samples should be treated as infectious, according to the standard procedure for hepatitis B. During delivery special precautions should be taken to prevent infection of those conducting the delivery, and maternal blood, placenta, and membranes should be regarded as infective.

Management of the newborn infant—All maternal blood should be cleaned off the infant's skin, and the stomach should be aspirated to remove swallowed maternal blood. The following procedure is recommended in the United States of America (hepatitis B virus vaccine (H-B-Vax, Thomas Morson Pharmaceuticals) has not yet been licensed in Britain, and, until it is, it can only be given on a "named patient" basis on prescription (obtainable from major pharmaceutical distributors or from the manufacturer)). (1) As soon after birth as possible, and in any case within 48 hours of delivery, give 200 mg (200 IU; 0.5 ml) of specific hepatitis B immunoglobulin intramuscularly. (2) Give 10 μ g (0.5 ml) of hepatitis B virus vaccine intramuscularly at the same time as immunoglobulin, or within one week). (3) Give a second dose of vaccine one month later and a third dose six months after the first. The immunoglobulin should be obtained from the Central Public Health Laboratory, Hepatitis Epidemiology Unit, Colindale, London, NW9 5HT, tel: 01 205 7041, which should be consulted in difficult or doubtful cases.

Liver disease in childhood—In infancy and childhood hepatitis B infection can cause various responses, ranging from the asymptomatic production of antibodies, with or without the carrier state, to acute hepatitis, chronic hepatitis, cirrhosis, or hepatocellular carcinoma in adult life. A manifestation that is unique to childhood is acute hepatitis with papular acrodermatitis (Gianotti-Crosti syndrome).

Conditions found in the children of Chinese families

GENETICALLY DETERMINED CONDITIONS

Haemoglobin Barts hydrops fetalis occurs when the infant is homozygous for a type of α thalassaemia, which is asymptomatic in its heterozygous form. It is common throughout South East Asia and in the south of China, but its distribution in the rest of the People's Republic of China is not yet known. There is an increased incidence of toxæmia in the mother, and the pregnancy may last for 30-40 weeks. There may be a history of stillbirths or early neonatal deaths of hydropic infants. The infant may die in utero or a few hours after delivery; despite generalised oedema the birth weight is lower than normal for the gestational age. The placenta is enlarged and oedematous and the infant anaemic, with a haemoglobin concentration of 6-7 g/dl or less. There is gross hepatosplenomegaly with the liver slightly more enlarged than the spleen. Though an anaemic hydropic infant with parents of Oriental origin is likely to have Hb Barts disease, it is essential to confirm the diagnosis by examining the baby's blood as diagnosis of the carrier state in the parents is difficult. On electrophoresis the infant's blood consists mainly of Hb Barts; HbF and HbA are completely absent. No treatment is possible as these infants cannot manufacture a haemoglobin that is capable of delivering oxygen to the tissues.

Useful addresses

For Chinese families:

Chinese Community Centre, 44 Gerrard Street, London W1V 7LP (01 439 3822)
Merseyside Chinese Centre, 32a Berry Street, Liverpool L1 4SQ
The Pagoda of Hundred Harmony, Chinese Community Centre, Henry Street, Liverpool L1 5BU 051 708 8833

For Vietnamese families:

Refugee Action (Head Office), The Offices, The Cedars, Oakwood, Derby DE2 4FY (0322 833310)
Refugee Action (London only), 171a Deptford High Street, London SE8

Genetic advice is important as there is a 1:4 chance of having a similarly affected child. Antenatal diagnosis may be practicable in the future.

Haemoglobin H disease—This form of α thalassaemia results from a doubly heterozygous state for two different α thalassaemia genes. The condition becomes obvious during the first year of life with symptoms, facial appearance, and physical signs similar to those of β thalassaemia major, though there is a much greater variation in the haemoglobin concentration, which is usually 7-8 g/dl. In general, the condition is less severe than β thalassaemia and life expectancy is reasonably good. Blood films also resemble those in thalassaemia major, but after the red cells have been incubated with cresyl blue inclusion bodies can be seen. The HbH concentration is 2-4 g/dl. The chronic haemolysis that already exists may increase during acute infections or after exposure to the same drugs or conditions that cause haemolysis in G6PD deficiency (see articles on Afro Caribbean families and Mediterranean and Aegean families). Confirmation of the heterozygous state in the parents may be extremely difficult.

β thalassaemia is not uncommon in Chinese families²; the clinical presentation and diagnostic features have already been described.

Glucose 6 phosphate dehydrogenase deficiency—The Oriental forms of G6PD deficiency are common in Chinese families from Hong Kong, and south China, particularly Guangdong (Canton) Province. The Hakka community, some members of which emigrated from Hong Kong, also has a high incidence. Though five variants of Oriental G6PD deficiency have been recognised the clinical behaviour of each variant is much the same, and all are inherited through an X linked intermediate gene with varying expression in heterozygous women, who are usually asymptomatic. Owing to the high incidence of the gene in affected groups, homozygous women are not uncommon and may be as severely affected as men. The behaviour of the Oriental forms of G6PD deficiency in relation to drugs, infections, and neonatal jaundice is similar to that of the Mediterranean variant. Exchange transfusions for hyperbilirubinaemia in the neonatal period may be required in the absence of exposure to drugs.

Lactase deficiency is thought to be inherited through a recessive gene.³ The homozygous state, which is extremely common in South East Asia and parts of India, Africa, and the Mediterranean area, causes reduction of intestinal lactase, present in normal concentrations in the infant, to very low concentrations, usually by the age of 6 months or 1 year.⁴ About 80-90% of Chinese adults show varying degrees of "lactose intolerance" after ingesting milk or milk products containing lactose; the usual symptoms are abdominal discomfort, flatulence, or diarrhoea. There is no evidence that continued consumption of milk products prevents the reduction of lactase. Yoghurt is, however, well tolerated in people who are lactase deficient as it contains bacterial lactase, which is activated in the intestinal tract.⁵

ACQUIRED DISEASE

Helminthiasis—Roundworm (*Ascaris lumbricoides*) and, less commonly, hookworm (*Ankylostoma duodenale*) may be acquired during a visit to South East Asia.

EMOTIONAL PROBLEMS

Chinese children born in Britain usually have few language problems when they start school, particularly if the school is used to

making special arrangements for children speaking little or no English. In schools where there are few non-British children, however, special facilities may not exist. Children who have come at a later age to the United Kingdom, often at 8-9 years, have great difficulties in adjustment after spending their early childhood with grandparents in Hong Kong or elsewhere. Not only do they not know their own parents and any siblings who have been born in this country, but their knowledge of English may be poor and their academic achievement quite different from those of British children of the same age. It is not always appreciated that many families from Hong Kong come from the New Territories, where the parents have had small farms, and the standard of schooling and general life is much less sophisticated than in urban Hong Kong and Kowloon.

Children with problems at school or conflicts arising from various circumstances may present to the family doctor with apparent somatic diseases, such as headache, recurrent attacks of vomiting, or abdominal pain. Chinese parents expect the school to provide homework from an early age, and at the same time the children accept their duty to help in the restaurant or shop on returning from school, which results in sleepiness at school and poor progress. Cultural conflicts may arise when a child, particularly a girl, unsuccessfully attempts to reconcile her life as an English schoolgirl during the day with being a dutiful daughter at home. Extreme forms of rejection of one or other culture may result in elective mutism at school or a refusal to talk Chinese at home. Playing truant may result from intolerable pressures at school or from racist taunting or bullying.

Vietnamese families

Since 1975 about 16 000 people from Vietnam have come to Britain. The first small group, who came in 1975, were from south Vietnam and were mostly ethnic Vietnamese. The second, much larger, group came during 1977-9, with a peak in 1979, from both north and south Vietnam and were predominantly ethnic Chinese (80%). Of these 16 000 refugees, about 11 000 came from north Vietnam via Hong Kong, the so called "boat people." During the war, and due to the difficulties of their escape, many families were split up, and it has only recently become possible for families in Britain to apply for exit facilities for relatives who were left behind in Vietnam.

On arrival in Britain the families were housed in camps; they were then dispersed throughout Britain in single families or small groups, according to the willingness and ability of local authorities to make housing available. Whatever the reason for this policy, it caused great hardship and distress for people who, in most cases, had had no contact with the Western way of life and generally spoke no English. The result was a complete lack of integration, difficulty in helping the scattered families and in organising classes in English, and very high unemployment. They became depressed and discouraged. Recently, many families have moved to the big cities, especially London, where they have been accepted and helped by the Chinese communities. Obviously integration is much easier for the ethnic Chinese who usually speak Cantonese; the ethnic Vietnamese may have greater difficulty in integrating. Families from Vietnam live mainly in London (south east), Birmingham, Coventry, Manchester, Wales, and in the north of Scotland.

Language—The ethnic Chinese speak Cantonese or Vietnamese, or both; ethnic Vietnamese speak Vietnamese. The Roman alphabet is in general use in Vietnam, though many of the Chinese also understand written Chinese.

Naming system—Normally, the first name is the family name or surname; this is followed by the middle name and finally the personal name. Children take their father's family name, but a woman usually keeps her maiden name after marriage without adding the husband's family name. Some families have revised the order, however, putting the surname last, to fit in with the British convention, so it is necessary to ask about this. The receptionist, nurse, or doctor should always ask how the patient would like to be addressed and should make a note of a phonetic rendering of the name below the official record, as the spelling gives little guide to

pronunciation. If a name is wrongly pronounced the patient will not recognise it when it is called out.

General medical problems

Traditional medicines and methods of treatment—Many families, particularly from north Vietnam, have had little or no contact with Western medicine and have a correspondingly firm belief in traditional practitioners and methods of treatment. "Coin rubbing" produces linear ecchymoses, usually on the back; these lesions can be mistaken for non-accidental injury, with disastrous consequences. Another form of physical treatment (for persistent cough) is to pinch or squeeze the area on either side of the trachea; this is repeated down the upper part of the anterior chest wall. The bruising that results is considerable and may be puzzling if its origin is not recognised.⁶

Pregnancy and termination of pregnancy—Termination of pregnancy is accepted in Vietnam, but generally knowledge about contraception is small.

Diet—As for Chinese families.

Death—If a member of the family dies in hospital the family should be consulted about its wishes. Families from north Vietnam in particular may be reluctant to agree to a necropsy.

Medical conditions found in the children of Vietnamese families

Blood disorders— β thalassaemia, haemoglobin Barts hydrops fetalis, haemoglobin H disease, and glucose 6 phosphate dehydrogenase deficiency all occur in Vietnamese families; these conditions have already been described under Chinese families.

Lactase deficiency—As for Chinese families.

Helminthiasis—Roundworm (*Ascaris lumbricoides*) infection was particularly common in children when they arrived in Britain but should have been eradicated by now. New arrivals should, however, have their stools examined for ova and other pathogens.

Tuberculosis was also common when refugees first arrived in the United Kingdom. Most children who were tuberculin negative were given a BCG injection; some, however, may not have received it. Newly arrived children should undergo chest radiography, tuberculin testing, and BCG vaccination if they are tuberculin negative.

Hepatitis B—As for Chinese families.

I wish thank the following for their help in the preparation of this article: Miss Andria Suk Ming Li, Chinese Community Centre, London and Dr A P Mowat, consultant paediatrician and Dr S K F Chong, lecturer in child health, King's College Hospital, London. I thank Mrs Sandra Parfitt for her care and patience in typing these articles, and I also thank all the parents who have tolerated my inadequacies with courtesy and patience. They have taught me a great deal and have helped me to a better understanding of their problems.

References

- 1 Zuckerman AJ. Perinatal transmission of hepatitis B. *Arch Dis Child* 1984;59:1007-9.
- 2 Wong HB. Haemoglobinopathies in Singapore. *J Singapore Paediatr Soc* 1967;9:1-27.
- 3 Newcomer AD, McGill DB. Clinical importance of lactase deficiency. *N Engl J Med* 1984;310:42-43.
- 4 Wong HB. Gastroenteritis. I. Infantile diarrhoea. *J Singapore Paediatr Soc* 1981;23:103-8.
- 5 Kolars JC, Levitt MD, Aouji M, Savaiano DA. Yogurt: an autodigesting source of lactase. *N Engl J Med* 1984;310:1-3.
- 6 Phillips S. Bizarre physical signs and traditional Vietnamese folk medicine. *Maternal and Child Health* 1981;6:145-7.

Further reading

- Ball R, ed. *Report of the Second National Conference on Chinese Children in Britain*. Huddersfield: National Children's Centre, 1978.
- Hunt W. Chinese children in Britain: a report. *China Now* 1984; No 110:25-7.
- Lynn IL. *The Chinese community in Liverpool*. Liverpool: Department of Sociology, University of Liverpool, 1982.
- Mares P. *The Vietnamese in Britain: a handbook for health workers*. Cambridge: Cambridge Health Education Council and the National Extension College, 1982.
- Pearson R. Understanding the Vietnamese in Britain. *Health Visitor Journal* 1982;55:426-30, 477-82, and 533-8.
- Weatherall DJ, Clegg JB. *Thalassaemia syndromes*. 3rd ed. Oxford: Blackwell Scientific Publications, 1981.

(This article is the seventh in a series)