THE UNIVERSITY OF AUCKLAND

FACULTY OF MEDICAL AND HEALTH SCIENCES

SCHOOL OF POPULATION HEALTH

THE FOURTH INTERNATIONAL ASIAN HEALTH AND WELLBEING CONFERENCE

"An Holistic Approach to Asian Health"

CONFERENCE PROCEEDINGS

5 – 6 July 2010
Auckland, New Zealand

Conference Organisers:
Centre for Asian Health Research and Evaluation (CAHRE), The University of Auckland.

Published by:
Centre for Asian Health Research and Evaluation (CAHRE), The University of Auckland, September 2008.

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Suggested citation:
Sobrun-Maharaj, A., Parackal, S., Rossen, F. (Eds.). (2010). *An Holistic Approach to Asian Health. Proceedings of the Fourth International Asian Health and Wellbeing Conference, July 5-6*. Auckland, New Zealand: University of Auckland.

ISBN 978-0-473-18206-9

Centre for Asian Health Research and Evaluation (CAHRE)

Faculty of Medical and Health Sciences, School of Population Health,
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The Centre for Asian Health Research and Evaluation (CAHRE), a research unit at the University of Auckland, is based at the School of Population Health (SOPH) in Tamaki. It was formed on the 19th of May 2004 at a time when reliable data to understand the extent and severity of Asian health problems was scant, and has since grown into a well-established centre of research excellence and information on Asian health and wellbeing. The mission of CAHRE is to develop a critical and inter-disciplinary approach to improve and visualise the health status of the fastest growing population in New Zealand. It also has a vision of international collaboration with individual researchers and organisations. More recently, CAHRE has also undertaken research into other ethnic minority immigrant communities who have commonalities with Asian immigrant communities. The goals of the Centre include the following:

- To establish a centre of national and international excellence in understanding health issues affecting Asian communities
- To cultivate an inter-disciplinary approach to studying Asian health
- To provide research-based information to enhance the capacity of health services in delivering effective and culturally appropriate interventions
- To conduct research that can foster health amongst Asians in New Zealand
- To collaborate with Asian communities, business, local government, and ministries to further research in the areas of Asian health
- To build a new focal point of exchange on Asian health with both the local and international research communities
- To disseminate and analyse the outcomes of relevant Asian health research

CAHRE offers independent, university-based professional research and evaluation services including:

- *Collaborative research*
- *Educational and workforce training opportunities*
- *Intervention and evaluation*
- *Consultancy services*

Partnerships:

CAHRE welcomes international and national research collaborations and community partnerships. The key advancements that CAHRE aspires to through the development and implementation of partnerships are:

- Excellence in research
- Innovative and strengths-based approaches to Asian health issues
- Exchanges of research expertise and academics
- Capacity building that benefits both emerging and established researchers
- Building meaningful and strong links with community

Furthermore, the International Asian health conference that CAHRE organises biennially increases the profile of the Centre and provides further prospects of research collaboration and partnership with delegates and their institutions.

Recognition
CAHRE has recently been recognized by the Human Rights Commission and Race Relations Office with an award at the New Zealand Diversity Action Programme 2009 for its academic and community contributions.

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FOREWORD

Members of the Conference Organising and Editorial Committee and the Centre for Asian Health Research and Evaluation (CAHRE) are pleased to welcome you to the Fourth International Asian Health and Wellbeing Conference and this Book of Proceedings. The theme of the 2010 conference is "An Holistic Approach to Asian Health".

Every presenter in the conference was invited to contribute to this Book of Proceedings. All manuscripts were double-blind peer-reviewed to ensure a high standard of publication. We wish to express our appreciation to the Peer-review committee for giving up their valuable time to review the manuscripts.

We also express our gratitude to Mr Sun Kim, the Centre Co-ordinator, for his help in formatting the manuscripts and putting this Book of Proceedings together.

Research on the health and wellbeing of Asians in New Zealand is a new discipline and most of us are emerging researchers in the sector; consequently, researching and writing in this field is not always easy and straightforward. We acknowledge the commitment of the authors to the cause of Asian mental and physical wellbeing, and thank them for their effort.

The 2010 Book of Proceedings consists of three sections:

1. Mental health and wellbeing
2. Physical health and wellbeing
3. Social and community health and wellbeing

We sincerely hope that this publication will make for interesting and thought-provoking reading.

Dr Amritha Sobrun-Maharaj
Chair of the Editorial Committee

This conference has been proudly supported by:
The Office of Ethnic Affairs, UniServices, The Northern Districts Support Agency, The Asian Network Inc., The School of Population Health, and the Faculty of Medical and Health Sciences' External Relations and Communications Office .
We are grateful for the support received from them.

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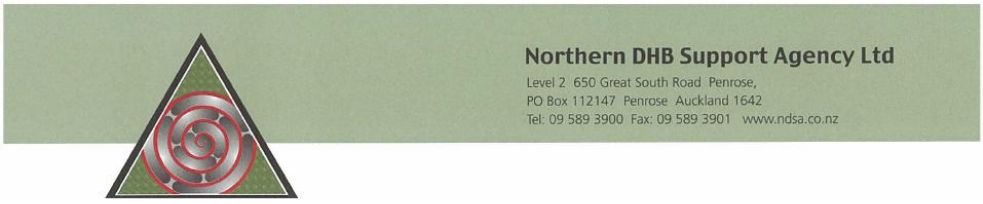

The Asian Network Incorporated

CONTENTS

Mental Health and Wellbeing

PSYCHOLOGICAL AND SOCIO-CULTURAL ADAPTATION OF ASIAN MUSLIM YOUTH

Colleen Ward, Zeenah Adam & Jaimee Stuart
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Victoria University of Wellington

ABSTRACT
The research used survey methods to examine the influences of identity and perceived discrimination on psychological and socio-cultural adaptation in 119 (75% first generation) Asian Muslim youth. The analyses revealed that a strong Muslim identity exerted a positive influence on life satisfaction, school adjustment and pro-social behaviours. It also buffered the negative influence of discrimination. Comparative data indicated that the adaptation of Asian Muslim youth in New Zealand was as good as, or better, than their Maori and Pakeha peers.

INTRODUCTION

The population of Muslims in New Zealand has increased by more than 50% over the past decade, reaching approximately 36,000 or almost 1% of the national population. About 77% of the Muslims currently residing in this country are overseas-born, with the majority originating from the Asian subcontinent (Statistics New Zealand, 2006). The steady increase of Muslims in New Zealand is reflected in many other Western countries, and rising immigration along with heightened media attention in the post-9/11 era has precipitated a worldwide increase in research on Muslim communities across the globe.

Many new settlers face prejudice and discrimination; however, there is reason to suggest that these pressures may be greater for Muslim immigrants than their non-Muslim counterparts. The 2009 Report on Race Relations noted that there were more complaints of discrimination on the grounds of religious beliefs from Muslims than any other group (Human Rights Commission, 2010) and a recent community survey indicated that New Zealanders have less favourable perceptions of Asian immigrants from predominantly Muslim countries compared to immigrants from other countries in the region (Stuart, Ward, & Adam, in press). This is of significant concern as there is a large body of research that has demonstrated the negative impact of discrimination on immigrant social integration and psychological wellbeing (Jasinkaja-Lahti, Liebkind, & Perhoniemi, 2006; Noh & Kaspar, 2003; Vedder, van de Vijver, & Liebkind, 2006).

In addition to the pressures of prejudice and discrimination, immigrants confront the challenge of maintaining their traditional culture and heritage while adapting to and participating in the wider society. Although negotiating these competing demands and blending and integrating multiple identities can be a stressful process, religious, ethnic and national identities often function as resources for acculturating youth (Ward, 2009). Consequently, this research explores the

ways in which these multiple identities impact on the psychological and socio-cultural adaptation of Asian Muslim youth.

This paper broadly examines the predictors of psychological wellbeing and positive behavioural adjustment in a diverse group of Asian Muslim youth living in New Zealand. It addresses two questions:

1. How do perceived discrimination and cultural identity (national, ethnic and Muslim) affect psychological and socio-cultural adaptation in Asian Muslim youth in New Zealand?
2. How well-adapted, psychologically and socio-culturally, are Asian Muslim youth in New Zealand compared to their host national peers?

METHOD

Participants and Procedure

One hundred and nineteen participants identifying themselves as Muslim participated in this study. All participants lived in New Zealand and had at least one parent of Asian origin. Participants were aged between 13-19 years old, with a mean age of 15.79 (*SD* = 1.41). Participants were 73.9% female. Of the sample, 33.7% were born in New Zealand, and 75.9% were New Zealand citizens. The breakdown of participants' ethnicities is presented in Table 1.

Participants completed an anonymous, voluntary questionnaire. They were recruited to the research by field assistants in Auckland and Wellington, who are members of the Muslim communities.

In addition to the Muslim participants, 396 New Zealand Europeans and 114 Maori youth (aged 13-19) recruited previously to participate in the New Zealand component of the International Comparative Study of Ethno-cultural Youth (ICSEY) served as the comparative sample (Berry, Phinney, Sam & Vedder, 2006)

Table 1
Ethnicities of Asian Muslim Participants.

	N	%
Afghani	33	28
Cambodian	1	1
Fijian Indian	23	19
Indian (unspecified)	35	29
Malay	1	1
Pakistani	22	18
Sri Lankan	4	3

Measures

All participants completed an adapted version of the survey used in the ICSEY project (Berry et al., 2006). In addition to personal background information, of interest in this research are the measures of perceived discrimination, cultural identity (Muslim, ethnic and national) and psychological (life satisfaction and

psychological symptoms) and socio-cultural (behavioural problems and school adjustment) adaptation. With the exception of the measure of behavioural problems, all responses are made on 5-point agree-disagree scales, and higher scores reflect greater perceived discrimination, stronger identities, greater life satisfaction, more psychological symptoms, better school adjustment and more behavioural problems, respectively.

Perceived discrimination was assessed by five items relating to unfair or abusive treatment on the basis of ethnic, cultural or religious background (e.g., "I have been teased or insulted because of my background").

The cultural identity scales tap aspects of belongingness (e.g., "I feel that I am part of the New Zealand community"), pride (e.g., "I am proud to be a member of my ethnic group"), and centrality (e.g., "Being a Muslim is an important reflection of who I am") in relation to religious, ethnic and national communities.

Psychological adaptation was assessed by positive (life satisfaction) and negative (psychological symptoms) indicators. The life satisfaction scale included 5 items (e.g.," In most ways my life is close to my ideal"), and the psychological symptoms measure had nine items tapping depression, anxiety and psychosomatic symptoms.

Socio-cultural adaptation was likewise assessed by positive (school adjustment) and negative (behavioural problems) indicators. Sample items for school adjustment include "At present I like school," and "I have problems concentrating on my homework." Behavioural problems included activities such as bullying, theft and vandalism and were measured on a 5-point frequency scale ranging from "never" to "many times during the last year." The psychometric properties of the scales are presented in Table 2.

Table 2
Psychometric Properties of the Scales

		Mean (SD)	No. Items	Cronbach's α
Asian Muslim	Life Satisfaction	3.46 (0.80)	5	0.78
	Psychosomatic Symptoms	2.38 (0.72)	9	0.89
	School Adjustment	3.99 (0.63)	7	0.79
	Behavioural Problems	1.39 (0.60)	8	0.83
	National Identity	4.01 (0.67)	5	0.79
	Ethnic Identity	3.51 (0.43)	15	0.86
	Muslim Identity	4.41 (0.56)	12	0.89
	Perceived Discrimination	2.12 (0.75)	5	0.84
NZ European				

	Life Satisfaction	3.43 (0.86)	5	0.82
	Psychosomatic Symptoms	2.73 (0.76)	8	0.84
	School Adjustment	3.60 (0.72)	7	0.72
	Behavioural Problems	2.02 (0.86)	8	0.84
Maori				
	Life Satisfaction	3.43 (0.81)	5	0.72
	Psychosomatic Symptoms	2.64 (0.76)	8	0.84
	School Adjustment	3.47 (0.59)	7	0.55
	Behavioural Problems	2.31 (1.03)	8	0.86

RESULTS

The Prediction of Psychological and Socio-cultural Adaptation

The analyses considered the influence of perceived discrimination, cultural identities and their interactions on psychological (Table 3) and socio-cultural (Table 4) adaptation. This was undertaken by hierarchical regression with the introduction of perceived discrimination on step1; Muslim, ethnic and New Zealand (national) identities in step 2; and the interactions between identity and discrimination in step 3. Where an interaction effect was present, graphs were constructed using Modgraph (Jose, 2008).

Table 3
Perceived Discrimination and Cultural Identity as Predictors of Psychological Adaptation

	Life Satisfaction			Psychological Symptoms		
Step	1	2	3	1	2	3
Perceived Discrimination (PD)	-.22*	-.06	-.15	.26**	.21*	.27*
Muslim identity (MI)		.23*	.12		.03	.11
Ethnic identity (EI)		.21*	.24*		-.21*	-.26*
National identity (NI)		.20*	.20*		.01	.02
PD x MI			.28**			-.18
PD x EI			-.04			.11
PD x NI			.02			-.00
R^2 change		.132**	.061*		.041	.028
R^2	.046*	.179**	.239**	.070**	.110*	.139*

*$p < .05$, **$p < .01$

Life Satisfaction

Discrimination predicted lower life satisfaction (ß = -.22, $p< 0.05$), but lost significance once cultural identities were added to the model. On the second step, all cultural identities were associated with greater life satisfaction (national identity, ß = .20, $p<0.05$; Muslim identity, ß = .23, $p <0.05$; and ethnic identity, ß = .21, $p<0.05$), and an interaction effect between discrimination and Muslim identity was found (ß = .28, $p< 0.01$) on the third step. This model accounted for 23.9% of the total variance.

Figure 1 depicts the interaction effect. When Muslim identity is weak, increases in perceived discrimination are associated with lower life satisfaction (slope $t(111)=-2.72$, $p<0.01$). In contrast, discrimination does not produce a significant effect for youth with moderate (slope $t(111)=-1.49$, *ns*) and strong Muslim identities (slope $t(111)=1.39$, *ns*). As such, Muslim identity can be seen to buffer the negative effects of discrimination on life satisfaction.

Psychosomatic Symptoms

Greater perceived discrimination (ß = .26, $p< 0.01$) and a weak ethnic identity (ß = -.21, $p< 0.05$) predicted more psychosomatic symptoms on entry and remained significant in the final step of the equation. There were no significant interactions. This model accounted for 13.9% of the variance.

Figure 1
Muslim identity as a Moderator of the Effect of Discrimination on Life Satisfaction

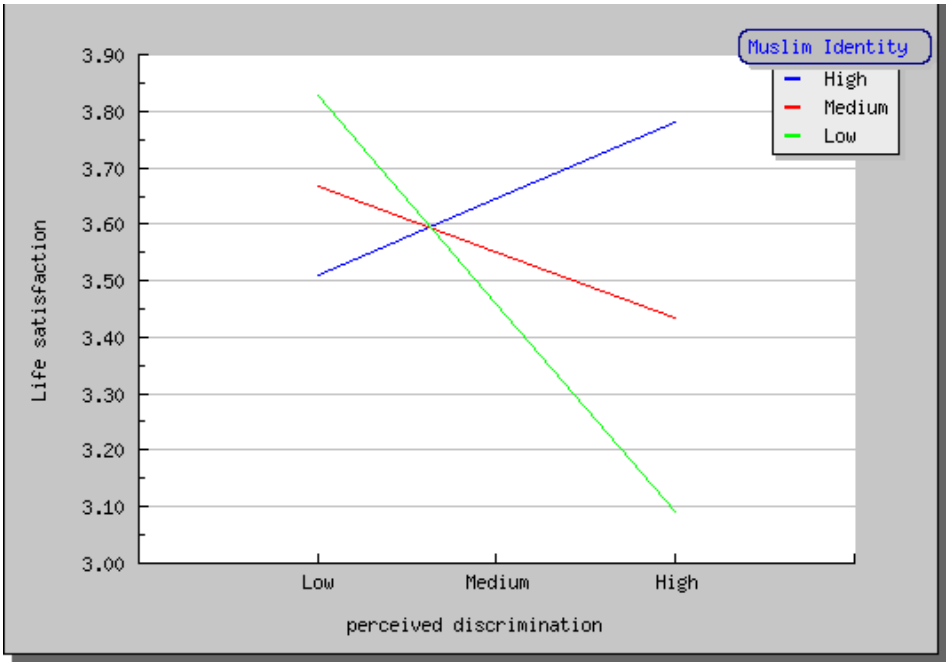


Table 4
Perceived Discrimination and Cultural Identity as Predictors of Socio-cultural Adaptation

	School Adjustment			Behavioural Problems		
Step	1	2	3	1	2	3
Perceived Discrimination (PD)	-.26**	-.13	-.16	.27**	.15	.22*
Muslim identity (MI)		.33**	.30**		-.22*	-.11
Ethnic identity (EI)		.03	.04		-.14	-.20
National identity (NI)		.05	.03		-.01	-.00
PD x MI			.07			-.23*
PD x EI			.02			.18
PD x NI			-.13			.01
R^2 change		.094**	.022		.063	.055
R^2	.070**	.164**	.186**	.074**	.137**	.192**

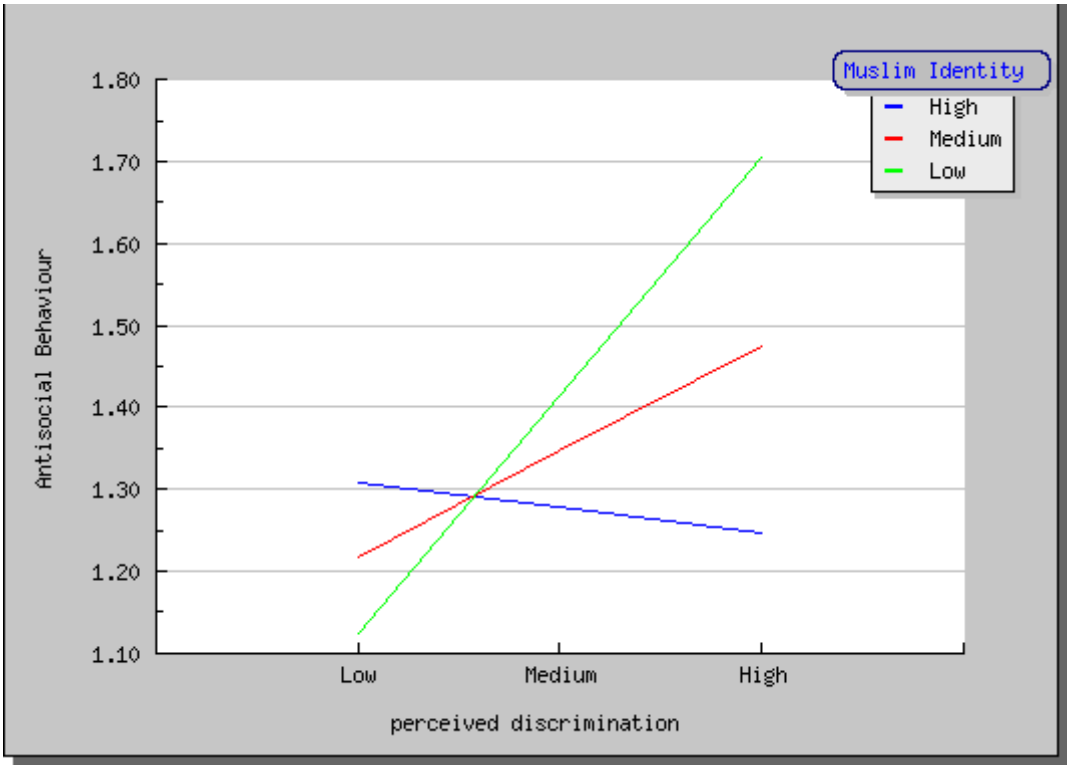
*p < .05, **p < .01

Behavioural Problems

Discrimination was associated with more behavioural problems (ß = .27, p<0.01) in step 1. Although steps 2 and 3 of the regression analysis did not further explain a significant amount of additional variance, a strong Muslim identity (ß = -.22, p<0.05) predicted fewer behavioural problems on entry, and a significant interaction was found between perceived discrimination and Muslim identity (ß = -.23, p<0.05). The model accounted for 19.2% of the variance in behavioural problems.

Figure 2 depicts the interaction effect, which shows that a strong Muslim identity buffers the negative effects of perceived discrimination (slope t(111)=-0.38, *ns*). The negative impact remains, however, for youth with moderate (slope t(111)=2.07, p<0.05) and weak (slope t(111)=2.71, p<0.01) Muslim identities.

Figure 2
Muslim Identity as a Moderator of the Effect of Discrimination on Behavioural Problems



School Adjustment

Finally, discrimination also predicted poor school adjustment (ß = -.26, p<0.01); however, it lost significance once cultural identities were entered into the model. Muslim identity (ß = .33, *p*<0.01) predicted better school adjustment on entry. No interaction effects were found. This model accounted for only 18.6% of the total variance of school adjustment.

These results suggest that all three dimensions of cultural identity exhibit some influence over positive adjustment in Muslim youth. A strong national identity is associated with increased life satisfaction, a strong ethnic identity predicts positive life satisfaction and a reduction in psychosomatic symptoms, and a strong Muslim identity is related to enhanced life satisfaction and school adjustment and protects against the detrimental effects of perceived discrimination on life satisfaction and behavioural problems.

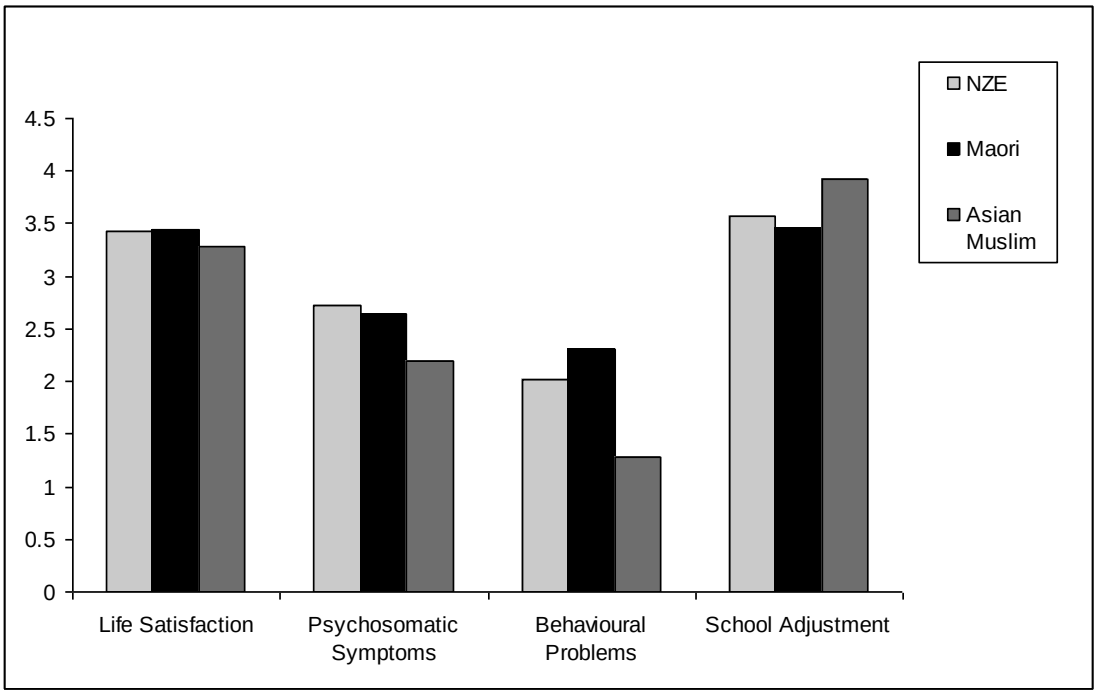
Adaptation in New Zealand Youth

Analyses of covariance were conducted to examine the effect of ethnicity on the four measures of adaptation, controlling for gender and age. Gender was significant for all analyses. Females reported more psychosomatic symptoms (*F*(1, 596)=9.09, *p*<0.005) and greater life satisfaction (*F*(1,596)=10.82, *p*<0.001), better school adjustment (*F*(1,596)=2.62, p<0.02) and fewer behavioural problems (*F*(1,596)=15.24, *p*<0.001) compared to males. Age

significantly impacted behavioural problems ($F(1,596)=5.97$, $p<0.02$), with a general downward trend in antisocial activities as age increased.

Figure 3 graphically depicts the difference in adaptation scores between the three ethnic groups. No significant difference emerged between the three groups on the life satisfaction scale, $F(2, 596)=2.27$, *ns).* Asian Muslims reported significantly fewer psychosomatic symptoms ($F(2, 596)=20.51$, $p<0.001$), fewer behavioural problems ($F(2, 596)=30.42$, $p<0.001$), and better school adjustment *(*$F(2, 596)=12.05$, $p<0.001$) than their New Zealand European and Maori peers.

Figure 3
Adaptation in New Zealand Youth



DISCUSSION

This research aimed to investigate the effects of discrimination and cultural identity on the psychological and socio-cultural adaptation of Asian Muslim youth in New Zealand. Results demonstrated that cultural identity exhibited a positive influence on adaptation, and Muslim identity in particular buffered the negative impact of discrimination. Results also indicated that Asian Muslims are adapting as well as, or in most cases, better than, their New Zealand European and Maori peers.

The ICSEY project conducted by Berry et al. (2006) presented strong evidence that an integration approach to acculturation, maintaining both ethnic and national identities leads to better adaptation outcomes. While there is some evidence in this study to support these findings, the introduction of religious connection as a third dimension of cultural identity generated a different trend. Muslim and ethnic identities typically facilitated adaptation, and Muslim identity

emerged as the only significant moderator of the detrimental consequences of discrimination. The effects of national identity on adaptation, however, were marginal.

The processes by which Muslim identity contributes to psychological and social wellbeing remain to be explored; however, parental influences on the development of identity are likely to play a key role. Immigrant parents must make choices about the core values to transmit to their children, and it has been suggested that religious parents often choose to prioritise the maintenance of religious over ethnic identities (Ross-sheriff, Tirmazi & Walsh, 2007). This has been borne out in research by Stuart, Ward and Adam (in press), which shows that Muslim identity is stronger than both ethnic and national identity in Muslim youth. Consequently, a strong Muslim identity may replace the positive influences that most immigrant youth derive from their ethnic identities.

The unique positive impact of religiosity in youth may also contribute to the outcomes. Van Dyke and Elias (2007) found that religiosity increased resilience in youth as it provided them with a higher purpose in life and encouraged forgiveness and abstinence from harm. In the case of Islam, the concept of staying on *'as-sirat al-mustaqeem'* ("the straight path") is heavily emphasised (Zine, 2001). A devout Muslim would recite a plea for this in their prayers at least 17 times a day, acknowledging both the struggle to stay on this path, and the blessing attained if achieved. This higher purpose can help attain a sense of tranquillity with one's worldly situation, as believed to be promised by God if His laws are correctly followed.

In conclusion, despite facing the challenges of acculturation and discrimination, Asian Muslim youth in New Zealand adapt well, and a strong identity as a Muslim facilitates this process. The protective functions of a Muslim identity highlights the importance of immigrants being encouraged to maintain their cultural and religious practices and ensuring that New Zealand remains a tolerant and inclusive society in the face of increasing diversity.

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Interpersonal violence against Chinese immigrant women: integrate coping-focused cognitive behaviour approach and multicultural counselling

Qing (Quin) Tang & Pablo Godoy

Abstract

The existing research on interpersonal violence in Asian immigrant population has supported a multicultural and interdisciplinary framework that stresses cultural sensitivity and responsiveness as well as therapeutic flexibility and compatibility. Substantial empirical research has supported the efficacy of Cognitive Behavioural Therapy (CBT) in the treating of the effect of relational trauma on the victims. Although there are a number of studies reporting to the integration of CBT to Asian culture orientated approach for Asian populations. This study is to explore the integration of CBT, specifically using coping focused strategies, along side of a Multicultural counselling (MC) approach. The combination of these therapeutic modalities will be applied specifically for intrusive thoughts or imagery relating to traumatic events experienced by Chinese immigrant women. To the writers' knowledge, study on this particular area has not been reported. Two case examples are used to illustrate the use of coping focused CBT techniques to draw out the clients' own solutions and resources that are relevant within their own cultural knowledge and experiences. These case studies are based on clinical interviews and observations, and the evaluations of the counselling process. The clients are recent Chinese immigrant women who have experienced domestic violence and have engaged with our service in the last two years. In order to protect these clients' identity, we have selected common characteristics of presenting symptoms, the process and the outcome from those clients to make up these two case examples, and the clients' identifying characters are altered. The CBT coping techniques are outlined, key components of multicultural counselling are explained, and the assumption of this integrating approach is discussed. The counselling progress is presented in the following aspects: the referral sources, the brief background of the client, the nature of presenting issues, the intervention, the outcome, and the evaluation of the process. Combining coping-focused CBT and MC can offer some assistance to these population clients by helping clients to manage their intrusive thoughts or images within their circumstance. Further clinical research needs to be conducted.

Introduction

The phenomenon of interpersonal violence against women is well known to staff working at the Relationship Services. The consequence of interpersonal violence (or domestic violence) is devastating. In the last three decades, research on interpersonal violence has increased and a multidisciplinary body of knowledge has been developing, but finding a solution to this phenomenon is still elusive (James, 2008; Sampselle, Bernhard, Kerr, Opie, Perley, & Pitzer, 1992; Straus & Gelles, 1986). Interpersonal violence against women is a tragedy

regardless of the women's color, age, education level, and socioeconomic class (Green & Roberts, 2008; McKay, Rogers, & McKay, 2003). In this study, we selected two clinical cases from the recent Chinese immigrant battered women.

Background

Since the 1990s, the population of Asian immigrants in New Zealand has grown rapidly, from 5% in 1996 to 9.2% in 2006. Among the Asian population, Chinese immigrants have made up the largest subgroup (147,570), followed by Indian (104,583) (Statistics of New Zealand, 2006). This rapid growth in the Chinese immigrant population is associated with a growing challenge to the public health sector. Owing to culture-bound values, language barriers, cross-national relocation processes, and immigration adjustment, Asian immigrants often face enormous difficulties when they need to access to or utilize the western-oriented mainstream services (Sue & Sue, 2008). In this context, Asian health issues can be unique in their own right, and deserve attention from health-care providers and policymakers. There is a need to develop evidence-based knowledge and delivery of the best practice for this population. However, research on health-related issues and wellness in immigrant populations is limited in western countries, even more so in New Zealand (Abbott, Wong, Williams, Au, & Yong, 1999). There is no clinical research on counseling surviors of interpersonal violence in recent Chinese immigrant women in New Zealand.

The East meets the West

Counseling Asian clients raises a question of compatibility of two worldview systems, the East and the West, or, generally, collectivism versus individualism. Existing literature has reported the possibility of integrating Western-oriented psychotherapy to Eastern traditional healing practices derived from major Asian schools of thoughts, such as Confucian (Heqin, 2005), Daoist (Heqin, Young, Tseng, & Zhou, 2005) and Buddhist (Chang & Dong-Shick, 2005). Specifically to CBT, research suggests the applicability of CBT to the Chinese population with some modification and adaptation in order to suit the Chinese cultural worldview (Chen & Davenport, 2005; Foo & Kazantzis, 2007; Hodges & Oei, 2007; Hwang, Wood, Lin, & Cheung, 2006; Lin, 2001). To treat trauma-related symptoms in relational violence in Western survivors, research supports the efficacy of CBT (Bryant, 2000; Green & Roberts, 2008). However, there is no literature on using CBT to treat Chinese immigrant female survivors of interpersonal violence. Therefore, this study is to report our work with two recent Chinese immigrant female survivors of interpersonal violence in which we used combining coping-oriented CBT (Tompkins, 2002) and a MC approach to work with the clients on trauma-related symptoms reduction. In the context of working with minority ethnic clients, it is unethical if the chosen approach or treatment modality is delivered in a purely clinical fashion. Thus, combining a MC approach with a particular treatment modality or eclectic approach was thought to be a more culturally sensitive and responsive practice (Arredondo & Arciniega, 2001; Ivey, Ivey, & Simek-Morgan, 1997; Pedersen, 1991, 2000; Sue & Sue, 2008).

CBT and MC

CTB was developed in a Western cultural value system in the late 1960s, reflecting an individualist worldview, it is largely outcome-based (Ivey, Ivey, & Simek-Morgan, 1997; Satterfield, 2002). The implication in counseling work is that a client would retain personal responsibility and accountability in the counseling process and outcome, could experience shame and guilt when the presenting problem is not managed well, may conceptualize help-seeking behavior as a personal failure, view an interdependent relationship as a sign of personal weakness, and blame the self for situational difficulties (McCarthy, 2005). MC was developed in the 1970s in response to concerns over the use of western-oriented psychotherapy and counseling with non-western clients. MC advocated integrating cultural factors into the established counseling body (Sue, 1978; Pedersen, 1988; Sue & Sue, 2008). MC, called a *fourth force* in counseling (Pedersen, 1991), asking professionals to develop multicultural *awareness*, *knowledge*, and *skills* in their research activity, training, theory-building, and practice (Sue, Arredondo, & McDavis, 1992). In contrast to standard psychotherapy and counseling practice, MC counselors may do considerable self-disclosure, presenting him/herself as a person more than a professional, giving advice when clients ask for it, accepting small gifts, socializing with clients outside the counseling setting, actively engaging in an advocate role, and having the flexibility to shift from the counselor role to being a helpful and active member in the ethnic community in line with cultural expectation (Roysircar, 2008; Satterfield, 2002; Sue & Sue, 2008).

The case studies

There are four objectives we attempt to achieve in this study. Firstly, to present the usefulness of combining CBT coping techniques and the MC approach with Chinese immigrant battered women. Secondly, to demonstrate those critical moments in the counseling process that lead to symptom reduction and tangible improvement in the clients' function. Thirdly, to discuss possible ways to help the clients cope with their circumstance when they do not wish to leave their batterers. For example, in a Hong Kong women's safe house, about a half of the Chinese women return to their batterers (Chan & Brownridge, 2008), and in a study of battered wives in rural Mainland China, the researchers found that *battered women never use divorce as a way out* (Liu & Chan, 1999). Finally, it is our desire to act as a voice for those clients who are not ready to speak up for themselves about their experiences of interpersonal violence.

In order to protect our clients' identification, we have made some alteration in the description of the referral process, assessment, and any other information that may indicate their identities. The interviewing process was introduced with a focus on those critical moments of change in the clients. The evaluation was based on the clients' feedback in the session, and discussion from clinical supervision. The total counseling sessions for each client were twelve (a protected person program we used which is presented in Appendix A).

The list of CBT coping skills (Edelman, 2007; Ivey, Ivey, & Simek-Morgan, 1980; Kazdin, 2001; McKay, Rogers, & McKay, 2003; Resick, Monson, & Rizvi, 2008; Tompkins, 2002) and MC skills (Arredondo & Arciniega, 2001; Berg-

Cross & Takushi-Chinen, 1995; Cheatham, Ivey, Ivey, Pedersen, Rigazio-DiGilio, Simek-Morgan, & Sue, 1997; Sue & Sue, 2008) we have used.

CBT coping skills	• Stress inoculating • Progressive muscle relaxation • Breathing control • Imagery • Self-monitoring of thoughts, feelings, behaviors • Adaptive self-statement • Cognitive restructuring • Homework • o Evidence-based argument o Thoughts as hypotheses instead of as conclusions • Self-control • Situational exposure hierarchies
MC skills	• Communicating a holistic view • Being aware of individualism vs collectivism • Understanding of key concepts in relationships o Saving face o Relational harmony and hierarchically relating o Family loyalty o Family face vs individual grievance o Collective identity o Extra assurance about confidentiality o Acknowledging counseling is a Western-product o Validate immigrant experience o Check out with clients about possible cultural barriers or misunderstanding and accepting their suggestion o Familiarity with clients' tendency to use physical discomfort to express psychological pain o Exploring traditional healing in the clients' culture, including Spirit and cosmos o Putting Chinese cultural symbols in the interviewing room o Providing small practical assistance, such as reading a letter in English o Taking extra time to listen to the Chinese style of talking: getting-around- the-point, not- getting- into-the point

Case one

Client A was a 45-year-old female who was a recent Chinese immigrant with a tertiary education in her country of origin. The client spoke little English, and apart from her husband, had no other family locally. The incident that initially brought her into counseling was the recent physical assault by her husband, which involved the police and the Judicial system. At the initial interview, Client A reported suffering from intrusive thoughts and images, nightmares, and an intense fear of being alone.

Session one: Introduction and safety plan

Confidentiality and its limitation were explained, an immediate safety plan was discussed, and the coping-oriented CBT was identified as the therapeutic modality, along with the MC approach. The rationale for choosing these approaches was presented, and the client's cultural needs in the counseling context were checked and explored. The client wanted to use the session to ventilate her grieving experiences of her marriage in the immigration context. This need was also found in western battered women, they prefer to ventilate their emotional pain in the early sessions, and then working on the presenting issues (James, 2008).

Session two: Identified the focused topic/s

1. The client's multiple situational stressors were acknowledged, and her coming for counseling was reframed as her strengths
2. To keep the work on the track, being clear, and staying-focused, *sorting issues* (Munro, Manthei, Small, 1988) was introduced. Client A has chosen to work on alleviating her levels of acute distress
3. Strengths-based (Barrett, Chua, Crits-Christoph, Gibbon, & Thompson, 2008). To find internal resources and strengths, Client A was asked to retrieve some of her memories that might bring her a sense of safety, comfort, and relaxation, and then she was guided to write down a short coping statement
4. Homework: wrote down more short statements
5. The client was responsive to developing coping skills

Sessions three-four: Explored the client's distress

1. The counselor used a scale of 0 to 10 (0 was the lowest and 10 was the highest level of distress) to monitor the changes of the client's level of distress and her degree of tolerance to the distress. The intention was to give the client some control over the pace of the process
2. Client A was encouraged to use her own short statements to help her cope with the distress when she felt the scaling point was getting higher
3. Client A described her repeated and persistent thoughts and images, and she

rated a 9/10 on the scale of feeling fearful and powerless, the 10 was the greatest fear and powerless

4. To challenge the client's irrational thoughts, she was asked to identify people who have been un/supportive of her since the incident occurred. This process involved using Socratic questions (Edelman, 2007) to find dis/confirming evidence, which prompt her develop alternative perspectives
5. Homework: the client was invited to write down more short self-statements on the paper when they came to mind

Sessions five-seven: Manage anger

1. The counselor introduced an anger log strategy (Holtzworth-Munroe, Rehman, Marshall & Meehan, 2002; McKay, Rogers, & McKay, 2003). The client was invited to develop alternative responses to anger signs
2. Homework: practiced the log and those alternative responses
3. The client was willing to practice the new anger-management skills between sessions

Sessions eight-ten: Educational focused

1. Talked about the cycle of violence and power/control in the intimate couple context (James, 2008)
2. Raising awareness of non-violent relating
3. Provided information of social services and resources
4. Home work: practiced alternative coping skills

The eleven-twelve: Enhancing adjustment in the immigrant context

1. Examined interpersonal violence in the cultural context
2. Complimented personal strengths
3. Helped the client identify the protective factors and the risk factors (Olson & DeFrain, 2000)
4. Introduced the local social and health services
5. Review the counseling work

The evaluation of the supervisor and the interviewing counsellor

1. As the client did not want to leave the batterer, the treatment goal was to help her develop coping strategies and skills within her circumstances. We promote and advocate non-violent relationships, but we would not take over the client's personal choices and responsibilities (James, 2008)
2. Client A has to face multiple problems which were beyond the scope of counseling work. We decided to stay focused on symptoms reduction and increasing day-to-day functions
3. There is an additional task often occurring when working with minority ethnic clients, counselors are expected to play multiple roles (Sue & Sue, 2008).

4. The client and the counselor could have had a pre-counseling session to prepare the client for the counseling process in relation to cultural and language barriers.

Case two

Client B was a 26-year-old Chinese female who has recently immigrated to New Zealand; she spoke little English, and knew few people locally. The client stated that her husband threatened to withhold an application for permanent residency if she violated his rules. The event which brought her into counseling was a recent physical assault by her husband. The incident led their neighbors to make a call to the police. Client B reported her experiences of intrusive thoughts and images consisting of fear of going out and meeting people, and has often been woken up by nightmares.

Session one: Introduction and safety plan

1. The confidentiality and its limitation were explained, an immediate safety plan discussed, the coping-oriented CBT procedure was identified as the most appropriate therapeutic modality, along with the MC approach, the rationale for choosing this approach was presented, and Client B's cultural needs in the counseling context were checked
2. Homework: the client was asked to think what small steps she could take to improve her day-to-day function

Sessions two-three: Identifying the focused topic/s

1. Normalized the difficulties in relation to immigration, complimented the client's effort to come to the counseling. *Sorting issues* was introduced. The client wanted 1) to deal with her nightmares and 2) to feel safe in public
2. Explored her distress while searching for coping strategies
    a. A 10 points scale was used to measure her level of feeling intense fear and anxiety when she was going out (0 indicated a low level of distress, 10, the highest). At the beginning of the session, the client rated herself a 9/10
    b. The client was asked to visualize herself in an outdoor place, the client stated that seeing the color of blue sky made her feel relaxed and safe
    c. Furthermore, the client stated that she would wear a thick grey uniform and a cap that was for the Justice Department Officers in her hometown
    d. The client was invited to think of herself in the uniform then commence with self-talk. She repeatedly said '*I am not scared of you'.* At this point, she rated herself from the 9/10 down to the 6/10 on the scale of feeling intense fear and anxiety
    e. Homework: invited the client to try to go out for a short time while thinking of the coping skills discussed in the session.

Sessions forth-five: Developing coping skills and challenging unhelpful thoughts

1. The client reported that she has ventured out for a half hour period. In the past, she said that she would often walk out of the gate, then go back.
2. The client described her internal experience of being woken by her nightmeares. Initially breathing and progressive muscle relaxation exercise skills were introduced (Davis, Eshelman, & M^{c}Kay, 2000) to cope with the nightmares. The client then said that these techniques made her think of Qi Gong, a traditional Chinese therapeutic exercise
3. Homework: Client B decided to start doing Qi Gong every evening and morning

Session six-eight: Managing intense anxiety and feeling of fear

1. The client was invited to describe her experiences of anxiety and feelings of fear, using four columns to category the trigger event, thoughts, feelings, and action tendency (Kazdin, 2001)
2. When the client started noticing signs and symptoms related to anxiety, she would take a deep breath or count, imaging the color of a blue sky, doing Qi Gong
3. Home work: Practiced the four columns and the coping skills
4. The client reported that she felt hopeful as she has found something she could do to manage her distress

Sessions nine-ten: Complicating cross-cultural issues

1. Since her case got involved the police, the client has been blamed by her family for making her family losing face
2. The counselor explored with the client possible solutions that might be considered culturally acceptable in her circumstance
3. The counselor explained to the client that couple counseling was not a safe option in a recent interpersonal violent situation. The batterers were mandated clients to take stop-violence program (McMaster, 1998) under the judicial system.
4. The counselor provided information about the local community services
5. Homework: Continued practicing Qi Gong

Sessions eleven-twelve: Develop relating skills

1. The counselor then invited the client to examine her views about her role in a relationship
2. The client described herself as a little girl wanting to be cared for and protected by a powerful authority figure. The counselor reminded the client of that grey uniform, a powerful authority figure that she created in the previous session
3. Review the counseling work
4. Homework: brainstormed self-support behaviors

The evaluation: The interviewing counsellor and the supervisor

1. The counseling has assisted the client to achieve her counseling goals-going out and managing her anxiety and nightmares
2. As the client would not want to leave the batterer, the counseling has assisted the client develop coping skills

Conclusion

As this was a case studies report, we could not make any generalization to a wider population of recent Chinese immigrant battered women. We could suggest that combining coping-oriented CBT with a MC approach has assisted these two clients to reduce their trauma-related effect of interpersonal violence. Owing to the clients' circumstances, developing coping strategies was considered to be practical and achievable goals. The challenge to this counseling work was to bridge the Western individualism and the Eastern collectivism for working with survivors of interpersonal violence.

The limitations of these case studies include 1) the counseling process is a kind of foreign experience to the clients, and its focus on a specific presenting problem seems hard to comprehend for the clients holding a holistic view; 2) the counseling room is a virtual reality to the clients, we would not know how much those coping strategies we discussed in the session could be transferred to their home environment where the interpersonal violence has occurred; 3) the counselor needs to develop skills with both clinical and soci-cultural processes, along with multiple roles. The future research on combining CBT and MC to battered minority ethnicity women who do not want to leave their abusers needs to look at both strategic and technique levels on counseling session management, counseling process, and outcome.

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Appendix A

Stage one with the Respondent:	***Stage one with the Protected Person:***
As a result of a Protection Order the "Respondent (the perpetrator of the abuse)" is *required* to undergo a facilitated programme either individually or within a group. This programme upon completion would have ideally targeted a number of variables that relate to reducing the risk of further abusive behaviour, not only within the dynamics of the intimate relationship, but to all relationships within the person's life.	As a result of a Protection Order the "Protected Person (the victim of the abuse)" is *invited* to undergo a facilitated programme. This programme upon completion would have ideally targeted a number of variables that relate to reducing the risk of further abusive behaviour, not only within the dynamics of the intimate relationship, but to all relationships within the person's life.

Stage two with the Respondent:	***Stage two with the Protected Person:***
However, as much as said programme attempts to engage with, and support a person towards an abuse free lifestyle, the programme at times may not shift a person enough to allow for safe and effective relationship counselling to take place. Therefore, an assessment of a person's learning around their abuse behaviour should take place. This assessment includes looking at key factors such as relevant safety plans (which should include safety of children), empathy towards others (particularly towards their victim(s), including children), taking responsibility for self management, identification of precipitating variables, insight into power and control, and motivation to maintain gains along with motivation to address issues within the person's intimate relationship. Ideally a good emphasis on behavioural evidence is	However, as much as said programme attempts to engage with, and support a person towards an abuse free lifestyle, the programme at times may not be attended by the person due to a number of factors as it is in nature an invitation as opposed to a requirement. However, if they are motivated to attend Couple Counselling then an assessment of a person's understanding of their abuse should take place. This assessment includes looking at key factors such as relevant safety plans (which should include safety of children), insight into power and control, development of support networks, motivation and rationale to address issues within the person's intimate relationship. The assessor in this case maybe the facilitator of the programme, and if not then should be conducted by a

required to ascertain where consolidation has been achieved and to also identify gaps in the person's learning. The assessor in this case would not be the facilitator of the programme, but should be conducted by a senior DV programme provider. The assessment will look at a number of avenues to derive a picture of the Respondent learning including talking to the DV facilitator, reviewing case files, interviewing the respondent, and having conversations with the Clinical Leader.	senior DV programme provider who is authorised to work with Protected Persons. The assessment will look at a number of avenues to derive a picture of the Protected Person's learning including talking to the PP facilitator, reviewing case files, interviewing the respondent, and having conversations with the Clinical Leader.

Stage three (a) with the Respondent: If the Respondent has been found wanting in any of the aforementioned key factors then addressing these issues will take priority until such time that the assessor feels able to proceed the case to the next step. ***Stage three (b) with the Respondent:*** If the Respondent has been found to have attended to the key factors appropriately, then an experienced couple counsellor whom also holds DV facilitation authorisation will then be allocated to work with the couple.	***Stage three (a) with the Protected Person:*** If the Protected Person has been found wanting in any of the aforementioned key factors then addressing these issues will take priority until such time that the assessor feels able to proceed the case to the next step. An example of this could be that the person may not take sufficient steps to ensure the safety of the children, or that the incidents of abuse may have resulted in the need for the person to engage with a counsellor to work on issues related to trauma. Trauma related to abuse is typical in such cases and if left unattended may impact on the person's life to such a degree that any couple work may re-traumatise the person. ***Stage three (b) with the Protected Person:*** If the Protected Person has been found to have attended to the key

	factors appropriately, then an experienced couple counsellor whom also holds DV facilitation authorisation will then be allocated to work with the couple.

Couple Counseling:

From here contracts and scope of work is negotiated between the counsellor and the two parties within the relationship. The contract will have a strong emphasis on risk management, both within the counselling sessions and within the life of the couple outside the sessions. There maybe a need for either one, or both parties to continue their individual work in parallel to the couple work for the purpose of having a safe space to reflect on or work through individual issues raised within the couple sessions.

Managing bipolar illness in a multicultural environment

Grace Wang

ABSTRACT
In New Zealand, 1 in 200 of the population suffers from some form of bipolar disorder (BD). Over the past decade, Chinese immigrants have made up an increasingly significant percentage of New Zealand's population. One consequence of this increase in migration has been enhanced incidence and admission rates for psychotic disorders for the Chinese cohort. Interestingly, there is no available data of prevalence of BD among Chinese or Asians in New Zealand. Recent studies have suggested that self-management strategies can play a key role in determining psychosocial outcomes. The aim of this paper is to explore how New Zealand Chinese with BD cope with their illness.

INTRODUCTION

Bipolar disorder (BD) is a relatively common psychiatric illness characterised by recurrent depressive episodes of low mood and distinct abnormally elevated mood (Belmaker, 2007). According to the World Health Organization (2004), BD is among the 20 leading causes of disability. In New Zealand, 1 in 200 of the population suffers from some form of bipolar disorder (Browne, Wells, & Scott, 2006). Traditionally, advances in the medication management of BD have been encouraging. Indeed, medicines such as lithium, antipsychotics and valproate were and still are very effective for many individuals with BD. However, medication use can result in a wide range of unwanted side effects, such as fatigue, weight gain and substance abuse (Goodwin & Sachs, 2004). Even though people with BD adhere to a regular medication regimen, some individuals still have considerable impairment in working, family and social relationships. It has become increasingly apparent that psychosocial factors have a crucial role to play in the treatment of this condition.

Over the past decades, Chinese immigrants have made up an increasingly significant percentage of New Zealand's population. According to the 2006 census, the Asian ethnic group accounted for 9.2% of the total New Zealand population, the fourth largest major ethnic group in New Zealand after European, Māori and other ethnicities (Statistics New Zealand, 2007). In the Asian ethnic group, 45% of people identified themselves as Chinese. One consequence of this increase in migration has been enhanced incidence and admission rates for psychotic disorders for the Chinese cohort (Abbott, Wong, Giles, Wong, Young, & Au, 2003; Rasanathan, Ameratunga, & Tse, 2006; Wheeler, Robinson, & Robinson, 2005). Interestingly, there is no available data of prevalence of BD among Chinese or Asians in New Zealand. The aim of this study is to explore how New Zealand Chinese with BD manage their condition to maintain and regain wellness by using self-management techniques.

METHODS

Given that the aim of the present research was to understand how people cope with the illness, a qualitative approach was considered appropriate. The qualitative researcher aims to develop an understanding of meaning and experiences of human's lives and social worlds (Fossey, Harvey, McDermott, & Davidson, 2002). The participants were selected according to the following criteria: 1) identified as New Zealand Chinese; 2) residing within the Auckland area; 3) aged 18 years or above; 3) reported by case managers to have a diagnosis of BD type I or II; 4) have a minimum global score of 2 on the Multidimensional Scale of Independent Functioning (MSIF). A total of nine participants took part in the study. Two participants were born in New Zealand and the remainder in China - Hong Kong and mainland China. Clinical and demographic details for the sample of people affected by BD are presented in Table 1.

The deliberate sampling method was used in this study to select people who are information-rich in relation to the research questions. In this study, it was proposed that individuals who have years of experience in coping with BD would have greater knowledge of the application of self-management strategies, which is the main focus of the study. Thus, the researcher initially approached relevant mental health services to identify the availability of potential participants. Subsequently, the researcher met with the relevant case managers or support workers and explained to them the purpose of the study and asked them to invite the potential participants to the study. Once verbal approval was granted by those potential participants, case managers or support workers gave their contact details to the researcher, and the researcher contacted them to arrange a time and place for an interview. All interview fieldwork was conducted after full approval from the Northern Region X Ethics Committee and the respective District Health Board.

Table 1.

Demographic and Clinical Characteristics of the Sample (n=9)

Demographic and Clinical characteristics	Number
Gender	
Female	5
Male	4
Age	41±12 (20-56)[a]
Age at first diagnosis	30±9 (14-41) [a]
Years with illness	10±6 (4-22) [a]
Employment status	
Part-time employment	3
Part-time student	3
Housewife (looking after dependent children)	1
Unemployed	2
Number of hospitalisations	
1-2	6

3-5	2
6	1

[a] Number shows Mean, Standard Deviation and Range (years)

The semi-structured interview was the main method for collecting data. Prior to commencing the interview, signed consent was gained from all participants. The interviews took place in a venue nominated by the participants that was most convenient for them. The interviews were carried out in either English or Mandarin according to participants' preference and usually lasted between 60 and 75 minutes. The researcher is fluent in both English and Mandarin. With participants' permission, a tape recorder was used to record the full dialogue and also notes were taken. Four participants refused to have their interview taped, thus extensive notes were taken. During the interview, participants were encouraged to talk openly and freely regarding their recovery experience. The researcher asked a set of questions designed to explore participants' experiences and thoughts regarding the self-management techniques used to regain or maintain wellness. Prompt questions included: "Could you describe what's going on in your life when you're feeling well?" "How do friends, family and co-workers affect your ability to stay well?" "How do you know it is the right time to start using self-management strategies?" The exact patterning of questions varied across the interviews depending on the participants' response to each question.

Four follow-up interviews were conducted with the participants whose responses in the first interview needed further exploration. The questions in the follow-up interviews were developed specifically for participants in relation to a preliminary analysis of the initial interview. Furthermore, the researcher double checked the accuracy of general themes that emerged from the initial interview with participants.

Data analysis focused on identifying content themes and patterns in the notes, which were checked against audio commentaries and notes from the interviews. The study used an in-depth and inductive approach as outlined by Ulin, Robinson and Tolley (2005), which included the following steps :(i) Reading: the process begins with reading and re-reading the transcripts to gain an overview of emerging themes raised by participants. (ii) Coding: the process begins to attach particular codes to the chunk of text that represents those themes. (iii) Displaying: once the transcripts have been coded, each thematic area is explored in detail through displaying the information relevant to each category. (iv) Reducing: reducing the information to its essential points.

FINDINGS

The findings are reported as a sequence used by Williams and Irurita (1998). Firstly, a label for the category is identified. Then, the meaning of the category is described. Subsequently, quotations from the raw text to elaborate the meaning of the category and to show the type of text coded into the category are displayed. All the participants' names were changed and reported here as pseudonyms.

Defining 'functioning well' in different ways

'Functioning well' is sometimes used to describe 'wellness'. Participants' comments reflected their recovery focus and the need to achieve the recovery. In this group, people had different understandings about what would be good for them and what they really wanted. The concept of 'functioning well' was frequently related to personal feelings and experience. The majority of the participants believed 'functioning well means feeling happy'. Happy was described by the present participants as an internal sensation, which related to progress on recovery to pleasure of daily life and to physical health.

> 'To me, I have had the illness, so I would think of the time not illness. I would hope that I could regain wellness. Considering my current recovery, I feel happy. I think functioning well is a feeling of being happy from inside.' (Jun, male, early 30s)

> 'It ('functioning well') means happy, feeling pleasure of the life, happy is health.' (Zhi, male, 40s)

Moreover, functioning well is associated with being relaxed, being able to develop social relationships, having a free choice in one's personal life, being mental stable, and being independent. Participants strongly emphasised the importance of mental health in relation to functioning well.

> 'Functioning well means both physical and mental health. Sometimes people feel well physically but not mentally, which means they are actually in the status of ill. Indeed, mental health is more important than physical health.' (Bei, female, 50s)

> 'Mentally healthy mean being in a really stable state that is a healthy mind and I think it ('functioning well') is more about mental health.' (Hua, female, 40s)

Although the importance of mental health was mentioned by most of the participants, symptom remission was not necessary associated with functioning well. Several participants strongly believed, "functioning well was not equal to being perfect or symptom free".

> 'It ('functioning well') does not mean 100 percent recovery. Even in the normal people, they may have some psychological problems. For example, when there was something wrong with me, I may need doctors' support and people's help. But with the progress of recovery, this need becomes less and less and the situations I can deal with more and more.' (Jun, male, early 30s)

Finding a source of hope

Sense of hope fosters the essential desire to survive and the need for self-care, which was consistently perceived as a central aspect of self-management by

many of the participants. Given the recurring, chronic, and episodic clinical characteristics of BD, many participants reported that experiencing relapse is the biggest challenge for their sense of hope and the process of rebuilding sense of hope is very difficult. All nine participants mentioned having various support systems in their recovery, and family support was considered as the most important to most of them. Thus, when they had problems in their daily life or experienced episodes, family members were approached first.

> 'When I am in difficult situation and want to give up, my family would encourage me by saying "you can do it". Their support makes me keep going.' (Hua, female, 40s)

> 'The most important person is my sister. She is always my support. She tried to understand my illness and helped me mentally and physically. '(Jun, male, early 30s)

Spiritual belief helps individuals find their sense of hope. In the present study, for those participants with Christian faith, their religious beliefs and practices served as a valuable source of hope. There is a long debate in terms of the relationship between religion and mental health. The current study adds evidence to support the potentially positive link between religion and recovery from BD.

> 'I have Christian belief, I think God will be with me, he will not give up on me. So last time, I was supposed to stay at hospital for three month but I was discharged after one month, I felt that God saved me.' (De, male, 30s)

For others in the present study without religious beliefs, Chinese traditional philosophy serves as a source of hope. Hope was expressed by the participants in the form of following their perceived notion of fate as a guidance mechanism, for example, "Time will heal the wound", "time will solve the problem". The participants with this belief tended to accept their conditions with a neutral attitude and were able to keep a sense of inner peace and calamity. In their view, patience is important to deal with the stress and frustration caused by recurrent episodes and helps to sustain their motivation for achievement.

> 'I tell myself that the sun will rise from the east, tomorrow is another day, be tough... I believe time will solve problems, I would not like this forever, I will be fine, I can go to university and go to work like normal people. Even if I have this illness, I still have a healthy body, I can do a lot of things.' (Fen, female, early 20s)

In contrast with the focus of symptoms remission in the clinical outcome, progress in recovery in patients' perspectives is more about personal feeling of being able to manage the illness.

> 'I know I get better every step, I am slowly getting better. The first time I was in hospital, I didn't know about bipolar. The second time, I knew a little bit and I became more relaxed and easier.' (Jun, male, early 30s)

Adhering to medication regime

All nine participants acknowledged the importance of taking medication. In their view, non-adherence to medication was significantly related to relapse. However, some participants still failed to take medication as prescribed. The most salient factor related to medication adherence found in the present study is the relationship with doctors. The majorities of the participants went to see Chinese psychiatrists and were professionally linked with Chinese social workers. Meetings with health professional have been described by the participants as forms of interpersonal interactions. They described that health professionals not only prescribed medication, but also tried to help them deal with life issues by listening to their life stories and offering advice.

> 'I went to see my doctor. I was often plagued by what my daughter did. I talked it out to him (my doctor). Certainly he couldn't help me out every time but he could listen to me. Sometimes he gave me advice too, telling me where to seek help.' (Jie, female, 40s)

With a deep feeling of trust and respect towards their doctors, the participants felt more positive towards using prescribed medication and believed that the doctor would eventually reduce the dosage of medication.

> 'Medication always leads to side effects. The best way to deal with it is to talk to your doctor. Doctor will help you to find suitable one for you. I had this experience before. I could not do anything when I took one medication. Then I told my doctor and he changed another one to me. Now I don't feel any strong side effects and it works.' (Bei, female, 50s)

However, when the participants in the present study saw Western health professionals, their attitudes towards medication were more related to perceived efficacy of treatment. Some participants stated that their doctor just knew about prescribing medication but did not know how to treat them. There are traditional Chinese health beliefs that Western medication is more effective in the acute stage of many diseases, but not for chronic conditions and also it works much faster than traditional Chinese medicine, but with more adverse side effects

(Chan & Parker, 2004). Thus, when the symptoms were not serious, Western medication was usually avoided.

> 'No doctor can cure me. During those years, I had to rely on myself to find way to deal with my illness. Recently I started to take some health products. It is very helpful. I cut half of my medication but I still feel ok. In the past, I probably would have relapse.' (Ping, female, 40s)

> 'You have to rely on yourself for most things. The doctor only asks you take pills, which makes you feel dizzy and give you a headache. Medication should not be taken too much, it only plays a role as an aid.' (Jie, female, 40s)

Maintaining harmony with others and oneself

Many participants considered having conflict with others as a main source of stress in daily life and expressed their willingness to be more understanding, helpful and kind to others as they expected that being harmonious with nature and others would benefit their health. As a result, participants had learnt to adopt the attitude of "take it easy", and "look at things from others' shoes" to deal with life issues.

> 'Going through many times of relapses has changed my world-view and belief a lot. In the past, I took money very seriously and wanted to do a lot of things. Now I took things easier. I started to put myself in others' shoes and look at things from other peoples' perspective. I tried to do meaningful things as much as I can……I also became more understanding of others and stop forcing others listen to me. For example, I contact my parents regularly and communicate with them better now.' (Zhi, male, 40s)

Furthermore, as a result of being ill, many participants experience important life changes such as changes in social status and income level, loss of one's social network, and greater dependence on family support systems and medications. Those changes inevitably stimulate the need for the participants to restore inner balance.

> 'Sometimes I go to hospital to visit old people. When I listen to their stories, I would find that what is the big deal about my illness, and then I would feel much better.' (Jie, female, 40s)

> 'I had my own business in China before coming to New Zealand. As I could not speak English, I could only find a job as a kitchen hand. After experiencing a few relapses, I decided to take better care of myself and not to take money seriously. Currently, I felt very relaxed staying at home doing gardening, cooking and housekeeping.' ((Zhi, male, 40s)

Reducing stigma associated with BD

Stigma can be either experienced or anticipated. Coping with stigma posed a big challenge to the participants in the present research. The majority of participants in the present research reported that anticipated and experienced stigma have negatively impacted on their self-esteem and social interaction. They described the experience of being treated differently after disclosing their illness.

> 'Chinese people find it hard to accept this illness. Some of my old friends stayed away from me, after knowing my illness, although we used to be very close. They thought I was worthless.'(Jun, male, early 30s)

Due to past negative experiences or expecting and fearing rejection, some participants became more vigilant and cautious when disclosing their illness to others. Avoidant coping strategies were commonly used, such as selective disclosure and withdrawal, particularly within Chinese communities.

> 'I have a friend who practices Chinese medicine, one day he saw me with red eyes and asked me what had happened. I answered that nothing, just I was in a bad mood, I have depression. He said that if I become physically violent when I am sick. His words made me very disappointed. He was a doctor but made such comment. Since then, I stopped to tell others. Also there are some Chinese friends, when they know my illness, they said that I was mad. Talking to them does not help me and they just laugh at me. Don't disclose the illness to Chinese people as they really discriminate against people with mental illness.' (Jie, female, 40s)

> 'My case manager suggested me to tell them that I have depression as people feel it easier to accept. Nowadays a lot of people have depression.'(Jun, male, early 30s)

Participants also described the difficulty of developing romantic relationships caused by BD.

> 'Because of taking medication every day, I could not find a boyfriend. Which man would like to see you take pills every day? Bipolar disorder affects the possibility of my marriage.' (Ping, female, 40s)

In contrast, there was no report of experiencing discrimination after disclosing the illness to Western people. Two participants who were locally born denied having experienced discrimination due to their illness and they appeared less concerned about others' attitudes towards their illness.

> 'My illness is not others' business, I don't have to tell everyone, but if they ask, I will tell.' (Li, male, 20s)

Stigma associated with mental illness may be shaped by culture and social context. One participant believed that stigma was actually about her own perception and described the attitude change she made after moving to New Zealand.

> 'We are Chinese we don't want to people know we are crazy, this is a problem I had when I was in Hong Kong. I hide from others. I didn't want them to know that I was crazy. Only here (New Zealand) after this episode, I am willing to say it aloud. I don't feel shame anymore. Especially here in New Zealand, there are lots of information and tools to help people with mental illness to speak up. Once you speak up, you get assistance, you will feel much better, when you are not scared of letting people know you, you will take treatment, you will take medication. That will help you to get well.' (Bei, female, 50s)

DISCUSSION

The majority of participants tended to adhere to Chinese language, living style, values and philosophies. Even in the case of the locally born participants, they are somewhat influenced by Chinese traditional values that were held by their family members. Recovery from the illness appears to be a self-balancing process. Passive and nature-oriented attitudes that involved 'not reacting vigorously' from New Zealand Chinese point of view followed the natural healing process. According to Western culture, this kind of 'passive acceptance' and 'emotional coping' are considered deconstructive, but seemingly assisted the Chinese participants to endure their suffering and develop a sense of hope when facing their hardship of being a person with chronic, recurrent illness.

Furthermore, an individual's mental health is invariably related to his or her family conditions. In contrast with the individualist orientation of European cultures, Chinese cultures are more collectivist. Family is regarded as a primary resource and used to manage stressful situations (Cheung, 1984; Cheung, Lau & Wang, 1984). The present study consistently supported this and showed that Chinese with psychological problems tend to seek support from their families and friends rather than professional help. As a result, some participants received little social support and less updated health information because their families were too busy or lacked knowledge in the form of illness management. Also, there was the potential risk for people not having family support at all as their family is not in the country. In this study, two participants have not had family support as their families are overseas. In fact, they may be the people who need most support.

The relationships with doctors played the most impacting role on the participants' attitudes towards medication. There is a strong need for facilitating the connection between health professionals and clients. Mitchell and Selmes (2007) reviewed recent studies on medication non-adherence and suggested that health professionals should facilitate a collaborative communication style and make a joint therapeutic plan with clients in order to improve satisfaction with medication and reliability of medication use. This may be of particular

relevance to Chinese clients given the Chinese traditional perception of doctor as authority figure. Furthermore, it would be useful for educating Chinese clients on how medication works and their side effects and interaction with other drugs. Chan and Parker (2004) suggested that medical professionals should provide accurate information about any medication, even if the patients appear uninterested. They also suggested providing pamphlets in Chinese to Chinese patients as some Chinese people are reluctant to raise questions about their prescription because acting like that may be regarded as posing a challenge to "authority".

Furthermore, Chinese people in general are more likely to value themselves through relationships with others. As a result, the connection with the Chinese community can be a 'double edge sword'. Both social and emotional support and mental illness stigma were rooted in the community. Peterson et al. (2006) argued that people with mental illness could gain the most support from their family and friends, but also the ones whose behaviour could hurt most. There is a need for improving health literacy in relation to Chinese patients and Chinese community. The discrimination from the Chinese community may become less and less with the community's improved understanding of mental illness

The study implied that there are complex and unique needs associated with Chinese immigrants recovering from mental illness. Fundamental to the facilitation of the recovery process is the acknowledgement that every Chinese immigrant is unique. The 'One size fits all' approach cannot apply to them. It is important to develop an understanding with respect to each of the client's own need. In order to meet their needs, it is necessary to develop culturally appropriate psychosocial interventions in the health service and to increase the cultural competence of Chinese mental health workers. Moreover, more resources and support are needed to facilitate Chinese community services so that relevant health information can be delivered more efficiently and effectively.

It is worth noting some of the limitations of this study. The qualitative analysis is based on a relatively small sample and is not intended to be representative of the larger Chinese population in New Zealand. In particular, the New Zealand Chinese are from a heterogeneous group which has a varied and geographically diverse immigration history. Further evaluation of the effectiveness of self-management strategies in improving psychological and social function and the effects of acculturation on self-management skills are recommended.

ACKNOWLEDGEMENTS

The author would like to acknowledge Associate Professor Samson Tse for his initial intellectual impetus and continued support to this study. This study followed the research protocol developed by Collaborative RESearch Team studying psychosocial issues in Bipolar Disorder (CREST.BD), established by Dr Erin E. Michalak in 2005, at the Michael Smith Scholar Mood Disorders Centre, Department of Psychiatry, University of British Columbia, Vancouver,

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Talking therapies for Asian people: Development of a best and promising practice guide for staff working in mental health and addictions services

Sai Wong, Patrick Au & Jenny Long

Abstract
Most talking therapy models and training in New Zealand is based on Western models of mental health. However Western models are not always consistent with the range of beliefs about causes of mental health or traditional helping practices of Asian communities. In the first half of 2010, Te Pou and a group of clinicians undertook consultation and a literature review to collate existing information about how to adapt talking therapy processes and models when working with Asian people. Therapist and expert opinion suggests that a range of talking therapies can be effective with Asian communities. It is recommended that talking therapy be adapted according to each individual's cultural and individual needs rather than cultural stereotypes. The guide will be made available at www.tepou.co.nz.

Introduction

The number of people who identify with an Asian ethnic group is increasing in New Zealand, and there is increasing awareness of the importance of cultural responsiveness for ethnic groups in New Zealand. Low rates of service access and therapist and service user comments suggest that Western models of talking therapy are not necessarily effective at addressing mental illness in Asian people (Chen & Davenport, 2005; Sue, et al., 2009; Tseng, 2004). Thus it is a matter of importance that culturally relevant and effective psychotherapy is available and delivered to people from diverse cultural backgrounds (Tseng, 2004).

Asian cultural groups are distinct; however, there are some overlaps in values, religions and norms across different groups. Most Asian cultures are collectivist and have a strong focus on the needs and interconnectedness of the community and family (Bae & Kung, 2000; Chan & Parker, 2004). Many cultures also include a concept of family allegiance or duty as a core trait (Tseng, 2004) and structured or hierarchical family systems are also common (Baptiste, 2005). Achieving educational and financial success is a common goal, particularly for migrant families (Baptiste, 2005; Kim, et al., 2001). Some Asian people also believe that hardships are part of life, should be tolerated and thus seeking help for emotional issues may be seen as a sign of indulgence (Tseng, 2004). Caution should be used in applying these generalisations to individual service users as there are a wide range of migration experiences, cultural practices, religions, communication norms and differences in the extent to which an Asian service person identifies with Asian values, or values that are common in New Zealand (Ho, et al., 2002).

In many Asian cultures, concepts of mental health are closely interconnected with physical health, and in some cultures, spirituality is also considered

inseparable from concepts of mental health (Tseng, 2004). As a result, symptoms of mental illness are often attributed to physical imbalances, spiritual curses, doing bad things in the past or not fulfilling family duties. Due to these attributions, many Asian people see value in pursuing physical and spiritual remedies to address symptoms of mental illness. Therapists and researchers often note a tendency for Asian people to present with physical rather than emotional symptoms of mental illness (Gater et al., 2009). High levels of stigma towards people with mental illness may also impact on the types of help Asian people would prefer to seek, with stigma and ill-feelings being closely aligned with mental health professionals and services (Jackson et al., 2008; W. Tseng, 2004). Again, beliefs about mental illness, experience of symptoms and help-seeking preferences vary between Asian cultures and individuals within those cultures.

A best and promising practice guide has been developed to support therapists to consider when and how to adapt therapy with Asian service users. This resource was developed by Te Pou with support from the Chinese Mental Health Consultation Services Trust and a range of therapists and other workforce development stakeholders. The guide is a starting-point for information about how therapies could be adapted and intends to be an adjunct to professional training around the use of talking therapies.

Method

Consultation with New Zealand practitioners who work with Asian communities and a literature review of the latest research literature and international expert opinion was used to *develop Talking therapies for Asian people: Best and Promising Practice Guide for Staff Working in Mental Health and Addiction Services*.

Literature search

A literature search was undertaken to identify research articles and academic opinion papers that relate to the provision of talking therapies to Asian service users. Synonyms for the various Asian ethnic groups, talking therapy types and talking therapies skills were used to identify relevant articles. The search focused on research published after 1995 and was limited to English language articles. One hundred and twenty papers were identified using the Web of Science search engine. The Google search engine was then used to identify further unpublished reports and information. Information from the literature review was used to draft the majority of recommendations presented in the above guide.

Consultation

The major round of consultation for this guide was managed by the Chinese Mental Health Consultation Services Trust (CMHST). The trust arranged focus groups and interviews in order to accommodate as many people as possible in the consultation process. A framework for the talking therapies document was drafted to support discussions during the consultation process.

Twenty five people were consulted in an initial round of focus groups and interviews. These 25 people included therapists with specialities in: adult mental health (15), child mental health (3), gambling (6), drug/alcohol (1) and marital/family (2). The professional background of therapists included psychiatrists (7), clinical psychologists (2), counsellors (9), clinical social workers (2), mental health nurses (2) and a psychotherapist (1). The ethnicity of those consulted included Chinese (17), Indian (3), Korean (2), Filipino (1), South-east Asian (1) and Japanese (1). Four further interviews were undertaken with New Zealand European (Pakeha) clinicians to ensure that their experiences and perspectives featured in the document. A convenience sampling method was adopted; the goal was to obtain a diversity of views from different ethnic groups rather than attempt to obtain a representative sample.

To expand and explore the consistency of the information from the first round of clinicians with other therapists, a further set of reviews and checks were undertaken. Three Pakeha clinicians who do a lot of work delivering talking therapies to Asian communities were also interviewed and the draft document was sent for review to by five therapists, a service manager, a service user and four therapists from the CMHST.

In many cases the most frequently used therapies reported by the consultation panel appeared to be the type of therapies most commonly researched. Furthermore, recommendations surrounding principles of engagement from the consulted therapists were also typically consistent with recommendations recorded in the research literature. Information from the focus groups, interviews and initial framework was integrated with information from the research literature. A draft guide was then sent out to the sector for feedback before this document was reviewed, finalised and published by Te Pou on www.tepou.co.nz.

Degree of available evidence

Much of the information available is practice-based evidence. There is little empirical research in New Zealand that relates to the use of talking therapies with people from Asian communities. The bulk of information available on talking therapies for Asian people is based on therapist opinion and service user feedback rather than empirical research. A recent meta-analysis demonstrated that adapting interventions to be more culturally relevant can improve patient satisfaction, service use and treatment outcomes (Griner & Smith, 2006); however, the available evidence is not sufficiently developed to conclude what aspects of a therapeutic intervention should be adapted to improve outcomes for Asian service users (Griner & Smith, 2006). A few practice-based guides have been recently developed on delivering mental health services for Asian communities (Chen & Davenport, 2005; Hwang, 2006). Empirical research with Asian people is largely limited to the efficacy of CBT.

Results and Discussion

Therapeutic skills working cross-culturally with people from Asian backgrounds

A range of 'key therapeutic skills' were identified from the literature review, consultation and further feedback. Some of the skills are discussed below, and more detail can be found in the *Talking Therapies for Asian People* guide (Te Pou, 2010a).

Curiosity and willingness to step into the person's cultural shoes

Cultural values, beliefs and practices held by an Asian individual are relevant for understanding symptom expression, help-seeking and problem-solving strategies and goals for therapy. There are many differences between Asian individuals; however, Asian values commonly held include: collectivism, family focus/duty, education and wealth focus, and tolerance of hardship.

Therapists should demonstrate an interest, understanding and acceptance of each person's cultural beliefs, family dynamics and other aspects of the service user's reality (Baptiste, 2005). Some New Zealand therapists have reported uncertainty about how best to discuss and explore ideas about culture. New Zealand therapists advise that relevant aspects of culture can be explored in tangible ways by asking about practices in the service users home country, e.g. *"how would people typically react to this action in your home country"* and "*how would people in your country respond to these feelings*". It is likely that this process will uncover common values, beliefs or practices that can be drawn upon to build rapport and engagement in the therapeutic relationship.

Broadening assessment

Information from the literature review, consultation and document feedback highlighted the importance of avoiding cultural stereotypes in providing recommendations for working with Asian service users. Each Asian person will have a unique combination of migration experiences, acculturation, language abilities, religious and other beliefs, practices and traditions (Tseng, 2004). Assessment and exploration of individual circumstances and beliefs is thus essential for applying talking therapies in ways that are relevant for the individual service user.

Considerations or exploration in assessment include: symptoms as the service user experiences them (mental and physical), perception of the cause of their symptoms, migration history including motivations for coming and challenges faced since arrival (Kim, Bean, & Harper, 2004), views towards healers, help-seeking, treatment options, goals for therapy, past trauma and grief, cultural values (Bhui, Chandran & Sathyamoorthy, 2002) and religious values (Bhui et al., 2002).

Working with interpreters and assessing and responding to cultural communication styles

Communication styles have implications for how communication and talking therapy should be approached. Communication styles may differ between Indian, Chinese and other cultures. For example some Asian cultures value suppression of emotion, humility and the use of non-verbal communication (Chen & Davenport, 2005). Other cultures are more direct in their orientation, but still prohibit open hostility and anger. Due to such variation, communication preferences should be explored on an individual basis. English language ability is also a key factor in how communication is approached during the therapeutic relationship. Research and therapists in New Zealand recommend that trained interpreters are essential when a service user has limited or no competence with the English language. Specific skills are required to work effectively with interpreters in therapy. Detail on these is provided in the *Therapies for Refugees, Asylum Seekers and New Migrants. Best and Promising Practice Guide for Staff Working in Mental Health and Addiction Services* guide (Te Pou, 2010b) and (Lim, 2010).

While ethnic and linguistic match may support the cultural appropriateness of talking therapy, matching therapists based on ethnicity or language is not essential or sufficient for culturally-relevant therapy. For example, matching therapists does not guarantee quality of the therapy session as languages, politics and religion differ between people from the same cultural group and there can be concerns about confidentiality when communities are small.

Ensuring engagement in treatment goals

Therapists need to ensure goals are culturally appropriate and align with the service users perceptions and desires for their own situation. Culturally-appropriate goals may move beyond a focus on symptoms to improve collective wellbeing such as better functioning in the family or community, improved relationships or in fulfilling work obligations (Tseng, 2004). It is important for therapists to explore what kind of characteristics and skills the service user should develop to function successfully in their social and cultural setting (Tseng, 1999). For example, training in assertiveness or a focus on personal needs over those of others may not be adaptive in traditional Asian social contexts. Therapists may need to be particularly careful to ensure Asian people participate in goal-setting activities, and that they agree and support the goals developed.

Involving and educating families

Therapists need to be aware of and work sensitively with family dynamics and values in Asian cultures. Family involvement is usually key to making therapy useful for many Asian service users; however, families need to be engaged in culturally sensitive ways (Bae & Kung, 2000; Chen & Davenport, 2005; Kim et al., 2001). New Zealand therapists recommend that when working with families, therapists should ask the service user if they would like family members to be involved. When family interactions offer mechanisms for change, family therapy can be applied to focus on these family interactions. Family members can also be engaged directly or indirectly to support individually-focused therapeutic work

undertaken with the service user. Family ties and obligations can be used as a strength for encouraging change. It may also be useful to incorporate improved family functioning or achievement of family duties as a goal of therapy in some circumstances. When working with families, it is important to identify and be respectful of the family hierarchies, values and parenting values and attempt to remain neutral in conflict situations whilst protecting the rights of the client. Psycho-education can be a very useful part of the initial family engagement process (Kim et al., 2004).

Consider preferred coping strategies in the choice of talking therapy

Some traditional Asian philosophies and health beliefs promote coping strategies that differ from those that underpin Western models of talking therapy. Beliefs about the origins of emotional distress also have an impact on the preferred help-seeking strategies of a number of Asian people. For example, many Asian traditions view mental illness as having an organic (physical) or spiritual basis. Physical and spiritual healing practices may seem more appropriate for addressing these causes than Western healing practices that focus on thoughts, emotions, past events or behaviour.

A number of Asian people may see education, family and wealth as more immediate issues to address than any emotional concerns (Snowden, 2007). Some Asian philosophies promote accepting one's fate as a virtue, and do not encourage actions to address discomfort or emotional issues (Jackson et al., 2008). Thus, talking about personal problems and dwelling on concerns is looked down on by some people as indulgent or a sign of weakness.

Particularly for Asian people with a pragmatic or practical orientation, immediate problem-focused approaches may be needed to build motivation, confidence in the valued of therapy and trust in the therapist (Bae & Kung, 2000; Chen & Davenport, 2005; Kim et al., 2001). Immediate problem-focused approaches may include offering small, tangible and observable goals and working to identify coping mechanisms in the first or second session of therapy (Bae & Kung, 2000; Chen & Davenport, 2005; Kim et al., 2001).

Psycho-education is important for Asian people who have little knowledge about the New Zealand health system, or Western forms of therapy (Bae & Kung, 2000; Chan & Parker, 2004). Psycho-education for service users and family members can include confidentiality, informed consent and patient rights (Chen & Davenport, 2005), treatment plan, fees, number of sessions, patient rights, appointment procedures (. Chen & Davenport, 2005), some information about the nature and causes of mental illness (Bae & Kung, 2000), boundaries around the talking therapies process, their role in deciding goals and communicating concerns about the process (Bae & Kung, 2000).

Therapists should keep an open mind and discuss traditional beliefs to understand how best to facilitate appropriate access to services and support.

Addressing experience of stigma

Shame, as well as stigma and discrimination, can have a large impact on a person's wellbeing and contribute to further feelings of isolation and hopelessness (Peterson, Barnes & Duncan, 2008). Stigma around the experience of mental illness for many Asian communities often motivates Asian people to be cautious about seeking help from people outside their family (Chan & Parker, 2004; Sue et al., 2009). Developing trust and confidence in the utility of the therapeutic relationship in the first session is important. Positive reframe and compliments are important for dispelling embarrassment, shame and facilitating continued interaction with therapy (Kim et al., 2001). It may also be useful to provide patients with information about the biological roots of depression and other forms of mental illness (Chan & Parker, 2004).

Selecting and applying talking therapy models with Asian people

Use of different talking therapy models in New Zealand

A number of Western forms of talking therapies have been used with Asian clients in New Zealand and overseas. Feedback from Asian therapists in New Zealand suggests that cognitive behaviour therapy (CBT), family therapy, social supportive counselling, problem solving, counselling, and motivational interviewing are commonly used with Asian people.

The consultation also reported that Acceptance and Commitment Therapy, dialectical behaviour therapy and psychodynamic psychotherapy were used with Asian service users. These therapies were used less frequently by the therapists consulted than the ones noted above. In many cases, it appears that therapy models are chosen according to the therapists training, and use may not indicate the appropriateness of therapy for Asian service users.

In a range of cases, therapists may move between different therapy 'models' within sessions. The process and content of talking therapy is often adapted to make it relevant for the motivation, communication norms and goals of Asian service users. Cognitive behaviour therapy is often the model of choice for people with limited English language skills due to its structured content and similarities with some Asian philosophies (Hodges & Oei, 2007). Family therapy may be another salient choice due to the role and importance of family in most Asian cultures. Therapy types that focus on language nuances may be less appropriate for people with limited English skills, or people who prefer a structured approach to therapy.

International evidence for talking therapy models

There is limited research investigating the effectiveness of Western models of talking therapies or traditional Asian therapies for facilitating improvements in mental health in Asian communities. The strongest research evidence exists for the use of CBT with Asian communities, with evidence of improved outcomes relative to no-treatment noted for some Asian populations (Chen et al., 2007; Hinton et al., 2004; Rahman et. al., 2008; Shen et al., 2006). There is tentative evidence for the use of family therapy models (Bae & Kung, 2000; Ma, 2008);

however, few other talking therapy models have been used with people from Asian communities. Other therapies may be applicable in a number of instances; however, there is limited research evidence on which to make specific recommendations. Recommendations for adapting CBT have been developed for Asian service users of Chinese ethnicity, and broad cross-cultural groupings (e.g. Bae & Kung, 2000; Ma, 2008); however, the impact of these models for improving outcomes of therapy has not clearly been tested.

Conclusion

"Asian" refers to a group of people with a range of cultural and religious viewpoints and language. As with any individual who presents for therapy, Asian service users will have unique values, opinions and needs, and thus the adaptation of therapy should be made based on assessment of each individual's preferences and needs. There are a number of possible forms of Western therapy that are likely to be applicable to Asian service users. The choice of therapy and degree to which the therapy is modified in line with Asian cultural beliefs, practices and values is likely to depend on characteristics of both the service user and the therapist. Inclusion of interpreters, psycho-education, additional assessment, family focus and consideration of culture, communication, stigma and preferred coping strategies can support the relevance of talking therapies for Asian service users. The *Talking therapies for Asian people: Best and Promising Practice Guide for Staff Working in Mental Health and Addiction Services Series* is available on the Te Pou website.

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Art-making, immigration and identity (re)construction among Chinese elders in New Zealand

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Abstract
Psychologists have foregrounded the importance of using material culture, which refers to the corporal and tangible object constructed by humans, to explore the construction of subjectivities and wellbeing. Material culture devotes attention to objects that are used, lived in, displayed and experienced by individuals. People interact with material culture as a normal part of their daily lives. Through such interactions, material culture and human beings are strongly influenced by each other. This paper explores the role material culture such as painting plays in identity reconstruction among older Chinese immigrants to New Zealand. The methods of data collection and analysis are informed by a narrative approach. Initial and follow-up interviews were conducted with 32 Chinese adults ranging in age from 62 to 77 years. Immigration to a new culture in old age gives rise to experiences of self-discrepancy which may lead to participants' vulnerability to anxiety-related disturbances. To address discrepant self, participants develop strategies to reproduce desire for the pursuit of the ideal self and wellbeing. Older Chinese immigrants can experience self-discrepancy in the transition to a new country in later life. Such a discrepancy often invokes a sense of dislocation and loss. Using material culture participants toil to address the biographical discrepancy by regaining desire and establishing biographical continuity across time and space between past lives in China and present lives in New Zealand.

The recent decades have witnessed the most profound demographic transformation around the world (Foner, Rumbaut, & Gold, 2000). Such border-crossing mobility has prompted investigation into the social and geographical lives of particular material culture. Material culture has provided materialised vehicles for narrating transnational changes of economy, political power and cultural identity (Foster, 2006). Kopytoff's (1986) idea of "commodity biographies" has traced the movement of material things through diverse contexts across cultural boundaries, during which the meaning of things shifts as a function of use by human agents in different social and cultural situations.

Limited studies have explored the function of material culture, such as paintings, in migration and in immigrants' attempts to create continuity in their identities and lives across countries. Ankori (2003) explored displaced bodies and embodied displacements in contemporary Palestinian art. By analysing a photography entitled *Grafting*, Ankori argues that the grafted tree symbolises that the migrant trees are bestowed with the hybrid identity of immigrants who retain elements of their cultural heritage even when they relocate. More recently, Tucker (2007) found that painting, both as practice and as art object, becomes a site for investigation of concerns of loss, un/belonging, dis/connection and home. Paintings make reference to a distant and an embodied encounter in the cross-cultural landscape and provide cultural ties to immigrants' home countries. In sum, research in other social sciences suggests that art-making, in Durrant and Lord's (2007) words, as "migratory aesthetic",

proposes the various processes of becoming that are triggered by the human movement: experiences of transition as well as the transition of experience itself into new art work and new ways of being. To better understand such experiences of transition and the transition of experience among older Chinese immigrants, this paper explores how art-making can assist older Chinese immigrants in defining who they are and where they belong. We will consider the role art-making plays in cultivating a sense of belonging by grafting the Chinese culture and the New Zealand culture and in facilitating older Chinese immigrants to better understand and appreciate the richness of multiplicities of the self.

Methods

Research participants are 14 males and 18 females ranging in age from 62 to 77 years. All participants were new migrants from the People's Republic of China. At the time of the initial interview, 22 participants lived with their spouse or lived alone, and 10 lived with their adult children. The participants' primary source of income was social benefits of no more than NZ$10,000 per annum. Such low income levels reflect the findings of other studies of older Chinese migrants living in Western countries and their situation of relative poverty (Chappell & Kusch, 2007). Prior to moving to New Zealand, the majority were employed as professionals including engineers, medical doctors, nurses, teachers, physiotherapists, and managers.

Three semi-structured interviews were conducted with the participants. All participants took part in the initial two interviews which were conducted between April and October 2008. Ten of thirty two participated in the third interviews which were carried out during May to September 2009. The interviews lasted approximately two hours each and were conducted in either Mandarin or Cantonese. The interviews covered the following themes: the participant's life in China, immigration and housing histories, routines at home and in the community, domestic relations, and perceptions of home, neighbourhood and community. With the participant's permission, a house tour was undertaken during the initial interview and the first author took photographs of objects and spaces that the participant felt were important. These photographs were then discussed with the participant in the follow-up interview. The house tours involved aspects of what is commonly termed the "Go-Along" interview (Carpiano, 2009). Researchers can explore participants' places with them and prompt the participants to reveal the history and personal relevance of particular domestic spaces in their everyday lives that would likely be missed by casual observers (Li, Hodgetts, & Ho, 2010).

The initial analysis was conducted in Chinese and the preliminary findings were translated into English for further interpretation. The thematic analysis involved the interpretation of each transcript as a whole. Relevant episodes were isolated and ordered into a chronological biographical account, then the underlying assumptions in each account were identified. Particular cases were then selected to illustrate general patterns and the underlying assumptions of different cases were compared (Riessman, 2008). The focus on art-making is significant in that we did not set out to research this facet of participants' lives. Art-making was an emergent theme from the research. Besides thematic analysis, we also used visual analysis which enables researchers and/or audiences to see as participants see, and to feel. We chose to use photography as part of our

methodology because it is ideally suited to the study of people's everyday life, providing a pictorial dimension of culturally meaningful objects and settings (*cf.*, Radley, Chamberlain, Hodgetts, Stolte, & Groot, 2010). In this way, the participants' experiences become "seeable" in ways that transcend the "sayable" (Riessman, 2008). As we will show, visual narrative is not a copy, substitute, or complement to text narrative. Instead it is an alternate form of representation that focuses on the parts of culture that cannot be accessed by just the use of words (Trafi-Prats, 2009).

Results

Our analysis is presented in two sections. The first illustrates how our participants' accounts of socio-economic status in China not only help them to recall their past lives, but also to articulate their present situations, sense of loss, and psychological consequences. The second explores the role of painting in identity (re)construction in a new country. Together these two parts contribute to an understanding of how, by creating art, our participants create a space for continuity and meanings, linking their new lives in New Zealand with their former lives back in China.

Movement and self-discrepancy: Hidden dragons

Although a majority of our participants were highly educated professionals, compared to their better-off socio-economic status in China, their marked drop in income suggests a psychological phenomenon of self-discrepancy among the participants. The concept of self-discrepancy was proposed by Higgins (1987), who suggests that there are three basic domains of the self: the actual self, ideal self and ought self. The actual self is one's representation of the attributes that he/she or others believe he/she actually possesses. The ideal self represents one's attributes that he/she or others would like him/her, ideally, to possess. The ought self is one's traits that he/she or others believe he/she should or ought to possess. These selves may not match one another. Instead, they may be discrepant and different from one another. Research has revealed that migrants, especially older migrants, are more likely to experience discrepancies that may impact their health and wellbeing (Roccas, Horenczyk, & Schwartz, 2000). These include discrepancies of cultural values, religious customs, and social support systems, and socio-economic statuses between their home and host countries. Below Sheng's account presented a discrepancy between the actual self and ought self arising from his different socio-economic status between New Zealand and China:

> *A majority [of older Chinese immigrants] were high-level intellectuals. They are hidden dragons and crouching tigers in New Zealand. I was a chief surgeon in China but now I am a beneficiary in New Zealand. She (Sheng's wife) was a senior teacher. But in New Zealand we are the poor. We are nobody here. (Sheng, 69 years old male, lived in New Zealand for six years)*

In Sheng's extract, the primary issue is one of shifting from a professional status to one of a beneficiary and a migrant. "Beneficiary" is bound up with the concept of actual self which represents a self that Sheng thinks he actually is, whereas "chief surgeon" is a symbol of the ought self which describes the kind of person that Sheng thinks he ought to be. Sheng perceives that he had lost and would probably never obtain the same social status he possessed in China. He felt sad and disappointed as he claimed that "we are nobody here". Sheng's account shows that his self-discrepancy is derived from social communication and interaction. The metaphor of "hidden dragon" – a chief surgeon becoming a beneficiary - grows out of the ways in which he interacted with others as a "chief surgeon" in China and a "beneficiary" in New Zealand. Sheng feels disruption between the old self (the professional) and the new self (the beneficiary and ageing immigrant). Migration has caused a disjuncture in Sheng's biography.

Higgins (1987) and Horenczyk (1996) have reported that self-discrepancy may lead to psychological vulnerability, such as anxiety, fear and edginess. Such psychological consequences were disclosed by Sheng's wife, Hua, in the second interview when Hua and the first author discussed one of the photographs the first author took in the first interview. The photograph (see Figure 1) posits a happy family picture in which Sheng and Hua were preparing for their lunch together. However, Hua's account offered a different picture when Sheng was absent in the second interview:

> *This was not what happens in our everyday life. I would not say that if he was here. He never helped me in cooking except last time (the first interview) when you were here. I look after everything in and outside our household, such as cooking and shopping. He didn't like me participating in community activities and sometimes was upset when I talked to my friends on the phone. He spends most of time in painting. He seldom goes out. He isolates himself. (Hua, 70 years old, lived in New Zealand for six years)*

Figure 1 Sheng and Hua Cooking Lunch

Here, not only does the photograph allow a more vivid presentation of the participants' lifestyles than does talking alone provide, but italso stimulates Hua to produce a private account of her story. In other words, the image has high iconic quality, which helps activate Hua's memories and encourage her to make statements about complex domestic situations (*cf.*, Flick, 2006).

We have illustrated that the participants' accounts of socio-economic status in China not only help them recall their past lives, but also to articulate their present situation, a sense of loss and the need for new connections in their lives. Next, we will explore how painting rooms provide a material and spatial basis for further considering how to make the present situation more habitable. We will demonstrate how bringing the past to the fore informs the present and provides insights into migration experiences. In a sense, just standing in the painting room talking to the researcher enables the participants to articulate key transition and immigration experiences (Li, Hodgetts, & Ho, 2010). Participants can wave their hands and point to the paintings while conveying their concerns. Painting rooms can function as memory containers, particularly when they contain painting materials from China. Painting rooms index another place and time into the present and materialise memories.

Responding to discrepancy through Art: Grafting cultures

As noted previously, the notion of self-discrepancy proposes that there is another domain of the self – the ideal self. Careful across-account examination suggests that notably absent from the narratives for some participants is the ideal self. Such absence is reflected when we asked the question: "what would you like to change in your home if you could?". By and large, the participants claimed that they did not think of change. For example, Jian stated:

> *I didn't think about it. This is not my house. I don't have financial ability to change it. I won't change it. (Jian, 69 years old male, lived in New Zealand for nine years)*

The question of "changing home if could" symbolises an ideal self that the participant would like to be. Kumashiro and colleagues (2006) have pointed out that people cannot achieve their ideals in the absence of adequate ability and sustained motivation. Jian and his wife's total income was approximate $550 per week. There was only $250 left to live on after rent. Jian's account suggests that his financial inadequacy restrains his motivation for pursuing an ideal self.

Besides financial restraints, a lack of desire is a more significant factor that defers the participants from pursuing the ideal self. Frank (1995) found that desire was lacking in illness narratives of his participants. Frank argues that desire is placed in a triad with needs and demands. Such needs are fully corporeal and can be satisfied at the corporeal level. The expression of the need is the demand, but this differs from the need itself. The demand asks for *more* than the need it seeks to express. Desire is this quality of *more*. Desire cannot be filled – there is always more. Frank maintains that some bodies, particularly ill bodies, do cease desiring. We would argue that the plot of desire loss informs not only the illness self, but also the discrepant self in our research. For those who cease to pursue the ideal self, their narratives lack of desire. For example, they claimed that there was no need to change their homes and they would not expect any *more* in their later life.

The narrative tension therefore lies in whether desire will be regained. Frank (1995) proposes that just as illness almost invariably plunges the body into lacking desire, illness can bring about new reflections on how to be a body producing desire. The narratives of our participants introduce a similar trend. The loss of desire is initially expressed in indifference to changing the home if they could. Nevertheless, when we studied their narratives intensively, we found the plot of regaining desire informs the participants at various points. Take Sheng again as an example. Even if Sheng stated that it was not his interest in changing home, he did modify his garage into a painting room (see Figure 2). The painting room is not merely a place in which he painted, but a place in which he could communicate with others and the outside world and express his desire:

> *I am somewhat unsociable. I have difficulties to get on with people I don't appreciate. I have been a doctor in my whole life. People asked for my help all the time… I seldom mingled with people spontaneously. I am sort of indulged in self-admiration … Now I have a painting room. I can paint again. Many people came to me asking for my paintings. I gave them my paintings as gifts (see Figure 3).*

FIGURE 2 SHENG'S PAINTING ROOM

When the friends ask for Sheng's paintings, this is symbolic of asking for his help. Painting is something that Sheng loves to do. Additionally, the activity of painting is also a part of Sheng's attempt to confront the discrepant self (albeit probably unconsciously) and to overcome his fear that he is no longer respected by others or worthy of being called on for help. Although Sheng did not go out, as presented in Hua's previous account, he communicates with the outside world through his paintings. Relationships have established when Sheng and his friends share artworks and ideas. As a group member, Sheng is "near and far *at the same time*" (Simmel, 1950, p. 408, emphasis in the original).

Figure 3 Sheng's Painting for His Friend

The art-making and sharing processes help Sheng explore his identity, move beyond his comfort zone, and look at his experience in new ways. Moreover, when Sheng brings painting materials from China he also brings a bit of China to New Zealand. In this sense, painting provides Sheng with continuity between China and New Zealand. Painting crafts a sense of home and functions as a strategy for constructing meaning through social interaction (*cf.*, Li, Hodgetts, & Ho, 2010). In this way, art becomes another language allowing Sheng's realities to take on new meanings (Song, 2009). Through art-making, Sheng engages in memory work. He paints memories. The memories are not about closure of the past, but enable Sheng to reconceptualise and renegotiate the present, to "re-member" himself (Davidson, 2008). Through such a process, Sheng achieves an understanding of multiple perspectives and sees the richness of his multiplicities. He is empowered to claim "all" of who he is.

For some time, researchers have explored the relationship between art and identity. As Trafi-Prats (2009) puts it, aesthetics encompass critical reconsideration of notions of belonging, emplacement, movement and identity. Donaldson (1997) also argues that throughout the history of human existence, culture and experience have remained alive in "the bosom" of the art. In

everyday life, as shown in Sheng's case, aesthetics envision alternative spatial and social relations. This can also be seen in Fen's work *Heaven* (see Figure 4) where the cultural and spiritual meanings, and symbolism and transformation of identity fulfil her multiple social and spiritual needs:

> *Heaven is my work I donated to my church. I call it as a cultural graft. I combined the Chinese image of Dunhuang Flying*[1] *to the Western image of angles in the Bible. (Fen, 68 years old, lived in New Zealand for eight years and five months)*

Figure 4 Fen's Painting: Heaven

Using the most basic metaphor – graft, Fen explores the experience of migration and hybridity. Grafting Chinese painting techniques and the Buddhist image of *Dunhuang Flying* fairies into Christian angels, *Heaven* symbolises Fen's desire to connect the Eastern and Western cultures. The concepts, techniques and materials inform the viewer of Fen's cultural identity and the merging of traditional ideals with new ideologies. The title *Heaven* is a symbolic expression

[1] Flying fairies is a symbol of Dunhuang's art. In almost all the caves of the Mogao Grottoes there are large numbers of Flying fairies flying in all directions with the help of their flowing garments and colourful dancing bands.

of Fen's text statement that "New Zealand is a paradise for us even though we are beneficiaries here".

A graft, literally, is "a small shoot or bud of a tree or plant inserted into another tree or plant where it continues to grow, becoming a permanent part" (Ankori, 2003, p. 78).Through grafting, a new identity is signified in Fen's aesthetic work. Ankori (2003) remarks that "in human beings, indeed in all living creatures, grafting implies the creation of a hybrid being, that is both self and other, both here and there" (p. 78). Fen's own position – oscillating between 'home' and 'away' – is analogous to that in her spatiotemporally and culturally grafted *Heaven*. Immigrants who are uprooted from their home countries need to literally graft themselves in the host country. In this regard, painting serves to facilitate Fen's reconstruction of the self and to ease her transition from China to New Zealand. As she constructs meaning in her work, Fen is simultaneously being constructed; often re-constructing her own identities in response to the images she creates and values (Milbrandt, 2003).

During the house tours offered by Sheng and Fen, the first author noticed that their paintings were used to decorate their homes. Hurdley (2006) explores the objects people display on mantelpieces in their homes as aspects of their identities. People in Hurdley's study talked about their objects as if they represented their character and the relationships they hold dear. Similarly, Clemons and Searing (2004) claim that people use objects, including art, within the home to describe their personal characters. That is, in trying to define the self, people use symbols and objects – things that are meaningful to them – to describe who they are in a material, concrete way (Clemons & Searing, 2004). Sheng and Fen do something very similar. The creation of interiors, using their own artwork, provides Sheng and Fen with identities that communicate a sense of place. In this sense, paintings themselves are places, "virtual places" (Tuan, 2004, p. 20). As Tuan (2004) argues, "the self is static if it is produced by homeplace and only homeplace, flexible and expansive if it is also nurtured by art" (p.23). A painting is of the creation on canvas, which becomes a virtual 'home' for the person to dwell in and return to should he or she so wish.

Discussion

We have explored self-discrepancy among older Chinese immigrants and their responses to the discrepancy. We have shown that people telling stories about material cultures in their homes are also telling stories about themselves, as moral beings with histories and beliefs, who are both socialised and individualised (Hurdley, 2006). As Olsen (2003) has maintained, material objects are never to be themselves, but always to represent something else. Our analysis of interactions between the persons, their homes and material cultures suggests that there is an active meaning-making process in which all three play a role. In that regard, the self is not the act of the person whose action can shape the self alone. Instead, the materiality of the world is integral to the self-construction process and interacts with the person. The objectivity of the social world is socially constructed. It is an objectivity that arises out of the human practices and interactions (Jovchelovitch, 2007).

Among material culture, painting is considered as an aesthetic practice. Yet, we have illustrated that paintings are more than aesthetic tastes; they are a means of cultivating and rethinking the self, of grafting cultures and of making a place of one's own. Painting rooms are culturally loaded spaces that are textured by human movement and action, identities and relationships. They are woven into the very fabric of peoples' lives and invoke complex relations between stakeholders, which can alert us to the ways in which people negotiate the regulation of the landscapes of everyday life and social participation somewhere new (Li, Hodgetts, & Ho, 2010). Through painting, the participants toil to repair the self-discrepancy by establishing biographical continuity across time and space between China and New Zealand. In the words of Foucault (1994), this implies the "techniques of the self", which refers to the procedures that individuals carry out "in order to determine their identity, maintain it … through relations of self-mastery or self-knowledge" (p.87). In other words, the techniques of the self are "a matter of placing the imperative to 'know oneself' … What should one do with oneself? What work should be carried out on the self? " (Foucault, 1994, p. 87). Despite hardship, our participants survive and flourish in a new land through processes of self cultivation and (re)construction (*cf.*, Hodgetts et al., 2010).

The creation of art is simultaneously as simple as accessing painting materials, and as complex as refining cultural heritage and one's very sense of self and belonging (Li, Hodgetts, & Ho, 2010). Painting enables the participants to retexture their physical worlds to resemble aspects of their countries of origin and histories. Culture and history are literally grafted into the new culture. Retelling the significance of painting invokes a nexus of relationships and meanings, which weaves people into place and which exceeds the physical restraints of time and space. People can reflect and imagine their lives and selves into being and becoming. Painting reveals how a home can literally be re-cultivated in a manner that allows people to both preserve aspects of their previous selves and grow a sense of place and self somewhere new (Graham & Connell, 2006). These participants are literally burrowing into a new life. Being able to resettle somewhere new and cultivate a sense of belonging is crucial to the continued self-construction and self-development of older Chinese immigrants (Li, Hodgetts, & Ho, 2010).

This paper exemplifies that cultural diversity requires much greater consideration in the formulation of policies and social services that address diversity of experiences and of approaches to ageing in multicultural societies (Li, Hodgetts, Ho, & Stolte, in press). Such work is crucial at a time when Chinese people continue to migrate to the West and when Western governments must grapple with meeting the needs of ethnically diverse populations and with increasing pressure on social welfare, housing and health care budgets (Bartlett & Peel, 2005). Such concerns appear to run counter to the tendency within the mainstream policy literature towards ever more predictable, rational and universally applicable models and approaches (Li, Hodgetts, Ho et al., in press). Situating culture in larger society and attention on interpreting social issues through the cultural lenses of those concerned will expand responsiveness of policymaking and aged care.

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Engaging Chinese Immigrant Communities to Counter the Stigma and Discrimination Surrounding Mental Illness: The Kai Xin Xing Dong Programme

Sheng Tang & Vanessa Cooper

Abstract

Addressing stigmatisation of mental illness requires culturally congruent community-based programmes. The Mental Health Foundation of New Zealand developed a project to counter stigma surrounding mental illness in Chinese immigrant communities, with thorough consideration of cultural beliefs on mental illness and effective methods to engage the Chinese community. The Kai Xin Xing Dong project was developed and implemented in Chinese communities in Auckland, New Zealand. The project comprised regular radio and newspaper features in ethnic media and bilingual website in addition to community-based training which includes workshop and presentation. Although the project was a component of the national 'Like Minds, Like Mine' campaign, activities were determined as a result of significant involvement and feedback from the Chinese community and in particular, Chinese persons with experience of mental illness. Focus groups demonstrated that the project utilised a culturally congruent approach to addressing stigma in the Chinese community. Credibility was determined as a key factor to achieving cultural congruence. Key culture based factors such as attitudes and beliefs about mental illness influence Chinese people when it comes to discuss mental health issues. KXXD created a platform to engage with the Chinese community to address this issue. Social marketing projects to address stigma must be sufficiently funded to be planned, implemented and owned by the community. To engage Chinese communities activities must be rooted in the cultural beliefs, practices and lived experience of those affected by mental illness. Future developments should include using website as a media to reach the wider Chinese community.

Background

The Like Minds, Like Mine programme seeks to combat discrimination faced by people with experience of mental illness through a number of strategies including a national media advertising programme, training and education, and advocacy and research (Ministry of Health, 2007). While this programme has had significant success (Vaughan & Hansen, 2005), the need to extend the programme beyond the general population and encompass the needs of specific population groups is noted in the *Like Minds, Like Mine National Plan 2007-2013* (Ministry of Health, 2007). Anecdotal evidence and a previous unpublished report (Yeo, 2004) suggests that within New Zealand Chinese communities, people who experience mental illness may experience higher rates of stigma and discrimination than the rest of the population. This project was undertaken to increase understanding of the attitudes and beliefs of Chinese people about mental health issues. The results will inform the direction of future Like Minds programme developments in relation to New Zealand's Chinese population.

Methods

A literature review was conducted focusing on studies found in international academic journals regarding knowledge about mental health, including attitudes towards people with experience of mental illness. Key related references discovered in the initial search of the literature were also reviewed.

Culture and its influence

Our cultures help define the way we see the world, they inform our individual and collective values, and our ways of behaving. Culture shapes our beliefs about how we should relate to other people, concepts of time and history, our understandings of nature, and the purpose and direction of humanity. In this way, our cultures give understanding and pattern to our lives and is therefore an inherent part of all human activities including the experience of mental illness and our responses to this experience through the receiving and providing of mental health care. Cultural values can be said to be incorporated effortlessly and often subconsciously into our daily lives giving us the meaning and context of behaviour and influencing what we see as 'normal' from our own particular cultural perspective.

Culture helps to shape how we respond to illness and what is or is not, defined as illness. For example, Western societies and health systems tend to emphasise the individual rather than the collective and all subsequent interventions are based on this fundamental understanding. While New Zealand is made up of many cultures - both an indigenous group – Maori – and a large multi-cultural migrant population, its institutions are primarily based on Western European systems that were imposed at the time of colonisation (Hall, 2007). This includes its health services, which, although increasingly challenged by indigenous models of healthcare, are still predominantly shaped by a science-based focus on disease and pathology rather than a belief in mind/body dualism and an holistic approach to health. In particular, concepts about mental health and mental illness pose particular challenges transculturally as the concept of mental illness itself is alien to many cultures (Kleinman, 1994).

The social role played by illness is also influential. Pederson (1982) also argues the way in which distress is manifested, how it is communicated, and who should be involved in treatment or healing is also culturally determined. He suggests, among many other researchers, that certain disorders also appear to be culture bound, for example Anorexia Nervosa in Western cultures, *Susto* in Latin America, and *Hsie-ping* in China (Pederson, 1982). Kleinman (1970) suggests that due to these phenomena, changes are necessary to the health care system and its dominant model (primarily the bio-medical model) in order to better incorporate cultural understandings. The health system "ought to include medical anthropology's understanding of medicine as a cultural system, as well as our appreciation of the mechanisms by which culture systematically influences disease/illness and healing" (Kleinman, 1970, p10).

Tao, Confucianism and Buddhism

Confucian perspectives are the most dominant among many Asian cultures today and govern thinking especially within Mainland China. It is suggested that within this framework a "mentally healthy individual is self-cultivated with a purified mind, a well disciplined manner and mild expressions of emotion. Externally s/he is humane, righteous, faithful and forgiving in interaction with others" (Yip, 2005, p394).

Yip (2005) also notes the major influence of Taoism and its concepts of harmony and peacefulness. Furthermore, traditional Chinese concepts, what Westerns view as 'mental health', encourages restraint, emphasizes the collective, and the avoidance of extremes. These constitute a very different view than that of Western mental health which emphasizes self-actualization, individual responsibility, and the expression of emotion.

Until recently, Mainland China was not "influenced by competing health paradigms" and as a consequence maintained a fairly universal approach to health and illness (Wong & Richman, 2003, p12). The connection between traditional medicine and both Confucianism and Taoist principles of balance and harmony suggest that "Chinese do not recognise the Cartesian dualism of mind and body. The heart is considered to contain the mind and the brain is not recognised as an entity" (Wong & Richman, 2003, p14).

In contrast, within Western medicine both the person and the health professionals who care for the person are compartmentalised, in other words, a physician will deal with the physical health and the social worker or therapist will deal with the mental and emotional health. They suggest this is in direct contrast to the holistic concepts expressed in the philosophies of Buddhism, Taoism, and traditional Chinese medicine (Chan, Ying, & Chow, 2001). Similarly in 2005 Yip found -

> In terms of the traditional Chinese medical, Confucian and Taoist schools of thought, Chinese concepts of mental health have a strong impact. All these have significant implications for culturally sensitive or culturally competent social work practice in Chinese communities (Yip, 2005, p395).

Influences on Chinese health beliefs also include beliefs in taxonomy, fung shui, Buddhist gods, Taoist gods, other historical gods/heroes, ancestor worship, and functional gods (Yip, 2003). This raises the questions about whether these values continue to maintain their influence amongst migrants. In a study of Chinese Australians, it was found that because of the influence of Confucian ideals "Chinese people's wellbeing is significantly determined by a harmonious relationship with others in the social and cultural context" (Hsiao, Minas & Tan, 2004, p998). In addition, Western clinicians are now arguing the importance of spiritual and philosophical concepts. Their study of the application of spirituality and religion in psychiatric clinical practice suggests that incorporation of these concepts is likely to enhance the outcome (D'Souza & George, 2006).

Traditional Chinese medicine

Based on influences from both Taoist and Confucian philosophies which emphasise harmony with the universe, Chinese medicine takes an holistic approach to health (Wong & Richman, 2003; Chan et al., 2001). Chinese medicine originated in relative isolation (compared with Western medicine) within a literate society where a readily coherent and easily traceable knowledge base is well preserved (Wong & Richman, 2003). Wong and Richman suggest the relationship of health with nature and natural forces and the opposite principles of yin and yang underpin its central concepts of harmony and balance. Harmony between the mental and the physical is also considered important but there are no separate categories, and therefore no separate approach to mental illness (Wong & Richman, 2003). *Jingshen* is the term given to what Western cultures understand as mental health, and *Diankuang* is the term for 'craziness' (Wong & Richman, 2003). [2] Wong and Richman argue that the understanding of this term has changed over time and their study found contemporary lay understandings to include mental illness, evil spirits, stress, and genetic or brain disorders. However, it also included stigmatising views of mental illness involving concepts of dangerousness, destructiveness and violence (Wong & Richman, 2003).

The essential elements of Chinese medicine provide a clear demonstration of the differences between what they describe as 'Eastern' and Western' approaches to health, with an 'Eastern' approach of health being perceived as -

> A harmonious equilibrium that exists between the interplay of 'yin'(阴) and 'yang'(阳): the five internal elements (metal, wood, water, fire and earth), the six environmental conditions (dry, wet, hot, cold, wind and flame), other external sources of harm (physical injury, insect bites, poison, overeating and overwork), an the seven emotions (joy, sorrow, anger, worry, panic, anxiety and fear) (Chan et al., 2001, p264).

Their research suggests that variations of this belief system/approach are practised by Chinese worldwide and that including these elements in clinical practise has positive effects on recovery (Chan et al., 2001). Other studies suggest that relying solely on 'cultural' explanations for poor service access may not explain poor service access. Fung, Tsang, Corrigan, Lam, & Cheng's (2007) study suggests that while cultural factors, such as explanatory models of illness, may have an influence they argue that -

> This effect may be significant only when help and access are already perceived to be available. For communities where there is a lack of services and a corresponding perception of lack of access, the attitude towards seeking services may be so poor that explanatory models have little meaningful significance. While the use of explanatory models of illness in the field of cultural psychiatry has made significant contributions by increasing researchers' and clinicians' sensitivity to the potential cultural

[2] From *dian* meaning insane and *kuang* forms of psychosis (Wong & Richman, 2003)

> influences on illness experience, there is increasing recognition of its limitations (Fung et al., 2007).

Many of the studies argue that there is a variable combination of cultural factors that influence Chinese beliefs about mental health and illness and levels of stigma and discrimination, and noted that Chinese medicine including acupuncture, herbal medicine, and massaging were believed to be effective treatments (Furnham & Wong, 2007).

Mental health and illness, discrimination and stigma

In the last decade numerous international studies have found that discrimination against people with experience of mental illness is both pervasive and damaging (Baumann, 2007; Corrigan & Shaughnessy, 2007; El-Badri & Mellsop, 2007; Wahl, 1999). A Mental Health Foundation (MHF) of New Zealand study, *Respect Costs Nothing* describes discrimination as occurring when "a person is treated differently from another person in the same or similar circumstances" (Peterson, 2004, p. 9). It notes that it may be both direct and indirect and may not be unlawful; however, in New Zealand this is legally defined under the *Human Rights Act 1993* (Peterson, 2004). This MHF study, which did not specifically survey the experiences of Chinese New Zealanders found that:

> Discrimination on the basis of mental illness permeates all aspects of the lives of those who experience mental illness – from employment and health services to interactions within communities and with friends and family. Not only is it present in people's lives, it has a major effect on their lives – resulting in job losses, lack of opportunities and social isolation" (Peterson, 2004, p4).

There is considerable debate about the concept of stigma, which is described as the public "endorsement of a set of prejudicial attitudes, negative emotional responses, discriminatory behaviours and biased social structures, towards members of a subgroup" (Mak, Poon, Pun, & Cheung, 2007, p. 245). It is argued that for Chinese families they -

> …tend to regard mental illness within the family as highly shameful and embarrassment is connected with the unpredictable symptoms. The uncertainty about the cause of the illness and the stigma that surround schizophrenia only serve to encourage schizophrenic family members to hide their schizophrenic relatives. The duty of family to care for the sick and disabled members is not only a reflection of the traditional family orientation of the Chinese society, but also the Chinese government's inability (due to lack of resources) to provide care to the mentally ill (Furnham, 2007 p. 138).

Watson and colleagues (2003) finds an economic and political context for discrimination arguing that both the stigma and discrimination of people with experience of mental illness is not a result of a "normal perception of a group of people who are dangerous and/or blameworthy" but rather a justificatory system

which is a "way of making sense of economic and political differences between the majority and stigmatized subgroups" (Watson, Ottati, & Corrigan, 2003, p152).

Corrigan argues that stigma, which is defined as a cluster of negative attitudes and beliefs that motivate people to fear, reject, avoid and discriminate against people with experience of mental illness (Corrigan & Penn, 1998) is widely experienced internationally, especially in Western societies (Corrigan & Penn, 1998). However, other researchers argue that within Asian cultures, stigma and discrimination are more extreme and impacts very negatively on individuals and their families economic and social prospects (Lin & Cheung, 1999; Ng, 1997).

In the New Zealand context, the Mental Health Commission has argued – "One of the biggest barriers to recovery is discrimination. That is why stopping discrimination and championing respect, rights and equality for people with mental illness is just as important as providing the best treatments and therapies" (1998, p3). Stigma and discrimination are more likely to occur when people lack understanding of mental health issues, therefore understanding people's attitudes and providing education are essential (Corrigan & Penn, 1998; Corrigan & Shaughnessy, 2007).

The connection of culture to mental health service access and anti-discrimination campaigns

There are many reasons why individuals may be reluctant to access health services including, lack of knowledge about services, economic factors, racism or fear of racism and cultural difference (Blignault, Ponzio, Rong, & Eisenbruch, 2008).

Laugani's (2004) arguments on the dangers of homogenised mental health approaches have particular relevance. He argues:

> Easterners in general tend to organize their private and social lives, which include their beliefs, attitudes, and values along communal lines. Communal goals often take precedence over individual goals. This is noticeable even within family structures where the goals of an individual are often subordinated to the goals of the family (Laungani, 2004, p199).

In other words, the studies cited above indicate that cultural factors not only influence how we interpret illness, but also what we are prepared to accept as appropriate interventions. It is therefore unsurprising that cultural bias may also prevent Western mental health service providers from recognising the value of different healing traditions. A clinician from a culture which values individualism and independence who is assessing a patient from a collectivist culture which values interdependence may misinterpret the patient's family involvement as over-involvement and dysfunctional.

Tse (2004) identifies three issues for mental health clinicians working with New Zealand Chinese. Firstly, the shame associated with mental illness, which may be added to by linguistic misunderstandings and mistrust of government

agencies or fear of racial discrimination. Secondly, the conflict of traditional views that place value on 'dependence' and harmony, family and community. Lastly, there is fatalism which has both positive and negative effects such as hopelessness' or powerlessness or a sense of acceptance (Tse, 2004). Tse suggests that these factors must be incorporated into effective, culturally appropriate treatment approaches.

Research undertaken in New Zealand shows that cultural barriers can limit access to health services (Abbott et al., 2000; De Sousa, 2005; Hall, 2007). In particular, that 'Asians'[3] underutilize health services. For example, it was found that Asians were less likely than other New Zealanders to have visited a health practitioner when they were first unwell and were less likely than other New Zealanders to use any type of telephone helpline (Scragg & Maitra, 2005). Similarly, a 2007 survey conducted in the Eastern suburbs of Auckland, which has a substantial Chinese population, found that a significant number of respondents reported symptoms that could be associated with depression and "72% would not seek help for mental health due to language barriers or the associated stigma" (Jury, 2007, p7). Furthermore, DeSouza and Garrett found that

> Barriers to accessing services for Chinese people included lack of language proficiency of respondents, lack of knowledge about civil rights and problems accessing general practitioners (DeSouza & Garrett, 2005).

He argues that a number of factors including language, lack of culturally competent practitioners, racism and lack of information contribute to this (Cowan, 2001). They also found cultural factors, such as viewing conditions as somatic, and the stigma associated with mental illness were influential in the lack of help-seeking (Li, Yee, Ng, & Logan, 1999).

Kumar and Tse (2006) argue that a number of New Zealand studies have found patterns of delayed help seeking, less specialist referrals by GPs, language, economic and family barriers are among the factors contributing to low mental health service access by Asians, including Chinese, in New Zealand. Spencer and Chen (2004) found language (rather than culture-based) discrimination was the most important factor in low mental health service access and was also associated with increased use of informal supports and services such as seeking help from friends and family. However, knowledge, understanding and acceptance of Western mental health concepts were also factors and were influenced by both the level of acculturation in the new country and the person's age (Hsiao et al., 2006, p59).

We found no studies that investigated Chinese specific anti-discrimination approaches. However, the studies reviewed above are clear about the impact of cultural factors on mental health service access. This suggests these factors must also be taken into account in mental health promotion and anti-discrimination campaigns for them to be culturally responsive.

[3] In New Zealand 'Asian' tends to refer to people from South East Asia. Rasanathan et al have argued that the term itself is problematic (Rasanathan, Craig & Perkins, 2004).

Conclusions

- There are key culture-based factors that influence Chinese understandings of mental health and mental illness which include religious and philosophical beliefs and the influence of Chinese medicine. These were found to include collectivism and strong family bonds and concepts of shame.
- There are differences in attitudes and beliefs about mental health and illness between Mainland Chinese, Chinese from other parts of Asia and Chinese migrants to Western countries. These were found to include levels of acculturation, the effect of socio-political changes in Mainland China, and exposure to Western health concepts.
- Stigma and discrimination impact on many Chinese with experience of mental illness and their families. This impact is found in the studies from across the range of countries we reviewed.
- There are both similarities and differences between Chinese and Western experiences of discrimination including a reluctance to discuss mental health issues which is also pervasive in Western societies. For example, in New Zealand, Peterson (2004) found that the fear of discrimination and stigma made many people with experience of mental illness afraid to disclose. However, the studies reviewed indicate that within Chinese societies this may be compounded by a sense of shame and a fear of bringing family into disrepute. Similarly members of the Kai Xin Xing Dong Advisory Group noted that amongst Chinese communities, there is a reluctance to discuss certain issues including mental health or illness despite a private awareness that they exist.
- The findings of the studies and the demographic information suggest that certain population groups such as older people and recent migrants from Mainland China are key audiences for anti-discrimination campaigns.
- Some of the studies called for an integration of Chinese traditional medicine and Western psychiatry and the addressing of other factors within mental health services such as lack of cultural expertise. These studies emphasised the positive effect of including Chinese health paradigms.
- An adjunct to this review was a stocktake of public health and mental health resources directed towards Chinese populations. The stocktake, which included a snapshot of international resources found evidence of emerging anti-discrimination, mental health promotion and mental health literacy campaigns in all the countries reviewed, including China.

The results indicate that culture along with its theological and philosophical beliefs have a significant influence on how Chinese view mental health and mental health services. There is evidence of both positive and negative effects of these influences on views about mental health and mental illness. However, we found no studies that were written from a consumer perspective and little evidence of anti-discrimination campaigns in either China or the other Asian countries we reviewed. At the same time there was evidence that the countries with Western style health systems were yet to recognise the importance of locating both their health service provision and anti-discrimination campaigns within a cultural context in relation to their Chinese populations.

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Building Evidence for Better Practice in Support of Asian Mental Wellbeing: An Exploratory Study

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Abstract

The Asian immigrant population has grown considerably in the past decade, and there is empirical and anecdotal data which suggests that this population may be experiencing mental health difficulties in New Zealand. In response to this, an exploratory study was undertaken to evaluate specific recovery-relevant components of the Wellness Recovery Action Plan® (WRAP), the training programme most widely used with Asian clients in the Waitemata District Health Board, and the Re-covery Model (RCM), and their impact on staff knowledge, skills, attitudes and behaviours about recovery. The study also identifies gaps that may exist in the training programme of Asian staff, recommends modifications for enhancing the use of the models for this cultural group, and finally produces a suggested model of delivery and toolkit that could be tested further with Asian practitioners and service users. Eleven Asian mental health support staff participated in the study, which comprised of two workshops, a focus group discussion, two case studies, and pre- and post-training evaluations. The two workshops consisted of a full-day programme each, and included training in the use of RCM and WRAP. The RCM and WRAP were integrated, and tested for their impact on and appropriateness for Asian mental health cultural support staff working with Asian consumers. The Recovery Knowledge Inventory (RKI) was used to assess the staff's recovery knowledge and attitudes before and after the workshops. Analysis of quantitative and qualitative data suggests a positive impact of the workshops on staff knowledge, attitudes and understanding of recovery. Qualitative feedback from staff indicated opportunities to modify the use of the models to improve their impact on and appropriateness for Asian mental health staff and consumers. Recommendations include continuing the use of the WRAP and adding the RCM to the training package; including cultural competency training for all practitioners that work with Asian clients; having family involvement in treatment processes; recognising the individual as a cultural being; building trust; dealing with practical needs; recognising the migration experience as a major source or trigger; and applying Asian models of health and cultural meanings of recovery.

Introduction

New Zealand has been experiencing a rapid increase in its immigrant population over recent decades, Statistics New Zealand (2006) estimates that 9.5 percent of New Zealand's current population is Asian, and projections estimate that Asian ethnic groups will account for almost 15 per cent of the total population in New Zealand by 2021 and 16 percent by 2026 Approximately 66 percent of Asians live in the Auckland region (Statistics New Zealand, 2006).

Settling into a new country brings both opportunities and challenges for immigrants. Many factors are known to impact on the well-being of Asians. There is increasing evidence that migration issues may be important for the mental and physical well-being of Asian immigrants, such as those relating to employment and level of income (Dixon, Tse, Rossen, & Sobrun-Maharaj, 2009; Sobrun-Maharaj, Rossen, & Kim, 2010; Tse & Hoque, 2006).

Mental health recovery in New Zealand

There is some information available on the mental health recovery process for the general population (Anthony, 1993). However, there is very little Asian-specific data available. The few Asian service models that have recently been developed have not been systematically evaluated and their efficacy tested. There is also limited research to support which actual staff behaviours or attitudes have a measureable impact on recovery outcomes for Asian clients (Fortier & Bishop, 2003). Research data (Tarrier & Barrowclough, 2003) suggest that interpersonal interactions and therapeutic relationships between consumers and mental health professionals could significantly affect the consumer's recovery. However, there is no information on the extent to which the application and practice of recovery-oriented principles by mental health professionals could be influenced by their cultural beliefs, values and attitudes about recovery.

In order to provide culturally appropriate mental health services to Asian clients, data on Asian service models and the role of culture on staff behaviours, attitudes and subsequent client outcomes is needed. To support translation of such knowledge into practice, appropriate tools and models that take into consideration these factors also need to be developed for use with this community. This paper outlines an exploratory study undertaken to evaluate the two recovery models WRAP (Copeland, 1997) and the RCM (Randal, et al., 2009), and to identify their impact on staff knowledge, skills, attitudes and behaviours about recovery. The study also identifies gaps that may exist in the training programme of Asian staff, recommends modifications for enhancing the use of the models for this cultural group, and finally produces a suggested model of delivery and toolkit that could be tested further with Asian practitioners and service users.

Western concepts of recovery in mental health

There has been a paradigm shift over the decades, whereby traditional treatment modalities in mental health have advanced from a traditional illness or stabilization model, to community or rehabilitation models, and in the present day, to a focus on recovery incorporating consumers' perspectives (Piat, Sabetti, & Bloon, 2009). The current meanings of recovery (in mental health or substance abuse) are no longer limited to medical (symptoms management) or rehabilitation (restoring functional ability) ones.

The importance of recovery goals, as opposed to treatment goals, has also been emphasised. Treatment goals, such as avoiding risks of relapses and hospitalisation, are often set by the clinical team. Recovery goals, on the other hand, are about the consumer's dreams and aspirations. Over and above this,

social support and inclusion has been recognised as an important factor in recovery. Slade (2009) states that: "…improving social inclusion is central, because hope without opportunity dies" (p. 370). This is of particular significance to immigrant mental health consumers settling into a new country.

Asian concepts of mental health and recovery

Most Asian cultures across greater Asia, from Afghanistan in the west to Japan in the east, view physical and mental health and illness holistically, as an equilibrium model. Explanatory models may include mystical, personal, or naturalistic causes (McBride, 1996). The basic logic of health and illness consists of prevention (avoiding inappropriate behaviour that leads to imbalance) and curing (restoring balance). It is a system oriented to moderation.

Rather than talking about mental illness, such as depression, Asians often talk about balance and harmony in health, e.g. *yin, yang* and *qi* in China, yoga in India, *timbang* in the Philippines, and *kwan* in Thailand (Burnard, Naiyapatana, & Lloyd, 2006). If balance is maintained, then a disease-free state of mind and body can also be maintained. Hence, Asians integrate the entire body, mind, and relations with family and society in the treatment of mental health disorders (Tarnovetskaia & Cook, 2008). Parallel to this holistic belief system is the understanding of modern medicine, with its own basic logic and principles that treat certain types of diseases. These two systems co-exist, and Asians often use a dual system of health care (McBride, 1996).

Hence, many Asian (and other non-Western) cultures do not appear to recognise the concepts of depression, schizophrenia, and other major mental disorders (see Lehti, Hammarström, & Mattsson, 2009's study). Psycho-education for the consumer and family is important, so that they can participate in treatment decisions.

The Mental Health Foundation in the United Kingdom reports that, in general, research has suggested that Western approaches to mental health treatment are often found to be unsuitable and culturally inappropriate to the needs of Asian communities who tend to view the individual in a holistic way, as a physical, emotional, mental and spiritual being (Mental Health Foundation United Kingdom, 2010).

Cultural patterns of illness

In the mental health context, somatisation is the term used when a client manifests mental health symptoms as physical symptoms. Tseng et al., (1990) report that many Asians tend to somatise and will avoid referrals to mental health clinics. This may be partly due to the stigmatisation of mental illness in most Asian cultures. In such cases, practical help is asked for more than psychological help.

Importance of family

In most Asian cultures, as collective societies, family is traditionally seen as of primary importance, and plays a significant role in all aspects of life. This is seen especially in terms of providing support and guidance through traditional values, such as filial piety, saving face, and maintaining harmonious relationships with others (Chan, Levy, Chung, & Lee, 2002; Kuo & Kavanagh, 1994). This is a recurring theme in studies of all Asian groups. To a large extent, the Western client-centred mental health system neglects the fact that a person is always a member of a social group. Family involvement might be seen as intrusive (Falloon, 1985). Concerns with confidentiality have also limited family input (Lin & Cheung, 1999). This individualistic emphasis is still strong today. Where treatment of Asians is concerned, the system needs to be more flexible and consider the well-being of the individual as part of the family unit, as well as the family.

Help-seeking behaviours amongst Asian people

Because collectivists consider the family as the basic unit of society, when a family member is ill, it is automatically assumed that the other family members will take responsibility for the ill person. Help-seeking becomes a joint venture, rather than an isolated decision by the consumer. The ability to have social support and connections is crucial to recovery. These support systems could also act as a preventative foundation.

Alternative treatments

Many Asians are known to seek alternative forms of treatment for mental health issues, as this is often considered more culturally appropriate and helpful (see O'Mahony & Donnelly, 2007; Yeung & Kam, 2006). Asian views have implications for mental health, including how it is perceived, health beliefs, help-seeking behaviours, stigma against people with mental illness, who holds control, and who influences changes, amongst other things.

Attitudes towards medication in recovery

Western and Asian attitudes toward medication in recovery may differ to some extent. For example, all Chinese consumers in a study of long-term individuals with schizophrenia in a rehabilitation facility based in Hong Kong (Ng, et al., 2008) acknowledged that taking medication is important, but most of them would not consider taking it themselves. Some consumers were of the view that being off medication means recovery.

The migration experience

While the migration experience is a positive one for many Asian immigrants, it is generally agreed that immigration to Western countries results in dramatic changes in language, social system, education system, lifestyle and work (e.g., Hsiao, Klimidis, Minas, & Tan, 2006). Such changes may result in a difficult and stressful time for many immigrants (Berry, 2001b; Harker, 2001; Sonderegger & Barrett, 2004; Sonderegger, Barrett, & Creed, 2004; Ward, 2006; Ward,

Masgoret, Berno, & Ong, 2004). Because of the many settlement issues immigrants experience, such as unemployment and social non-acceptance, many immigrants are known to experience psycho-social issues, such as poor acculturation and identity confusion, which have been associated with lower self-esteem, increased levels of anxiety, and poor mental health (Sonderegger, et al., 2004).

Employment issues

Psychological research conducted by Akhavan, Bildt, Franzén, and Wamala (2004) has shown that adverse socioeconomic circumstances start psychological, behavioural, and biological reaction patterns, which have a negative impact on both mental and physical health. This is supported by numerous other psychosocial studies (e.g., Banks & Ullah, 1988; Goldsmith, Veum, & Darity, 1996; Hammarstrom, 1994; Kokko, Pulkkinen, & Puustinen, 2000; Oswald, 1997; Rodriguez, Frongillo, & Chandra, 2001) and it is clear from this that employment issues need to be explored when working with Asian immigrant clients presenting at mental health services.

Coping with stress

When faced with the migration issues discussed above, families under stress often adopt dysfunctional ways of coping with their situations. This is exacerbated in youth who are not mature enough to deal with adversity in a positive way (Gance-Cleveland, 2004). Ho, Au, Bedford and Cooper (2002) state that the levels of stress endured by older immigrants should not be underestimated. Furthermore, inability to participate satisfactorily in the new society can lead to loss of status and self-esteem in individual family members, which can in turn lead to poor mental and physical health (Pernice, Trlin, Henderson, & North, 2000).

Service provision for Asian mental health consumers in New Zealand

Incommensurability between Western and Asian systems

A significant factor impacting on recovery, rehabilitation and relapse amongst Asian clients is the apparent incommensurability between Western and Asian health systems (Kozuki & Kennedy, 2004). Asian cultures differ in certain respects from the Western culture of New Zealand, and this difference is reflected in understandings of health and recovery, and in treatment preferences, amongst other matters (Chin & Kameoka, 2005). These can lead to misfit and misunderstanding between systems, providers and clients which could result in misdiagnoses and inappropriate treatment plans, which could significantly affect the client's recovery journey (Kozuki & Kennedy, 2004). This highlights the importance of the cultural appropriateness of mental health services, and of cultural competency and trust within the therapeutic relationship.

Cultural competency

The cultural appropriateness of mental health services may be the most important factor in the accessibility of services for people of different ethnicities. By developing culturally sensitive practices, barriers can be reduced, leading to more effective treatment and utilisation of services. Being culturally competent includes being culturally aware, which refers to acknowledging and appreciating the different values, beliefs, behaviours, and rituals of a particular culture (Cavaiola & Colford, 2006). This is important to better equip mental health professionals to work with culturally diverse clientele, to ensure that clients are understood and feel confident that they will have their needs met, and to enable culturally appropriate service provision. Building rapport is a critical component of competency development. Building trust with the client and their significant others will facilitate and enhance the client's participation in treatment.

Role of mental health providers

Relationship between the consumer and service provider in recovery

Providers of mental health services are considered an important environmental factor that can either support or hamper recovery. It has been demonstrated by Tarrier and Barrowclough (2003) that interpersonal interactions, including those with mental health professionals, significantly affect individuals with psychological or psychiatric disorders.

The extent to which mental health professionals embrace recovery-oriented principles and practices could predispose their attitudes and hopefulness concerning their client's prospects in recovery (Crowe , Deane, Oades, Caputi, & Morland, 2006; Haddow & Milne, 1995). Hence, Rickwood (2004) says that attitude shifts towards recovery (orientation) for mental health service providers are needed in order to implement practices that support and maximise the well-being of the consumer (Rickwood, 2004).

As the New Zealand population grows and changes, the shifts in ethnic diversity will increasingly require new approaches to be considered in service delivery to address cultural differences among mental health service users.

METHOD

Participants

Eleven Asian Mental Health Support Staff participated in the study. Six were core staff (the whole core staff team) and five were bureau staff who participated voluntarily. The majority of the staff received their mental health training after they settled in New Zealand.

Design

This research adopted an ecological approach (see Bronfenbrenner, 1979) and acculturation framework (see Berry, 2001a) to studying and understanding the mental health and recovery experiences of Asian consumers through their

service providers. A mixed-methods design was used which produced both quantitative and qualitative data and contributed to triangulation of the data. The quantitative survey enabled a multidimensional assessment and understanding of the key behaviour and attitudes that support or impede the recovery outcomes for Asian clients, while the qualitative interviews provided the key informants the opportunity to further explore relevant contextual issues. The study comprised of two workshops, a focus group discussion, case studies and evaluations. The RCM and WRAP were integrated, and tested for their impact on and appropriateness for Asian mental health cultural support staff and Asian consumers. The RKI was used to assess recovery knowledge and attitudes before and after the workshop.

The study consisted of seven phases shown in Figure 1:

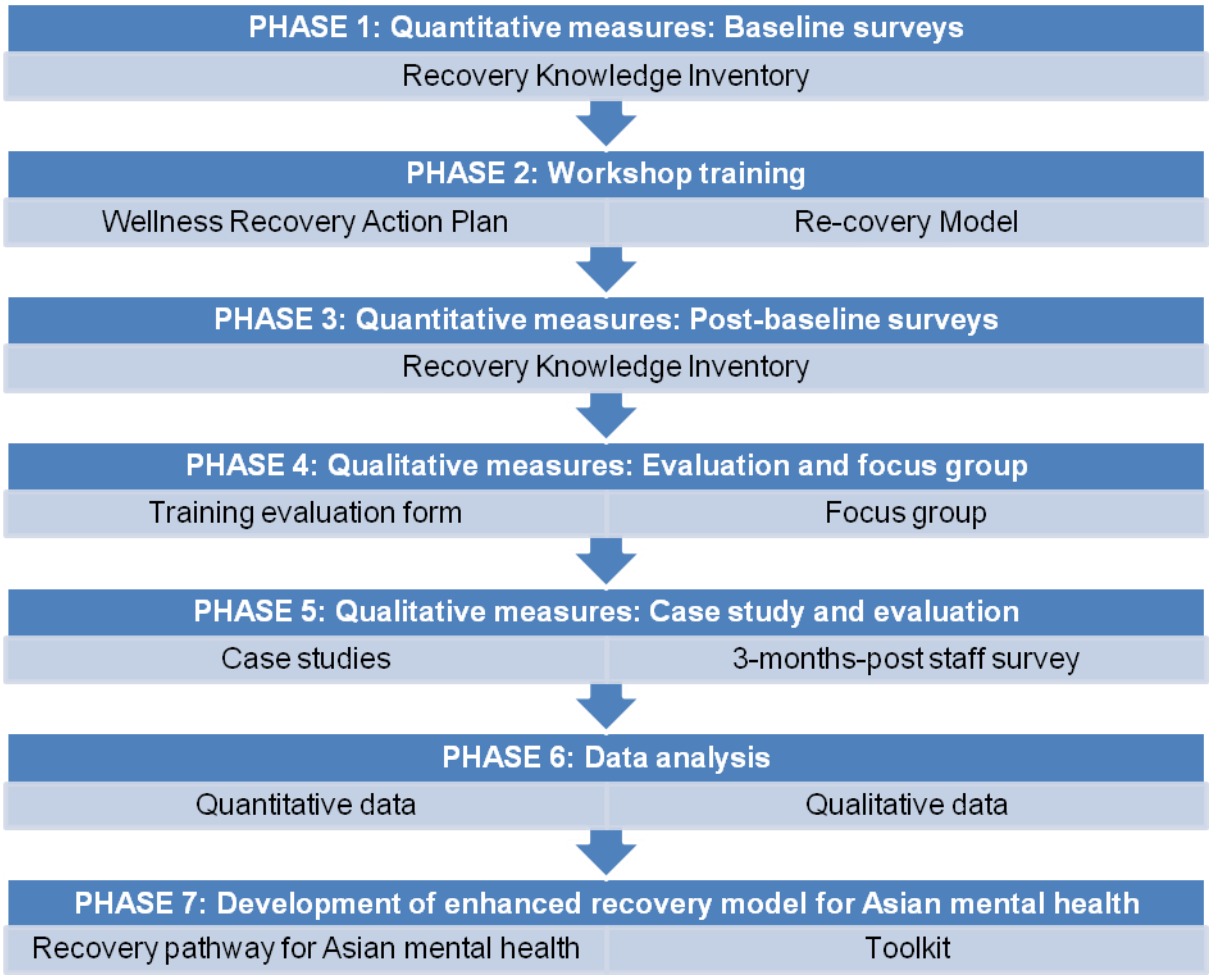

Figure 1. Outline of phases one to seven in the project

The Statistical Package for Social Science (SPSS) version 14 was used to do statistical analyses for the quantitative data. The qualitative analysis was conducted using a general inductive approach (Thomas, 2006) that enables the identification of themes, clusters and categories relevant to the project objectives.

Prior to any investigations ethics approval was gained by The University of Auckland Human Participants Ethics Committee (UAHPEC).

RESULTS

The results presented are a summary of the important components identified in this study.

Knowledge, skills, attitudes and behaviours of staff that support or impede implementation of recovery principles

The RKI results indicated that the staff's knowledge, skills, attitudes and behaviours supported recovery principles; that they were more recovery-oriented as a service provider after attending the workshop training, and appeared to be more aware of their role and responsibilities as a provider.This was supported by qualitative data e.g., staff were providing culturally appropriate care to their clients at the client's pace, meeting practical needs first, then exploring recovery goals. The quantitative and qualitative data indicated that their recovery-orientation increased after workshop training.

Asian staff's cultural beliefs and practices that influence implementation of recovery principles with Asian clients

The qualitative data from staff revealed the following cultural beliefs and practices that influence implementation of recovery:

- Differences in concepts of recovery could influence the implementation of recovery principles e.g., the meaning of recovery and the concept of empowerment.
- Hierarchical social structure played a part e.g., staff found it difficult at times when working with a client older than themselves, since the elderly are seen to have authority and respect in traditional Asian culture.
- Asian clients were accustomed to professionals being prescriptive about treatment and methods, so they may feel uncomfortable at the beginning about client-centred approaches, e.g. informed consent.
- Many Asian clients prefer to solve current issues and to receive support around practical needs, rather than having a "therapy session" about "recovery". Case study staff generally, at the first few meetings with new clients, explore practical solutions in helping the client address immediate stresses, e.g. making a referral to social services. Having immediate and practical needs dealt with first will enable the client to feel more comfortable with progressing to the next stage of talking in depth about aspects of recovery.
- Familiarity with Western models increases with time, and the more acculturated the client is to the New Zealand system, the more comfortable they feel towards client-centred tools. Being aware of the client's stage of acculturation was important, as this would mean using different approaches to meet their recovery needs. This awareness would also be useful in terms of understanding which recovery tools are appropriate for the client, e.g. sort cards, WRAP workbook.

Appropriateness and impact of the WRAP and RCM on staff knowledge, attitudes and behaviours about recovery

Overall, staff felt that the training with the WRAP and the RCM was appropriate for Asian mental health service providers; however, some parts of the RCM still need to be tested in order to see its effectiveness on Asian clients. For example, with the RCM's 5-part model tool, staff suggested that Asian clients often find it difficult to express their thoughts, feelings, body sensations and actions, and avoid focussing on the self and using "I statements". Instead, most Asians find it easier to speak about themselves in a third person context, e.g. "My mother thinks I'm…", rather than "I think I am...". Also, most Asian clients usually answer questions in a non-directive way, for example, instead of saying, "I thought I was useless in...(situation)", they will say, "There was nothing to do then". This may stem from the collectivistic nature of Asian cultures, where the collective is the focus rather than the individual.

Some staff felt that the RCM component in the training did not address particular cultural ways of working with Asian people when utilising the RCM, but they felt the WRAP worked with both Chinese and Korean communities. . This was also due to greater familiarity with the WRAP which had been utilised by staff for a longer period. More importantly, staff appreciated the fact that the migration context could be accommodated within bothmodels, which recognised the impact of migration on the mental health of Asians.

Recommendations & LImitations

Recommendations

Based on the data, the following recommendations are made for the adaptation of the training package for Asian staff working with Asian immigrant mental health clients:

- The WRAP continues to be utilised, with the emphases recommended above, as its tools are useful for Asian clients.
- The RCM is introduced into the training package, with the adaptations recommended above, as it increased the knowledge and understanding of staff during the workshops, and has some useful tools that can be used with Asian clients, e.g. the Building a Bridge of Trust and the Feelometer.
- The migration experience is included as a significant component in the delivery model used for treatment, as it is reported to be a major source or trigger of mental health problems for Asian immigrant clients.
- Culture should be emphasised in training, as it is a significant component. Cultural competency training should be compulsory for all core and bureau staff, with ongoing refresher courses to ensure that staff understand and appreciate the impact of culture on clients, staff and service provision. Cultural competency is also necessary at an organisational level and not only at an individual level.
- Self-reflection is included and emphasised as a component of cultural competency training, to enable empathy and improve service provision.

- The family should be a significant component of the recovery process to form a triadic relationship, rather than a dyad, between service provider and individual client.
- Practical needs of clients should be worked with first, especially those associated with the migration experience, as this can alleviate or eliminate some mental health problems.

These recommendations have been incorporated into the WRAP and RCM to create a suggested model of delivery for Asian mental health clients. The following significant components have been included, and examples of where and how they could be used are shown in Table 1.

Table 1

Components to be included in model of delivery

Component	How and when it could be included
Cultural competency and self-reflection for staff	**Cultural competency training should be provided to all mental health workers prior to working with clients. This should include self-reflection to create awareness about one's own culture, beliefs and practices, and their implications for service delivery. The organisation should also be culturally competent, not just the individual.**
Include family in client care	**It is important for the support worker to include family in the treatment process from the onset of treatment, and to work within this triadic relationship rather than a dyad.**
Build trust	**Build trust with the client at the beginning of the treatment process by including family and recognising the cultural context of the client.**
Recognition of individual as a cultural being	**Determine the cultural context of the client at the beginning to ensure understanding and empathy – the client is a cultural being with values, beliefs and practices that impact on treatment.**
Deal with practical needs	**Asian immigrant clients usually have practical issues associated with settlement that need to be resolved first, e.g. employment, isolation. This needs to be determined and worked with before delving into other mental health issues.**
Recognise the migration experience as a major source or trigger	**The migration experience is usually a major source of mental health issues for Asian clients or a trigger for dormant issues. This needs to be considered at the onset and these issues dealt with first as they may eliminate or alleviate mental health problems.**
Apply Asian models of health and cultural meanings of recovery	**Utilise Asian models of health where possible and appropriate, such as Chinese and Ayurvedic models, and consider cultural meanings of recovery for each client and how this may impact on treatment.**

This proposed model of delivery is depicted in Figure 2.

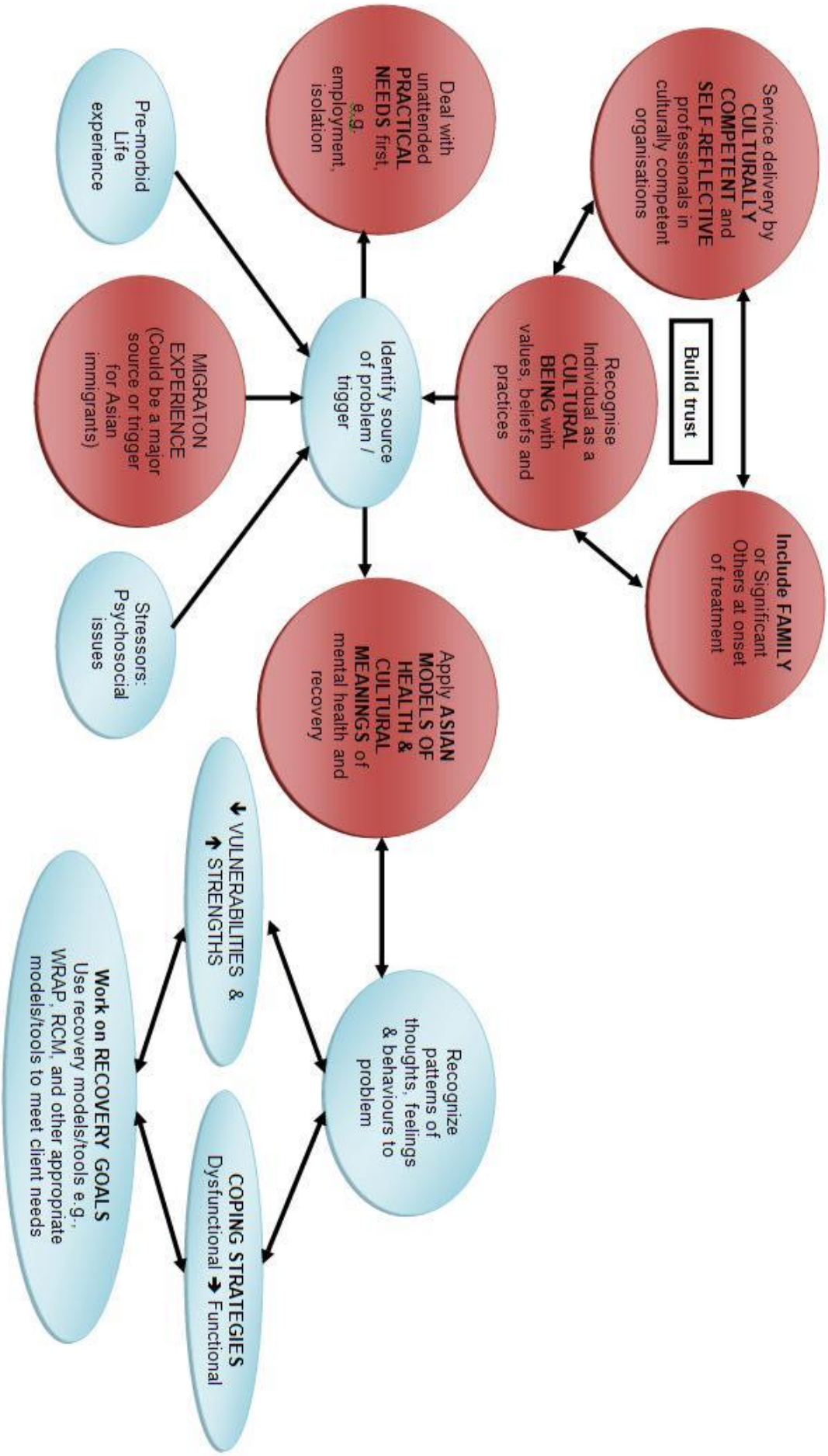

Figure 2. Recovery Pathway for Asian Mental Health

Limitations

The study has some limitations which are acknowledged below:

- The time-frame of project was short, which did not allow sufficient time between pre and post measures; workshop and post measures, for case studies, and to test the suggested model of delivery. Within the short timeframe, the workshop enabled introduction to the RCM, but not in-depth uptake. This requires further work.
- The sample size was small (n =11) due to the small team of support workers in the full team (n = 21); hence, findings cannot be generalised. While all core staff of this team participated in the project, it was difficult to recruit all of the bureau staff who are part-time employees.

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Physical Health and Wellbeing

Exploring weight status and migration in women from India and Pakistan living in Brisbane, Australia

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Abstract
This study aimed to explore the associations between acculturation, diet patterns and weight status in Indian and Pakistani women residing in Brisbane, Australia. An interviewer-administered questionnaire was used to collect socio-demographic characteristics, acculturation, physical activity, dietary pattern and anthropometric data from twenty-two women who identified as either Indian or Pakistani and who had been in Australia for at least one year. Results indicated that Pakistani women were more overweight and obese (30.8% and 38.5%) compared to Indian women (14.3% and 25%). Indian women were more acculturated than women from Pakistan and were more physically active than Pakistani women. The women appeared to have higher consumption of bread and cereals, fruit and vegetables groups than Australian women but were more likely to consume full-fat milk. The results are not statistically significant but are clinically as they show a trend towards obesity particularly among Pakistani women and towards higher chronic disease risk for both Indian and Pakistani women. The results highlight the need for early identification, prevention and treatment of obesity in these communities. It also demonstrates the need for culturally specific data collection and ethnic specific dietary recommendations in Australia in order to develop targeted programs at particular stages of migration.

INTRODUCTION

Australia has a diverse population, yet our understanding of the impact of migration on the dietary patterns of these diverse cultural groups and their chronic disease risk, in an Australian context, is limited. There has been little collection of meaningful dietary data from culturally and linguistically diverse (CALD) groups contributing to the vacuum of data that is required to develop effective nutrition programs.

When discussing changes to dietary patterns, acculturation describes both adaptations of some dietary practices to the host culture, as well as the maintenance of traditional practices (Satia-Abouta, Patterson, Kristal et al. 2002). Research has shown that the main impact of acculturation on dietary patterns, of those moving from less to more industrialized countries, is an increase in the consumption of energy dense foods and an increase in sedentary behaviour (Mellin-Olsen and Wandel 2005; Kolt, Schofield, Rush et al. 2007). This effect becomes more marked with time such that the length of stay in the host country is directly related to weight gain and an increase in risk factors for chronic diseases (Richman, Bermingham, Ko et al.

2000; Hayes, White, Unwin et al. 2002; Varghese and Moore-Orr 2002). These factors can be compounded by the fact that migrants are potentially disadvantaged in terms of accessing quality health care, particularly preventive health care, due to a lack of knowledge about the health care system, language barriers and differing beliefs and customs (Goel, McCarthy, Phillips et al. 2004; Kousar, Burns and Lewandowski 2008).

The majority of this research however, looks at migrants from countries that are in the early stages of the nutrition transition or are still experiencing widespread malnutrition. Little research has been undertaken looking at dietary changes and the trajectory of chronic disease among migrants from countries in later stages of the nutrition transition. India and Pakistan, for example, have both undergone demographic and epidemiological transition and are in stage four of the nutrition transition indicating the presence of degenerative disease (Popkin and Gordon-Larsen 2004; Pingali 2007). It is known that both men and women from South Asia have increased morbidity and mortality from chronic diseases, both in Australia and in their countries of origin (Jafar, Levey, White et al. 2004; Jafar 2006; Jafar, Chaturvedi and Pappas 2006; Kousar, Burns and Lewandowski 2008). While the traditional Indian and Pakistani diets are rich in grains, legumes, fruits and vegetables (Varghese and Moore-Orr 2002; Mellin-Olsen and Wandel 2005), the consumption of fast food and soft drinks have become increasingly popular in these countries (Pingali 2007).

Migration from India and Pakistan to Australia has, in recent years, doubled from seven per cent to 14 per cent. India is now the second largest source country for migrants, overtaking China with the Indian sub-continent now providing nearly 20 per cent of the total number of migrants (Australian Department of Immigration and Citizenship 2008). Queensland is home to 7.5 per cent of the total Indian population in Australia and 6.7% of the Pakistani population (Australian Department of Immigration and Citizenship 2009; Australian Department of Immigration and Citizenship 2009). To be able to effectively bring about behavioural change with respect to lifestyle, it is imperative that we understand the relationship between acculturation and dietary patterns.

This paper explores the association between acculturation and weight status among a sample of women from India and Pakistan living in Brisbane, Australia.

METHOD

Ethics approval was obtained from the Queensland University of Technology Human Research Ethics Committee. The sample for this study was women from India and Pakistan, currently residing in Brisbane, Australia. Women were recruited through community organizations, local schools and cultural events and then through a snowballing technique. Women were included in the study if they identified as either Indian or Pakistani; were living with children; had lived in Australia for at least one year and held a skilled migrant or family visa. Women were excluded if they were on either student or humanitarian visas as these visa types indicate forms of migration that could impact on the degree of acculturation and possible changes to dietary patterns.

Due to the exploratory nature of the study, the difficulty in recruiting from small minority groups and time and resource limitations, the aim was to recruit between 15 and 30 women with even numbers from India and Pakistan.

Data was collected on socio-demographic factors, acculturation, dietary intake, and weight status. All data was collected in the preferred language of the participant (Urdu or English) and collected via interview in the participant's home.

Socio-demographic characteristics

Socio-demographic data was collected to align with factors that are associated with the social determinants of health and included: age; place of residence; geographical origin; religious affiliation; income; education; and family (Burns, Friel and Cummins 2007).

Acculturation

Acculturation was determined using an adaptation of an acculturation scale developed in Australia with Arabic speaking adults (Rissel 1997). The scale utilises eight questions with a score range of five to 24 where five indicates no acculturation (no adoption of host culture) while 24 indicates a high level of acculturation to the host country (little retention of culture of origin). The score was divided into three categories, that is, low acculturation (score 5-10), moderate acculturation (score 11-20) and high acculturation (score 21-24).

Weight Status

Weight status was assessed by measuring weight, height and waist circumference using World Health Organisation (WHO) protocols. Weight was measured by an electronic weighing scale, in light clothing. Height was measured with a stadiometer and three readings were taken and an average was obtained. Body mass index (BMI) was calculated from measured weight and height, and is recognised internationally as the most sensitive assessment of weight status (World Health Organization 2000). Waist circumference was measured using standard procedures (Sundquist and Winkleby 2000). A waist circumference of 80 cm was considered low risk for chronic disease development, while above 88 cm was considered high risk (National Health and Medical Research Council 2003). As with BMI, there is considerable discussion regarding appropriate cut-offs for Asian populations. While the cut-off for 80cm is thought to apply for Asian women, a waist measurement of above 72cm warrants initial intervention (Vikram, Pandey, Misra et al. 2003; Misra, Wasir and Vikram 2005; Misra, Vikram, Gupta et al. 2006).

Statistical Approach

All statistical analyses were performed using SPSS version 16.0 (2007). Continuous statistics were described by using median and range as data was not normally distributed, while percentages and frequencies were used to present categorical data. The Chi square test was used to explore the relationship between two categorical variables. A Mann Whitney test for continuous variables across groups was used;

while a Kruskal-Wallis test was used for comparing the scores on continuous variables for three or more groups. As this is an exploratory study the small sample size means that results can be interpreted as a trend rather than as statistically significant and may not therefore be generalizable to the entire community.

RESULTS

Data was collected for a total of twenty-two women, eleven identifying as Pakistani (59.1%) and nine as Indian (40.9%). The median length of stay in Australia was four years (range one-25). The median age of participants was 38 years (range 24-50 years). Half of the women were working in paid employment, with the remaining half describing their employment status as home duties. 86% of women lived in suburbs identified as being of relative advantage while the remaining 14% of women lived in suburbs identified as being of relative disadvantage (Australian Bureau of Statistics 2008). All participants were married and living with male partners and/or in-laws. The median number of children was two with the range being one to five. The majority (90.9%) of women are living with at least one child under 18 years. The median number of people in each household was four (range three to seven).

Other characteristics of the women are presented in Table 1 including level of education, native language, religious background and country of origin. As noted, the women came from a variety of religious backgrounds and this was considered a variable due to the religious-based inclusion and exclusion of certain food items (Sevak, Punam, McCormack et al. 2004). Nearly 60 per cent of women identified as Islamic and 27 per cent identified as Hindu.

Table 1: Selected socio-demographic characteristics of the sample (n=22)

Characteristics		Percentage %
Country of origin	India	40.9
	Pakistan	59.1
Religion	Islam	59.1
	Hindu	27.3
	Christian	9.1
	Sikh	4.5
Native Language	Urdu	27.3
	Punjabi	27.3
	Pashto	9.1
	Telegu	9.1
	Sindi	9.1
	Gujrati	9.1
	Other	9.1

Level of Education	Up to secondary schooling	57.9
	Tertiary education	42.1

Acculturation

The median acculturation score was ten (range six-18). Scores were categorized into low acculturation (five to ten), moderate (11-20), and high (21-24). Half of the women were categorized as having low acculturation and the remaining half were moderately accultured. No participants were found to have an acculturation score categorized as high. More women from Pakistan (76.9%) had low levels of acculturation to the host country when compared to women from India (23.1%). Nearly twice as many Indian women are under the moderate acculturation category compared to Pakistani women (66.7% versus 33.3%). This difference was statistically significant (P=0.041)

Weight Status

The median weight of participants was 62.7kg (45.0-120.0 kg); median height was 1.55m (1.47-1.74m). Body mass index was calculated from the weight and height of each participant and median BMI was 24.9 kg/m^2 (17.4-43.0 kg/m^2). The median waist circumference was 83.16 cm (68.1-118.8 cm).

Table 2: Anthropometric measurements of the sample

Anthropometric measurements	**All women (n=22)**	**Indian women (n= 9)**	**Pakistani women (n= 13)**
Weight (kg)	62.7 (45-120)	59.0 (45.0-78.1)	65.0 (50.1-120.0)
Height	1.50 (1.4-1.7)	1.59 (1.5-1.6)	1.55 (1.47-1.74)
BMI (kg/m^2)	24.9 (17.3-43.03)	23.6 (17.36-30.0)	27.3 (20.7-43.0)
Waist (cm)	83.1 (68.1-118.8)	81.7 (68.1-95.0)	88 (70.8-118.8)

Tables 3 and 4 provide a breakdown of chronic disease risk based on BMI and waist measurement status respectively. Pakistani women were more likely to be at greater risk of chronic disease based on a waist circumference greater than 88 cm when compared to Indian women (54% and 33% respectively) (P=0.6). Over 80% of women had a waist circumference greater than the Asian waist cut-off of 72cm indicating the need for initial intervention. The prevalence of overweight (14.3%) and

obesity (16.3%) among Indian women was less than that of Pakistani women (30.8% and 38.5% respectively). However, it is important to note that while fewer Indian women were obese or overweight, 33% of Indian women had a waist circumference above 80 cm and the same percentage had a greatly increased risk, that is, a waist circumference above 88cm. Only one woman had a BMI less than 18.5kg/m^2. Only 13.6% of women indicated that they had been diagnosed as overweight or obese by a health professional.

Table 3: Chronic disease risk based on BMI status

BMI (%)	**All women (n=22)**	**Indian women (n= 9)**	**Pakistani women (n= 13)**
Healthy weight (18.5-24.99 kg/m^2)	45.0	66.6	30.8
Overweight ($\geq$25 kg/m^2)	27.3	14.3	30.8
Obese ($\geq$30 kg/m^2)	22.7	16.3	38.5
BMI (WHO cut-offs) (%)			
No increased risk of chronic disease (<23kg/m^2)	31.8	44.4	23.1
Increased risk (23-27.5 kg/m^2)	31.8	33.3	30.8
High risk (>27.5 kg/m^2)	36.4	22.2	46.1

Table 4: Chronic disease risk based on waist measurements

Waist Category (%)	All women (n=22)	Indian women (n= 9)	Pakistani women (n= 13)
No increased risk	27.3	33.3	23.1
Increased risk (80-87.99 cm)	27.3	33.3	23.1
Greatly increased risk (≥ 88cm)	45.5	33.3	53.8
Asian waist cut-off (>72cm)	81.8	77.8	84.6

There was an association between BMI category and religion where those who practiced Islam were more likely and those practicing Hinduism less likely to be overweight or obese. However, this association was not significant. There was no significant association between acculturation and BMI or waist measurement. The median length of stay for Indian women was found to be three years (range one-12); while for Pakistani women it was six and a half years (range three-25). While there did not appear to be an association between acculturation and obesity there did appear to be an association between command of English and length of time in Australia and higher rates of obesity which warrants further investigation. The majority of women who were identified as having a low acculturation score, that is were less likely to speak, think, read or write English, were from Pakistan and had been in Australia for between 3 to 25 years. These women were also more likely to be obese.

DISCUSSION

Most immigrants experience some form of dietary acculturation when they move to reside in a new country (Kim, Lee, Ahn et al. 2007). The level of dietary acculturation is affected by a number of factors including: availability of food items; cost; convenience; religion; number of years in host country; and age (Gilbert and Khokhar 2008). It has been found that after migration traditional diets can be modified leading to an increased intake of calories and fat as well as a decreased intake of complex carbohydrates mainly fibre (Jeongseon and Mabel 2004).The focus on women from India and Pakistan is relevant with a number of other studies undertaken in Europe and the United States of America showing that South Asian migrants are at increased risk of developing chronic diseases when compared to the host population. This increased risk is attributed to higher rates of obesity with a tendency towards an abdominal distribution of weight (Misra and Vikram 2004; Kousar, Burns and Lewandowski 2008). Although studies have been conducted in Australia and other developed countries, the strength of this study is that it is an effort to capture the factors that may contribute to or minimize obesity and chronic disease risk.

Acculturation

Acculturation describes the degree to which an individual has adopted the practices of their host nation; language is seen as a proxy for a range of factors. The measure of acculturation used in this case looked at the main language spoken in the home, with others, used to think with, read or write. In Queensland, the Indian community is quite large and established with approximately 11, 000 who identified their ancestry as Indian from the 2006 census compared to the Pakistan-born population at about 1100 persons (Australian Department of Immigration and Citizenship 2009; Australian Department of Immigration and Citizenship 2009).

When looking at acculturation it is hypothesized that the variance between Indian and Pakistani women could be attributed to the small Pakistani community in Brisbane and the need for a common language to develop a sense of coherence. This is less important in the larger Indian community where it would be more practical to maintain individual native languages and therefore ethnicities. This study demonstrates that language and not food was used to build a communal sense of public identity. The sense of identity however could extend to the maintenance of dishes from particular regions and this warrants further investigation.

While there did not appear to be an association between acculturation and obesity there did appear to be an association between command of English and length of time in Australia which warrants further investigation. The majority of women who were identified as having a low acculturation score, that is were less likely to speak, think, read or write English, were from Pakistan and had been in Australia for between three to 25 years. These women were also more likely to be obese. Being able to communicate in the host language may assist with the identification of healthy food items and in communication with health professionals. Similar results were found in Norway where migrants who had good command of the Norwegian language were less likely to consume butter. Chinese Americans residing in Pennsylvania showed that those who had a good command of English had a greater chance of consuming healthy food like grains, meat and meat alternatives (Ly and Cason 2004; Kumar, Meyer, Wandel et al. 2005).

Weight Status

The first main finding of this study is that half of the women originally from India and Pakistan are categorised as being overweight and obese. In addition, nearly three-quarters (72.8 per cent) of women from Indian and Pakistan had waist measurements that placed them in the "at risk" category for chronic disease. Waist measurements followed the same trend as BMI, that is the more acculturated the less likely the women were to have waist measurements that placed that at greatly increased risk (that is above 88cm).

BMI is a general measure of relative weight, while waist circumference provides an indication of abdominal adiposity which is a strong predictor of chronic disease risk (Adams and Subramanian 2008). These measurements are well accepted in Australia

and internationally (Nanan 2002; Kumar, Meyer, Wandel, Dalen and Holmboe-Ottesen 2005). There is however, considerable discussion regarding the cut-offs for BMI and waist circumference measurements indicative of increased risk for different ethnic groups, especially for those with Asian backgrounds (Misra and Vikram 2004; WHO Expert Consultation 2004). The WHO cut-offs for overweight are set at 25 kg/m^2 and over, and for obesity above 30 kg/m^2. There are indications that there are higher levels of body fat at lower BMIs in Asian populations although there is considerable variation across different groups. For many of these countries a BMI greater than 23 kg/m^2 is considered to indicate some risk of chronic disease while a BMI above 27.5 kg/m^2 is indicative of high risk. Using the WHO cut-offs 30% of women were considered overweight and 25% obese. Using the cut-offs for risk for Asian populations 31.8% of women were at risk (BMI >23kg/m^2) and a further 36.4% at high risk (BMI > 27.5kg/m^2) (International Diabetes Federation 2005; Commonwealth Department of Health and Ageing 2009). This suggests that for the South Asian population living in Australia the use of ethnic specific criteria for BMI will highlight a greater proportion of this population at risk of developing chronic disease.

When compared to other Australian women, these women from India and Pakistan have a comparable prevalence of overweight and obesity. In the 2007-08 National Health Survey using measured BMI, 30.9% of Australian women aged 18 years and over were overweight compared to 30% for these women and 24% and 25% were obese respectively (Australian Bureau of Statistics 2009).

Another important finding of this study showed that although nearly two third of participants are overweight or obese, only 13.6% indicated that a health professional had identified them as overweight or obese. This indicated that either these women do not access health professionals or have language barriers that prevent accurate communication. Alternatively health professionals may not be aware of the ethnic specific criteria for measuring obesity this again requires further investigation.

LIMITATIONS

As with many small studies there are a number of limitations including: the cross sectional design of the study made establishing a temporal relationship between exposure and outcome difficult; the small sample size meant that the results cannot be generalized however, they are still useful in indicating trends in obesity and overweight prevalence, adoption of Australian culture in this community. The questionnaire used in this study was adapted from validated questionnaires; however the final questionnaire was not validated.

CONCLUSION

This study indicates that the process of acculturation may have both positive and negative impacts on obesity and chronic disease risk for migrants coming from countries experiencing the later stages of the nutrition transition. It also demonstrates the need for more research of migrant populations in Australia, with larger sample size using a combination of qualitative and quantitative methodologies in order to understand the impact of acculturation on obesity and chronic disease risk among migrants. In particular this research raises questions such as, when should

interventions be introduced after migration? How linked is English language development to obesity and overweight?

ACKNOWLEDGEMENTS

The authors are thankful to all participants of the study. Also, thanks to Dr Katherine Hanna for her assistance in statistical analysis of the results.

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A HEALTH PROMOTING INTERVENTION PROGRAMME FOR THE SOUTH ASIAN POPULATION: FOCUS ON PROGRAMME DEVELOPMENT

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Abstract:

South Asians (SA) are at higher risk for lifestyle health related problems such as heart disease and diabetes primarily, due to poor dietary habits and a sedentary lifestyle. To promote awareness of heart disease and diabetes risk and to support changes in healthy eating and activity behaviours, a "Healthy Eating Healthy Action" (HEHA) programme was developed and implemented in the Mt Roskill suburb of Auckland, New Zealand. This paper focuses on the developmental process of a culturally appropriate programme for South Asians. This project was funded by the Auckland District Health Board and was done in partnership with The Asian Network Incorporated (TANI). A comprehensive health promotion programme was developed for the South Asian community to address the health issues for this population. The overall goal of the programme was to promote healthy eating and healthy activity among South Asians. The community's interpretation of healthy eating and healthy activity was used as a framework to ensure that the programme was culturally appropriate, achievable and sustainable. The process of programme development included three key steps. Firstly, key findings of the ANGELO Survey on knowledge gaps and behavioural changes considered relevant and changeable by the participants of the survey were identified. The second step in programme development was community engagement and was done by facilitating a HEHA open day, conducting education workshops with community and religious groups, facilitating group discussions with the community and by periodic engagement and consultation with the Project Advisory Group members. The third step in the process of developing the programme was to review national and international literature to identify nutrition and physical activity issues for South Asian immigrants in New Zealand and Overseas.The developed programme was culturally appropriate for the South Asian population and maintained cultural autonomy throughout the process of development.

Introduction

Studies done in New Zealand and overseas indicate an elevated risk for type 2 diabetes and Coronary Heart Disease among South Asian immigrants (Ministry of Health 2006; Kanya et al 2010; Kuppuswamy and Gupta 2005). International evidence indicates that the "healthy migrant effect" of new migrants mitigates as duration of residence increases (McDonald and Kennedy 2004). The process of migration can represent a substantial shift in a person's lifestyle and environment and these changes can result in rapid modifications in chronic disease risk (Ziegler et al 1993) due to changes in disease risk factors (Sundquist and Winkleby 2000).A change in environment is one of the major factors that could bring about positive or negative changes to food habits and activity levels. Changes in food habits are influenced by social context of migration, new social networks, the strength of ties maintained with country of origin, age, phase of life, work or school attendance, socio-economic status, duration of stay in the new country, employment, fluency in host language and other demographic factors (Satia et al 2002). Cultural factors also influence the degree of exposure to host culture, which in turn leads to changes in psychological factors, taste preferences and changes in food procurement and preparation (Satia et al 2002) leading to dietary acculturation. Physical activity levels can also decrease after migration due to the obesogenic environment of the Western world. Other reasons that may impact on activity levels include religious and cultural barriers, clothing barriers, lack of time, settlement issues, financial issues and poor adaptability to the new environment. Lower physical activity levels are reported for Indians in New Zealand and overseas (Scragg 2010; White 2004). Migration is an important contributing factor in the development of obesity and diet-related chronic disease patterns (Huang et al 1996) and hence efforts need to be directed to improve risk awareness and promote behavioural changes with respect to modifiable risk factors of chronic diseases namely eating and activity patterns among those at risk.

An important principle, on which the New Zealand Health Strategy is based, is "good health and wellbeing for all New Zealanders throughout their lives" (Ministry of Health, 2000). However, inequalities in health, especially among ethnic minorities including the Asian people, are highly prevalent in New Zealand (Ministry of Health, 2006). Asian people are the fastest growing ethnic group in New Zealand and efforts are currently directed towards assessing and tracking the health status and health needs of the Asian population. Among the Asian group, people of South Asian origin, i.e. people from India, Sri Lanka, Pakistan, Bangladesh, Afghanistan and Indians from Fiji and South Africa, seem to be most at risk for chronic diseases. The census 2006 statistics indicate that over 100,000 people of South Asian origin live in New Zealand, with the majority (> 80%) residing in the Auckland region (Statistics New Zealand, 2006). Current statistics indicate that South Asian people have double the risk for being on treatment for high cholesterol and a four-fold increased risk for diabetes compared to European New Zealanders (Scragg, 2010). Overseas studies have echoed similar findings for South Asian migrants in the United States and the United Kingdom (Kanya et al., 2010; Kuppuswamy & Gupta, 2005).

Evidence from national reports indicates that the majority of South Asians in New Zealand do not meet the recommendations on daily fruit and vegetable intake and

physical activity levels (Ministry of Health, 2006; Scragg & Maitra, 2005). Evidence also indicates that these low prevalence rates have remained the same in a 4-5 year period (Scragg, 2010).Beneficial effects of adequate physical activity and consumption of fruit and vegetables on chronic diseases are well established (WHO/FAO, 2003; US Department of Health and Human Services, 1996). The World Health Organization estimates that over 80% of premature heart disease, stroke, and diabetes and 40% of cancer can be prevented by increasing fruit and vegetable consumption and physical activity and reducing the use of tobacco. Hence, advocating and promoting healthy nutritional behaviours and increasing physical activity levels are public health measures for reducing the prevalence of chronic diseases in any population.

Healthy Eating Healthy Action (HEHA) is the New Zealand Ministry of Health's strategic approach to achieving good health and wellbeing for all New Zealanders (Ministry of Health, 2003). The HEHA strategy provides a framework to promote healthy lifestyle behaviours as a means of promoting health in the population. Based on this strategy, a health promoting initiative among South Asians living in the Auckland suburb of Mt. Roskill, New Zealand was developed, implemented and evaluated. This project was funded by the Auckland District Health Board and was done in partnership with The Asian Network Incorporated (TANI). The aim of the current pilot health promotion project was to promote awareness of heart disease and diabetes risk and to endorse and support changes in healthy eating and activity behaviours among South Asian people. To achieve this objective a "Healthy Eating Healthy Action" (HEHA) programme was developed and implemented in the Mt Roskill suburb of Auckland, New Zealand.

Methods: A comprehensive health promotion programme was developed for the South Asian community to address the health issues for this population. The long-term goal of the project was to promote healthy eating and healthy activity. The short terms goals of the programme focused on learning and aimed to increase awareness of health issues faced by migrant South Asians; increase knowledge about New Zealand guidelines on healthy eating and activity and the benefits; facilitate change in mindset/attitudes and increase the level of motivation, confidence and ability to change behaviour of self and others. Expected medium term outcomes were change in behaviour by adopting the New Zealand guidelines on healthy eating and activity.

The process of programme development included three key steps which are described below.

Firstly, key findings of the ANGELO Survey commissioned by ADHB and executed by SWAASTHH that were relevant to the current project were identified. The knowledge gaps identified were

1. knowledge of appropriate serving sizes

2. knowledge that takeaways, deep fried snacks, food with coconut cream, ghee and cream, and fizzy drinks/sharbats are largely fattening
3. knowledge that legumes, seeds, dhal, whole grain bread are healthy
4. knowledge on limits of time spent watching TV
5. knowledge of optimum physical activity to improve or maintain health

Behavioural changes considered relevant and changeable by the participants of the survey were as follows

1. changing cooking medium from ghee to oils
2. changing eating deep fried foods to toasted or grilled dishes
3. increasing amounts of fruits and vegetables eaten regularly
4. changing from high sugar drinks to water mainly

The second step in programme development was community engagement. Engagement with the community was done by facilitating a HEHA open day, education workshops with community and religious groups and a group discussion with volunteers. In addition periodic engagement and consultation was done with the Project Advisory Group members. Feedback on healthy eating indicated that the community had

1. low awareness of the national food and nutritional guidelines and their relevance to maintaining good health
2. misconceptions on healthier fats and optimum consumption quantities
3. low awareness of optimum cooking methods of vegetables
4. low awareness of health benefits of fruit and vegetables
5. low awareness of benefits of consuming low fat dairy products
6. low awareness of optimum quantities of food (portion size) and what constitutes a balanced meal

Feedback on healthy action indicated that the community needed more information on

1. inexpensive ways of increasing physical activity
2. how to incorporate physical activity in everyday life to achieve health benefits
3. using household chores as avenues for moderate physical activity
4. locally available facilities for increasing exercise levels

The third step in the process of developing the programme was to review national and international literature to identify nutrition and physical activity issues for South Asian immigrants in New Zealand and Overseas.

Issues with regard to healthy eating identified were:

1. Increased consumption of total energy (Lip et al 1995)
2. Increased consumption of total fat (Lip et al 1995; Wandel et al 2007)
3. Increased consumption of red meat, milk, butter, margarine and oil (Maheshwary and Wagle 2009; Wandel et al 2007)
4. Increased consumption of fruit juice, cola and alcoholic beverages (Raj et al 1999)
5. Decreased consumption of fruit and vegetable (Ministry of Health 2006)
6. Decreased consumption of beans and lentils (Wandel et al 2007)

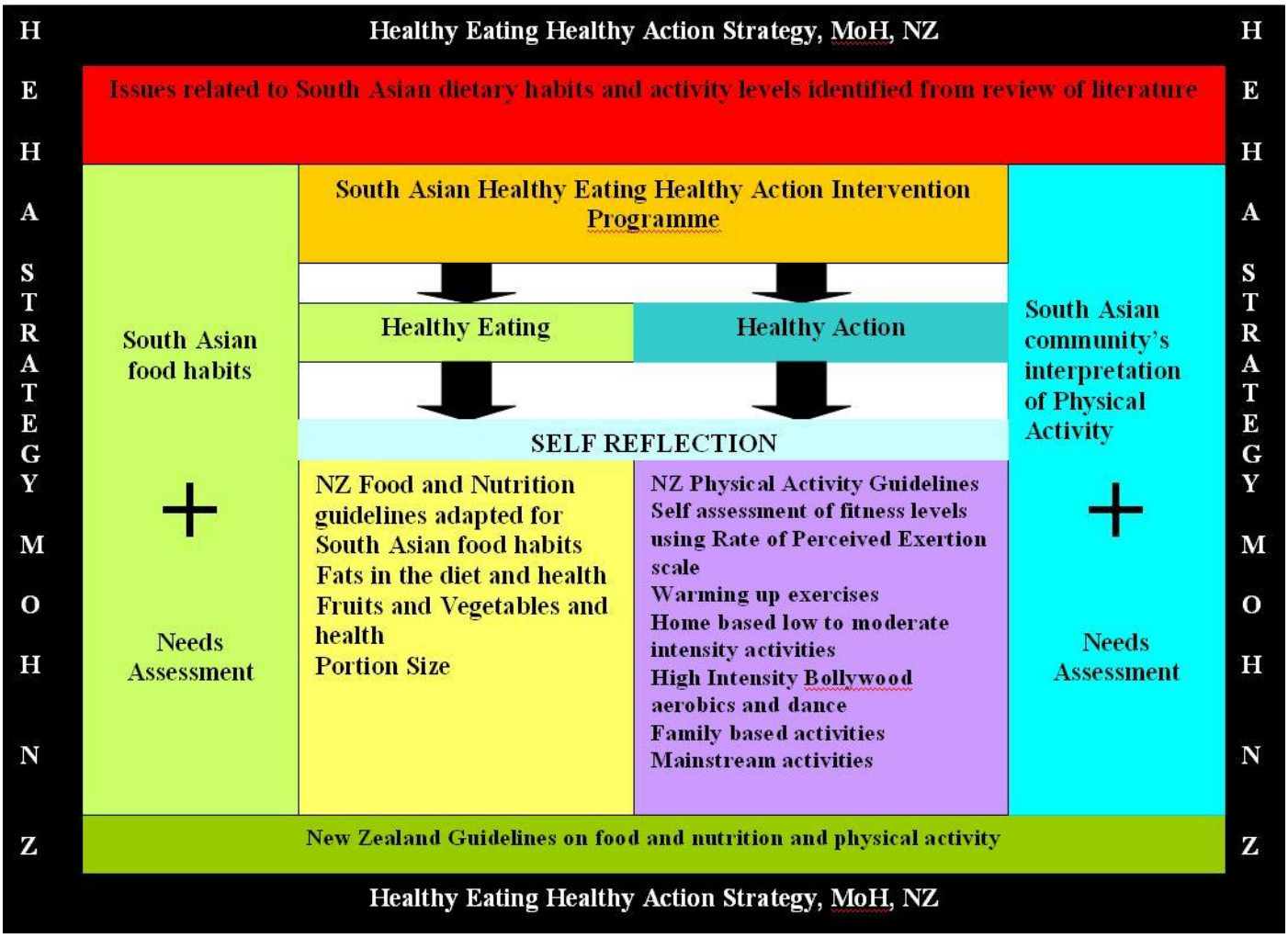
Issues with regard to healthy action identified were:

1. Low levels of physical activity compared to total population counterparts in New Zealand (Ministry of Health, 2006)
2. Only one in three older South Asian adults are likely to be active (Kolt et al., 2007)
3. Physical activity levels decrease upon migration to a western country (Mahajan and Bermingham 2004)
4. Increased levels of household chores upon migration is considered as adequate physical activity by women (Lawton et al 2006)

Results:

Figure 1 depicts the building blocks of the developed programme. The foundation of the developed programme was the national guidelines on healthy eating and healthy action. Adaptation to the New Zealand food and nutrition guidelines were made to make it more relevant to South Asians. A self-reflection component was also included in the programme to facilitate desired behavioural changes. Healthy eating and activity issues pertinent for South Asian migrants identified from national and international sources of literature formed the core of the programme. Engagement with community and religious groups enabled the identification of specific issues of various South Asian subgroups. This process also enabled identification of the community's interpretation of healthy eating and healthy action, which formed the platform to develop a culturally appropriate, achievable and sustainable intervention programme.

Figure 1: Building Blocks of the South Asian Healthy Eating Healthy Action programme



Conclusions: The process adopted for developing an appropriate programme to promote healthy eating and action among South Asians was successful in ensuring that the programme was comprehensive, culturally appropriate and sustainable. Cultural autonomy was maintained throughout the process of development.

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Exploring socio-cultural factors related to diet and physical activity for women from India and Pakistan living in Brisbane: a pilot study.

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Abstract
This research is part of an overall study exploring the associations between acculturation, diet patterns and weight status in Indian and Pakistani women residing in Brisbane, Australia. This paper reports on responses from twenty-two women to semi-structured qualitative interview exploring socio-cultural factors affecting food consumption and the concepts of "physical activity" and "exercise". The interviews were transcribed verbatim and analysed for major themes. The four primary themes identified were: using food to (re)create home; health took precedence over all other considerations in food choice; the food preferences of children and husbands are privileged; and housework is physical activity and so exercise is an optional activity. This study indicates that the development of programs for this population to promote healthy eating and reduce the risk of chronic disease will resonate strongly but also need to consider the cultural value of foods and involve all family members. In addition, more culturally sensitive physical activity guidelines need to be included.

INTRODUCTION

Australia has a diverse population, yet our understanding of the impact of migration on the dietary patterns of these diverse cultural groups and their chronic disease risk, in an Australian context, is limited. There has been little collection of meaningful dietary data from culturally and linguistically diverse (CALD) groups contributing to the vacuum of data that is required to develop effective nutrition programs. In recent years, the proportion of migrants from southern and central Asian countries has doubled from seven per cent to 14 per cent. India is now the second largest source country for migrants, overtaking China with the Indian sub-continent now providing nearly 20 per cent of the total number of migrants (Australian Department of Immigration and Citizenship 2008). Queensland is home to 7.5 per cent of the total Indian population in Australia and 6.7% of the Pakistani population (Australian Department of Immigration and Citizenship 2009a; Australian Department of Immigration and Citizenship 2009b).

A review of the literature suggests that diet patterns and their changes on migration are complex and multidimensional (Kumanyika 1993). Most immigrants experience some form of dietary acculturation when they move to reside in a new country (Kim et al. 2007). The level of dietary acculturation is affected by a number of factors including: availability of food items; cost; convenience; religion; number of years in host country; and age (Gilbert and Khokhar 2008). It has been found that after migration traditional diets can be modified leading to an increased intake of calories and fat as well as a decreased intake of complex carbohydrates mainly fibre (Jeongseon and Mabel 2004). It has been observed that for migrants, length of stay in the host country is directly related to weight gain and an increase in risk factors

for cardiovascular and other non- communicable diseases (Bhopal et al. 1999; Richman et al. 2000; Hayes et al. 2002).

Research undertaken on twenty-two women from India and Pakistan residing in Brisbane, Australia for more than twelve months indicates that nearly one-third of Indian women and over two-thirds of Pakistani women are overweight or obese. Over 80% of women had waist measurements greater than the Asian cut-off of 72cm indicating the need for early intervention to help prevent the onset of chronic disease (Gallegos and Nasim 2010). The quantitative data collected as part of this study provided an understanding of the size of the problem and some details regarding the foods eaten. However, more information was required in order to understand the experience of food provisioning and in order to better design culturally appropriate dietary interventions. Interviews are commonly used in health related qualitative research, helpful in understanding particular aspect "in depth" (Liamputtong 2006).The quantitative approach of the study is published separately while this paper will cover the qualitative approach.

METHODS

Ethics approval was obtained from the Queensland University of Technology Human Research Ethics Committee. The sample for this study was women from India and Pakistan, currently residing in Brisbane, Australia. Women were recruited through community organizations, local schools and cultural events and then through a snowballing technique. Women were included in the study if they identified as either Indian or Pakistani; were living with children; had lived in Australia for at least one year and held a skilled migrant or family visa. Women were excluded if they were on either student or humanitarian visas as these visa types indicate forms of migration that could impact on the degree of acculturation and possible changes to dietary patterns.

Due to the exploratory nature of the study, the difficulty in recruiting from small minority groups and time and resource limitations, the aim was to recruit between 15 and 30 women with even numbers from India and Pakistan.

Data was collected on socio-demographic factors, acculturation, dietary intake (food frequency and food diary), and weight status (weight, height and waist measurement). At the completion of this data collection participants were then asked a series of open-ended semi-structured questions. Interviews were conducted in the preferred language of the participant (Urdu, English or Hindi) and collected via interview in the participant's home. The interviews were conducted by one interviewer who is Pakistani in origin and who is fluent in Urdu, English and Hindi and took on average thirty minutes to complete. The questions asked as part of the qualitative interview were designed in light of previously conducted studies and piloted with one Indian and one Pakistani woman in order to ensure the questions were understood and reasonable. Participants were made aware that they could refuse to answer any question or stop the interview at any point. Four questions related to diet and encompassed the relationship between food and identity, availability of food items and household food production as they related to dietary acculturation (Mellin-Olsen and Wandel 2005; Benari et al. 2007) (Ristovski-Slijepcevic et al. 2008). Two questions were asked about physical activity and exercise, the first question to discern how much physical activity women were

undertaking and the second relating to their perceptions around what constituted physical activity and how this differed from exercise (Marshall, personal communication, 2009).

Data Analysis
Ideally the interviews should have been translated into English and back-translated into the first language and checked with the participants to ensure meaning was not lost. However, this was not possible due to time and financial constraints. Each response was analysed for general themes independent of country of origin.

RESULTS AND DISCUSSION

Twenty-two women participated in the study. Their median age was 38 years (range 24-50 years) and the median length of stay was 4 years (range 1-25 years). Half of the women were working in paid employment; the remaining half described their employment status as home duties. The median number of children was two with the range being one to five. The median number of people in each household was four with the range being three to seven. In describing religious affiliation, 59.1% identified as Muslim, 27.3% as Hindu, 9.1% as Christian and 4.5% as Sikh. Over half of the women (57.9 per cent), had a tertiary level of education up to a bachelor's or medical degree with an additional 42.1 per cent holding a Masters degree from their country of origin. It is important to note that the schooling system in Pakistan and India are different to Australia and may not necessarily equate to the same numbers of years of schooling. Half of the women were identified as having low levels of acculturation, that is, they had not assimilated many aspects of the host country and the remaining half had moderate levels of acculturation. Despite at least one woman being in Australia for 25 years no women had high levels of acculturation.

In analyzing the qualitative interviews four main themes were identified: using food to (re)create home; health takes precedence over all other considerations in food choice; the food preferences of children and husbands are privileged; and housework is physical activity and so exercise is an optional activity.

Using food to (re)create home

Women made a strong association between particular foods and their home country. The preparation of certain dishes brought the sense of "home" much closer and provided a link with those still living in their country of origin. There was a sense that food practices that were "healthy" needed to be maintained including concepts of hot/cold, avoiding certain foods at certain times or seasons. In addition, the retention of food practices was seen as important for children so that when they returned to India or Pakistan they would recognise and consume certain foods. The main food item they want to maintain by most of participants was roti/chappati (these two terms are often used interchangeably).

> *In Pakistan we have tradition of making pakoras and samosas in the rainy season, so I make such items here Australia and feel that I am in Pakistan*. (*Participant 13)*

> *I want to maintain food traditions from my country so when we go back to India our children will be familiar with Indian food and our relatives will not feel embarrassed by not providing Australian food. (Participant 18)*

A few women did not make the connection between the preparation of certain foods and identity arguing either that their meal pattern had not changed or that they were fully acculturated.

> *I am following the same dietary pattern as in my country. (Participant 8)*

> *There is no such association since I have been living in countries other than India for last 23 years. (Participant 17)*

Most women found that all the ingredients they required for the preparation of culturally specific foods were available; however, they were at a higher price and did not necessarily have the same taste or flavour. The availability of certain equipment and utensils such as the tandoor (oven) and karahi (a utensil used for making curries) was an issue that impacted on the ability to make foods with a certain recognisable flavour.

> *In India I used to make fish curry in a clay utensil, here it is not available so it's not much tasty here. (Participant 3)*

While there was a definite link between cooking foods from the country of origin in creating a sense of identity this was tempered by practical considerations such as time and convenience. Time was a particular factor for women in the paid workforce.

Most women mentioned that after coming to Australia breakfast had totally changed or was completely missed. Women working in the paid workforce indicated that they either skipped breakfast due to a lack of time or were consuming breakfast cereals which were quick to eat and gave a feeling of fullness. Women not in paid employment and who were alone at breakfast said they tended to skip breakfast and only eat it on the weekend when their husbands and children were at home.

> *Breakfast is changed because of busy life, I eat cereal which are healthy, quick, and give a feeling of fullness. (Participant 12)*

> *Totally changed, because of time and I am alone at home, only on weekend I eat proper breakfast. (Participant 19)*

Traditional breakfasts tended to be consumed only on the weekend when there was adequate time for preparation. Traditional paratha or roti were replaced by breakfast cereal as women did not have the time or the assistance to prepare these.

> *[Breakfast is] totally changed, as in India my mother used to make breakfast for me, here I only eat a light breakfast. (Participant 17)*

The lunch time meal had changed for both working women due to time and convenience and for women at home due to lack of company and the age of their children. Women in paid employment were eating more western foods and convenience foods in the workplace. They were also dining out more often.

> *At the start I totally skipped [lunch] because I was alone, now as my child is growing I make lunch for him and I also eat. (Participant 5)*

Dinner had also changed and was described as a combination of traditional and western food mainly to accommodate children. However, it was always fresh, hot and an occasion where all family members ate together.

> *It contain both traditional and western food, I eat dinner because my husband is at home*. *(Participant 4)*

Women are using food to create a sense of home, what Hage (1997) describes as a sense of security, familiarity, community and possibility. This creation of "home" occurs both privately and publicly with the creation of an ethnic boundary. Formation of these boundaries is described in the private sphere where food is one of the things used to provide "a stable homely structure from which they can have access to a better life in Australia" (Hage 1997:110). In the public sphere, food as one of the practices of home-building fosters "intimations of homely communality" (Hage 1997:111). Food is a medium for examining and constructing identity regardless of whether we are considering migrant groups in alien environments or mainstream groups on "home" soil. Ethnic food is no longer a simple marker of a group's boundaries but now takes on a whole range of other issues relating to self-identity that need to be viewed in the context of globalisation, the diasporas, and survival in a risk society. As James (1996) indicates:

> the abundant referencing of identity through food consumption practices contains excluding, and often contradictory, statements about cultural identity. Mobilized in different social contexts and at different times through particular food items, fine lines of discrimination are revealed, markers of differences which are used to distinguish the Self from other selves in everyday life. (James 1996:80)

Changes in meal patterns for migrants have been well documented overseas (see for example, (Gillespie 1995; Ray 1998; Lee et al. 1999; Raj et al. 1999; Gilbert and Khokhar 2008; Wandel et al. 2008). These studies have shown that, breakfast and lunch have changed but more "traditional" meals are retained for "the major meal at dinner, which has higher emotional attachment" (Lee, Sobal and Frongillo 1999:1089). Skipping breakfast altogether has also been documented in other migrant groups. A study conducted in the US among Chinese immigrants found a similar pattern with 62% of participants skipping breakfast with the main reason a lack of time (Ly and Cason 2004). Similarly, among Sub-Saharan African migrants in Melbourne, 21% of the sample indicated they skipped breakfast due to a lack of time(Renzaho and Burns 2006).

Health takes precedence over all other considerations in food choice

The main factors considered by women in the selection of food items were health, followed by taste and tradition. The qualitative interviews revealed that most participants considered any non-traditional food as western food, and did not distinguish Australian food specifically. All women irrespective of country of origin

replied that it did not matter that food was traditional as long as it was healthy. For most participants, cost did not appear to be an important factor. Foods considered healthy by participants were fresh, well cooked, and included a variety mainly vegetables and fruits. Foods high in sugar, fat, that were more processed or refined items and junk food were considered as unhealthy.

> *Firstly health, it doesn't matter whether it's Pakistani or Western, also it doesn't matter if it's expensive or not (Participant 5)*

Most women considered the healthy aspects of Australian food to be the high consumption of fruit and vegetables, less cooking and the higher awareness of eating healthy food. Within the Indian and Pakistani diet roti/chappati was considered as the healthiest components followed by spices as theses were thought to help with digestion.

> *I think Australians always eat food in original form. If they cook any food they even don't add salt and pepper and at the end of cooking they will keep salt and pepper separate. (Participant 4)*

The unhealthy aspects of the Australian diet were thought to be the higher intake of snacks, junk food and fast foods. The unhealthiest aspect of traditional food identified by women was overcooking as it causes loss of nutrients.

> *Healthy, food items from every food group, then taste, e.g. steamed veggies are healthy, but I don't like taste, so I will find some alternative and eat veggies as salad which are equally health but good in taste. (Participant 8)*

Considerations of healthy and unhealthy came from a number of sources including friends, children, the internet and television and tended to follow a modern, western scientific nutritional sense rather than a personal, objective opinion (see also (Murcott 1993; Santich 1994). Women who had been in Australia longer were less likely to be obese and this could relate to the ability to understand health-related information in English. A greater understanding of the host language can contribute to the consumption of healthier food options after migration (Satia-Abouta et al. 2002). A command of English might be helpful in identifying healthy food items and in communicating with health professionals. Similar findings have been reported in Norway where those who had a good command of the Norwegian language were less likely to consume butter (Wandel, Råberg, Kumar et al. 2008). Another study conducted among Chinese Americans residing in Pennsylvania showed that those who had a good command of English had a greater chance of consuming healthy food like grains, fruits, meat and meat alternatives (Ly and Cason 2004).

Food preferences of children and husbands are privileged

When it came to preparing meals, the majority of women (especially those not in paid employment) indicated that this was their responsibility although other family members did help.

I do the cooking myself, as I am not working, I have lot of time, and I don't want to put extra burden on my family members, as they are quite busy, but still when they come home, they help me. (Participant 16)

While the majority of women indicated that cooking was their responsibility, grocery shopping was considered a family affair to enable all the family to choose the foods they wished to consume. Initially all women indicated that it was their choice as to what food was prepared when asked for more detail the majority of women indicated that the choice regarding what was eaten were based on the preferences of their husbands and/or children. Women indicated that the preparation of food and the privileging of their husband's and children's food choice was their way of expressing concern and by following their choices they could maintain harmonious family relationships. The family still came together for the evening meal but the women indicated that this was generally a combination of traditional and Western foods mainly because their children had adapted to both healthy and unhealthy Western foods.

I always followed my husband and children likes and dislikes. I never choose anything particularly for me, whatever is cooked I eat. (Participant 8)

I always prefer my husband and children choices as I can't afford to cook food and then waste it. (Participant 13)

Children often made requests for unhealthy foods and the majority of women indicated that they offered these foods as snacks rather than meals. It did however depend on the age of the children. Women with children less than 3 years indicated that their children currently have no choices and they wanted to train them to eat healthy foods and a balanced diet irrespective of traditions. For women with children aged between 5-10 years women indicated that their requests for unhealthy food were only allowed as long as they did not replace "proper" meals. This was important so they grew up being able to make healthy choices. Women with children over the age of 10 years said their children were more health conscious and tended to make healthy food choices they had learned from the internet and school.

This pattern of privileging the food preferences of husbands and children has been described previously (see for example (Charles and Kerr 1988; DeVault 1991). In families where women assume responsibility for household tasks female self-interest are subsumed by the family's or husbands interests. Women feel they had control over day-to-day food choice but they still continued to provide the foods their husbands preferred (Brown and Miller 2002). There are implications for the introduction of healthy food practices if such practices are in conflict with husband's or children's preferences. This finding in Pakistani and Indian families living in Brisbane is worthy of further investigation.

Housework is physical activity and so exercise is an optional activity

Women were asked an open-ended question about what they considered to be physical activity and what they considered as exercise. The majority of responses indicated that the terms physical activity and exercise are used interchangeably. Most participants considered physical activity as a part of the work of daily life, for example, household work, particularly cleaning, was considered to be compulsory, not continuous and not optional. In other words it was a duty and did not necessarily count towards healthy practice. Most of the participants considered exercise to be good for their health, irrespective of whether they were participating in either regular exercise or physical activity.

> *For me, household work and childcare is physical activity. (Participant 3)*

Exercise was considered to be an activity that was assigned to a special time, it was optional and continuous. It was not considered to be part of the daily routine. Exercise implied that they were health conscious and taking care of themselves. South Asian women living in the United Kingdom have also indicated that they consider exercise as a formal activity rather than a component of lifestyle (Farooqi et al. 2000).

> *For me household work, climbing stairs is physical activity, I can take intervals in between while exercise is continuous and I can't take intervals. (Participant 20)*

The analysis of qualitative questions of this study shows that Indian women living in Brisbane were more physically active than Pakistani women. The results of this study seem to support work undertaken in Newcastle, England, that indicated Indian women were more physically active when compared to women from Pakistan (Bhopal, Unwin, White et al. 1999). In Pakistan and India, the level of physical activity undertaken by women depended on socioeconomic status and where women were living (that is either in a rural or urban setting). Pregnant women living in a major city in Pakistan undertook on average of 127 minutes/day, including work, transportation, household chores as well as leisure time activities (Iqbal et al. 2006). A study comparing physical activity levels among two South Indian populations, one in India and one in Sydney, found that women residing in India spent significantly more time walking compared to their Australian counterparts (Mahajan and Bermingham 2004).

When questioned further, the Pakistani women indicated that in Australia they were doing more physical activity due to an increase in household work (usually undertaken by maids in Pakistan not available in Australia) and this meant there was no need for additional exercise. Pakistani women residing in the United Kingdom shared this view that is that high levels of household work negated the need for additional exercise (Lawton et al. 2006). When looking at other migrants who have moved from less developed to more developed countries there is a trend to less physical activity. However, like the participants in this study, many believe they have integrated physical activity into their daily lives (Sundquist and Winkleby 2000; Lu et al. 2008).

For Australian women major life events, such as starting a new job, getting married, and starting a family can have a negative impact on physical activity (Brown and

Trost 2003). For migrants these events are compounded by a switch to a completely new environment. For some cultural groups this can improve physical activity, however, for women from India and Pakistan it would appear to potentially cause a decrease.

CONCLUSION

This study raises some important questions regarding the relationship between food and health for migrants. In particular it raises issues such as: conceptualizations of what is considered "healthy" and "unhealthy" in terms of diet and physical activity; the important role of food in maintaining ethnic and self identity and whether this transcends health considerations; and whether healthy dietary changes are possible if they are not sanctioned by husbands and children. These have implications for working with families from India and Pakistan who have migrated to Australia in making dietary and physical activity changes to manage obesity and chronic disease. It is clear that more research needs to occur with this population and other migrant communities in Australia, with larger sample sizes using a combination of qualitative and quantitative methodologies.

The results from this study will be useful for practitioners in identifying populations most at risk of chronic disease with the view to developing interventions that will reverse the development of these risk factors. It will assist in the planning of nutrition education programs for South Asians living in Australia, in order to improve the making of informed decisions regarding adaption to new eating patterns and the making of healthy food choices in their new environment. More research needs to be undertaken to ascertain when in the migration process interventions should be delivered in order to minimize the take up of unhealthy host country food choices and the retention of healthy traditional foods.

ACKNOWLEDGMENT

The authors would like to acknowledge all participants for their cooperation in the study. Also, we would like to thank Dr Alison Marshall for her guidance regarding qualitative questions for "Physical activity" and "Exercise". This work was undertaken in part completion of a Masters in Public Health by coursework for Sumaira Nasim.

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Injury behaviour and attitude of young Asians in New Zealand:

A stakeholders' perspective

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Abstract

Background: Injury death rate for Asians in New Zealand (NZ) was 27/100,000 during 1993 to 2002. One third of unintentional injury among 20-25 year old Asians was attributed to road traffic crashes and another one-fifth to falls. Risk factors and risk-taking behaviours, environment and individual variations in attitudes influence the occurrence of injury. Clear understanding of Asian injury behaviours and stakeholders view would be beneficial in appraising the situation. This study examines stakeholders view points on injury risk behaviours and attitudes towards injury prevention among Asian youths in Auckland.

Methods: Information was collected by face-to-face individual interviews with key stakeholders who had regular contact with tertiary students and were aware of their injury risks and behaviours. Analysis used statements of discussants as the basis of describing the findings.

Findings: Domestic injuries of Asian migrant students from affluent background were linked to their inexperience in domestic or kitchen work. Other injuries resulted from unprovoked race-related street assaults by locals. Road traffic injuries may be attributed to the driving quality of Asian youths that may be influenced by traffic orientations in their country of origin. Some Asians are reluctant to seek medical help for their injuries due to under-the-table employment situations. Asian youths are quite reactive to minor injuries, and expect robust medical procedures for minor problems. Mental health and suicidal status is hard to assess due to the attached stigma. A protective factor against injuries may be the limited involvement with alcohol and drugs amongst Asian youth, due to family pressure against such behaviour.

Conclusions: Asian family values are protective against injury risk behaviours, and negative parental attitudes may have the opposite effect. Great concerns were expressed regarding under-reporting of injuries and unprovoked racial attacks on Asian youths. Mental health and suicidal behaviour of Asian students need to be explored. Further research and information dissemination and culturally acceptable prevention programmes are advocated.

Background

Injuries constitute one of the leading causes of premature death in New Zealand (Dyson, 2003). A recent analysis reported an annual injury death rate of 27 per 100,000 population for Asians in New Zealand (Hoque, Lee, & Ameratunga, 2006). One third of all road traffic crash injuries occurred among young Asians aged 20-25 years old. Given the growing number of young Asians in New Zealand, both in permanent and temporary resident categories, it is imperative to identify the contributing factors of injury incidents and the injury behaviours in this population.

Knowledge on risk factors and risk-taking behaviours that influence the occurrence of injury (Alexander, Somerfield, Ensminger, Kim, & Johnson, 1995; Shaughnessy, Doshi, & Jones, 2004; Ward, 2004; Wesner, 2003; Westaby & Lee, 2003), as well as the environments that predispose people to such events (Grossman & Rivara, 1992), are vital for developing an effective injury prevention strategy. A number of important psycho-social factors that may influence injuries among youth has been considered, such as social influences and risk-taking orientation (Gibbons, Helweg-Larsen, & Gerrard, 1995). Recent studies suggested three important sources of social influence that predict youth risk-taking perceptions (Westaby & Lowe, 2005), and are categorised as supervisory, peer, and parental influences (Latane, 1981).

It has also been observed that the directions and monitoring of superiors on their subordinates' safety behaviours have a positive effect on the reduction of injury (Zohar, 2002) and that peer influences may have effects on individual behaviours, as youths are predicted to adjust their behaviour to match with their peers to gain greater acceptance (Brown, Clasen, & Eicher, 1986). Social modelling processes theoretically state the expected influence of parental risk-taking on the perception and tendency of youth's risk-taking behaviour (Bandura, 1986; Shah, 2003). Several studies have demonstrated that parental influence may impact on children both negatively with risk-taking behaviours (Raffaelli & Crockett, 2003) and positively with preventive behaviours (Peterson, Farmer, & Kashani, 1990). Conversely, risk-taking orientation is reported to be influenced by intentional engagement in acts that may have elements of physical danger – causing traffic violations and injury (Elander, West, & French, 1993; Horswill & McKenna, 1999; Parker, Stradling, & Manstead, 1996).

Individual variations in attitudes are important components in assessing risk-taking behaviour, with Baron and Kenny (1986) reporting that safety cognitions are mediated by various factors like time spent in external activities, participation in safety activities, self-esteem, leadership, self-concept and gender. It was also reported that self-esteem exhibited a more complex functioning with both positive and negative safety outcomes and predictably, females exhibited better safety cognitions than males. There are existing knowledge gaps in the understanding of risk taking perception and attitude among young people in New Zealand, especially among new migrants from Asia.

Over one-third of all tertiary students in New Zealand are aged between 18 and 24 years. In every five tertiary students, one is of Asian ethnicity. About 9% of students undertaking tertiary studies in New Zealand are from overseas – mostly from Asia (Anonymous, 2006). It was recently revealed that the Asian community is not using public supported health services sufficiently compared to other ethnic communities, despite having injury rates close to the national average (Hoque et al., 2006). As such, there is a clear need to improve service providers' and stakeholders' understanding on the attitudes and behaviours of Asians towards injury risks, especially among the younger generations.

The present study aimed to explore levels of knowledge and responsiveness among young Asians towards specified parameters of injury prevention and to explore the willingness of the group to engage in risk modifying behaviours from the viewpoint of professional stakeholders'.

Methodology

This qualitative study involved a series of face-to-face interviews with representatives from agencies that have had professional contact with young Asian people in relation to injury prevention and road traffic safety issues. The subjects for interviews were selected by snowball sampling method, mainly through professional contacts.

Individual interview samplings

Background of stakeholders	**Interviews**
Health professionals	4
ACC (Accident Compensation Corporation) case manager	1
Community Police	1
Driving instructors	1
Total individual interviews	7

Interview procedures

- Seven key stakeholders linked to service providers from education, injury and health related sectors were interviewed to record their views on the research topics.
- The interviewees were chosen from a wide range of agencies that have experience in dealing directly or indirectly with young adult injury problems.
- A semi-structured interview procedure was followed, asking key stakeholders to express their opinions on young Asian tertiary students' injury prevention behaviour and perceptions. Interviews covered information on:
  - **Injury prevention**
    - Attitudes to injury prevention
    - Awareness of injury prevention
    - Awareness of injury risk and appropriate behaviour to avoid injury

  - Knowledge of key road codes
- **Specific factors related to injury prevention**
  - Focused on both protective and risk factors
  - Occurrence of injuries (road traffic accidents and falls): predisposing, precipitating and perpetuating factors
  - Access to, knowledge of and use of alcohol and drugs (and possible links to road traffic accidents and falls)
  - Key factors influencing injury prevention awareness, knowledge and behaviour
- **Other comments**
  - Any other information or comments on young Asian tertiary students' attitude and awareness of injury prevention (road traffic accidents and falls)

Data analysis:

Data collection and analysis was concurrent and reflexive. Analysis began following the first interview. Initial data was treated as a case analysis creating a framework within which emerging topics were identified, to be addressed in more depth in subsequent interviews. Data was analysed using a general inductive approach to identify key themes relevant to the research objectives. Close attention was paid to possible meanings of emerging themes and sub-themes. Findings were synthesised into a framework to describe the various factors associated with road traffic accidents, domestic and workplace injuries, and falls.

Results

This study gathered injury related information from key stakeholders through individual interviews. The stakeholders came from a variety of disciplines ranging from health and family practitioners to health and service providers. Some of the stakeholders appeared quite receptive within the interviews, while others appeared to give somewhat guarded responses during their interview.

Individual interviews with key stakeholders took place mostly at the work places of the interviewees, except for the driving instructor. Among the stakeholders interviewed, four were health professionals who dealt directly with young clients and injury cases. Other stakeholders came into contact with young persons during their official or professional duties and were able to comment on injury related activities and behaviours of this target group.

Health professionals:

Among the health professionals, three were medical professionals and the other was a physiotherapist. The medical professionals were from an accident and emergency (A&E) centre, a tertiary institute medical centre and a general practice surgery. One of them was New Zealand born South Asian, with the remainder being European/Pakeha, including the physiotherapist.

While the medical professionals came across Asian students or young Asian migrants in their practices on a regular basis, they did not often come across those who had been involved in major road traffic injuries, as these students would mostly go straight to a hospital-based A&E. They were more likely to see traffic injury cases that involved minor cuts or bruises as they would attend the practices. The interviewees attributed these injuries to a lack of attentiveness on the street. The practitioners also dealt with a number of martial art related injuries, for example, twisted knees or fingers; and patients with domestic or work place injuries. Asian international students are mostly from affluent families, they may not have had experiences of working in kitchen in their own countries. This group of inexperienced students mostly visit practitioners with domestic injuries such as burn and cut injuries, and workplace injury that had occurred through working in a restaurant kitchen. There was a perception that international students would mostly attain work through personal connections, irrespective of previous experience, and receive under-the-table payments. It was also felt that they are very vulnerable to workplace injuries similar to the domestic injuries, and other occupational injuries which require physiotherapy.

> *"…… a Japanese female student in her early 20s, …… had a part-time job working in a restaurant …… know nothing about restaurant work. But she was in the kitchen cutting up sushi, she came in with a tendonitis of the wrist, through over use. …… one might presume that because she was Japanese, and because she was making sushi, she was an expert just through the cultural connection. ……...then they put her into a job that she really hadn't experienced it."*

Practitioners were quite distressed to report incidents of unprovoked assaults on Asian students. These injuries resulted from race-related attacks on the students. In some instances practitioners themselves reported the incident to the police. They expressed significant concern about such incidents which are occurring in the city.

> *"……I had a student with injuries from physical. It was a racist injury, where he was attacked by a group of boys while going home. We certainly see a distressing number of Asian students that have been assaulted…because one it reflects on my culture, and these assaults seem to be unprovoked, …. it's not an insignificant thing to see a young student, male or female, who had been assaulted in the city."*

Asian students were reported as being very reactive to minor injuries, especially females. It was thought that some of their injuries could be stress related or that they might try to use their minor injuries to gain some kind of favour. Some Asian students demanded robust investigations and diagnostic methods as well as treatment procedures for a minor medical problem. This could be due to internet investigation before consulting the practitioners. Some differences have been observed between Asians from different geographical environments, with regard to seeking medical attention when required. For example, Taiwanese students appeared more likely to bring medicines from their homeland, without a clear idea of what was in it, and would try these first, before reporting to a doctor in a severe condition several days after the injury. Conversely, with a similar kind of problem, students from mainland China may be more likely to go immediately to the doctor. The

practitioners could not decipher the reasons behind such disparity in attitudes when they apparently represent the same ethnic sub-groups.

> *"……a young student who had fallen and clearly had a skateboard fracture and didn't want to spend 40 days in plaster, he rung his dad somewhere in mainland China and Dad said now do a MRI scan, you've got him on a Friday night, it'll be a thousand…… it's sort of comes in risk behavior, an overdose intended of otherwise of medication, very difficult to support."*

> *"……a Taiwanese student may tend to treat that with medication bought from home, often to the detriment of scarring and problems, so presenting a week later with severe looking skin infections, scarring. That's a generalization."*

It is likely that Asian tertiary students suffer from similar peer pressure issues as the mainstream student population. However, drugs or alcohol do not appear to be so problematic amongst Asian tertiary students. They are also reported to abide by the traffic rules. There also may be a protective peer pressure when Asian students stay together. Practitioners are also not certain about the suicidal risk among the young Asian population. It is considered shameful for this ethnic population to reveal any suicidal ideation and/or suicide incidents, and most importantly, they would never discuss such events with their parents. They attend A&E only with severe suicidal cases – less severe attempted suicide cases will never come to the clinics.

> *"……we may not see the attempted (suicide) ones, we see the people who are brought in by their friends. They don't seem to want to talk with their parents, …..more severe shaming the family risk than ……."*

It was reported that on many occasions, Asian students did not reveal the actual cause of the injury as they were worried about their resident status. On other occasions they would be very eager to please the doctor by affirming the doctors' statement, even if the truth about their injury is quite different. The practitioners found tertiary students quite knowledgeable and found they had no difficulty with English language. However, they may not be aware of the health system and where to seek information. Although there is plenty of informative literature available at the surgery, there is a lack of literature targeted at the Asian populations. One participant also discussed that 'Treaty' obligations ensure that most injury prevention messages provided by the ACC are targeted to both Europeans and Maori, and that Pacific Island Peoples are also represented in promotional advertisements, but not Chinese. Practitioners do not consider it is part of their role to discuss injury prevention with their Asian clients. However, health professionals believe that among the Asian students the international students need more help on injury prevention.

> *"Those who have done it at work delay them, and I think this is because they're anxious that if they present with an injury it may require notification they will lose their job or won't be employed. …… so they'll present their injuries that are infected."*

"…… they (Asian students) want to reassure you and tend to answer "yes" when they really mean "no", or even give you symptoms when they don't have them, so they are trying to predict what you're going to ask them."

"……because we have treaty obligations to look at two major cultural groups, …… but then the Asian population exceeds the Maori population, when you look at advertisements, for road injury, you will see quite a few Polynesian faces, …… but you don't see Chinese students represented,……. I'm not impressed that ACC hasn't targeted any other ethnic group than European and Maori."

Other professionals:

Three personnel were interviewed in this category: a community police officer; a driving instructor; and, an ACC case manager. All of them were from an Asian ethnic background. With the exception of the ACC case manager, all others were quite aware of injury related behaviors and injury prevention through their professional connections and experiences. Their discussions mainly involved road traffic related injuries and activities.

The discussants identified existing gaps in local knowledge and an initial adjustment to the local environment by the migrant population, as the main obstacles for injury prevention in New Zealand. They felt that those who were locally born and/or raised in New Zealand did not experience obstacles to injury prevention issues to the same extent as recent migrants. It was thought that some migrants are facing problems in accepting and adjusting to New Zealand's traffic laws and regulations as they have been influenced by the traffic rules of their own country. In some instances it was thought that parental influences may affect students' attitudes and their driving practices, which may ultimately end up causing major crashes. One participant commented that parents with driving experiences from their native countries have stereotyped attitudes and find some of the systems here quite strange to comply with.

"……if their parents have stopped teaching them, don't give them bad influence. Because most of their parents they drive in their country. And then some of the things we do here is just like funny for them, and they don't understand it why"

The participants suggested that most of the International students and many new migrants would have brought driving licences from their own country and would have limited or no prior driving experiences. They thought that the students and new migrants would drive here and then try to obtain a full licence over their international licence. It was thought that as their driving skills are influenced by the traffic orientations of their native country, which is likely to be quite different from that of New Zealand, it is sometimes difficult to remodel them here. Many of them are required to go through the whole process of assessment for a local driving licence rather than the mere conversion of their international driving licences.

"Those students they come to this country, …… they never drove in their country, years ago they had bicycle. ……..so they go to their country to get the full licence, and then come here for conversion. Finally ask for full licence which is not safe for them not for others either. ……Yeah that's absolute difference between the children who grew up here, and who just come here."

"Many Asian think they know everything and are not conscious at all. ……. And for many Asians, New Zealand road is little bit funny."

The participants felt that Asian students, in general, are good at complying with injury prevention procedures, like using seatbelts or helmets. However, compliance rates (e.g. with seatbelt use) are reported to be much better than local born students. Women drivers are more conscious and patient than their male counterparts. Asians involvement in car crash injuries are reported to be linked mostly to minor traffic maladjustments such as, unsafe change of lanes, unaware of the blind spots, etc. They are terrified about car crash incidents and assume a bad consequence resulting from the incident.

"…… but for one the seatbelt is like tight on them. And they don't like it. I had some argument with some of the students. …… one who comes here thinks they don't need it. As far they can drive they are OK."

Language was not seen as a problem for Asian students as they were required to speak and understand English at an acceptable level to maintain effective communication. However, participants felt that stereotyping by local New Zealanders against Asians, in the event of accidents, was frequent and inappropriate. It was argued that adjustment to a new country and new environment, requires time, and is something that authorities should ensure is taken into account, and that the host community should accept and be patient with.

"….on the road if people look at the vehicles and see the person is an Asian driver, …… 'it's another Asian driver' so what can you expect it's that negligence you know on their part. …… like people could go into Asian countries as well, and it would take a while getting used to the roads and that. ….. so give them a fair chance, and things will improve."

It was thought that peer pressure is very important and that isolation among Asians may elicit many risk behaviors in the community. There are instances that occurred under the influence of drugs and alcohol and pressure from friends, which resulted in students indulging in risky street driving. At times they ignored the traffic laws and subsequently caused road crashes.

"Well perhaps setting up groups with people from the same ethnic background, more comfortable listening and people will feel more comfortable, and may open up even more, to speak."

The stakeholders emphasised information dissemination and regular educational programmes, regardless of how competent drivers are, whether they have a full New Zealand licence, or were born here. The family of young Asians also need to be involved in such programmes to ensure that a positive contribution is made among the family members. Basic and general information, with frequent reorientation programmes, would produce better outcomes. To offer a culturally appropriate and acceptable educational programme of injury prevention, the involvement of the community would be important.

Discussion

This study aimed to explore risk behaviours and attitudes towards prevention of injuries among young Asian students, including levels of knowledge and awareness and their risk modifying intentions, from the viewpoint of professional stakeholders.

In addition to traffic injuries, the stakeholders also prioritised domestic injuries as a relevant issue. Although, nationally, some forms of domestic injuries are more common among certain age groups, such as fire injuries amongst those in the 'under 15 years' or 'above 75 years' age groups (Duncanson et al., 2000), the reported injuries of young Asian students in New Zealand would be a new concern. The General Practitioners (GP) in this study placed emphasis on the occurrence of domestic fire injuries, and cuts and stress related injuries amongst international students. The domestic injuries were mainly attributed to a lack of domestic work and/or cooking experiences among the Asian students, particularly the international students who tended to live on their own in New Zealand (i.e. without adult/parental supervision). It was thought that as many students are employed through 'under-the-table' arrangements, they often try to hide work-related injuries and engage in self-treatment. It was argued that this type of behaviour can increase the risk of infection, and disfigurement or disability in the long run. This phenomenon requires further investigation to protect the students' health and wellbeing. Awareness building alone will not solve the problem. Motivational campaigns for the victims and careful monitoring by the superiors is required (Zohar, 2002).

Some parental influence encourages positive behaviour among the students, preventing them from risk taking activities (Peterson et al., 1990). However, sometimes over-control by the family may generate frustration and confusion among students, which ultimately may impact negatively on their behaviour (Raffaelli & Crockett, 2003). Initially it can be difficult for international students to adjust to the local environment because of isolation, which impacts negatively on their self-esteem and self-control, and may affect their cognitive behaviours (Baron & Kenny, 1986). However, it is thought that peer pressure can be a positive influence if Asian students establish well-formed networks and support each other. Health professionals felt that international students need better coordinated support to avoid undertaking any risky behaviour. This support should begin from the moment of their arrival at the airport, and continue in the classrooms, with the involvement of the community.

Driving was perceived as an important issue for migrant youths, especially for the international students. Most of these students formerly came from large Asian cities where, unlike New Zealand, they enjoy robust public transport networks that are affordable. In contrast, the public transport system in New Zealand encourages the need to own a car. Many of them carry overseas driving licences here and begin driving, in some cases, without sufficient orientation with the local traffic system; consequently increasing the risk of car related incidents. This issue also needs to be examined by the appropriate authorities in order to improve the situation for the students without jeopardising their prospects for driving.

The participating health professionals also raised concerns of unprovoked, possibly race-based, attacks on Asian students in New Zealand, particularly on international students. Due to the limitations of the present study, data was not collected on this issue. To date, there are no statistics or literature on this area available in New Zealand. This is not only a concerning situation for the victims but also for the health professionals and the community, and therefore deserves further investigation.

The mental health needs of Asian students also need to be highlighted, especially with regards to suicide and attempted suicide (Rasanathan, Ameratunga, Chen, & et, 2006). We did not collect any suicide related data for Asian students in this study and the participating health professionals expressed uncertainty on the issue due to the paucity of data and resources with which to address the problem. A previous study has suggested suicide as the second most common type of injury deaths among Asians in New Zealand, although the age-standardised rates of suicide were lower than that for European/Pakeha, and those aged between 15-34 years are believed to be the most vulnerable to suicide and attempted suicide among Asians (Hoque et al., 2006). There are well-recognised cultural norms and taboos among people of Asian ethnicity that may impact on identified rates of suicide (Fauveau & Blanchet, 1989). Another study postulates that cultural norms, religious beliefs, and strong and supportive family networks may serve to decrease the likelihood of suicide among peoples of Asian ethnicity (Stirbu, Kunst, Bos, & van Beeck, 2006). In this context international students' secluded lifestyle bears a potential risk. The contributing factors for suicide and unmet mental health needs, substance use and other risk issues, as well as sources of resilience, require further investigation.

The Asian population in New Zealand is increasing rapidly. Asians are the second largest ethnic group in Auckland after European/Pakeha (StatsNZ, 2006). Findings and discussions in this project indicate that Asian health promotion initiatives, particularly those related to injury prevention, are not matched to the rapid growth of the Asian population in New Zealand. Asia is the largest contributor of international students in New Zealand. Being a relatively new migrant ethnic group, much work is required to be done to understand the health needs of the diverse Asian community. Therefore, it is recommended that the health needs of Asian youths and the available support mechanisms, be reassessed and adjusted accordingly.

Acknowledgements

ACC (Accident Compensation Corporation of New Zealand) for funding the project and Dr Sapna Samant for helping in conducting interviews.

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NUTRITIONAL NEEDS ASSESSMENT OF EAST ASIANS LIVING IN CHRISTCHURCH

Zhongxian (Katherine) Zhang, Wayne Reid

ABSTRACT

First generation Chinese, Korean and Japanese migrants (East Asians) living in Christchurch were the target population for this project. This project aimed to 1) Gain understanding of the target population's eating behaviour, influencing factors, associated health issues, healthy eating knowledge and practice and access to existing nutritional resources and programmes; 2) Identify and prioritise the main nutritional needs among the target population; 3) Identify the needs of health professionals who work closely with the target population and 4) Make recommendations on desired nutritional services to meet identified needs. Focus groups and Key informant interviews were conducted to collect primary data. The major nutritional needs identified were linguistically and culturally appropriate nutritional resources and services. The development of the required resources and services is strongly recommended.

INTRODUCTION

Background

A range of healthcare needs for Asian peoples in Christchurch has been identified by research conducted by Partnership Health Canterbury between 2007 and 2008. Nutritional issues such as a lack of healthy eating knowledge, low access to hospital dietetic services and a lack of nutritional education resources in appropriate languages were highlighted (Reid, Tam, Tam, Ahkuoi & Hou, 2008). In order to further investigate nutritional needs among Asian peoples living in Christchurch, this project was initiated.

The Asian Health Chart Book 2006 suggests recent migrants are healthier than long-standing migrants, or those New Zealand-born to migrants, due to the "healthy migrant effect". It also suggests that their health will deteriorate over time due to the effects of health selection decreasing as acculturation progresses. The Chart Book also shows that longer duration of residence is significantly associated with the likelihood of self-reported high blood cholesterol, high blood pressure and obesity among Asian New Zealanders (Ministry of Health, 2006).

It is well recognised that nutrition plays an important role in managing high blood cholesterol, high blood pressure and obesity. Identifying nutritional needs amongst Asians becomes a pressing task. It will contribute to the understanding of how to

help Asian migrants make informed and sensible decisions during dietary acculturation and how to successfully promote healthy eating to better prevent and/or control nutrition-related diseases or conditions.

Chinese, Korean and Japanese (referred to as East Asians in this report) make up 72% of Christchurch's Asian population (Thorpe, Marr & Richardson, 2007). This needs assessment intends to focus on first generation East Asian migrants living in Christchurch.

Christchurch demographics

Christchurch is becoming a more ethnically diverse city. The minority population has increased from 4.1% (12,015 people) of the city's total population in 1991 to 11.2% (39,063 people) in 2006, and includes Pacific Peoples, Asian and Other ethnic groupings (Thorpe et al., 2007).

Of the minority population, the Asian ethnic groups (26,631 people) were the largest in 2006, and also experienced the greatest growth (330%) since 1991. It is projected that Asian ethnic groups will reach 37,300 people by 2016. The largest four Asian ethnic groups in Christchurch were Chinese (12,480), Korean (4,566), Indian (3,057) and Japanese (2,208) (Thorpe et al., 2007). This research concentrates on East Asians as both language and culture are significant barriers for them to access the New Zealand health system.

Japanese have the greatest gender imbalance compared to Chinese and Korean with 84.9% more Japanese women than men. This may be due to the greater number of Japanese women with New Zealand partners (Thorpe et al., 2007).

With the exception of the 20-24 age group, the Chinese ethnic group has similar gender numbers in each age group. This is possibly due to the many young Chinese adults travelling to Christchurch for study. Similar to the Chinese, many Korean students live in Christchurch, thus contributing to the large proportion of this ethnic group included in the 5-24 age group. The second largest Korean group is the 35-49 age group. The majority of both Chinese and Koreans are new migrants. Approximately 50% of Chinese people and 55% of Korean people have been living in New Zealand for four or less years (Thorpe et al., 2007).

Though many East Asians are very well educated, their income is low. 32.6% of Chinese people and 30.3% of Koreans aged 15 and over had a Bachelor or higher degree in 2006 compared to 19.4% of the total Christchurch population. However, Japanese ($11,100), other Asian ($10,400), Chinese ($8,000) and Korean ($7,900) were the four ethnic groups with the lowest median annual total personal income in 2006. The greater numbers of students in these ethnic groups may impact on these groups' total personal income (Thorpe et al., 2007).

Migration, acculturation and health

There are very few health-related data for East Asians living in Christchurch. The Asian Health Chart Book 2006 (MOH, 2006), is the first comprehensive review of

Asian health. describes the health status of three Asian ethnic groups - Chinese, Indian and 'Other Asian': Though Asian migrants are generally healthier than native-born people due to the "*healthy immigrant effect*", their average health will "*deteriorate towards the all New Zealand average*" (MOH, 2006, p. 105). The Chart Book suggests:

- Though the avoidable mortality is significantly lower for Chinese, Indian and Other Asian ethnic groups than for the total population, it increases for Chinese who have lived in New Zealand for longer periods or who were born in New Zealand.
- The longer the duration of residence in New Zealand, the higher is the cardiovascular disease mortality rate among Chinese and other Asian ethnic groups and among Indian females.
- Longer duration of residence is also significantly associated with the likelihood of self-reported high blood cholesterol, high blood pressure and being obese (using ethnic-specific cut-off points) for all Asians.
- Chinese are less likely than New Zealand Europeans to have a usual carer and all Asian ethnic groups are less likely to have seen a doctor or a complementary/alternative provider in the last 12 months than Europeans.
- Chinese and Other Asian females are significantly less likely to achieve at least 150 minutes of physical activity per week than their total population counterparts.

OBJECTIVES

First generation East Asian migrants living in Christchurch were the target population for this project. The objectives of this project were to:

- Gain understanding of the target population's eating behaviour, influencing factors and associated health issues.
- Gain understanding of the target population's healthy eating knowledge, practice of label reading and access to existing nutritional resources and programmes.
- Identify and prioritise the main nutritional needs among the target population.
- Identify the needs of health professionals who work closely with the target population.
- Make recommendations on desired nutritional services to meet identified needs.

METHODOLOGY

Focus groups were organised with the target population. The inclusion criteria for participants were:

- Older than 18, not born in New Zealand.
- Chinese, Korean or Japanese.

Participants were recruited through Churches, Chinese, Korean and Japanese community groups and personal networks. Before group discussion, informed consent was obtained from each participant and a short questionnaire was completed. Focus group discussion followed a detailed pre-developed schedule. Snacks, light meals or small gifts were offered to participants in appreciation of their participation.

Six focus groups were conducted comprising three Chinese groups, two Korean groups and one Japanese group. The three Chinese groups included Chinese women, Chinese young people and Chinese older people. Two Korean groups included one women's group and one young people's group. The Japanese group included Japanese women.

The three Chinese focus groups were conducted in Mandarin. Korean and Japanese focus groups were in English. An assistant from the participants' ethnicity was present at each focus group to help with taking notes and interpreting.

The majority (n=39, 80%) of the participants were female. 38 participants (78%) were aged between 25 to 64. 69% of the participants (n=34) had been living in New Zealand for more than 5 years. All of the participants (n=49) had enough money to buy food. 19 participants (39%) had gained weight since they moved to New Zealand.

Key informant interviews were conducted with nine health professionals working closely with Asian migrants from Partnership Health Canterbury, general practices, a traditional Chinese medicine practice, hospitals, Christchurch Resettlement Services and the New Zealand Problem Gambling Foundation. Eight out of nine interviews were conducted in English and one in Mandarin.

Each interview followed the pre-developed schedule. All focus groups and interviews were audio-recorded and then abridged transcripts developed. Abridged transcripts for Chinese focus groups were translated into English.

The computer-based long-table approach was used for analysis (Krueger & Casey, 2000). Each quote was coded and categorised under different themes.

RESULTS

1. Focus groups

1.1 Eating behaviour, influencing factors and associated health issues

Eating behaviour

In general, almost all participants had made dietary changes, to a certain extent, since arriving in New Zealand. The majority had a diet somewhere on the continuum between their traditional diet and a Western diet. Although some still ate a traditional breakfast, many were moving onto a western breakfast. Ignoring breakfast seemed to be very common amongst young people. Although sandwiches were often eaten at lunchtime, more traditional foods were still preferred. Others bought their lunch

depending on what was available. Noodles were a popular lunch option. Traditional food at dinnertime remained the most common choice. For young people, irregular mealtimes and dining out were also common.

A range of drinks including water, coffee, tea, juice and fizzy drinks were consumed. Some stated that they didn't drink milk. Some parents, especially Japanese, commented that their children often drank juice. The high consumption of fizzy drinks and alcohol in young people was of concern.

Influencing factors

There were a range of factors impacting on participants' eating behaviour. The main ones identified were availability, cost, time, age, taste preference, transportation and other factors.

Though a few participants commented that the availability of ethnic food had gradually improved, the low availability of familiar food was still of considerable concern to most. Freshness of food was very important. Most Chinese stated that fresh leafy vegetables were far less available. Korean and Japanese participants mentioned not being able to enjoy as much seafood as they were used to. As a result, meat consumption increased and vegetable and/or fish intake decreased. The high cost of familiar food was a concern for many participants. They also believed that meat/meat products were relatively cheaper, so meat consumption increased. When buying food, price is one of the important factors considered.

Many participants stated they were very busy with family life, work or study. Korean young people also stated they often go to bed late and rise late. Time significantly impacts on their eating behaviour.

Age also impacted on eating behaviour. Some participants stated their young children experienced peer pressure about what food to bring to school. When these children had Kiwi classmates, they preferred to bring western food to school. If they had Asian classmates, they felt more comfortable bringing traditional food for lunch. As many young people have poor cooking skills, eating out was common. It was also common for them not to have regular meals. Awareness of the importance of healthy eating was low among many young people.

Participants had diverse taste preferences. Many of them preferred their traditional foods. Some also liked New Zealand food. Korean participants mentioned that New Zealand food was too sweet. Canned, frozen or raw food was not liked by some Chinese, especially older people. However, taste preferences changed over time for some participants.

Transportation was an issue for some participants as they were unable to drive, especially older people. Other factors included resettlement stress, relationships and living situation.

1.2 Diet related health issues

The main diet related health issues discussed were weight gain and high blood pressure. Weight gain since arrival in New Zealand was stated by many participants. This was due to dietary change and decreased physical activity. Weight gain was especially common amongst young people. High blood pressure was another health concern raised.

1.3 Healthy eating knowledge, label reading and access to resources and programmes

Healthy eating knowledge

A healthy diet for many participants meant many vegetables, much fruit, less meat products and eating lean meat. They believed that variety was an important component of a healthy diet. Some mentioned fish as being better as is eating less canned food.

Many Japanese participants stated that they had good nutritional knowledge; that healthy eating was consuming less sugar and fat and eating more vegetables, fruit and fresh food. However, they were confused about *5+ a day*. They would like to have ethnic-specific healthy eating guidelines.

Label reading

Though some participants read labels, most stated that they were unable to read English food labels. Numbers cannot be interpreted, as the standard was not understood. It was also not known if the information on labels was reliable.

Access to resources and programmes

Very low access to existing healthy eating resources and programmes was common amongst participants. When participants were asked if they had seen healthy eating resources such as "*Eating for Healthy Adult New Zealanders*" or heard about "*Pick the Tick*", "*5+ a day*", most of them shook their heads negatively. Some participants had seen or heard about "*Pick The tick*" and "*5+ a day*", but very few knew the exact meaning of these programmes. Some had access to the resources through midwives, Plunket Nurses, preschools, schools and learning experiences. For participants who had access to the resources, some felt they were not culturally relevant.

The Japanese group wondered if the information was applicable to Japanese or Asians.

1.4 Nutritional needs and recommendations

The major nutritional needs identified by participants were linguistically and culturally appropriate nutrition resources, group activities and food safety control.

Nutrition Resources

Language-specific nutrition resources were important to most participants due to the difficulties and concentration needed to read and understand such resources in English. Participants also wanted these resources to be culturally relevant.

The need for information on healthy eating was identified. Participants suggested this information should cover the importance of healthy eating, age and gender specific healthy eating guidelines, use of dietary supplements and healthy cooking methods. Calcium intake was of concern to some participants, especially females.

Information on healthy western food and new foods including dairy products, new vegetables and fruit, local fish, legumes, herbs, canned and frozen food was required by many participants.

A recipe book including recipes using readily available healthy local ingredients for making their ethnic food was required by many participants. The recipes could be collected from experienced migrants and group meetings. The recipe book would also be beneficial for new migrants and students.

Suggestions were made about incorporating information as to where to buy ethnic food.

Group activities

The major group activities suggested were nutrition talks, supermarket tours and cooking classes. Nutritional talks which would be more effective if combined with cooking classes are needed. Recommended topics were healthy eating for different age groups, how to cook local food, whether it is healthy to use monosodium glutamate and what type of salt to use. Supermarket tours would be a practical way to teach people how to choose healthy food; an activity especially helpful for new arrivals. Cooking classes are required on how to cook ethnic food with healthy western ingredients, and how to cook healthy, easy western food. Some students also stated that they want to learn how to use a microwave and an oven – neither are common appliances in their home countries. Participants recommended incorporating healthy eating information into the cooking classes.

Migrants' group meeting

It would be very helpful to organise group meetings for migrants which provide opportunities for them to share cooking ideas, support new migrants and also to meet people from the same culture. Cultural barriers prevent migrants from participating in groups for Europeans.

Surveillance and regulations

Chinese participants expressed concerns about food safety issues. They commented that food safety should be better controlled in Asian groceries and Chinese restaurants. Chinese participants also wanted more information on the content of

preservatives, pesticides and antibiotics in food products sold in New Zealand. They also suggested limiting the use of monosodium glutamate (MSG).

1.5 Physical activity

Many participants said that their physical activity level had dropped since arriving in New Zealand due to the change of lifestyle, change of transportation, limited time and lack of support.

2. Key informant interviews

2.1 Environmental impact on dietary acculturation

Many interviewees stated that a range of environmental factors including cost, availability, more exposure to fast food, social events and resettlement stress effected migrants' dietary change. Many migrants show a lack of knowledge about western food, thus cannot make healthy food choices.

2.2 Nutrition related issues

The main nutritional-related health issues are weight gain due to change of diet, overweight, high cholesterol, high blood pressure, diabetes, and cardiovascular disease. Linguistically and culturally appropriate resources on the prevention and control of these conditions are required.

Concerns were expressed about international students' and young migrants' diet. As most had very low awareness of the importance of healthy eating, do not have cooking skills and are under time pressure, they often ate out. Junk food was commonly consumed. Young people's alcohol and fizzy drink consumption were also of concern. Most young people's physical activity level had dropped after they arrived in New Zealand. Due to the change in diet and the decrease in physical activity, many young people gained significant weight in a short period of time after arrival. This could lead to other health problems such as fatty liver.

Health professionals working in the eating disorder area stated that the number of Asian patients was increasing. The trigger in developing an eating disorder was the change from a 'regarded' healthy Asian diet to western food or from dieting after weight gain.

Many nutritional related issues were identified amongst children. These included oral health, high exposure to fast food, peer pressure and failure to thrive.

2.3 East Asian Nutritional needs

To ensure every migrant has equal access to a healthy diet in New Zealand, East Asian nutritional needs identified by interviewees were mainly in the following four areas: nutrition resources and services, nutrition education, Asian workforce development and Asian health service. Suggestions were also made on appropriate strategies to deliver nutrition resources, services and education.

2.4 Nutrition resources and services

Interviewees identified linguistically and culturally appropriate nutrition resources and services were required to raise awareness and knowledge of healthy eating. Pictures were considered an important part of any written resources. Interviewees also commented on the use of existing resources and programmes.

Almost all interviewees agreed that East Asians need nutritional resources in their own languages. For existing healthy eating programmes such as "*Pick the Tick*" and "*5+ a day*", comments were made that these can be very helpful for East Asians if the materials were translated into East Asian languages.

Many interviewees believed that it was important to have resources which were related to East Asian cultures and foods.

Pictures should be used to make the resources more attractive, easier to understand and to "*show them the food*".

Concerns were expressed at the low awareness of the importance of healthy eating in disease prevention. Interviewees suggested resources need to be developed to raise awareness.

The following information was suggested be included in the resources: healthy eating guidelines, the difference between New Zealand food and East Asian food, new healthy food, new healthy cooking methods, how to make healthy food choices, unhealthy food and recipe modification.

Comments were made by most interviewees that current resources have been developed for the New Zealand mainstream - not for migrants. Information is about New Zealand food rather than migrant food. Almost all resources are available only in English making it difficult for migrants to read and understand. Lack of appropriate resources to give to East Asian patients was a concern raised by interviewees.

2.5 Nutrition education

It was advised that it was important to have nutritional education. Recommendations made by interviewees included:

- It is important to take culture into consideration when conducting nutritional education with East Asians.
- To raise East Asians' awareness of the importance of healthy eating.
- To include exercise as part of that education.

2.6 Delivery

A range of practical strategies were suggested to deliver nutritional information, including talks, supermarket tours and cooking classes. It was recommended to organise these activities through ethnic social, church and community groups. Ethnic media such as Chinese and Korean newspapers could be used to facilitate healthy eating promotion. A website was also suggested to be used for nutrition education.

2.7 Workforce Development

Concern was expressed about the seeming lack of Asian workforce development. Employing health professionals trained in Asian countries, encouraging more Asian migrants to obtain health qualifications in New Zealand and providing job opportunities for Asian health professionals either trained in their home countries or in New Zealand would greatly contribute to migrant well-being.

2.8 Asian Health Service

The need for developing an Asian health service was identified as being vital to aid in the reduction of inequalities and barriers to health access.

3 Health professionals' needs

Health professionals have a great need for linguistically and culturally appropriate nutritional resources for them to use for East Asian patients/clients. They also need to have a better understanding of Asian culture and diet. Organising cultural workshops for health professionals to improve their understanding of Asian culture, Asian diet and Asian migrants was suggested by many interviewees.

An Asian information/service centre and an effective and efficient interpreting service would be advantageous for health professionals working with Asian patients.

DISCUSSION

Dietary acculturation

Participants' eating behaviour suggested most participants have made dietary changes since arriving in New Zealand. Their diet is more or less moving from a traditional diet to a western one. The process by which immigrants adopt the dietary practices of the host country is defined as dietary acculturation. It is considered to be a multidimensional, dynamic and complex process (Satia-Abouta, Patterson, Neuhouser and Elder, 2002). Consistent with our findings, one form of dietary acculturation identified was the westernising of breakfast and lunch whereas the consumption of traditional foods at dinner (Satia-Abouta et al., 2002) remained. Other forms identified (Satia-Abouta et al., 2002) included finding new ways to use traditional foods, replacing some traditional foods with new foods, incorporating ingredients available in preparing traditional meals, and fully adopting the dietary pattern in the new country.

The main influencing factors of dietary acculturation identified by focus group participants were availability, cost, time, age, taste preference, transportation, stress, relationships and the living situation. Additional factors suggested by interviewees were environmental change, knowledge, awareness, cooking skills and peer pressure. According to the PRECEDE (Predisposing, Reinforcing, and Enabling Constructs in Educational Diagnosis and Evaluation) model, the influencing factors can be categorised under predisposing factors, reinforcing factors and enabling factors (Satia-Abouta, Patterson, Kristal, Teh and Tu, 2002). Table 2 lists the influencing factors under these three categories. A better understanding of these factors is important in planning successful nutritional education programmes for East Asians.

Table 2: Influencing factors

Predisposing factors	Reinforcing factors	Enabling factors
Age Taste preference Knowledge Awareness	Relationships Living situation Peer pressure	Availability Cost Time Cooking skills Environmental change Transportation Stress

Weight gain

Among diet-related health issues identified by East Asian participants and health professionals, weight gain after migration was significant. This is consistent with findings from other studies. Using the pooled data from the National Health Interview Survey (NHIS) in the United States, Lauderdale and Rathouz (2000) suggested that in first generation Asian Americans, the odds of being overweight or obese increased with the years spent in the United States; this after adjustment for age and ethnicity. The Asian Health Chart Book (MOH, 2006) shows similar findings.

As suggested by this project and other studies (Song et al., 2004; Popkin & Udry, 1998), the increased prevalence of overweight and obesity among migrants was attributable to changes in environmental factors such as diet and physical activity. Overweight and obesity have been associated with increased risk of cardiovascular disease, type two diabetes, stroke, some cancers and gallbladder disease (World Health Organisation, 2000). Thus, understanding migrants' nutritional needs and developing appropriate nutritional resources and services plays an important role in preventing and reducing overweight, obesity and associated diseases among East Asian migrants.

Nutrition resources and services

The key nutritional needs identified in this project were linguistically and culturally appropriate nutritional resources and services. These included resources on healthy eating, unfamiliar local food, recipes using available local ingredients to make ethnic food, places to buy Asian food and prevention and management of diet-related conditions and diseases. Suggested services were nutritional talks, supermarket tours and cooking classes. It is also important to raise awareness of the differences between Western and Asian food and the importance of healthy eating in disease prevention among East Asian migrants.

To develop successful nutritional resources and services for migrants, some studies suggested that encouraging maintenance of traditional dietary patterns in migrants is important (Pan, Dixon, Himburg & Huffman, 1999; Tan & Watson, 2004). For example, it has been pointed out that the maintenance of traditional Chinese dietary patterns may be crucial in decreasing the prevalence of chronic disease in Chinese migrants (Satia-Abouta, Patterson, Kristal, Teh and Tu, 2002). Tan & Watson (Tan & Watson, 2004) suggested that there is a need to encourage Chinese migrants in New Zealand to maintain their traditional eating habits by increasing whole grains and vegetable intake. Lu & Watson (2002) concluded that the maintenance of the traditional Chinese cereal-based diet and adopting healthy Western food habits was crucial for migrant Chinese children in New Zealand during their dietary acculturation. Thus an important nutritional education objective would be to encourage East Asians to maintain their traditional eating patterns while adopting the healthy dietary practices of the host country.

Limitations and strengths

This project had some limitations. English was used when conducting focus groups with Korean and Japanese participants. As English was their second language, this might have made it difficult to accurately express their thoughts, though there was either a Korean or Japanese bilingual person present to help. Secondly, this project focused on the common needs among Chinese, Korean and Japanese peoples. It is desirable to look at their specific needs separately.

This project also has many strengths. This is the first project assessing the nutritional needs of East Asians living in Christchurch. Some significant nutritional issues were identified. Secondly, primary data were not only collected from East Asians but from health professionals. This enabled this project to assess East Asians' nutritional needs from both East Asians' and the health professionals' perspectives.

Conclusions and recommendations

This project showed that a gap exists in providing culturally and linguistically appropriate nutritional resources and services to East Asian migrants. East Asian migrants require a range of nutritional resources to help their understanding of eating healthy and nutritious food. They also need nutritional services and a nutritional education programme for new migrants - including international students - to raise their awareness of the benefits of healthy eating in preventing rapid weight

gain is also desired. Cultural support and interpreting services are required by health professionals to help them provide culturally and linguistically appropriate services to their East Asian clients.

Based on these needs, the following recommendations are made:

- Develop linguistically and culturally appropriate nutritional resources. Translate and adapt existing nutritional resources to suit migrants' needs. The key resource development areas include healthy eating, unfamiliar healthy local food, recipe books and prevention and management of diet-related diseases.
- Design, develop and deliver a tailored nutritional service to all East Asian communities. These include nutritional talks, supermarket tours and cooking classes to teach the knowledge and skills to enable a healthy diet. This service could be delivered through language schools, ethnic social/cultural groups and churches.
- Work with East Asian communities by involving migrants who have nutritional qualifications and/or working experience in resource development, nutritional education and healthy eating promotion.
- Work with organisations/services which work closely with East Asian communities to promote healthy eating.
- Promote physical activity in East Asian communities - especially amongst younger people.
- Provide information on the New Zealand Food Safety Authority and relevant regulations to East Asian communities - especially Chinese.
- Provide cultural support and interpreting services to health professionals to enable them to work better with East Asian migrants.
- Establish a position to coordinate the above work as part of Asian workforce development.

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Social and Community Health and Wellbeing

PRIMARY HEALTHCARE ISSUES AMONGST ASIAN PEOPLES IN CHRISTCHURCH
Results from patient data collection over a two year period

Wayne Reid

Abstract
Canterbury's Asian population is the fastest growing cultural group in New Zealand. The urban Asian population is now the second largest ethnic group - after European - in the wider Christchurch area. The aim of this project was to evaluate actual patient data over a two-year period (1st January 2008 to 31st December 2009), thus ascertaining the levels of access to primary health care services amongst migrants of Asian descent.Using patient data collected by Pegasus Health (Charitable) Ltd, we have been able to ascertain patients' usage of services such as youth sexual health, annual diabetes checks, end-of-life care, child health and chronic care management and mental health brief intervention counselling. This is the first time such data has been made available in the South Island.Whilst its collection is ongoing, we now have a two year data stream which draws a disturbing picture of inequality in both primary health care consultations and access to primary healthcare services. Unless addressed, the result will be an increasing burden of preventable disease amongst our Asian population.Highlighted results include:

- Of the total number of the under 21 youth sexual health consultations only 1.5% were for Asian patients. Within the total Asian group, males accounted for 5.5% of total patient numbers whilst females accounted for 94.5%. Under 21-year-old Asians make up 6.7% of the total PHO population.
- In the year ended September 2009, a 34% drop in accessing the free annual diabetes check up service was noted amongst Asian peoples
- Of the total number of people referred to the Mental Health Brief Intervention Counselling service, only 1.7% was of Asian origin. They were accountable for 2.1% of the total number of consultations.
- End-of-Life Palliative Care enables a general practice to offer free medical treatment for those in the final three months of life. Only 1.9% of enrolled Asian patients took advantage of this service.
- The Child Health Service was targeted at children under the age of 14. 2% of those accessing this service were of Asian origin.
- Chronic Care Management funding was accessed by 6.4% of Asian patients.

Our paper looks at the reasons behind such low access figures, discusses cultural and gender issues and proposes ways in which these can be addressed.

INTRODUCTION

Background

The 'healthy migrant effect' is a well documented phenomenon amongst those migrating to New Zealand. (This does not include those arriving with Refugee status.)

During the acculturation process, health declines as exposure to a different diet, resettlement stress and its associated mental health issues prevail. An increasing rate of chronic diseases such as diabetes and CVD, pregnancy termination being used as a contraceptive, sexually transmitted infections and a lack of knowledge/information about the New Zealand health system, all combine to reduce health status.

Major differences in health and health service use between recent migrants and established communities exist, similar for all Asian ethnic groups.

For almost all health indicators, recent or first-generation migrants do better than long-standing migrants or the New Zealand born. This is believed to largely reflect a healthy migrant effect (i.e., health selection). Over time, this health advantage is likely to dissipate, as the selection effect wears off and acculturation progresses. The relatively low utilisation of health services by Asian peoples, particularly recent migrants, will need to be carefully monitored. (The Asian Health Chart Book MoH 2006)

Following the publication in 2008 by PHC of its research into the health care needs of Asian migrants to Christchurch, the collection of general practice health services data by specific ethnicity was formalised. This would give us more accurate information about access to general practice and the usage of specific health care services by migrants.

It became apparent that access to many of the primary health care services by Asian migrants was at a rate less than other ethnicities. Anecdotal and published evidence pointed to a lack of awareness that such services existed, cultural shame especially in the areas of sexual and mental health, lack of knowledge and confusion about the New Zealand health system and concerns around the negative effects of acculturation.

Population Data

Ethnicity	Total - Canterbury	% of Population	Total - Christchurch	% of Population
European	393,219	75.4%	281,385	73.6%
Maori	36,669	7.0%	27,735	7.3%
Asian	29,169	5.6%	27,438	7.2%
Pacific Island	10,926	2.1%	9,756	2.6%
Middle Eastern/African	3,360	0.6%	3,036	0.8%
Other	70,254	13.8%	49,398	12.9%
Declined to State	13,647	2.6%	10,521	2.8%

(Statistics New Zealand)

Table 1 Ethnic Groups in Canterbury and Christchurch – 2006 Census

The majority of Canterbury's Asian population is urban-based, with 95% living within the wider Christchurch area. The remaining 5% include rural areas such as Ashburton and Timaru where the main employment is on dairy farms and in manufacturing around Ashburton.

Ethnicity	Total - Canterbury	% of Population	Total - Christchurch	% of Population
Chinese	13,410	46.0%	12,807	46.7%
Korean	4,746	16.3%	4,611	16.8%
Indian	3,429	11.8%	3,171	11.6%
Japanese	2,580	8.8%	2,319	8.6%
Filipino	1,287	4.4%	1,059	3.9%
Thai	822	2.8%	738	2.7%
Sri Lankan	453	1.6%	435	1.6%
Cambodian	258	0.9%	255	0.9%
Other Asian Groups	2,463	8.4%	2,301	8.4%
Total	**29,172**		**27,438**	

(Statistics New Zealand)

Table 2 Asian Ethnic Groups in Canterbury and Christchurch – 2006 Census

The Chinese make up the largest Asian ethnic group, followed by the Korean and Indian groups. The 'Other Asian Groups' includes people from Vietnam, Burma, The Philippines and Tibet. The fastest growing sub-group are the Nepali-speaking refugees from Bhutan.

In 2009, the Asian population made up 5.9% of the total Partnership Health enrolled population which was a 13% increase over the previous year.

Ethnicity	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65+
New Zealand European	6.2%	11.6%	11.8%	25.8%	28.2%	16.3%
European (Other)	5.3%	10.7%	8.9%	31.8%	26.9%	16.4%
Maori	12.2 %	21.5%	18.5%	27.3%	16.8%	4.0%
Asian	8.6%	14.5%	13.2%	36.0%	22.0%	5.7%
Pacific Island	11.5 %	21.1%	17.9%	28.2%	17.2%	4.0%
Middle Eastern	9.9%	18.5%	14.4%	30.9%	22.2%	4.1%
African	13.0	20.2%	16.0%	36.2%	12.3%	2.4%

	%					
Other	3.5%	32.4%	3.3%	11.8%	7.3%	2.4%
Total	**6.7 %**	**12.8 %**	**12.6 %**	**26.6%**	**24.5%**	**14.2 %**

(Partnership Health Data – on file)

Table 6 Capitated Age Groups by Ethnic Group against the Total PHC Population - 2009

With the exception of the 45+ age groups, the percentages of the Asian population are above the group averages.

SECTION 2: OBJECTIVES AND METHODOLOGY

Objectives

The objectives of this long-term (and continuing study) were to ascertain the primary health care usage of Partnership Health Canterbury's enrolled population by ethnicity and capitated age group.

Patient data – broken down into ethnicity – has not been objectively collected before making any primary health care planning too general to meet the demands of our burgeoning ethnic population.

Methodology

Commencing in October 2007, actual (non-identifiable) patient data was collected on a quarterly basis from general practices enrolled with PHC. The service lines and periods covered were:

1st January 2008 – 31st December 2009

- Free under 21 youth sexual health consultations
- Free annual diabetes check
- End-of-Life Palliative Care

1st July 2007 – 30th June 2009

- Child Health Service targeting children under the age of 14

1st April 2008 – 30th June 2009

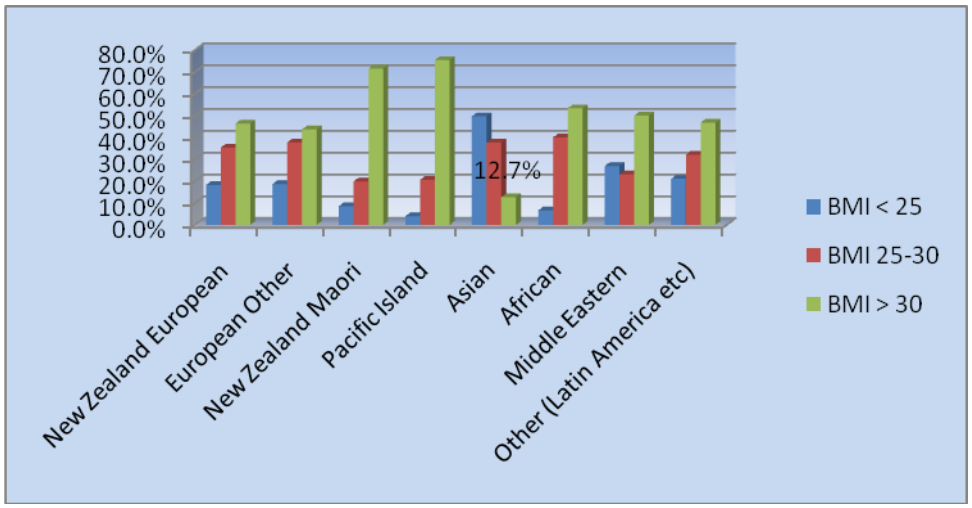
- Mental Health Brief Intervention Counselling Service
-

SECTION 3: RESULTS AND COMMENTARIES

3.1 Diabetes

In the year ending December 2008, general practices enrolled with PHC carried out 6,852 annual diabetes checks; 1.9% of the total PHC population. These annual checks were free to all enrolled patients diagnosed with diabetes. Of this total 5.6% were for patients of Asian origin. This total represented 1.8% of the total PHC Asian population.

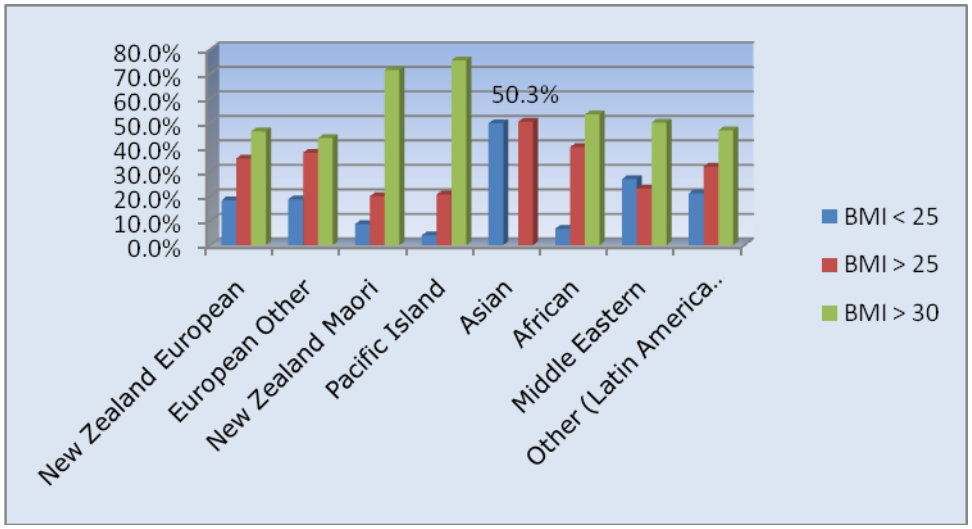
In the year ending December 2009, practices enrolled with PHC carried out 5,192 annual diabetes checks. This was 1.4% of the total PHC population. This was a 24.2% decrease over the previous year. Of this total, 5.1% of the total represented 1.2% of the total PHC Asian population.



(Partnership Health Data – on file)

Figure 1a Body Mass Indices by Ethnicity 2009

Body Mass Indices (BMI) are normally 'generalised' into three categories as shown in Table 10a. Those with a BMI above 30kg/m² are considered obese. However this does not take culture into account.



(Partnership Health Data – on file)

Figure 1b Body Mass Indices by Culture 2009

When culture is taken into account (green), overall Asian obesity increases markedly from 12.7% to 50.3%; Asians being considered obese[1] with a BMI over 25kg/m².

3.2 Youth Sexual Health

ETHNICITY	2008	% OF TOTAL	2009	% OF TOTAL	% CHANGE 2008/2009
New Zealand European	65,443	65.5%	67,363	66.9%	2.9%
European Other	4,818	4.8%	6,663	6.6%	38.3%
New Zealand Maori	9,953	10.0%	10,372	10.3%	4.2%
Pacific Island	3,531	3.5%	3,775	3.7%	6.9%
Asian	5,927	5.9%	6,732	6.7%	13.6%
African	462	0.5%	534	0.5%	15.6%
Middle Eastern	309	0.3%	357	0.4%	15.5%
Other (Latin America etc)	9,469	9.5%	4,962	4.9%	52.4%
TOTAL	99,912		100,758		0.8%

(Partnership Health Data – on file)

Table 11 Total PHC Under 21-year-old Populations

The Asian under 21 year-old population grew by 13.6% from 5.9% of the total to 6.7%.

	Total Numbers		% Change	% of total patients		% of Total Under 21 Population	
	2008	2009		2008	2009	2008	2009
New Zealand European	12,423	13,660	10.0%	77.3%	77.2%	19.0%	13.6%
European Other	616	762	23.7%	3.8%	4.3%	0.9%	0.8%
New Zealand Maori	1,485	1,791	20.6%	9.2%	10.1%	2.3%	1.8%
Pacific Island	217	261	20.3%	1.4%	1.5%	0.3%	0.3%
Asian	233	280	20.2%	1.5%	1.6%	0.4%	0.3%
African	31	34	9.7%	0.2%	0.2%	0.0%	0.0%
Middle Eastern	15	25	66.7%	0.1%	0.1%	0.0%	0.0%
Other (Latin America etc)	1,045	879	15.9%	6.5%	5.0%	1.6%	0.9%
Total	16,065	17,692	10.1%			24.5%	17.6%

(Partnership Health Data – on file)

Table 12a Youth Sexual Health Patient Numbers 2008 – 2009

Although the total under 21-year-old Asian group made up 5.9% (2008) and 6.7% (2009) of the total, it was only responsible for 1.5% and 1.6% of the total number of youth sexual health patient numbers. It was also responsible for only 1.3% and 1.4% of the total number of consultations. European and Maori were over-represented in both patient numbers and consultations.

Of the total number of youth sexual health patient numbers, 8.2% were male and 91.8% were female. Within the total Asian group, 7.3% were male and 92.7% were female.

Of the total number of youth sexual health patient numbers, 7.7% were male and 92.3% were female. Within the total Asian group, 3.9% were male and 96.1% were for female.

3.3 End-of-Life Palliative Care

	Ethnicity	Numbers	%
Male	New Zealand European	573	43.1%
	European Other	45	3.4%
	New Zealand Maori	21	1.6%
	Pacific Island	3	0.2%

	Asian	13	1.0%
	African	0	0.0%
	Middle Eastern	0	0.0%
	Other (Latin America etc)	18	1.4%
Female	New Zealand European	565	42.5%
	European Other	42	3.2%
	New Zealand Maori	20	1.5%
	Pacific Island	5	0.4%
	Asian	12	0.9%
	African	0	0.0%
	Middle Eastern	0	0.0%
	Other (Latin America etc)	11	0.8%
	Total	1328	

(Partnership Health Data – on file)

Table 14 Patients Accessing End-of-Life Care services 2008 -2009

It is worth noting that ethnicities other than European access this service at a very low level. Asian access is 1.9% of the total.

3.4 Child Health Service

Female	NZ European	128
	European Other	34
	NZ Maori	49
	Pacific	19
	Asian	4
	African	1
	Middle Eastern	1
	Other (Latin America etc)	17
Male	NZ European	207
	European Other	39
	NZ Maori	54
	Pacific	23
	Asian	8
	African	1
	Middle Eastern	2
	Other (Latin America etc)	12

	Total	599

(Partnership Health Data – on file)

Table 15 Child Health Access July 2007 – June 2009

At the end of June 2009, 62,555 children under the age of 14 years were enrolled with PHC. Of this total 6.8% (4,261) were Asian. Only 2.0% of the Asian group accessed the child health service. Very low access was also noted amongst the African and Middle Eastern groups.

	Total Asian		
Age	**No. eligible**	**Fully immunised for age**	**%**
6 Months	**89**	**76**	**85%**
12 Months	**121**	**117**	**97%**
18 Months	**127**	**111**	**87%**
24 Months	**87**	**79**	**91%**

(PHC Patient Data; Jan-Mar 2010 – on file)

Table 16 Asian Childhood (6-24 months) Immunisations January-March 2010

The number of Asian children fully vaccinated increases with age up to 24 months old.

	% Vaccinated	
	4-year-olds	**11-year-olds**
NZ European	**86%**	**81%**
European Other	**78%**	**75%**
Maori	**81%**	**73%**
Pacific Islander	**72%**	**70%**
Asian	**81%**	**69%**
Middle Eastern	**63%**	**92%**
African	**74%**	**95%**
Other	**78%**	**72%**
Total	**84%**	**79%**

(PHC Patient Data; Jan-Mar 2010 – on file)

Table 17 Asian Childhood Immunisation (4-11 years) January-March 2010

The number of Asian children vaccinated decreases markedly between the ages of four and eleven years-of-age.

HPV Vaccination

PHC data also shows that 75% of all applicable age Asian females have received the HPV vaccination. It should be noted that – along with the Pacific Island group – Asian girls have the highest vaccination rate.

3.5 Mental Health Brief Intervention Counselling Service

Female	New Zealand European	747
	European Other	59
	New Zealand Maori	69
	Pacific Island	10
	Asian	18
	African	5
	Middle Eastern	2
	Other (Latin America etc)	31
Male	New Zealand European	441
	European Other	43
	New Zealand Maori	48
	Pacific Island	6
	Asian	8
	African	0
	Middle Eastern	1
	Other (Latin America etc)	9
	Total	1497

(Partnership Health Data – on file)

Table 19 Mental Health Service April 2008 – June 2009

A total of 1,497 new contacts were made in the initial 15 months of the brief intervention counselling service. Of these 1.7% was for those of Asian origin.

3.6 B4 Schools Checks

In Canterbury B4 Schools checks are carried out - unlike in other areas - through general practice. Although these checks were targeted at 4-year-old children, in the first year they also included many who had just turned 5-years-old. The total 4- and 5-year-old PHC population (2009) was 4,985 and 4,917 respectively. Thus the total number of B4 Schools (2,376) checks was 24.0% of the total 4/5-year-old population. Of the total number of checks 3.7% were for Asian children. At the end of December 2009, 508 4- and 5-year-old Asian children were enrolled with PHC. 17.5% of them received a B4 School check.

SECTION 4: DISCUSSION

4.1 Diabetes

Due to the rapid nature of the acculturation process, the incidence of diabetes amongst refugee and migrant populations is increasing. That this is mostly avoidable type 2 diabetes is all the more reason for developing counter measures.

In a March 2010 paper, published in the New England Journal of Medicine, Chinese researchers noted the incidence of diabetes and pre-diabetes in Mainland China was now 9.7% and 15.5% respectively amongst the adult population. This means that one in ten Mainland Chinese adults are afflicted. 90% of these cases are type 2 diabetes. Compounding this is weight gain through a more sedentary lifestyle. Diabetes incidence also increases with age.

In the 2006/07 New Zealand Health Survey, Asian males and females had almost 2.5 (males) and over 1.5 (females) times the prevalence of diagnosed diabetes than males and females in the total population. This placed the Asian adult group with the second highest incidence of diagnosed diabetes behind that of Pacific Islanders.

The New Zealand Health Survey also stated that the incidence of diagnosed diabetes amongst the Asian adult population was 6.5% (95% CI).

This being the case, why have a mere 1.8% of our total Asian population accessed the free annual diabetes check? Due to the rapid increase of diabetes in Mainland China, we can assume that a similar situation exists in New Zealand. This could mean that the PHC Asian population may have between 1,900 and 3,400 people with diabetes or pre-diabetes; most of who do not appear to be accessing primary health care.

In Canterbury, Diabetes Christchurch Inc has no language-specific literature available.

4.2 Youth Sexual Health

In many Asian countries, little or no sexual health education occurs. Discussion of sexual health matters is considered to be highly personal and thus not openly

discussed. (Omura et al 2006) This lack of discussion extends to seeking medical help and advice.

The increase in induced abortions amongst Asian women has been noted in a number of publications. *Data on termination service usage by non-resident Asian females in one abortion clinic increased from 12 percent in 1995 to 55 percent in 2002* (Goodyear-Smith and Arroll, 2003). This paper also stated that "*In 2002, 97% of Asian women used no contraception or only condoms pre-conception, and 62% chose condoms or abstinence post-termination. Oral contraceptives are used significantly less by Asian than European women both pre-termination (p = 0.0002) and post-termination (p = 0.00001).*"

In research published in 2005 (Rose et al) on the incidence of chlamydia, it was noted that whilst Asian women had not been previously identified as an at-risk group, there had been a 14-fold increase in chlamydia infection identified since an audit of pregnancies twelve months earlier.

The apparent lack of understanding about sexual health issues is all too clear amongst Asians of both sexes. Abortion may be seen as a means of contraception, a lack of coherent contraceptive knowledge exists, contraception is not deemed necessary for the first week after menstruation and many females believe that contraception should be up to males.

4.3 End-of-life Palliative Care

Significant differences exist in attitudes towards end-of-life care amongst all cultures. For many, specific rituals are required in the belief that these will aid both the healing process of the living and the wellbeing of the soul as it passes. End-of-life care is therefore more than merely financial help from a general practitioner during this stressful time. These factors are overlooked in the holistic nature of such events.

Western attitudes towards death tend more towards fear and despair (Sok 2009); fear because of the unknowing and the unknowable. Asian people see death as a passing; one of transgression to a better place; a step towards – perhaps – enlightenment. In other words, death is not seen as the end by many Asian – and other – cultures.

A need also exists for many – if not all – migrants, to end their life in their country of birth. How much this impacts on access to end-of-life care is not known. Anecdotal evidence suggests that at least some of the older generation – i.e. those arriving in New Zealand as older parents or grandparents - may indeed return home when they understand that life may be near its end.

4.4 Child Health

In many discussions with Asian people during presentations and research, the author has spoken to a number of East Asian people who have claimed that whilst they (the mother) may be enrolled with a general practitioner, the children are not. When asked for the reason, the answer is invariably "*They are not sick!*" Whilst

immunisations are generally kept up-to- date in the home country, they may be slipping in New Zealand.

This begs the question about the viability of childhood immunisation statistics. They only reflect those who are enrolled patients.

4.5 Mental Health

In PHC research carried out in 2007/08, only 2% of those interviewed accessed mental health services. This is borne out by the low Asian access figures (1.7% of the total population) for the initial 15 months of the mental health brief intervention service.

Across the mental health conditions measured in the 2006/07 New Zealand Health Survey (mood and anxiety disorders), Asian men and women were all much less likely to have been diagnosed with a mood or anxiety disorder than men and women of the total population. It is hypothesised that this low access by Asians may be triggered by cultural mores thus presenting an unclear picture of the true costs of mental health conditions amongst Asian peoples.

Coupled with all this is the total lack of culturally sensitive mental health services. For example, only two Mandarin-speaking counsellors work within the Canterbury area. Such services cannot be addressed through the use of interpreters. They can only be addressed through the intervention of qualified Asian professionals who understand how to approach such issues.

4.7 B4 Schools Checks

As the B4 Schools checks are being carried out through general practice in Canterbury, this could possibly be seen as one reason for the low access to this service. Asian parents tend to send their children to Asian preschools where they then communicate in their native language. As far as the writer is aware, little contact was made with these preschools. Many of these preschools are informal groups thus difficult to locate. Information may have been sent in English thus many Asian parents may not have understood the import of this service.

SECTION 5: WHAT OF THE FUTURE?

The most recent Health Needs Analysis (HNA) published by the Canterbury District Health Board (CDHB) was carried out in 2004 using data from the 2001 census. At that time the Asian population totalled 18,000. Since then, the Asian population has grown by over 10,000 people. The 2004 HNA is woefully out-of-date.

That HNA highlighted several areas:

1. Health-trained interpreters are essential
2. Increasing numbers of Chinese GPs and nurses in Christchurch have helped ease worries for non-English speaking Chinese new immigrants.
3. Instructions about taking medications are often not completely understood
4. Cultural difficulties in accepting Western medicine

5. The lack of English language skills
6. Discrimination

Few of these issues have been addressed.

1. Canterbury does not have an affordable, easily accessible interpreter service.
2. Worries for non-English speaking immigrants have not eased as stated.
3. Miscommunication about medicine instructions begin in general practice and are then compounded at pharmacy level.
4. The lack of understanding of our primary and secondary health care systems confuses most immigrants.
5. Due to Immigration New Zealand's 'Centre of Gravity' policy, the fastest growing Asian group in Canterbury is that of Chinese over the age of 50 years. Many will never learn to speak adequate English.
6. Discrimination exists and will only increase with the pressures of increasing migration.

The most recent CDHB District Annual Plan (2009/10) states that "*…with the exception of level of educational achievement, where the Asian ethnic group provided the lowest scores*." Yet the Christchurch City Council's publication The Migrants Report 2007 states that "*In 2006, 24 per cent of ethnic minorities had a Bachelor or higher degree compared to 19.4 per cent of the total Christchurch population*." These two statements are at odds with each other indicating a lack of awareness at decision-making level.

It is vital that the DHB recognise the increasing Asian population and its impact on health care spending - both now and in the future. This will avoid 'blowouts' in the cost of chronic health conditions such as diabetes (type 2), obesity and CVD. Asians are under-reported in most official 'reports' through combining their figures with those of Europeans or simply including them as "Other" with all those outside European, Maori and Pacific. This occurs despite the fact that the Asian group will be the second largest culture in Canterbury within the next 10 years.

Whilst more up-to-date information is available for European, Maori and Pacific peoples, the Ministry of Health shows little inclination or interest in collecting Asian data.

SECTION 6: CONCLUSION AND RECOMMENDATIONS

Current Initiatives

Partnership Health Canterbury is initiating the following projects to address the issues facing Asian migrants:

1. Cooking Skills: To address the lack of housekeeping skills amongst young people and the lack of local food preparation knowledge of primary care-givers a hands-on pilot cooking skills programme has been developed from the

successful "Great Little Cookbook" project. The cookbook has been translated into Chinese with added sections on herbs and spices, food storage, hygiene and the use of western cooking implements such as ovens and a supermarket tour.

2. In conjunction with the National Heart Foundation, healthy heart seminars are held.

3. A series of cultural communication presentations to health professionals have been presented to various community sectors since late 2008.

4. An Asian DAP was presented to CDHB Planning and Funding for inclusion in their 2010/11 DAP.

5. Effective networks have been developed with all Canterbury agencies working with refugees and migrants.

6. The 2009 arrival of H1NI influenza (swine flu) highlighted the urgent need for language-specific literature.

Recommendations

1. As it will be impossible to invite all those who would like to attend the cooking skills course, a DVD presentation is being evaluated.

2. The development of language-specific literature across *all* health spectra is imperative if we are to address current barriers to health access.

3. The collection of ethnicity data must be improved if we are to accurately target specific groups.

4. The current barriers to employment must be addressed. All too often we are presented with qualified people who are employed in menial jobs as their qualifications are not recognised in New Zealand.

5. A concerted push through the ethnic media and societies to increase the level of enrolment to general practice.

6. The creation of an integrated health centre based on culture. A centre such as this would offer a wide range of health and related services in a culturally appropriate manner.

The following chart outlines where we need to proceed.

Next Steps in 2010/2011			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	***What is the DHB trying to achieve?***	***What actions will we take to make this happen?***	***What impacts will this have?***
Establish an Asian Health Advisory Board	To support Asian participation in the development of services	Establish a DHB/PHO Asian Health Advisory Board Establish a clear pathway for participation Identify key target areas for Asian Health improvement	A clear understanding of opportunity areas to improve Asian health outcomes
Focus on health promotion, early intervention and a reduction in risk behaviours	To provide good foundations for improved health, improved access and a reduction in health inequalities	Improve the availability of language-specific health information.	Reduction of the impact of chronic disease, increase the number of Asian people enrolled at general practice
		Undertake community education around diet and disease prevention.	Reduction in pregnancy terminations, chronic disease and inappropriate ED usage. Improvement in access to health resources.
		Improve access to all screening programmes to provide an increase in the	To increase screening rates to the National Target of 75%

		number of Asian people accessing these services	
		Improve access to Family Planning and related services	To increase the usage of contraception, to reduce the incidence of pregnancy termination and sexually transmitted infections.
To improve the access and utilisation of appropriate health services	To improve health outcomes for Asian people and reduce inequalities in health status	To provide correct Asian ethnicity data for all Asian cultures	It cannot be assumed that all Asian cultures have the same needs and ideals. By providing correct ethnicity, better health platforms can be provided.
		Develop consistent clinical treatment and referral pathways for all chronic diseases. These must be based in primary settings - and supported by specialists - to improve health outcomes.	The decreasing trend in Asian people accessing regular reviews - such as diabetes - will be reversed thus allowing better understanding and management of their condition.
To provide an effective, safe interpreting and translation service for Asian people	To improve access to health care through better access to linguistically appropriate services	Develop an interpreting and translation service which is easily accessible by Asian people, general practice and all other health care providers	Better access to culturally appropriate healthy services through the use of language and culture
Create an Asian Health Careers Service	To improve Asian provider capacity to meet future demand	Support Asian people with health-related qualifications to find employment through mentoring and	The creation of an Asian workforce will not only permit an Asian for Asian environment but help meet future demand across all health

		easier access to NZ training	services. Barriers to access will be reduced thus lessening the health burden.
		Reduce the current barriers to employment such as unrealistic English requirements	
Implement an Asian Mental Health Governance and Management project	Support Asian provider and workforce development to provide quality Mental Health and Addiction services for Asian people	Support providers in development and training through scholarships and workforce development plans	The effectiveness and governance of culturally appropriate Asian providers is improved thus improving the services provided
Develop an Asian Health Profile for Canterbury	To provide a clear picture of local mortality, morbidity and risk fact prevalence	Complete an Asian Health Needs Analysis written and approved with Asian input	Opportunities for improvements in Asian health status are identified.
		Establish clear areas of priority and inequality	Information collected builds a picture of Asian health outcomes and assists in improving the planning and funding of health and disabilities
		Provide a picture of Asian utilisation of hospital, ED, primary and specialist services in Canterbury	Identifies areas of inequality and low access thus enabling barriers to be reduced.
OUTCOMES			
How we will measure our success.			
An increase in the number of Asians enrolling with general practice			
A decrease in the number of inappropriate attendances at ED by both enrolled and un-enrolled Asian people			
An increase in the number of Asian people accessing breast and cervical screening services			
A decrease in the number of unwanted pregnancies amongst Asian women			

An increase in the number of Asian people accessing diabetes screening and annual checks
An increase in the level of nutritional and lifestyle knowledge which in turn will lead to a decrease in chronic disease
An increase in linguistically and culturally appropriate health care information

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An Innovative, Self-Paced, Self-Reflective, Accredited CALD Cultural Competence Online Learning Tool

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Abstract

Cultural competence training for the health and disability workforce is important because of the increasing number of patients from culturally and linguistically diverse (CALD) backgrounds using New Zealand health and disability services. There are growing concerns in health services about the miscommunication between practitioners and their CALD clients. There is a demand from the health and disability workforce for CALD cultural competency training to prevent misdiagnosis; poor treatment and poor compliance in CALD populations; and to comply with the cultural competence requirement of the Health Practitioners Competence Assurance Act 2003. Waitemata District Health Board (WDHB), Asian Health Support Services (AHSS) has developed flexible learning option concepts for training the health workforce in CALD cultural competencies. These include six classroom-based CALD cultural competency training courses. The first of the six courses "Culture and Cultural Competency" was converted into an innovative, self-paced online learning tool in March 2010. Waitemata DHB AHSS sub contracted the University of Auckland Goodfellow Unit (GFU) in August 2009, to provide project and quality management for this online development. The Goodfellow Unit was contracted to ensure that firstly, the content development, e-learning technical development, evaluation and users testing development, and implementation phases are managed on time and on budget. Secondly, that the e-learning content and design achieved the required concept, quality and standards. The AHSS provided the subject matter expertise and the content included in the production of video and audio scenarios. The Northern DHB Support Agency (NDSA) has purchased the rights from WDHB AHSS for staff working in primary and secondary health services in the Auckland-metro region to access this online tool and others as they become available from April 2010.

Introduction

The concept of 'cultural competence' was developed in health care to better meet the needs of culturally diverse populations, and in response to the growing evidence of health disparities between ethnic minority groups and other health populations in the United States (Betancourt, Green, Carillo & Ananeh-Firempong, 2003; Betancourt, Green, Carillo & Park, 2005; Betancourt, Weissman, Kim, Park & Maina,2007; Bhui, Warfa, Endonya, McKenzie, & Bhugra, 2007; Brach & Fraser, 2002). New Zealand studies of Asian, refugee and migrant health outcomes have identified health professionals' lack of cultural awareness, knowledge and skills as a major barrier to

accessible, safe and equitable health services for the ethnically diverse groups served (Denholm & Birukila, 2001; Denholm & Jama, 1998; Ho, Au, Bedford & Cooper, 2003; Ho, Guerin, Cooper & Guerin, 2005; Jackson, 2006; Lawrence & Kearns, 2005; Ministry of Health, 2001; Mortensen, 2008; North & Lovell, 2002; Auckland Regional Public Health Service, Harbour PHO and Waitemata DHB's Asian Health Support Services, 2007).

Waitemata DHB Asian Health Support Services has developed flexible learning options for Cultural and Linguistic Diversity (CALD) cultural competency training for the primary and secondary health workforces in the Auckland region. The need to provide accredited, self-paced, convenient and sustainable CALD e-learning options was driven by the needs of the health workforce, in particular, general practitioners for training options that:

- Provided evidence of accreditation in cultural competence
- Were suitable for practitioners working in rural locations and those who have no access or time to attend face to face classroom-based courses
- Provide convenient and sustainable training

The Ministry of Health contracted through the Northern DHB Support Agency funds Waitemata, Auckland and Counties Manukau District Health Boards to provide CALD cultural competency training to their primary and secondary health workforces.

Background

New Zealand health studies and the health needs assessments conducted by Waitemata, Auckland and Counties Manukau DHBs have highlighted the need for culturally competent workforces to meet the needs of the diverse populations served (Asian Public Health Project Team. 2003; ADHB, 2006a;2006b; WDHB, 2005; 2007; WDHB & RAS, 2007). The need to develop cultural competence is underpinned by legislative requirements. Section 118 (i) of the Health Practitioners Competence Assurance Act, 2003 (HPCAA) requires that health practitioners observe standards of cultural competence as set by their professional authority. The availability of cultural competency training is part of the programme of work for the *Auckland Regional Settlement Strategy Refugee and Migrant Health Action Plan.* The regional programme of work is administered by the Northern DHB Support Agency on behalf of Waitemata, Auckland and Counties Manukau DHBs (Department of Labour and Auckland Sustainable Cities Programme, 2007).

Since the early 1990s, the ethnic demography of the Auckland region has changed significantly (Department of Labour, 2006; Department of Labour and Auckland Sustainable Cities Programme, 2007; Statistics New Zealand (SNZ), 2006). Auckland is the gateway to New Zealand for many Asian, migrant and refugee communities, and where the greatest proportion chooses to settle. The region has settled over 200 diverse ethnic groups (SNZ, 2006). Over half of the population in the Auckland region is born overseas (SNZ, 2006). Of the 50,700 New Zealand adult non-English speakers more than 65 percent live in the Auckland region. Two-thirds of those who come to New Zealand from Asia live in the Auckland region.

The Health Practitioners Competence Assurance Act, 2003 (HPCA Act) includes a requirement for registration bodies to develop standards of cultural competence and to ensure that practitioners meet those standards. Professional bodies such as the New Zealand Medical Council (NZMC, 2006), Royal College of General Practitioners, Public Health Physicians, Nursing Council of New Zealand (NCNZ, 2007), and the Aotearoa New Zealand Association of Social Workers (ANZASW) have an interest in developing the cultural competence frameworks for the culturally and linguistically diverse (CALD) groups served. For example, the Royal College of General Practitioners has developed an accreditation package specifically for General Practice which includes indicators for a culturally competent workforce[4]. The issues of relevance for the development of CALD cultural competencies in the health sector includes the recognition of culture as a determinant of health status; and the recognition of the need for a culturally competent workforce to address both issues of equity and of health disparities. Cultural competence focuses on the skills, behaviours and attitudes required to work with the culturally, linguistically and religiously diverse groups served by Auckland region District Health Boards.

Studies of Asian, refugee and migrant health care in New Zealand indicate that the health workforce is under prepared to meet the needs of the diverse ethnic populations served (Denholm, 2004; Lawrence, 2007; North & Lovell, 2002; Mortensen, 2008). North and Lovell's (2002) survey of the impact of immigrant patients on primary health care services in Auckland and Wellington showed that health practitioners believed that clients from ethnically diverse backgrounds expressed their concerns, symptoms, and pain differently from other patients. Health practitioners reported that understanding the presentation of symptoms is central to diagnosing, and providing adequate treatment. Two-thirds of the respondents in the survey were nurses, less than half had received any training related to the care of CALD clients and most expressed the need for cross-cultural education (North & Lovell, 2002).

The skills of cross-cultural communication including the use of interpreters are essential to client safety (Gray, 2007; Wearn et al., 2007). Practitioners who can use interpreters effectively, and communicate cross-culturally are more likely to receive accurate information; to ensure that the client understands the result of tests and screening; and to provide the client with information and instructions on medications, treatments and follow up. Communicating effectively with the client depends on the practitioner's ability to gain rapport. The ability to adapt to different verbal and nonverbal communication styles where the culture of the practitioner is different to that of client is important to avoid the misunderstandings and actions that the client and family may find unacceptable (Meeuwesen, Harmsen, Bernsen & Bruijnzeels, 2006). The ability to use cultural assessment tools and to use the information gained aids good client outcomes (Greenholtz, 2005). Working with the client's cultural beliefs, values, and practices and applying this knowledge in planning care is more likely to lead to client satisfaction with the services offered (Hofstede, 2001).

Cultural Competency Training Development

[4] The Royal New Zealand College of General Practitioners (2007). *Cultural Competence: Advice for GPs to create and maintain culturally competent general practices in New Zealand* is available on line at: http://www.rnzcgp.org.nz/assets/Documents/qualityprac/culturalcompetence.pdf

Since 2000, WDHB AHSS has provided training to health care workers in primary and secondary health services on "Cultural Perspectives on Asian Patient Care". This training has included the rationale for delivering culturally competent care to clients of health services as well as developing practitioner's skills in cultural competence; understandings of health beliefs and concepts; and improving skills when working with Asian patients and with interpreters.

In 2005, WDHB AHSS set up the Auckland Region Asian Mental Health steering group and working group which led to a regional project for "Curricula and Guidelines Development for Asian Interpreters and Mental Health Practitioners to Work Effectively Together". The project produced six training modules after consultation with key stakeholders across the Auckland region. The curriculum development was guided by the findings in the international literature on curricula and standards for cultural competence; a stocktake of training curriculum; the feedback from regional consultations. The working group included Dr Sai Wong, Dr Sanu Pal, Paula Nes, Eileen Swan, Patrick Au, Dr Ratana Walker, Victoria Camplin-Welch, Hien Mack, Janet Chen; and Patrick Hinchey provided advice. The training programme was piloted and rolled out successfully in 2006.

In 2007, WDHB AHSS in a joint venture with Refugees as Survivors (RASNZ) developed the face to face CALD Cultural and Linguistic Diversity training Courses 1, 2, 3, and 4 for primary and secondary care workforces. The programme was written and compiled by Dr Kathy Jackson and Victoria Camplin-Welch with input and resources from Sue Lim. In 2008, additional CALD Courses 5 and 6 were added to the suite of courses available. The CALD 5 resource was produced by Dr Sai Wong and CALD 6 by RASNZ. In Feb 2009, the NDSA Auckland Regional Settlement Strategy (ARSS) migrant health project contracted WDHB AHSS to provide sustainable and flexible learning options (including face to face and e-learning options) for primary and secondary care workforces.

In Mar 2009, WDHB AHSS rolled out the face to face CALD courses 1 to 6 which comprise:

CALD foundation courses for all health practitioners:
- CALD 1 – Culture and Cultural Competency
- CALD 2 – Working with migrant clients
- CALD 3 – Working with refugee clients
- CALD 4 – Working with interpreters

CALD courses specifically for mental health practitioners only
- CALD 5 – Working with Asian mental health clients
- CALD 6 – Working with refugee mental health clients

Refer to CALD website for course information

The overall learning objectives for the CALD training programme courses are to enable participants to:
1. Understand and recognize their own and CALD clients 'normal' behaviours;
2. Gain an understanding around cultural competence
3. Learn how to communicate with CALD clients

4. Receive help recognizing different communication styles and interpreting non-verbal clues
5. Gain knowledge and practical skills on working with CALD clients
6. Gain knowledge and practical skills working with interpreters
7. Develop the skills needed in working with clients who have been through the refugee experience

The following described the learning objectives of CALD courses 1, 2, 3, and 4:

- **CALD Module 1: Culture and Cultural Competency**
  Duration: 4 hours face to face delivery
  Participants: This course is for anyone working in secondary care, primary care and mental health services, who wish to gain an understanding of what is involved in developing cultural competence. The participant will gain knowledge and the skills to work in a culturally sensitive and safe way with clients who are culturally and linguistically different from the practitioner.
  As a result of attending CALD 1, participants will be able to:
  - Understand the need for cultural competence and the impact of cultural interactions on health system
  - Be more aware of one's own cultural values
  - Understand the four elements of cultural competence (cultural awareness,
  - sensitivity, knowledge, skills)
  - Understand how to apply the elements of cultural competency in practice

- **CALD Module 2: Working with migrant clients**
  Duration: 4 hours face to face delivery
  Participants: This course is for anyone working in secondary care, primary care and mental health services, (who has completed CALD Module 1) and who wishes to understand how to work more effectively with migrant/Asian clients.
  As a result of attending CALD 2 participants will be able to:
  - Understand the emotional reactions of migrants
  - Understand the phases of settlement and acculturation processes
  - Broadly understand health concepts/beliefs and spiritual/faith-based issues of CALD clients and how they impact on the clients' communication, presentation, and interaction with practitioners.
  - Gain skills on how to raise sensitive issues with migrant/Asian clients
  - Integrate learning on migrant/Asian clients in case studies

- **CALD Module 3: Working with refugee clients**
  Duration: 4 hours face to face delivery
  Participants: This course is for anyone working in secondary care, primary care and mental health services, (who have completed CALD Module 1) and wish to understand how to work more effectively with refugee clients.

  As a result of attending CALD 3 participants will be able to:
  - Understand the pre and post-settlement challenges for refugees
  - Understand the physical and mental health challenges for refugees
  - Handle sensitive issues with refugees

- Initiate the development of a resource for low literacy clients for your practice
- Use the strengths and resilience of refugee clients in interventions

- **CALD Module 4: Working with Interpreters**
  Duration: 4 hours face to face delivery
  Participants: This course is for anyone working in secondary care, primary care and mental health services, (who have at least completed CALD Module 1) and who wish to understand how to work more effectively with interpreters.

  As a result of attending CALD 4 participants will be able to:
  - Understand the roles, code of ethics, rights and responsibilities of interpreters and apply this knowedge to situations in which there are ethical dilemmas
  - Understand the challenges for each profession when working with the other
  - Understand the principles of session pre-briefing, structuring and de-briefing (practitioners)
  - Understand some of the factors that affect the working relationship (the therapeutic triad, transference and counter-transference)
  - Conduct a pre briefing and post briefing session with an interpreter

Project Description
In Aug 2009, WDHB AHSS contracted the University of Auckland Goodfellow Unit to provide project management, quality control and the e-learning design for the development of the first accredited, self-paced, e-learning course: "CALD 1 Culture and Cultural Competency".

Project Timeframe: Aug 2009 to March 2010

Project Objective
To develop an accredited, self-paced, self-reflective and effective "Culture and Cultural Competence" online learning course that offers an interactive e-learning environment for the health workforce to learn online at home and at work.

Methods
- Goodfellow Unit – University of Auckland – contracted to provide:
  - Project management
  - E-Learning quality and professional standards requirement
  - Instructional learning designer
  - Technical development
  - Technical instructions for learners
  - Evaluation and User Acceptance Testing (UAT x 2)

- WDHB Asian Health Support Services Team to provide:
  - Subject Matter Expert (course content, materials, resources,)
  - Online Study Short and Full Course Workbooks
  - Production of video clips and audio clips

The following section describes the four phases of the e-learning CALD Culture and Cultural competence course development which was undertaken by AHSS and GFU teams.

Phase One: The Content Development Phase

The first phase of the project included:

- Designing the e-learning product to work in synergy with the existing WDHB AHSS CALD website www.caldresources.org.nz and administration system
- Ensuring the purpose of the e-learning CALD Culture and Cultural Competency Course is aligned with the purpose of the classroom-based course
- Ensuring parity between the e-learning objectives of the online and the existing classroom- based course to achieve synchronicity with the changing learning platforms
- Ensuring the e-learning product contributes to learning in a dynamic, educational and effective manner
- Repackaging and streamlining the existing 3.5 hour classroom-based CALD Course into 3 parts of one-hour online learning blocks
- Ensuring that the group exercises of the classroom-based course is modified for individual participation and turned into asynchronous sessions that either create group processes or provide individual interaction
- Ensuring that the course has central exercises that will present the learning information in a relevant and interesting manner, for example, include video, audio, and interactive applications. At the end of each part, a quiz is to be included to cover the material learned and to provide a summary to enable the learner to achieve self-paced learning
- Ensuring that the course will work concurrently with the existing CALD training programme
- Designing and producing an online workbook to accompany the e-learning training session for learners with the navigation tools
- Producing an online workbook with comprehensive course notes as an option for learners to use as a reference

Phase Two: E-Learning Quality and Professional Standards Requirements

The second phase focussed on the e-learning quality and cultural competence standards requirements for health professional registration bodies. This phase included:

- Ensuring the development of the e-learning modules are communicated and linked with the Royal NZ College of General Practitioners, National Institute of Health Innovation and Continuing Medical Institute;

- Ensuring that the e-learning product achieves the required standard and quality to enable registration boards of various disciplines to issue health practitioners undertaking this course, with Continuing Medical Education/ Continuing Nursing Education (CME/CNE) or equivalent accreditation credits /points
- Ensuring the e-learning product is fully evaluated before finalising (see Phase Five)

Phase Three: Technical Development

The third phase of the project included:

- Ensuring the e-learning product runs within the existing technical parameters of the WDHB CALD Resources administration website (www.caldresources.org.nz) which provides user registration, course enrolment of both face to face and online CALD courses and, tracking and reporting of the online courseware delivery.
- Ensuring that the product is developed with a SCORM [Sharable Content Object Reference Model] compliant web product and will incorporate the existing graphic user interface of the CALD Resources website www.caldresources.org.nz
- Ensuring that the online courseware is compliant and can be hosted on the "Moodle" platform
- Adjusting purpose-built technology to become a Learning Management System for the purpose of a pilot programme
- Developing the online product on a third party system to ensure a seamless user experience while still providing all of the desired functionality
- Ensuring the online product will use various forms of Web 2.0 technology including the application and delivery of audio and/or video material, flash driven exercises, (MCQ) quizzes plus the delivery of static resources including pdf resources, HTML content, and possible PowerPoint presentations.
- Ensuring accreditation in the form of a certificate be delivered to the learner upon completion of the course materials.
- Enabling that all user management of the discrete program will be within the course. This will include:
    - The ability to stop/start within the session
    - Prevent the learner from doing sessions out of order
    - Provide for the collection of learner information at discrete points for evaluation purposes

Phase Four: Evaluation Development

The fourth phase of the project included:

- Ensuring that the evaluation is staggered throughout the project

- Providing two forms of testing: the effectiveness of the product and the effectiveness of learning provided
- Testing the learning functionality before the completion of the final development and then retesting at the end of the project to ascertain whether the learning design, navigation and usability are effective
- Collecting learner responses about the effectiveness of the material and whether the tool was interesting, informative and fun to use
- The evaluation objectives include:
    - A snapshot view of the learner's self assessment of how culturally aware and confident he/she is to work with clients who are culturally and linguistically different in their current practice after using the e-learning training;
    - Identifying the key points that the learner has retained from the e-learning training
    - The learner's assessment of the e-learning tool in terms of content and the effectiveness of the e-learning delivery (that is, easy to use, navigate, fun, create thinking, interesting, enjoyable, interactive);
    - Suggestions for improvement and any other feedback
- Testing of the web product to include the following:
    - Technical compatibility and functionality (does the site work? Can people use it? Can they achieve their objectives?)
    - The effectiveness of the learning (success of learning objectives?)
    - The effectiveness of the project

Findings

- User Acceptance Test (UAT) One
    - When: 3 December 2009
    - Aim: To test PART A of the online course before developing PART B and PART C
    - Purpose: To find out from UAT participants what they like or do not like about the e-learning design and concept, ease of navigation, the quality of learning, and its visual appeal
    - Method:
        - The participants were sent an invitation letter explaining the project, the UAT, the purpose, when, and where (School of Population Health)
        - Participants were selected by WDHB AHSS based on a mix of genders and age groups
    - Process:

        - Participants were provided access to the partially developed online tool, with UAT instructions and an evaluation form to complete
    - Participants
        - 8 participants (made up of 5 female and 3 male, age ranged from 28 to 56) took part in the UAT One
    - Outcome: The feedback received was very positive, with only minor changes to the content and navigation tools for PART A. It gave the project team a good indication to continue with PART B and PART C using similar navigation, interactive exercises, quizzes, audio and video clips to engage e-learners.

- User Acceptance Test (UAT) Two
    - When: 26 January 2010 to 29 January 2010
    - Aim: To test the overall online course which makes up three parts (Parts A, B and C) which includes all audio and video examples using the online workbook
    - Purpose: To find out from UAT participants what we need to change in terms of ease of use and navigation, as well as gather ideas from users relating to the effectiveness of its learning and usability before finalising the online course for rollout
    - Method:
        - More than 30 participants working across primary and secondary health and disability sectors were invited to participate in the UAT
        - The range of participants were selected by WDHB AHSS
    - Process:
        - Participants who accepted the UAT, were provided:
            - The project information
            - UAT and purpose
            - Access to the online link to the courseware
            - Pre and Post Evaluation Forms, Workbook and instructions about the process and duration of the following
                - a pre-test evaluation (5 minutes)
                - the online training sessions (90 minutes)
                - the post –test evaluation (5 minutes)
                - the user testing survey (20 minutes)
            - Options of where to carry out the online test: at home or at work
            - A certificate of completion offered to participants
            - A deadline and where to submit evaluation form

- Participants
  - 30 participants were invited
  - 20 participants accepted the online UAT, made up of 1 general practitioner, 2 doctors, 1 nurse professional leader, 2 learning managers, 1 e-learning instructional designer, 1 quality manager, 1 Pacific health manager, 4 mental health practitioners, 2 community support workers, 2 interpreters, 3 migrant and refugee health project managers

User Acceptance Test 2 – Summary Results

(See Appendix 1: User Acceptance Test 2 - Detailed Results)

CALD 1 CULTURE & CULTURAL COMPETENCY

User Acceptance Test 2 - Summary Results

Total Respondents = 20
All the feedback forms are numbered from 1 to 20

A. Getting Started

A1. Were the directions for the CALD 1 Session easy to understand?
90% (17) found it very clear or clear

A2 On the CALD Challenges Exercise, did the language of the buttons relate to how you think about your CALD challenges in practice?
55% (11) understood the exercise instructions

A3 Did the exercise cause you to think about how CALD challenges affect your work?
75% (15) reflected on the challenges

B. Part A - Cultural Awareness

B1. Did you find out anything new about your own cultural values and understanding?
75% (15) found they learnt something new

B2. Was this part easy to

understand?
80% (16) found this part easy to understand

B3. Did you view all the tabs in this part?
90% (18) viewed all the tabs

B4. What part resonated with you the most?
50% (10) found the My Values Exercise resonated with him/her most
40% (8) found the Cultural Dimensions resonated with him/her most
35% (7) found the Best Practice Video resonated with him/her most
0.5% (1) found the Three Things of culture exercise resonated with him / her
0.5% (1) found the Worst Practice video resonated with him / her
0.5% (1) found the assessment resonated with him / her
0% (0) found any part particularly insightful

C. Part B - Sensitivity and Knowledge

C1. Was this part easy to understand?
0.65% (13) found this part easy to understand

C2 What part resonated with you the most?
0.35% (7) found the Cultural Relativism video resonated with him / her most
0.30% (6) found the Being Sensitive video resonated with him / her most
0.25% (5) found the Observations and Interpretations (exercise) resonated with him / her most
0.15 (3) found the Assumptions resonated with him / her most
0% (0) found any part particularly insightful

D. Part C - Cultural Skills

D1. Was this part easy to understand?
0.65% (13) found this part easy to

understand

E. Assessments

E1. Did you find the assessment at the end of each section useful?

0.75% (15) found the assessment at the end of each section useful

E2. If you got an answer incorrect did you go back and try again?

0.75% (15) did go back and try again when they didn't get the correct answer

F. Learning Feedback

F1. Does everyone conform to cultural dimensions in the same way?

0.60% (12) agree that not everyone conform to cultural dimensions in the same way

Positives qualitative comments from User Acceptance Test 2 include:

- The video at the beginning was helpful in understanding points of view from other colleagues
- Like the interactive pages – especially being able to get immediate display of graph after responding to Discover My Values and Ethnocentric Exercises
- Observation/ interpretation picture exercise really hit home
- Assumptions part had good learning opportunity
- Definitions of ethnocentrism and stereotyping with examples was helpful for learning
- Ethnocentrism exercise was interesting to see scoring
- CALD cultural competency skills were well set out and would be a good reference
- Found the online tool generally very useful and interesting
- Definitely learned a lot especially from the videos
- Enjoyed the questioning related to the videos
- The feel of the website – excellent, looks great, nice colours, user friendly, good tools
- Scenario viewing was very interesting for learning
- CALD skills is definitely and ongoing learning process
- Following the workbook and spending time being culturally aware and consciously practising sensitivity would be beneficial
- Liked the systematic approach and the combination of videos, text, audio and visual – well done
- Video clips and exercises were well chosen and presented, they all show reality of cross cultural situations

- Overall, easy to use and everything worked smoothly including the videos. Kept me interested. Surprisingly enjoyable and interesting with some helpful concepts and tips. Well done.
- I found it quite useful as it made me think before answering.
- I really enjoyed the self-assessment because I could compare it to the other graphs that were given.
- It's a very user-friendly design, I like it.
- Very easy to use and navigate
- Very engaging, and kept me interested
- All materials are very useful, and learned a lot

Areas for Improvement Comments from User Acceptance Test 2 include:

- Cultural theory was confusing – need to bullet point the dimension
- Worst practice video needs to be repositioned before Best practice video
- Frustrated with the speed of video streaming
- A few multiple choice questions need fixing
- Instructions for navigating videos in PART C were confusing
- Text in tabs were too small
- Would like the workbook with more comprehensive information about cultural dimensions, audio scripts and the CALD skills for easy reference.

The User Acceptance Test 2 results confirm the e-learning design concept and content has achieved the required quality and standards. The suggestions for improvements from the UAT-2 informed the modification requirements to finalise the CALD 1 online product.

Thematic analysis of the qualitative feedback received from the UAT participants shows that the online tool is effective, systematic; and kept learners interested, engaged and involved through the combination of text, audio, video, interactive exercises, quizzes and multiple choice questions.

Most importantly, the users felt that they had learned a lot from the on-line tool and had found that: the materials are very useful, the video examples and exercises are well chosen and presented; the CALD skills/tips are relevant and useful for reference and; the course has increased awareness.

In summary, the online tool has achieved the aim of providing a self-reflective learning environment that meets learners' needs. The project achieved its e-learning environment requirements and learning objectives

Conclusion

The online tool is an important innovation aimed at improving the responsiveness of health services to the CALD populations served. It is the "first of its kind" available in New Zealand which facilitates health practitioners' ability to increase cultural awareness, knowledge, sensitivity, skills and understandings of cross-cultural interactions. The development has enabled sustainable and flexible learning options for the Auckland region, and this online tool is easily expandable across New Zealand health and disability workforces

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Appendix 1: User Acceptance Test 2 - Detailed Results

A. Getting Started

Total Respondents = 20
All the feedback forms are numbered from 1 to 20

A1. Were the directions for the CALD 1 Session easy to understand?

Response #	Very Clear	Clear	Adequate	Hard to Read	Unclear
1	x				
2		x			
3		x			
4	x				
5	x				
6	x				
7		x			
8		x			
9	x				
10		x			
11	x				
12		x			
13		x			
14					x
15	x				
16	x				
17					
18					
19	x				
20	x				
	10	**7**	**0**	**0**	**1**

A2. On the CALD Challenges Exercise, did the language of the buttons relate to how you think your CALD challenges in practice?

Response #	Yes	Too Vague	Too Specific	Didn't understand them	I don't see these as challenges	No
1						
2	x					

3						
4	x					
5	x					
6		x				
7	x	x				
8	x					
9	x					
10	x					
11	x					
12			x			
13			x			
14						x
15	x					
16	x					
17						
18						
19						x
20	x					
	11	**2**	**2**	**0**	**0**	**2**

A3 Did the exercise cause you to think about how CALD challenges affect your work?

Response #	Yes	No	N/A
1	x		
2		x	
3	x		
4	x		
5	x		
6	x		
7	x		
8			x
9	x		
10	x		
11	x		
12	x		
13	x		
14	x		
15	x		
16	x		
17			
18			
19		x	
20	x		
	15	**2**	**1**

B. Part A - Cultural Awareness

B1. Did you find out anything new about your own cultural values and understanding?

Response #	Yes	N o
1	x	
2		x
3	x	
4	x	
5	x	
6	x	
7	x	
8	x	
9	x	
10		x
11	x	
12	x	
13	x	
14	x	
15	x	
16	x	
17		
18		
19		x
20	x	
	15	**3**

B2. Was this part easy to understand?

Response #	Yes	Hard to read; text too small	It was hard to understand the language	Found the navigation difficult to use	No – too much text.
1	x				
2					x
3		x			
4	x				
5	x				
6	x				
7	x				
8	x				
9	x				
10	x				

11	x				
12	x				
13	x				
14	x				
15	x				
16	x				
17					
18					
19	x				
20	x				
	16	**1**	**0**	**0**	**1**

B3. Did you view all the tabs in this part?

Response #	Yes	No	I didn't see any tabs
1	x		
2	x		
3	x		
4	x		
5	x		
6	x		
7	x		
8	x		
9	x		
10	x		
11	x		
12	x		
13	x		
14	x		
15	x		
16	x		
17			
18			
19	x		
20	x		
	18	**0**	**0**

B4 What part resonated with you the most?

.

Response #	Three things of culture exercise	Cultural dimensions	Worst Practice video	Best Practice video	My Values Exercise	Assessment	I didn't find any part particularly insightful.
1		x		x	x	x	
2		x					
3			x		x		
4		x					
5				x			
6		x		x			
7		x			x		
8		x					
9		x		x	x		
10				x			
11					x		
12					x		
13					x		
14		x		x	x		
15				x			
16	x						
17							
18							
19					x		
20					x		
	1	**8**	**1**	**7**	**10**	**1**	**0**

C. Part B - Sensitivity and Knowledge

C1 Was this part easy to understand?

Response #	Yes	Hard to read; text too small.	It was hard to understand the language	Found the navigation difficult to use	No – too much text.
1		x			
2			x		
3					
4	x				
5	x				

6	x				
7			x		
8	x				
9	x				
10	x				
11		x			
12	x				
13	x				
14	x				
15	x				
16	x				
17					
18					
19	x				
20	x				
	13	**2**	**2**	**0**	**0**

C2 What part resonated with you the most?

Response #	Assumptions	Being Sensitive Video	Cultural Relativism movie	Observations and Interpretations (the photos)	I didn't find any part particularly insightful.
1		x	x		
2					
3				x	
4			x		
5		x			
6		x	x		
7			x		
8		x			
9		x	x		
10				x	
11			x		
12				x	
13	x				
14	x			x	
15				x	
16			x		
17					
18					
19	x				
20		x			
	3	**6**	**7**	**5**	**0**

D. Part C - Cultural Skills

D1. Was this part easy to understand?

Response #	Yes	Videos took too long to load	It was hard to understand the language	Found the navigation hard to use	No – too much text.
1				x	
2	x				
3		x			
4	x				
5	x				
6	x				
7	x	x			
8		x			
9	x	x			
10	x				
11	x				
12				x	
13	x				
14		x		x	
15	x	x			
16	x				
17					
18					
19	x				
20	x				
	13	**6**	**0**	**3**	**0**

E. Assessments

E1. Did you find the assessment at the end of each section useful?

Response #	Yes	No	I didn't take any Assessments
1	x		
2	x		
3	x		
4	x		
5	x		
6	x		

7	x		
8	x		
9	x		
10		x	
11			x
12	x		
13	x		
14	x		
15	x		
16	x		
17			
18			
19	x		
20			x
	15	**1**	**2**

E2. If you got an answer incorrect did you go back and try again?

Response #	Yes	No
1	x	
2	x	
3	x	
4	x	
5	x	
6	x	
7	x	
8		
9	x	
10	x	
11	x	
12	x	
13	x	
14	x	
15	x	
16	x	
17		
18		
19		
20		
	15	**0**

F. Learning Feedback

F1. Does everyone conform to cultural dimensions in the same way?

Response #	Yes	No	What's a dimension?
1	x		
2			x
3			
4	x		
5		x	
6		x	
7		x	
8			
9		x	
10		x	
11		x	
12		x	
13		x	
14		x	
15		x	
16		x	
17			
18			
19			
20		x	
	2	**12**	**1**

Migrant Health Problems along the Thai-Cambodian Border Solutions as a Tool for Building Better Relations

Saowapa Pornsiripongse

Abstract

Thailand borders Cambodia to the northeast and east with 789 kilometers of border territory. Cambodia's per capita income is low compared with Thailand's, so many Cambodians migrate to Thailand illegally to work in "3 D jobs"; dirty, dangerous and difficult.

The purpose of this study were to investigate the situation concerning the health management of Cambodian migrants along Thai–Cambodian border areas, including health services, patterns of service use, strategies and methods of coping with problems encountered by hospitals along the border areas. The findings and suggestions emerging from the study will help determine suitable health management policies for the governme

The research methodology used was in-depth interviews. Interviews took place from January to December 2008 and were conducted with the following: 10 hospital directors and 10 social insurance officers of hospitals in Surin, Sakaeo, Chanthaburi and Trat, 2 Cambodian experts, 4 officers of the Health Province Organization responsible for migrants, 4 local administrative officers, 2 NGO officers, 20 Cambodian migrant patients, both legal and illegal using health services in those hospitals.

Findings & body of discussion: Legal and illegal migrants have different patterns of health service uses. Illegal migrants usually rely on self care and use health services only when they encounter serious and rare health conditions. They encounter numerous problems when dealing with local health care providers because of their illegal status, different economic, and social status and communication problems. The result is often manifest in discrimination, suspicion and misunderstandings.

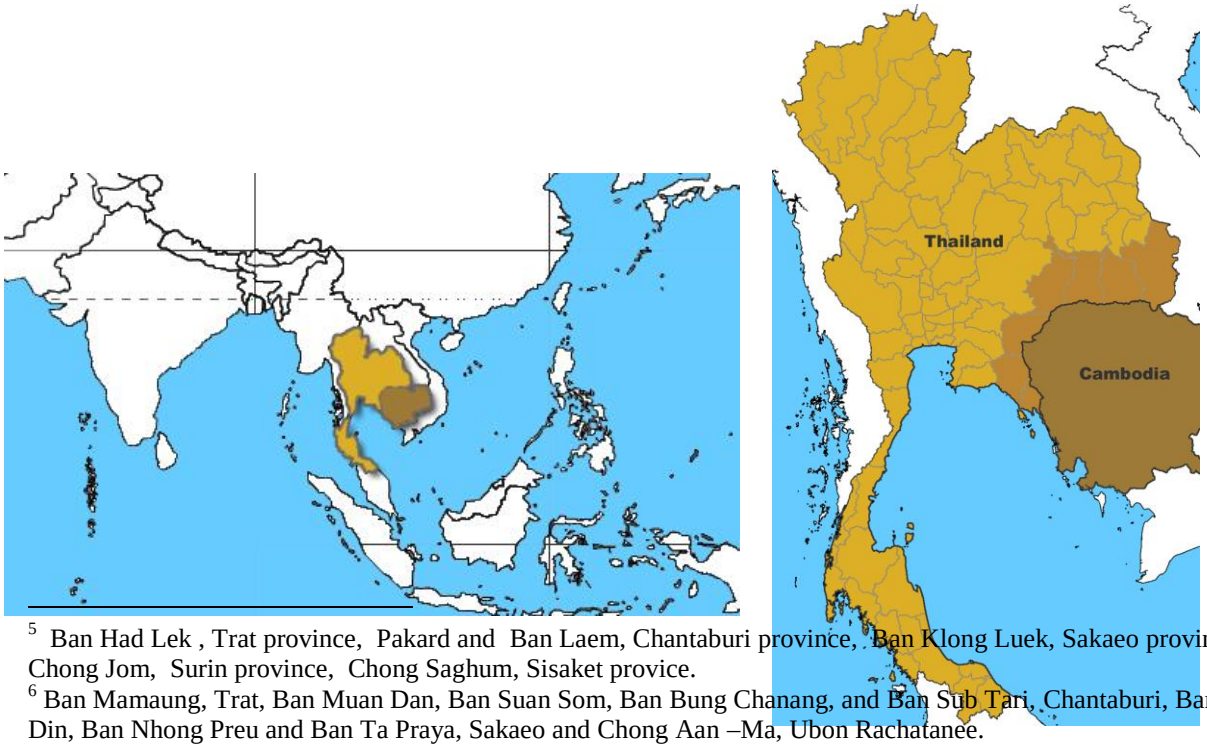
Conclusion: Because legal and illegal migrants have different patterns of health service needs, Thai hospitals have been forced to develop multiple strategies to solve problems resulting from the need to provide medical care in response to their special needs.

Key words: Migrant health, Cambodian migrants, Thai-Cambodian border

Introduction

Among the neighboring countries of Southeast Asia, Thailand and Cambodia have, perhaps, the most similar customs, traditions, beliefs, and ways of life. Despite these similarities, relations between the two countries can be characterized by ignorance, misunderstandings, and prejudice, shaped by history and politics both between and within each country. Charnvit Kasetsiri (2003), a senior Thai historian, termed this relation "a love-hate relationship." The burning of the Royal Thai Embassy in Phnom Penh in 2003, recent border skirmishes and political tensions reflect the uneasy relationship between Thailand and Cambodia.

The Thai government realizes that conflicts between the two nations affect Thai political, economic and social dimensions. A border trade promotion policy was implemented to narrow the economic gap by linking transportation routes and tourism. As a result, movement along the border has increased rapidly and this has had an adverse impact on the health of Thai people in the border area. The border between Thailand and Cambodia is approximately 800 kilometers long, (Maps 2 and 3), stretching along the Northeast provinces from Ubon Ratchathani and to Trat province in the east. Along the border, there are three types of border crossing – permanent, temporary and geographical or natural. Six permanent crossings[5] are generally open to all foreign nationals who are in possession of a valid passport and visa, while nine temporary crossings[6] are open only to locals on either side of the border, who are able to cross back and forth using some form of border pass. An infinite number of geographical crossings are available to locals without a border pass. A great number of Cambodian workers use these two means of crossing into Thailand, especially during the harvest season.



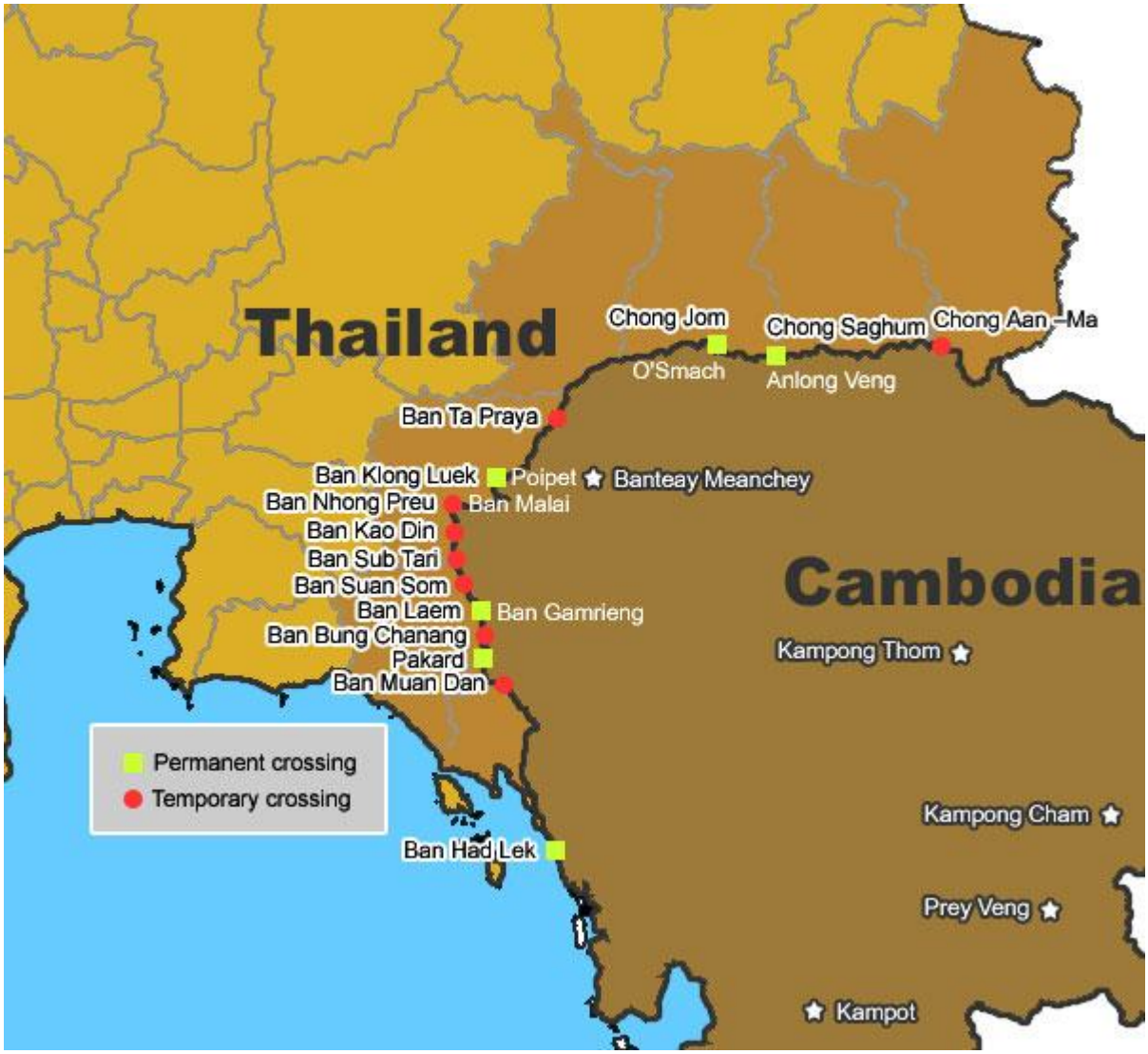
Map 1

[5] Ban Had Lek , Trat province, Pakard and Ban Laem, Chantaburi province, Ban Klong Luek, Sakaeo province, Chong Jom, Surin province, Chong Saghum, Sisaket provice.

[6] Ban Mamaung, Trat, Ban Muan Dan, Ban Suan Som, Ban Bung Chanang, and Ban Sub Tari, Chantaburi, Ban Kao Din, Ban Nhong Preu and Ban Ta Praya, Sakaeo and Chong Aan –Ma, Ubon Rachatanee.

Location map of Thailand and Cambodia in Southeast Asia.

Map 2 Highlight of seven Thai provinces bordering Cambodia.



Map 3 Thai- Cambodian border crossings

In general, migration is caused by an inter-play of border "push" and "pull" factors between the origin and destination countries. Cambodia, ravaged for almost 30 years by internal conflicts, is one of the poorest nations of the world (Levine & Gardner, 2008) and is the most poverty-stricken country in Southeast Asia (Walford, 2000). While the Thai economy is in the process of rapid growth and industrialisation, low-skilled labourers are required, especially for "3 D jobs" (dirty, dangerous and difficult). Cambodian social networks in Thailand, [7] middleman system[8], and higher wages compared to Cambodia are also pull factors. These labourers are important for Thai economic development as they command low wages, are patient, and hard working. In particular, they fill a need for labor in the agricultural, industrial and fishery sectors. On the other hand, they also bring back diseases which were eradicated from Thailand because the majority of these workers migrate illegally without having first had a medical check by the government (Lee., 2006).

Aim and objective

The aim and objective of the study were to investigate the situation concerning the health management of Khmer migrants in Thai–Cambodian border areas, including health services, patterns of service use, strategies and methods for coping with problems encountered by hospitals in the border areas. The findings and suggestions emerging from the study will help determine suitable health management policies for the Thai government that can be used as a tool for building better relationships with other neighboring countries.

Method and sample

This study is a qualitative study. That means the data is based on in-depth interviews. Ten hospital directors and 10 social insurance officers from all levels of hospitals, one regional hospital, 3 provincial hospitals and 6 community hospitals, along the Thai-Cambodian border namely Surin, Sakaeo, Chanthaburi and Trat were selected, 2 Cambodian experts, 4 officers from the Health Provincial Organization responsible for migrants, 4 local administrative officers, 2 NGO officers working on Khmer migrants, and 20 Khmer patients, both legal and illegal, using health services in those hospitals. Interviews took place from January to December 2008. Site observation was also used to verify the data.

Findings

Cambodia in the Context of Migration

[7] Cambodian social network is a network of connections among Cambodians who have worked and experienced living in Thailand. They persuade their relatives and friends to come to work in Thailand.

[8] Middleman is a person who receives money from workers for getting them jobs in Thailand and also receives money from the employers for bringing in workers. This system is a cause of the number of illegal migrants scattering throughout the country.

Health management in the border areas relates to the socio-economic and political context of Cambodia. The Cambodian population in 2008 was 13.4 million, 7.2 million of them were in the working-age category. About 74.2 percent of this group or 5.3 million were in the agricultural sector, 1.4 million in the service sector, and 0.5 million in the secondary sector. The Cambodian economy is based on agriculture, 73 percent of the population are farmers living up-country with low income and poor production. The dependency ratio between the working-aged, children 0-14 years and elders over 65 years, is one-fourth (National Institute of Statistics, Phnom Penh, Cambodia, 2008).

Suffering from the three decades of civil war, drought and famine has resulted in Cambodia having the worst health outcome in Southeast Asia because of limited access to healthcare (Levine& Gardner, 2008). Table 1 provides some health indicators for Southeast Asian countries.

Table 1: Some health indicators for Southeast Asian countries

Indicators	Thailand	Cambodia	Laos	Myanmar	Indonesia	Malaysia	Philippines
Life expectancy at birth (2005)							
Male	**67**	**51**	**59**	**56**	**66**	**69**	**64**
Female	**73**	**57**	**61**	**62**	**69**	**74**	**71**
Pregnancy-related Mortality							
Infant mortality, per 1000 live birth(2005)	**18**	**98**	**62**	**74**	**28**	**10**	**25**
Neonatal mortality, per 1000 live birth(2004)	**13 (2000)**	**40**	**30**	**49**	**17**	**5**	**15**
Maternal mortality, per 1000 live birth(2000)	**44**	**450**	**650**	**360**	**230**	**41**	**200**
1-year olds immunized(2005)							
w/ one dose measles	**96%**	**79%**	**41%**	**72%**	**72%**	**90%**	**80%**
w/DTP 3	**98%**	**82%**	**49%**	**73%**	**70%**	**90%**	**79%**

Hep B	**96%**	**-**	**49%**	**62%**	**70%**	**90%**	**44%**
Neo-Natal visits							
At least 1 visit	**-**	**44% (2000)**	**44% (2001)**	**-**	**97% (2003**	**-**	**94%**
At least 4 visits	**86% (2001)**	**9% (2000)**	**29% (2001)**	**76% (2001)**	**81% (2003)**	**-**	**70%**
Nutrition (children<5)							
% Stunted	**15.5 % (2006)**	**49.2 % (2000)**	**48.2 % (2000)**	**40.6 %**	**28.6 % (2004)**	**-**	**33.8 %**
% Underweight	**7.3% (2006)**	**7.3% (2000)**	**36.4 % (2000)**	**29.6 %**	**19.7 % (2004)**	**-**	**20.7 %**

Source: Levine& Gardner, 2008.

Cambodian Health problems are mainly lack of sanitation, malnutrition, infectious diseases and injury related. Major causes of infections and injuries are AIDS, tuberculosis, malaria, dengue fever and infectious diarrhea, land mine explosions, and intentional injuries. Cambodia has the 22nd highest rate of tuberculosis in the world, two-thirds of which are in the transmission period and 13,000 related deaths occur every year (WHO, 2006). In 2000 and 2006, Cambodia's health expenditure, as a percentage of gross domestic products (GDP), was the highest in Southeast Asia. In terms of general government expenditure on health as a percentage of total health expenditure, Cambodia ranked second compared to other Southeast Asian countries in 2000, and third in 2006. As for out-of-pocket expenditure as a percentage of private expenditure on health, Cambodia was second both in 2000 and 2006. Table 2 provides Health expenditures in Southeast Asian countries.

Table 2 Health expenditures in Southeast Asian countries

Countries	**Health expenditure ratios**			
	Total expenditure on health as percentage	**General government expenditure on health as**	**Private of expenditure on health as percentage**	**Out-of – pocket expenditure as**

	of gross domestic product		percentage of total expenditure on health		of total expenditure on health		percentage of private expenditure on health	
	2000	2006	2000	2006	2000	2006	2000	2006
Thailand	3.4	3.5	56.1	64.5	43.9	35.4	76.9	76.6
Cambodia	5.8	5.9	22.5	26.0	77.5	74.0	96.2	96.2
Laos	3.2	4.0	32.5	18.6	67.5	81.4	91.8	76.1
Myanmar	2.1	2.2	13.4	13.1	86.6	86.9	99.2	99.4
Indonesia	1.6	2.5	38.3	50.5	61.7	49.5	63.0	70.4
Malaysia	3.2	4.3	52.4	44.6	47.6	55.4	75.4	73.2
Philippines	3.4	3.8	47.6	32.9	52.4	67.1	77.2	83.5

Source: World Health Statistics 2009 accessed on 28 April 2010.

According to the 2005 Demographic and Health Survey (DHS), the average family of five spent nearly 12 percent of their income on healthcare. Expenditure for the public health sector alone was 34 percent of non-food consumption expenditure – 47 percent in rural areas and 42 percent for the poorest. An average in-patient hospital visit amounted to more than 100 percentage of expenditure on non-food consumption for all but the richest quintile (World Bank, 1999). So the cost of health care is clearly burdensome for the poor. The major proportion of health service provided in Cambodia was by private sector (48.2 percent), 21.6 percent by government providers, 20.8 percent used alternative health methods, and 8.5 percent depended on self care (National Institute of Statistics of Cambodia, 2005).

Thai Policy on Neighboring Migration

In 1993, Thailand had a policy of forcing all migrants from neighboring countries to have a physical check up for six diseases, namely leprosy, tuberculosis, elephantiasis, malaria and intestinal parasites. In 1995, these migrants had to buy a 500 Baht health insurance card, which increased to 1,000 Baht in 1996, and 1,200 Baht in 1998. In 2001, all migrants were forced to join the Coverage Health Insurance System, the same as Thais, by paying 1,300 Baht per year and 30 Baht for each hospital visit. However, many migrants did not benefit much from the system because their employers kept their insurance cards to prevent them from moving to other employers. Table 3 and 4 show the numbers of migrants in Thailand, both legal and illegal in the regions and provinces along Thai-Cambodia border which generally declined after the implementation of the policy. The number of the legal migrants was one-fourth in 2008, down to one-seventh in 2009 but rose again to one-fifth in 2010. It is notable that the migrant statistics issued by the Ministry of Labor are an underestimation, especially in the provinces along the Cambodian border.

Table 3: Numbers of registered and non registered migrants in Thailand during 2008-2010.

Region	Number of Migrants in Thailand								
	2008			2009			2010 (to March 31, 2010)		
	Total	Legal migrants	Illegal migrants from Cambodia, Myanmar, Laos	Total	Legal migrants	Illegal migrants from Cambodia, Myanmar, Laos	Total	Legal migrants	Illegal migrants from Cambodia, Myanmar, Laos
The whole kingdom	790,664	228,353	501,570	1,544,902	210,745	1,314,382	1,093,237	185,408	889,743
Bangkok	196,981	106,834	83,337	351,591	98,823	250,891	243,172	84,114	157,012
Vicinity	167,522	34,220	129,923	374,516	33,022	340,598	254,144	28,163	224,814
Central	123,845	40,629	72,206	289,531	39,680	248,377	173,556	35,419	136,086
North	129,501	8,836	83,816	178,389	7,207	156,097	148,390	7,047	128,954
Northeast	19,547	12,259	6,898	32,881	11,941	20,889	25,603	11,030	14,521
South	153,268	25,575	125,390	317,994	20,072	297,530	248,372	19,635	228,356

Source: Ministry of Labor, Thailand.

Table 4: Numbers of registered and non registered migrants in the provinces along the border during 2008-2010.

Region	Number of Migrants in Thailand

	2008			2009			2010 (to March 31, 2010)		
	Total	Legal migrants	Illegal migrants from Cambodia, Myanmar, Laos	Total	Legal migrants	Illegal migrants from Cambodia, Myanmar, Laos	Total	Legal migrants	Illegal migrants from Cambodia, Myanmar, Laos
The whole kingdom	**790,664**	**228,353**	**501,570**	**1,544,902**	**210,745**	**1,314,382**	**1,093,237**	**185,408**	**889,743**
Trat	**8,351**	**1,512**	**3,108**	**17,635**	**1,522**	**16,100**	**11,339**	**1,355**	**9,965**
Chantaburi	**3,257**	**1,328**	**1,921**	**10,087**	**1,476**	**8,579**	**6,763**	**1,107**	**5,557**
Sakao	**1,233**	**943**	**235**	**3,937**	**909**	**3,049**	**1,983**	**683**	**1,203**
Burirum	**879**	**637**	**236**	**1,479**	**636**	**843**	**1,052**	**507**	**545**
Surin	**1,056**	**741**	**315**	**1,729**	**774**	**955**	**1,320**	**743**	**577**
Sisaket	**600**	**447**	**150**	**893**	**449**	**444**	**709**	**350**	**359**
Ubon Ratachani	**1,625**	**1,080**	**539**	**2,454**	**1,060**	**1,393**	**1,668**	**864**	**803**

Source: Ministry of Labor, Thailand.

Note: The figure of migrants from Cambodia, Laos and Myanmar is underestimated because numerous migrants used unmonitored geographical crossings.

These migrants were scatter throughout the country and have many types of work. Table 5 shows that the first three category of work was agriculture and livestock, construction and domestic work.

Table 5: Numbers of neighboring migrants working in Thailand according to areas of employment in 2005.

Types of Work	Number of migrants	Percent
Agriculture and livestock	**182,906**	**21.8**
Construction	**123,148**	**14.7**
Domestic works - Servant	**129,659**	**15.5**
Fishery related works	**72,575**	**8.7**
Sea and inland fishery	**60,123**	**7.2**
Mills, brickyards, Icehouse	**16,778**	**2.0**
Wharf	**4,231**	**0.5**
Mine	**1,544**	**0.2**
Others	**247,979**	**29.6**
Total	**838,943**	**100.0**

Source : Archavanitkul, K. and Saisunthon, K.P., 2005.

Thailand has received illegal migrants from all neighboring countries. In 1997, there were 41,000 neighboring patients from Cambodia, Myanmar and Laos, accepting health services from 36 hospitals along the borders at a total cost of 44.70 million Baht. In 1998, the number of patients increased to 57,488 costing 72.94 million Baht. Only 20-30 percent of patients from neighboring countries can afford to pay the cost of the health services they received. The number of out-patients increased more than 10 percent a year and over 25 percent for in-patients (Pattarakulwanich, & Rugpao, 1999). One severe in-patient case may cost up to one hundred thousand Baht because the hospital provides the same medical care as for Thai nationals.

Migration and Health Problems along the Borders

Along the Thai-Cambodian border, there are multi-ethnicity, minority people who consist of legal and illegal migrants with their families and followers without Thai nationality. With people of different cultures, languages, customs and ways of life, this area is rather difficult in terms of health management. Many health problems exist along the Thai-Cambodian border. These are infectious and re-emerging diseases such as malaria, tuberculosis, venereal diseases, AIDS, SARS and bird flu. Infant and maternal mortality rates are higher among these people compared to Thai

nationals. Lack of family planning results in high birth rates. As Thailand has health insurance coverage solely for Thai nationals, minority peoples and illegal migrants face difficulties in obtaining access to health services. Compared to health services in neighboring countries, Thailand has more state of the art medical technology and better equipment.

Most of the Cambodian labourers who migrate to Thailand are landless, poverty-stricken and unemployed. With only a primary education, most are aged between 18 and 45 years, married, and work in Thailand for 1-6 months (Lee., 2006). Almost all of them are low-skilled, moving from the Banteay Meanchey, Prey Veng, Kampong Cham, Kampong Thom and Kampot areas (Map 3). The number of Khmer migrants moving to Thailand varies each year, but reliable migration data are hard to find.

Every morning at the Thai-Cambodian border crossing, especially the permanent crossing at Ban Klong Luek, Aranyaprathet, thousands of Khmers, adults and children, wait for the border gates to open. At six o'clock when the border opens, a wave of people move across the border, a scene generally unwitnessed by tourists. They come in the morning as daily workers and return in the evening. Many boys and girls come to study at Thai schools and some intend to use the health services of Thai hospitals. In the harvest season, numerous Cambodian workers, accompanied by families, followers, and relatives, come to work in the rice fields. All agricultural work such as rice, cassava, lychees, and longan harvesting along the border, employ these Cambodian laborers. Wages depend on the distance from the city, for example at Ta Phraya District, the daily wage for a charter worker is about 80-100 Baht[9]or 300 Baht per 1 Rai[10]. Usually, these labourers prefer charter work because, if they work hard, they can finish in a short time and move on to other jobs. The harvest season lasts about 2-3 months so they change employers from time to time. These are seasonal migrants without legal documents.

Others work in construction, fisheries, mills, brickyards, icehouses, on the wharves and as domestic workers permanently or on a monthly basis. Very few employers register their labourers and usually keep possession of their documents to prevent them from leaving to work for others.

[9] 1 $ us is equal to 33 Baht
[10] Rai is a unit of area equal to 2.5 Acres

Health Problems and Access to Health

Cambodians using health services from Thai hospitals can be classified into three groups:

Legal migrants

Those Cambodians who come to work in Thailand with official permission will have health insurance. They can use health services from Thai hospitals at which they are registered whenever they get sick, and pay 30 baht for each visit[11]. According to interviews with hospital directors, very few migrants in the working age-group use their health insurance because they are relatively healthy, rarely having serious health problems, apart from accidental injuries. Usually, if they fall sick, they buy drugs over the counter from local pharmacies because it is cheaper than at a clinic, and pharmacists are willing to provide any medicine requested by customers. If they have enough money, they will go to the clinic because they are more attentive to the client's needs, more available and more efficient. In particular, they are more willing to provide the treatment of patient's choice.

Communication problems were also a barrier to hospital health service access. Another factor was the case of employers holding on to the insurance[12] cards of their workers to prevent them from moving on to other employers. Neither employers nor the migrant workers bother much about being registered because there is no strict control by government officers. As a result, the number of registered migrants decreased each year from 11,498 cases in 2004 to 10,402 in 2005 to 5,577 in 2006 (Archavanitkul, 2007).

Illegal migrants

Illegal migrants are Cambodians who come to work in Thailand without official permission. This group doesn't have any health insurance. If they have a common illness, initially they prefer self-medication through the purchase of medicine from pharmacists and drug stores. If they don't get better, folk healers and health volunteers working at the refugee camps are their second choice (Tapraya hospital directors, November 13, 2008). Visiting public hospitals is their last choice and only for critical or serious conditions. If their condition is serious, they will be admitted as in-patients. In cases where the community hospital cannot provide adequate assistance, they are referred to provincial or regional hospitals at a cost they generally cannot afford. These patients often come with infectious diseases, injuries from quarrels and fights or work related injuries. Most of the referred patients are in a critical condition, some cases cost 400,000-500,000 Baht, but we can't get even one Baht (Trat Provincial hospital directors, 12 December, 2008).

[11] Since 2005, it is free of charge for any visit.

[12] In general, employers pay in advance for each migrant's registration, 3,800 baht each, and then employees will pay back monthly. So, employers have to ensure their workers remain until the advance has been paid back.

As for human rights, hospitals are required to provide the same standard of treatment regardless whether the patients can afford it or not. Revenue statistics for hospitals show that yearly revenue from providing health services does not cover expenditure, leaving a deficit of about 3-4 hundred thousand Baht for community-level hospitals, approximately 4-5 million Baht for provincial-level hospitals and more than 20 million Baht for Regional-level hospitals (Hospital directors, November-December 2008). That creates a big burden on Thai hospitals.

Cambodians

Another group using health services from Thai hospitals is Cambodians living along the border. This group can be classified into three levels; rich, moderately rich, and poor. In the past when private hospitals were not so popular, rich and moderately rich Cambodians would use health services available at Thai government hospitals so the hospital could use surplus funds to support the poor. But now, Thai government hospitals offer services only to the poor. The two better-off groups prefer to use private Thai hospitals, which are more expensive but provide good services, are more attentive to patients' needs, respond well to customer desires, use equal or higher quality medical equipment compared to government hospitals, and have short waiting lists. Many wealthy Cambodians seek treatment from famous private hospitals in Bangkok.

The poor come to Thailand whenever they have a severe illness and after having tried many forms of treatments at home. They prefer treatment from Thai hospitals because of better medical technology and medicine. Poor patients are only permitted to receive treatment at community hospitals near the border crossing. Hospitals receive very little income from this group. Table 6 shows the five main diseases and symptoms borne by Cambodians seeking health services from Thai hospital during 2000-2006.

Table 6: Five main diseases and symptoms borne by Cambodians seeking health service from Kab Cheang Hospital during 2000-2006.

Diseases and illness of Cambodians					
2000	**2001**	**2002**	**2003**	**2004**	**2005**
1. Delivery and complication	**1. Gastrointestinal Symptoms**	**1. Respiratory**	**1. Respiratory**	**1. Respiratory**	**1. Respiratory**
2. Malaria	**2.Respiratory**	**2. Diarrhea and**	**2.**	**2. Diarrhea and**	**2.**

		food poisoning	**Gastrointestinal Symptoms**	**food poisoning**	**Gastrointestina Symptoms**
3. Explosion Injury	**3. Accidents**	**3. Delivery and complication**	**3. Delivery and complication**	**3. Gastrointestinal Symptoms**	**3. Delivery and complication**
4. Gastrointestinal Symptoms	**4.Urological and gynaecological diseases**	**4. Motorcycle accidents**	**4. Pneumonia**	**4. Delivery and complication**	**4. Accidents**
5. Pneumonia	**5. Delivery and complication**	**5. Gastrointestinal Symptoms**	**5. Motorcycle accidents**	**5. Motorcycle accidents**	**5. appendicitis**

Source: Kap Cheang Hospital, Kap Cheang District, Surin province.

Health Management of Thai Hospitals along the Borders

All Thai hospitals along the borders have raised the problems of migrant health with the Ministry of Public Health and related organizations. However, the problems are quite complicated, sensitive and involve various arms of government, private, international, Non Government Organizations and Local Administrative Organizations. Many of the problems still exist. The following are examples of what hospitals along the border have tried to do to solve their own problems.

Klong Yai hospital

"Cambodian hospital" is how Klong Yai people refer to Klong Yai hospital because the majority of the patients are Cambodians. The director tried many ways to improve the service towards Cambodian patients such as:

- Changing professional attitudes towards Cambodian patients by introducing study trips for health professionals to Cambodian hospitals for a better understanding of their problems. Many hospitals such as Surin also used this measure.
- An infant delivery package program for pregnant Cambodian women was introduced to address the need of the increasing number of deliveries for Cambodian women without prenatal care, and also address the high risk of infant and maternal mortality and the risk of HIV transmission. Provisions of quarterly installment payments of medical

cost were also introduced to ease financial burdens of the clients. This program is very popular among Cambodian mothers to be and can reduce health providers' anxiety about contacting HIV (Klong Yai director hospital, 13 December, 2008).

- Health education and condoms were provided to Cambodian communities in Klong Yai district, through Cambodian Health Volunteers and World Vision[13] to reduce the number of HIV cases.
- To minimize cultural and language barriers among health providers and patients, the hospital uses Cambodian Health Volunteers who can speak Thai, as interpreters.

Sunrin and Trat Hospital

- Developing human resources, training Cambodian doctors, and providing medical equipment to Cambodian hospitals in border areas in order to reduce the number of non-critical cases.
- Sending Thai paediatricians and gynaecologists to train Cambodian health providers which can limit complications arising during delivery.
- Introducing mobile clinics to serve Cambodian as well as Thai patients.

Conclusion and recommendations

It is undeniable that Thailand and Cambodia are dependent on each other, despite their politically sour relationship. The volume of trade, particularly cross border trade, is increasing every year. Thai economic growth still relies on Cambodian labour and this means increasing numbers of migrants. Migrant health unavoidably affects Thai health so the Thai government should pay more attention to create a systematic and sustainable management system for migrant health. In the past, hospitals along the border tried to tackle the situation using their own potential and capacity. The Thai government needs to develop a national policy for solving border health problems, including the participation of related health organizations based in the border regions. An appropriate budget allocation to support these hospitals should be considered seriously with the realization that a national health policy benefiting border communities will not only help Thailand's socio-economic condition and security, but also serve to build better relations between the two nations.

[13] World Vision is a non government organization dedicated to working with children, families, especially the vulnerable, and communities to overcome poverty and injustice.

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New Zeland's Asian Health Workforce: trends, challenges, and future opportunities

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Abstract

Background
The Asian resident population in New Zealand has doubled in the last ten years from 1996 to 2006, an increase of 104 percent, while the European population has declined by 9 percent. The 2006 Census showed that Asians make up 9.2 percent of our population, and this proportion is expected to increase to approximately 15 percent by 2011.

The growth in New Zealand's Asian workforce can be mainly attributed to the changes made to New Zealand's immigration policies in the mid-eighties, and more recently in 2003 with the introduction of the Skilled Migrant Category, that has a focus on matching the skills needed in New Zealand's labour market. As a result of this there has been a growth in the number of Asians entering Professional occupations, especially in the Health and IT sector.

Methods
The datasets used in this analysis are from the 1996, 2001 and 2006 Censuses. The analysis is predominantly descriptive. Given the diversity within Asians in New Zealand, the Asian ethnic group is stratified into 3 main sub-groups: North Asian; South East Asian and South Asian in the analysis.

Findings
The number of Asians employed in the Health Care industry has grown almost three times from 3,291 in 1996 to 11,496 in 2006. Of Asians in the Health Care industry almost half were employed as Professionals. Overall 18 percent of Asians were employed as Professionals. Within the Professional occupation category, a quarter of Asians were working as Business Professionals and a fifth as Health Professionals (including nursing). This was considerably higher than the national average. In the Health sector, differences in the Asian ethnic sub-groups were apparent, such that 28 percent of Southeast Asians were employed as Nursing and Midwifery Professionals, compared to 10 percent of all Asians, and 12 percent of the national average. This reflects the growing demand for nurses in New Zealand, and migrant nurses from Southeast Asia are of increasing importance in filling this gap. Similarly, 12 percent of South Asians were employed as Health Professionals compared to 6 percent of the national average.

Conclusion
The demand for workers in the health industry is expected to continue to grow, particularly with the ageing of New Zealand's population being one of the main drivers of this demand. As occupations within this industry tend to be very mobile, with health professionals moving overseas to seek better opportunities the demand for workers in this industry is expected to continue to grow.

The Asian workforce is expected to grow particularly in the health care sector with doctors and nurses from various parts of Asia filling the gaps. As China, Philippines and India continue to train health professionals; migrants from these regions are likely to become a major source of New Zealand's skilled labour supply in the future. In addition to this, there has been a strong growth in the number of Asian students (both domestic and international) studying medicine or nursing. This suggests that Asians are likely to be an essential source of labour in the health care sector and will probably form a major part of New Zealand's health workforce in the future.

Introduction

The Asian workforce[14] has grown since 1996, when they made up 5% of the total workforce, rising to 7% in 2001 and 9% in 2006. It is projected that the Asian workforce will make up 15% of the total workforce in 2026, demonstrating that Asians are a critical part of New Zealand's current and future labour market (Badkar and Tuya 2010).[15] But as many other commentators have noted, the overall Asian group is very diverse on a range of characteristics including where people were born, languages spoken, and religious beliefs. Despite this diversity the Asian workforce occupies a variety of distinct parts of New Zealand's labour market.

As a result of the 1986 Immigration Policy Review, the Asian population in New Zealand grew rapidly in the 1980's and 1990's. This review, and subsequent legislation in 1987, introduced major change from the earlier focus on nationality and ethnic origin as the basis for admitting immigrants to policy settings that allowed people who met specific education, business, professional and age requirements, to be considered for residency. The legislation removed the source country criteria and permitted migrants who applied under the General Category to have skills contained in the Occupational Priority List to be considered for residence. In addition to this, a Business Immigration Policy was also established which allowed migrants with proven business capability and investment capital to be accepted (Bellamy 2008).

This change in migration policy led to a growth in the number of skilled Asians entering Professional occupations in New Zealand in areas where there have been labour shortages, especially in the Health, Business and Computing/ Information Technology sectors (Badkar and Tuya 2010). In relation to the health sector, the 2006 census indicates that just over half of doctors, nearly a third of nurses and a quarter of caregivers were born overseas and that Asians are an important component of the overseas-born workforce (Zurn & Dumont 2008; Callister, Badkar & Didham 2008; Badkar, Callister & Didham 2008; Badkar, Callister & Didham 2009). Hence, the focus of this paper is on the Asian workforce working in the Health sector.

Methods:

The datasets used in this analysis are from the 1996, 2001 and 2006 Censuses. The analysis is predominantly descriptive. Given the diversity within Asians in New Zealand, the Asian ethnic group is stratified into three main sub-groups: North Asian,

[14] We use the term workforce and working-age population (WAP) interchangeably in this paper. WAP is defined as those aged 15 years and over.

[15] Badkar, J and Tuya, C. The Asian Workforce: a critical part of New Zealand's current and future labour market. Department of Labour 2010 (Add link)

Southeast Asian and South Asian in the analysis in order to minimise the averaging effect.

Results:

The results presented in this paper are drawn from a recent Department of Labour report, *The Asian Workforce: a critical part of New Zealand's current and future labour market*.

The Asian workforce in the health and community services industry

Table 1 shows that the number of Asians employed in the Health and Community Services industry has grown almost three times from 3,291 in 1996 to 11,496 in 2006. This was around 8% of the employed Asian working-age population in 2006 working in this sector (which was slightly below the national average of 9%). The Southeast Asian subgroup experienced the biggest growth in the health industry compared to the other Asian subgroups (347% between 1996 and 2006), which can be attributed to the growing reliance on migrant nurses from the Philippines over the last few years (Badkar et al 2007; Badkar, Callister and Didham 2008). Growth across the other Asian subgroups was also high, when compared to the national average, indicating that Asian workers are an essential and growing source of labour in the health sector.

Table 1: Proportion of Asians in the Health and Community Services industry, 1996-2006

Health and Community Services	North Asian	Southeast Asian	South Asian	Other Asian	Total Asian	Total employed in NZ
			1996			
Number in the industry	1,401	474	1,458	45	3,291	107,367
% of the total employment of this ethnic group	5%	6%	8%	8%	6%	7%
			2001			
Number in the industry	2,229	1,050	2,868	177	6,210	139,737
% of the total employment of this ethnic group	6%	9%	10%	12%	8%	9%
			2006			
Number in the industry	3,927	2,121	5,376	183	11,496	160,281
% of the total employment of this ethnic group	6%	10%	10%	11%	8%	9%
Percentage increase (1996-2006)	*180%*	*347%*	*269%*	*307%*	*249%*	*49%*

Source: Census of Population and Dwellings 1996-2006, Statistics New Zealand.
Note 1: Due to rounding, some figures may not sum to the stated total.
Note 2: Industry is based on ANZSIC96 and is reported at the 1-digit level.

Table 2: Share of ethnic groups in the Health and Community Services industry, 1996-2006

Ethnic group	1996		2001		2006		Growth
	Number	%	Number	%	Number	%	
Asian	3,291	3%	6,210	4%	11,496	7%	249%
Maori	9,312	9%	13,566	10%	17,091	11%	84%
Pacific Peoples	3,678	3%	5,457	4%	6,888	4%	87%
European	97,164	90%	121,758	87%	132,912	83%	37%

Source: Census of Population and Dwellings 1996-2006, Statistics New Zealand.
Note 1: Confidentiality rules have been applied to all cells in this table, including randomly rounding to base 3.
Note 2: The European ethnic group includes 'Other Ethnicity' which includes the 'New Zealander' response.

Although the proportion of Asians employed in the Health sector is slightly below the national average between 1996 to 2006, the overall share of the Asian workforce in this sector has grown from 3 percent in 1996 to 7 percent in 2006 (Table 2). When compared to the other main ethnic groups, Asians had the largest percent increase of 249 percent during 1996 to 2006. Although increases in absolute numbers were observed in Maori, Pacific and European ethnic groups, the percentage increase in Asians is significant.

Skill level of the Asian workforce in the health and community services industry

Table 3 shows that more than half (52%) of Asians employed in the Health and Community Service industry were working in highly skilled occupations compared to 43% of the total population. Within the highly skilled occupations, 93% were employed as Professionals. While these will be primarily doctors, nurses and midwives, other professions include radiologists and pharmacists.

Table 3: Occupational breakdown of the Asian workforce in the Health and Community Services industry, 2006

Occupation breakdown in the Health and Community Services industry	Asian	Total employed in NZ
Highly skilled		
Legislators, administrators and managers	4%	6%
Professionals	49%	37%
Highly skilled subtotal	*5,991*	*69,207*
Skilled		
Technicians and associate professionals	13%	17%
Trades workers	0%	0%
Skilled subtotal	*1,566*	*28,218*
Semi-skilled/elementary		
Clerks	7%	10%
Service and sales workers	23%	25%
Agriculture and fishery workers	0%	1%

Plant and machine operators and assemblers	1%	1%
Elementary occupations (incl residuals)	2%	3%
Semi-skilled/elementary subtotal	*3,936*	*63,699*
Overall total	**11,496**	**161,127**

Source: Census of Population and Dwellings 2006, Statistics New Zealand.
Note 1: Due to rounding, some figures may not sum to the stated total.
Note 2: Occupations are coded according to NZSCO99 and are reported at the 1-digit level.

About a quarter (23%) of Asians employed in the Health industry were working as Service and Sales Workers (which was similar to the national average of 25%). In relation to health related jobs, this occupation group mainly comprised of Personal Care Workers (refer to the Appendix for occupation classification definitions).

The next section provides a detailed analysis of the Asian subgroups employed in health related occupations.

The Asian workforce in health related occupations

The Asian workforce is not homogenous, and within the health sector, the diversity in relation to health related occupations is apparent.

Within Professional occupations, Table 4 shows that in 2006, 21% of Asians in professional occupations were working in health related jobs,[16] which was higher than the national average (18%). The differences within the Asian subgroups were noticeable, such that 28% of Southeast Asians were employed as Nursing and Midwifery Professionals, compared to 11% of South Asian and 5% of North Asians. This reflects the growing demand for nurses in New Zealand, and migrant nurses from Southeast Asia, particularly the Philippines are of increasing importance in filling this gap (Badkar et al 2007; Badkar, Callister & Didham 2008). Similarly, 12 percent of South Asians were employed as Health Professionals compared to 10 percent of North Asians and 7 percent of Southeast Asians, reflecting the global demand for doctors (OECD 2007; Callister, Badkar & Didham 2009).

In relation to lower skilled occupations within the health sector, a quarter of Asians were employed as Service and Sales Workers. Within this category in 2006, 9 percent of Asians were working as Personal Care Workers.[17] Although the proportion of Asians working as Personal Care Workers is lower than the national average (15 percent), the proportion of Southeast Asians and South Asians employed in this occupation is at par with the national average (13 percent and 14 percent respectfully). This not surprising as the demand for caregivers has increased due to the ageing of our population, and the reliance on immigrant caregivers for the elderly has grown. For example, the number of immigrant caregivers for the elderly almost doubled from 947 in 2006/07 to 1,769 in 2007/08, with migrants from the Philippines making up half of the aged-caregivers issued with a work permit (Badkar, Callister & Didham 2009).

[16] Those employed as Health Professionals (except Nursing) and Nursing and Midwifery Professionals
[17] See Classification Definitions for the type of jobs this occupation covers.

Table 4: Proportion of Asians in health related occupations working as Professionals and Service and Sales Workers, 2006

Occupation	North Asian	Southeast Asian	South Asian	Total Asian	Total employed in NZ
Professionals					
Health professionals (except nursing)	10%	7%	12%	11%	6%
Nursing and midwifery professionals	5%	28%	11%	10%	12%
Other professionals	85%	65%	77%	79%	82%
Total professionals	11,565	2,976	10,980	25,569	290,784
Service and sales workers					
Personal care workers	5%	13%	14%	9%	15%
Other service and sales workers	95%	87%	86%	91%	85%
Total service and sales workers	15,840	4,431	8,997	29,307	267,645

Source: Census of Population and Dwellings 2006, Statistics New Zealand.
Note 1: Due to rounding, some figures may not sum to the stated total.
Note 2: Occupations are coded according to NZSCO99 and are reported at the 3-digit level.
Note 3: Data for Other Asian were excluded in the table due to its small numbers.

Gender differences

When gender dimensions of Asian health workers are considered, there are both some clear patterns but also some complexity. While in the past most non-nursing health professionals such as doctors were male, across New Zealand as a whole the number of women doctors has increased dramatically over recent decades (Callister, Badkar & Didham 2008). Table 5 shows that in 2006, 47 percent of all New Zealand health professionals (excluding nurses) were female. While the proportion of all Asian health professionals who were female was slightly lower than this at 43 percent, Southeast Asians stand out with 57 percent being female health professionals.[18]

In contrast, historically most nurses and midwives have been female and this trend continues. Overall, in 2006 93 percent of New Zealand nurses and midwives were female. Nurses from most areas of Asia follow this pattern, but again Southeast Asian is the exception where 15 percent of nurses and midwives were male. The data for doctors and nurses may suggest that in Southeast Asia either occupation is more open to both men and women.

Like nurses, the caregiver occupation has, and continues to be, female dominated. Overall in New Zealand in 2006 89% of personal care workers (which includes caregivers) were female; however male personal care workers were slightly more common from all Asian areas than in the total population. The incidence of male personal care workers was most common from North Asia with 14% of personal care workers being male.

[18] This includes medical doctors, dentists, veterinarians, pharmacists, dieticians & public health nutritionists

In absolute numbers, there are overall more nurses and caregivers working in the health sector, which is a gendered role, with more women than men in these occupations. It is worth noting that although there are more men working as health professionals (such as doctors), a growing number are women. As the demand for health services increases in the future, we will be relying on migrant health professionals, many of whom will be from Asia, and if this trend continues, it will result in a highly gendered migration of Asian health professionals (Badkar et al 2007).

Table 5: Proportion of Asians in health occupations working as Professionals and Service & Sales Workers by gender, 2006

Occupation	North Asian		Southeast Asian		South Asian		Total Asian		Total employed in NZ	
	M	F	M	F	M	F	M	F	M	F
	Number									
Professionals										
Health Professionals (except Nursing)	681	522	87	114	798	531	1,557	1,167	9,531	8,421
Nursing and Midwifery Professionals	33	549	126	714	90	1,083	255	2,382	2,451	32,562
Other Professionals	4,812	4,977	861	1,083	4,731	3,762	10,386	9,819	112,572	125,238
Total professionals	5,526	6,048	1,074	1,911	5,619	5,376	12,198	13,368	124,554	166,221
Service and sales workers										
Personal Care Workers	111	663	84	507	156	1,119	351	2,295	4,167	34,950
Other Service and Sales Workers	6,906	8,160	1,392	2,454	4,167	3,552	12,465	14,202	90,057	138,480
Total service and sales workers	7,017	8,823	1,476	2,961	4,323	4,671	12,816	16,497	94,224	173,430
	Percentage (%)									
Professionals										
Health Professionals (except Nursing)	57	43	43	57	60	40	57	43	53	47
Nursing and Midwifery Professionals	6	94	15	85	8	92	10	90	7	93
Other Professionals	49	51	44	56	56	44	51	49	47	53
Total professionals	48	52	36	64	51	49	48	52	43	57
Service and sales workers										
Personal Care Workers	14	86	14	86	12	88	13	87	11	89
Other Service and Sales Workers	46	54	36	64	54	46	47	53	39	61
Total service and sales workers	44	56	33	67	48	52	44	56	35	65

Source: Census of Population and Dwellings 2006, Statistics New Zealand.
Note 1: Row percentage totals to 100%.
Note 2: Due to rounding, some figures may not sum to the stated total.
Note 3: Occupations are coded according to NZSCO99 and are reported at the 3-digit level.
Note 4: Data for Other Asian were excluded in the table due to its small numbers.

Conclusion

The demand for workers in the health industry is expected to continue to grow, with the ageing of New Zealand's population being one of the main drivers of this expansion. Not only is demand going to increase, but health professionals within this industry tend to be very mobile. New Zealand will have to work hard to retain its own New Zealand-born health professionals, but will also have to continue to recruit from overseas. Asians, both from Asia, and elsewhere, seem likely to be a growing and critical part of New Zealand's future health workforce.

In recent years the Philippines and India have been important sources of doctors and nurses. Increasingly we are likely to recruit from other Asian countries, particularly China. While the focus in the past has been on doctors and nurses, health care worker projections suggest that we will soon need to seek out caregiver workers as well.

In addition to this, there has been a strong growth in the number of Asian students (both domestic and international) studying medicine or nursing.
Asians are already an essential part of the health care sector labour force. As we continue to recruit and retain Asian health professionals, it seems certain that this group will form a major part of New Zealand's health workforce in the future.

Challenges and opportunities
Diversity in our health workforce, in relation to service delivery has many advantages as New Zealand's population becomes more and more multicultural. This means that there will be several cross-cultural interactions between patients and health providers in the future.

In future, this will be beneficial for certain migrant groups from Asia, in terms of communication where English may be a second language, who will be able to speak to a health provider in their native language.

However, the challenge arises in terms of perception of where an Asian immigrant may be from, and where they were trained. With a growing number of Asian health professionals being New Zealand-born and trained, it is crucial that employers and consumers of health services be aware of this.

Appendix

Classification Definitions:
NZSCO 222 Health Professionals (except Nursing) Diagnose, treat and prevent diseases, disorders and injuries in humans and animals, inspect animal products, make and dispense medicines, control diets in a variety of establishments, plan and execute health programmes. (Includes medical doctors, dentists, veterinarians, pharmacists, dieticians & public health nutritionists and other health professionals)
NZSCO 223 Nursing and Midwifery Professionals Plan, supervise and provide nursing care to patients in a variety of health care situations. (Includes nurses and midwives)
NZSCO 513 Personal Care Workers Performs tasks to assist nursing and medical personnel in a variety of settings and drive ambulances. (Includes hospital orderlies, health assistants, ambulance officers, nurse aides and caregivers)

Source: New Zealand Standard Classification of Occupations 1999, Statistics New Zealand.

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Lessons learned from a Yi community: qualitative study of an HIV/AIDS peer education project among Yi minority adolescents in Southwestern China

Shan Qiao

Abstract

Since first being introduced in 1994, HIV/AIDS peer education projects have been scaled up in numerous communities and for various high-risk sub-populations in China. Compared to wide applications of peer education approach, published studies on qualitative analysis of factors reshaping peer education is lacking. In addition, existing studies usually focus on college students or high risk target populations in urban areas rather than ethnic minority areas. This study discusses how cultural and social factors affect implementation of an HIV/AIDS peer education among Yi minority youth in a rural community suffering from HIV/AIDS and a drug epidemic based on qualitative data. It concludes that adaption to local cultural and social context is a big challenge for success of a health promotion project. Support from government is key to gain trust from local people during project implementation.

BACKGROUND

By the end of 2005, it was officially estimated there were 650 000 people living with HIV/AIDS in China (Chinese Ministry of Health, 2006; Lu, F., Wang, N., Wu, Z., Sun, X., Rehnstrom, J., & Poundstone, K., 2006). Although the HIV infection rate is relatively low (<0.1% among adults) for the country's entire population of 1.3 billion (Yang, H., Li, X., Stanton, B., Liu, H., & Wang, N., 2005), surveillance data indicates that the epidemic of HIV/AIDS in China has reached a rapid phase (Grusky, O., Liu, H., & Johnston, M., 2002; Yang et al., 2006; Liu, 2006). The distribution of the HIV epidemic in China has a strong geographic character. Five provinces, Yunnan, Sichuan, Henan, Xinjiang and Guangxi have been especially hard hit by HIV/AIDS. Except for Henan, the other four provinces are major residential areas for most of the ethnic minorities in China. The HIV epidemic has had a significant impact on these ethnic minorities (Lu et al., 2006).

Liangshan Yi Autonomous Prefecture (Liangshan) is located in the drug trafficking route across the western part of China, stretching from Yunnan to Sichuan, and reaching Xinjiang (Beyrer, C., Razak, M., Lisam, K., Chen, J., Lui, W, & Yu, XF., 2000). Yi people living in this area have experienced a localized HIV/AIDS epidemic owing to widespread injection drug use among young men (Zhou, F., Ma, ZE., Hu, W., Feng, ZL., Chen, KL., & Qin, GM., 2004; Yin et al., 2007). However, the diffusion of HIV/AIDS and reproductive health knowledge is limited due to widespread educational and economic disadvantage. High-risk sexual behaviors are common in Yi traditional practices (Mose, D., Zhang, JH., & Gong, YH., 2003; Gu, XD., Yang, HY., Yang, Q., & Chen, HG., 2004), though the official approach of anti-epidemic projects has not paid enough attention to the diversity of cultural backgrounds of ethnic

groups (Wang & Keats, 2005). Hence, there is an urgent need to develop a strategy of intervention which can be adapted to specific social and cultural contexts in Liangshan, among the Yi and other ethnic minority communities.

Recently, international non-governmental organizations (NGOs) and Yi local NGOs have been cooperating with each other to conduct interventions in Liangshan to help Yi communities protect themselves from drugs and HIV/AIDS. One example is the Giving Leadership Opportunities to Young Women (GLOW) project conducted by Mercy Corps and the Development Center for Liangshan Yi Women and Children (Yi Center) with support from the Nike Foundation. The GLOW project was based on the peer education model. Motivated young people (peer educators) undertook organized educational activities with their peers who were similar to themselves in gender, age, education or interests. Peer educators made use of their influence in a positive way during the process of disseminating knowledge of HIV/AIDS and reproductive health and changing peer norms (Mercy Corps, 2006). Peer education may be a good strategy for HIV/AIDS prevention, but has not been tested among the Yi minority population.

GLOW was a three-year (2006-2009) project conducted in Zhuhe Town, Zhaojue County in Liangshan targeting Yi adolescents aged from 15 to 25 years. The objective of GLOW in the health sector was that "ethnic minority adolescents (target 2,500) participate in peer-to-peer education networks and have measurable improvements in their sexual and reproductive health knowledge, attitudes and increase their health seeking behaviors."(Mercy Corps, 2005:5) The specific intervention activities included

- Establishing Youth Clubs in 12 villages,
- Training at least 30 peer educators ;
- Conducting health education among the participants in the Youth Clubs.

The curriculum applied in this peer education was the Stepping Stones training package on HIV/AIDS, gender, communication and relationship skills, which was originally developed for use in Uganda in 1995 and has been widely used in over 40 countries and translated into 13 languages (Wallace, 2006). The final version localized by the GLOW was composed of 12 sessions and three full workshop meetings. All the sessions were participatory learning processes filled by shared discussions and creative activities such as role play, games and drawing exercises, without the need of literacy.

This study will explore the factors which have reshaped and influenced this intervention based on qualitative data and discuss the lessons learnt from practices in a Yi community. This paper will describe the complexity of conducting a peer education intervention for HIV/AIDS prevention in such an ethnic context in rural Southwestern China.

METHODS

Qualitative data was collected by semi-structured interviews, everyday observations and conversations with local people. Six interviewers did quasi-structured interviews among parents in target villages. They identified potential key informants by convenient sampling method, i.e. recruiting adults aged above 30 years they encountered in the villages. Health care providers in community were interviewed in depth about their experiences in health care delivery and services as well as HIV/AIDS prevention. Project facilitators organized symposia to discuss with peer educators implementation of the GLOW project and feedback from participants about peer education. The sample sizes of the various key informants are given in Table 1.

Table 1. Sample Size of the Qualitative Study

	Intervention villages	**Town health center**	**County CDC ***
Quasi-structured interviews N=41			
Parents (Male)	**17**		
Parents (Female)	**17**		
Village cadres	**7**		
Symposium N=28			
Peer educators	**28**		
In-depth interview N=10			
Project facilitators	**4**		
HIV/AIDS prevention officer			**1**
Health care workers		**2**	
Private practitioners	**1**		
Traditional healers	**2**		

* CDC: Center of Disease Control and Prevention

RESULTS

Indigenous medical culture

Traditional health beliefs rooted in their cosmology and customs have been major factors influencing Yi people in terms of health care practice. In the Yi cosmology, spirits have feelings like human beings. Dissatisfaction, anger, punishment, and

invasion by spirits are common causes of sickness (Lin, 1961; Bamo, 2003). Ancestors' spirits are particularly related to health problems of individuals and even the whole household. Ancestors' spirits can cause illness in their descendants either directly or indirectly. Direct causation is an expression of ancestors' blames and punishments of their descendants for not providing sacrifices on time; indirect causation is the result of ancestors being too weak to protect their descendants.

Accompanying these health beliefs, traditional diagnoses and treatments pay little attention to biomedical symptoms but hold rituals to worship their ancestors or use magic to control or change evil intentions of spirits (Bamo, 2003). In practice, Yi people make use of public health care services provided by the state as well as believe in traditional practitioners namely, the Bimo.

In the project targeted communities, traditional healers did not have a clear and united interpretation of HIV/AIDS, a new disease they had to face in recent years. For instance, Bimo Jike heard of HIV/AIDS, but he did not answer if HIV/AIDS was caused by ghosts or even spirits of ancestors. He didn't think traditional medical ritual can diagnose or treat this disease because it was not a problem in a specific organ.

> *You can do rituals to prevent diseases, but it is hard to prevent a disease caused by bad behaviors (such as drug addiction). (Jike)*

Some villagers believe that traditional ritual could prevent HIV/AIDS. A family in Dawenquan reportedly invited a Bimo to conduct a big ritual of dispelling evil spirits. Several members of this family had died of AIDS. The rest of the family members believed that their family had got entangled with evil spirits. Thus a six-hour ritual to expel evil spirits was crucial to protect other members from this disease.

Indigenous medical beliefs affected Yi people's understanding of HIV through the view of biomedicine. One dramatic situation observed in a training workshop for peer educators in 2007 was as follows: Before introducing basic biomedical concepts of bacteria and virus, the lecturer asked the audience:

"What are the things you are not able to see in eyes but are harmful for your health?" Almost each peer educator answered immediately: *"Ghosts!"*

Indigenous medical culture challenged existing methods of disseminating knowledge about HIV/AIDS prevention. As Dr. Lei, an officer in charge of HIV/AIDS prevention in the Health Center of Zhuhe reported,

> *So far social marketing is not effective. Not many people participate in it because Yi people would not talk about sex or sexual behaviors. Distribution of condoms is also regarded as a shame thing. (Dr. Lei)*

A huge difference between local medical practice and biomedical practice resulted in a passive attitude of Yi patients toward biomedical therapy. Traditional treatment was a ritual, and the treatment had been completed when the ritual ended. In

contrast, biomedical therapy to fight AIDS required a long course of taking medicines. This was a challenge for the Yi patients as taking the medicine on time each day was not part of the treatment they were used to. A doctor in Health Care Center in Zhuhe complained,

> *Yi patients did not take medicine according to a doctor's advice but their individual feelings on many occasions. They stopped taking medicine themselves when they felt uncomfortable without consulting doctors. (Dr. Ahga)*

In addition, many Yi villagers equated biomedicine to surgery. In their views, any modern medicine should have an obvious effect as surgery does. It is easier for them to lose patience with official health workers than with traditional healers. The worst situation was that Yi patients doubted the motivations of HIV/AIDS treatment projects. Dr. Lei said:

> *They (patients) thought they were white mice for a medicine testing…We hope to offer free health care services to them. I cannot stop rumors or misunderstandings. (Dr. Lei)*

Labor migration

Although the Yi people were living in the mountains, those of the Zhaojue communities still experienced the great social transformation of the 1980s. Modern culture has been diffusing into this community through TV programs and advertisement, new entertainment, music and video broadcasted in coaches across counties in Liangshan. To some extent, their lives are no longer isolated from the outside world, but are more or less connected to the global economy. Due to improvement of agricultural technology and decreased per capita arable lands, Yi people moved into cities to seek opportunities to earn money.

In their peers' eyes, the adolescents who have migrated from rural to urban areas become fashionable and more beautiful and are very popular. From their parents' point of view, they become mature, considerate and contribute to increasing the household income. Elders who were interviewed in local communities opposed migration out of villages because of its negative impacts.

> *Adolescents who have moved out do not change much. They have not learned much knowledge or technique. Our community is lack of labors for farming. (One 65-year-old male village cadre)*

> *That (migration) is not a good thing. Old proverb saying that 'People who tempt you to leave home intend to hurt you by tricks' it is good to stay at home and earn money by working hard. Going out of hometown may earn money, but there are a lot of risks to be involved in bad things, illegal behaviors, such as stealing, robbing, etc."(Jike)*

The concerns of elders in the villages are not groundless. Despite labour migration becoming a means of earning an income in the project target villages, where farming families lack the capital necessary to build up small business or any other income generating activities, it brings costly consequences in terms of sustainable development and public health in the specific social and cultural context. As mentioned before, the vast majority of laborers have only primary education and are unprepared for difficulties and challenges in working in cities due to language and culture barriers. Temporary jobs, frequent switching from one factory to another and floating back and forth between the urban and the rural cannot guarantee improving their technical skills.

Discrimination and social pressures from stereotypes that Yi people are dirty, lazy and backward marginalize them and put them in a vulnerable situation for accessing essential social welfare, particularly health care services. Labour migration had an unexpected impact in the implementation of peer education not long after the startup of the project. Since early 2007, the labour needs of coastal cities dramatically increased, and many Yi adolescents were recruited as cheap and submissive workers by factory recruiters and set off for remote cities, leaving more and more "empty" houses in local communities. We lost many target population aged from 15 to 25 years old, and it became difficult to retain current peer educators, let alone recruit new ones. Compared to spending months in training workshops, earning money immediately in big cities was much more attractive. Peer education couldn't continue for a while in villages, and hence was conducted in high schools in Zhaojue County after project facilitators decided to expand target population to high school students.

Seasonal floating of labour migration increased uncertainty of designing strategies of implementation since the population of adolescents in target villages changed from month to month. In addition, participants in peer education dropped out of sessions due to temporary labour migration, which significantly affected completion rate of the intervention. The full Stepping Stones workshop was designed as an18-day training with 3 hours per day. To adapt to the floating nature of the target population, project facilitators had to shorten the original version into a 6-day intensive version by adhering to core topics with more focus on community problems. During the traditional Torch Festival and Yi New Year, peer educators conducted short version workshops in villages for those youths who returned home from cities. In addition, in winter time or busy agricultural seasons, young people had to help their family work the land and couldn't participate in the workshop for the whole period. Therefore the peer education team also offered a 6-day intervention at such times.

Parents whose children have experienced or plan for labour migration are more likely to support peer education since reproductive health of their children migrating to the cities has become a big concern. On the one hand, it is reported that many female adolescents are employed in low-grade service industries, such as hotels, beauty shops, and karaoke halls where women are often expected to provide sexual services for extra wages. Some female adolescents are even abducted and sold into marriage (Mercy Corps, 2009). On the other hand, Yi parents have difficultyin regulating the activities of their children in a remote city. Many Yi adolescent workers do not know a specific address of their factory and neither do their parents.

More and more Yi parents have become aware of the potential high risks throughout the labour migration of their children in terms of reproductive health and sexual behaviour. However, traditional social norms result in a lack of effective communication between parents and their children about sex. Their poor knowledge of reproductive health due to low education level limits their response to advising and mentoring. As Yi parents recognized the significant role peer educators could play in sex education, they began to encourage their children to participate in peer education.

> *I know my children lack such knowledge. It will be good for them if they got to know how to protect themselves when they migrate out of home. Those youths who are far away from home may have multiple girlfriends or boyfriends. They may meet bad friends…it is necessary to let them aware dos and don'ts with respect to sexual behaviors. (Mother of two daughters working for a toy manufacturer in Guangzhou*).

Community trust and ownership

Peer educators told us that many villagers referred to the peer education project as "Pandeng Jiao" (religion of Stepping Stones). During the process of recruiting participants for Stepping Stones sessions and evaluation study, quite a few villagers expressed their confusion: "Do you (the GLOW project staff) belong to Christian missionary or Falun Gong[19]?" This question is reasonable considering the context of missionary activities in Liangshan.

In the background of open religion politics since 1980s, Christian missionary activities revived in1997 in the Liangshan area. According to reports of staff in the Yi center, Christianity has expanded its popularity since 2006 in several GLOW project target villages such as Rekou and Huoluo. In terms of providing public services and eliminating behaviors with high risks for community health, missionary activities and the GLOW project shared similar objectives and contents of activities, and even common implementation ways, such as household visiting, regular meetings, inviting target population to workshops, addressing the risks of old habits or bad behaviors, and further, introducing a new behavior (e.g. using condoms, taking vaccine, and other hygiene habits) or new belief system. Christian missionaries introduced their religious beliefs while NGOs staff such as the GLOW facilitators introduced a biomedical treatment belief.

As long as local villagers interpreted the peer education program as a missionary activity, they were cautious and hesitated about allowing their children to join in it on account the attitude of the local government toward religion. On the one hand, the local authorities supported the people's religious freedom; on the other hand, they kept an eye on diverse religious organizations and their activities to ensure all the activities were legal and harmonized with policies. In addition, parents worried about their children being involved in gangs and learning bad things in a group.

[19] Falun Gong is a system beliefs and ritual practices found by Hongzhi Li in 1992 in China. It spread rapidly between 1992 and 1999 and developed into a folk religious movement in mainland. Falun Gong was declared by Chinese government as "evil cult" since 1999.

It was discovered that village leaders could play an essential role in improving acceptance and trust from communities because they were viewed as representatives of local government. Their support and positive comments were regarded as strong proof that "Pandengjiao" i.e. the peer education was not equal to "Falun Gong" or any other evil cult. Adolescents in communities could participate in such a project without a political risk.

Local villagers appreciated what the project facilitators had done for their communities, and some of them encouraged their children to work as peer educators. However, it was difficult for staff in the Yi center to be identified as members of the target communities rather than as "strangers". Although the community mobilization activities conducted by the GLOW project were designed to cover all relevant stakeholders, many villagers still lacked a feeling of ownership of this project. This project was designed, initiated, implemented and managed by "strangers" not local people themselves. For most common villagers, they were objects of education. They were expected to benefit from peer education but not to make a contribution to it.

It was a pity that local villagers in target communities did not bring their own subjective initiative and creativity into full play. One of crucial reasons for this is that health education was not the priority issue they were confronted with or the most urgent change they wanted to see in their villages. For the local villagers participating in the quasi-structure interviews, the biggest concerns in their communities included epidemics of drugs and HIV/AIDS, environment, economy, out-migration and the decadence of Yi traditional culture with a focus on drug trade and use, infrastructure construction, and economic development. Although many villagers, particularly females thought HIV/AIDS prevention was an urgent issue, they did not list it as the top priority of changes needed by their communities.

Local Yi people did not distinguish the deaths caused by AIDS from the deaths resulted from drug overdose. Thus they were shaken by tragedies of the families destroyed by drug use and related criminal behaviors such as drug use, stealing and robbing, but they were not strongly affected by the harmfulness of HIV/AIDS without "compelling evidence". In their minds, it is drug use but not HIV/AIDS that was severely threatening their lives. It will take time for them to understand and accept the connection between this disease and their sexual behaviours.

Relationship between local government and NGOs

As a comprehensive program, the GLOW project depended on cooperation and collaboration of multiple organizations and agencies to be smoothly implemented. To fulfill the objective of training girls and introducing jobs for them, Mercy Corps and the Yi Center cooperated with related government bureaus such as Education Bureau, Liangshan Prefecture Labor Bureau and other International NGOs such as PATH and local NGOs such as Zhaojue Youths Vocational Training Center and the county Women's Federation. For conducting peer education, the Yi Center mainly coordinated with county government and county CDC.

Town government in Zhuhe had a complicated and even paradoxical attitude towards the Yi Center. They hoped it could contribute to developing local

communities in terms of fighting drug and HIV/AIDS epidemic They also had a concern about its social network which is a potential social power to influence the government and make use of its resources. The social network of Yi center expanded from different ranks of governments in Liangshan to research institutes and various media and news agencies, from Yi paternal clans to international organizations[20]. They also wished to put this NGO under surveillance as it may report incidents that may be embarrassing to the government, while treating it as a collaborative partner.

The leaders of the Yi Center were always making efforts to keep its financial and administrative independence and autonomy. However, as the GLOW project progressed, they realized that community mobilizing and participant recruiting would not be successful without the approval and support of local officials. The project facilitators and particularly the peer educators suggested that their activities in the villages were affected by whether the village cadres would like to support the activities in the Youth Clubs.

When asked about problems encountered, Muqie, a male peer educator described the difficulties in organizing the entertainment activities and teaching the Stepping Stones sessions:

> *Since the village committee provides their meeting room as the Youth Club activity room, the cadres also take charge of the security and help peer educators to maintain order of the Youth Club. When we teach the Stepping Stones, there are always many curious kids who are trying to burst into the room. They make noises and might break the door, which annoys the neighborhood. The cadres have authority in front of the youths in their villages. Thus the kids don't dare to go against their words. (Muqie)*

He then addressed the key role of village cadres in overcoming such difficulties.

> *Some cadres supported our work so they would like to keep order for our activities and explained the significance of peer education to the villagers and coordinated with the neighborhood. Some cadres didn't like our project, and they blamed us for the noises and damage of their meeting rooms due to conducting peer education. In such situation, it was hard to continue our working in the villages. (Muqie)*

CONCLUSIONS

It will never be easy to introduce biomedical knowledge of a new disease (HIV/AIDS) and spread health promotion behaviours (safe sexual behaviors) in communities where most of its members have their own traditional medical beliefs. For most Yi people in the target communities, traditional medical belief will remain and function in their lives for quite a long period. The key point is how to represent

[20] The founders of the Yi Center are Yi elites in the areas of political and culture, etc. Quite a few of them are either scholars in academic institutes or officials in governments. Their students, colleagues, friends and clans compose of a huge social network across government and non-government organizations.

HIV/AIDS within the indigenous knowledge system; or how to integrate the knowledge of HIV/AIDS with their existing medical belief so that Yi people can understand the connections between risk of being infected by HIV and their behaviours. As Liu Xiaojun pointed, when a society confronts a new knowledge system from outside, some members within this society will be empowered as "local experts" to interpret new knowledge and test if it will benefit the whole society (Liu, 2005). Those local experts usually have a good reputation in their communities and understand traditional culture and values in their societies. They are trusted because of their capacity and authority in some specific areas. For Yi communities, clan leaders, Degu (social coordinators in communities) and Bimo are regarded as essential experts and wise men among people. They would have played a more crucial role during the process of understanding, representing and taking advantage of new knowledge.

It is a pity that the GLOW project did not enable Bimo in the target communities to positively participate in the activities of peer education. As the traditional healers and religious people, Bimo function as primary health practitioners in a diverse and pragmatic health care system on the one hand, and function as folk intellectuals of Yi traditional culture and authorities of indigenous medical belief on the other hand. In fact, their attitudes toward biomedicine are flexible and open. Based on our interviews, Bimos in local communities have heard of HIV/AIDS, but they have not yet developed a mature strategy to interpret and deal with this disease. It is possible to encourage them to learn more about HIV/AIDS and inspire them to integrate new concepts into existing medical beliefs so that they can persuade Yi people to protect them from high risk behaviours.

Although the quantity of NGOs in China has been significantly increasing these years and they have launched and/or participated in numerous programmes in diverse areas of public health and community development, the experience of the GLOW project indicates that the government is still a key partner in multi-agency cooperation, particularly for implementing projects in rural areas. The approval and support of the government is necessary to launch a project in local communities because without such a permit project facilitators cannot even enter target villages. Moreover, it will be hard to obtain trust of communities without the cooperation of the local cadres who are political authorities in the eyes of local people. Support from local government is very helpful in terms of eliminating confusion and suspicion of communities because most villagers believe that participating in a project advocated by the government will not result in political troubles.

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ISBN 978-0-473-18206-9